SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room
Plot No.5, Survey No. 83/1 Survey No. 83/1, Hyderabad, Knowledge City Rd, Madhaur, Telanga 500081, India

AGENDA
July 26, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

The Board of Directors will call the meeting to order at 4:30 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 4:35 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:00 P.M. or via Zoom: https://svmc.zoom.us/j/85249774335

Call to Order/Roll Call

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

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

II. **Adjourn Open Session and go into Closed Session**

CLOSED SESSION

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

III. **Public Comment**

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all

interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment.

IV. Closed Session Business

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report (Time Limit – 5 minutes)

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): (Time Limit – 5 minutes)

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 21-001051 (Time Limit – 5 minutes)

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (2 Items). Estimated Date of Disclosure – February 2023 (Time Limit – 10 min)

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (2 Items). Estimated Date of Disclosure – December 2022 (Time Limit – 10 min)

F. 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); Pursuant to Evidence Code Sections 1156 and 1157, 1157.7; Health and Safety Code Section 32106(b) and Health and Safety Code Section 32155 (1 Item)(Time Limit – 20 min)

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 (1Item)

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

V. Adjourn Closed Session and go into Open Session

OPEN SESSION

VI. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. Conference with Legal Counsel regarding BETA Claim No. 21-001051
Recommended Action: Approve/Reject BETA Claim No. 21-001051

D. Discussion Regarding Trade Secret
Recommended Action: Approve/Disapprove

E. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

F. Conference with Legal Counsel
Recommended Action: Information only; no action taken

G. Conference with Legal Counsel about recent work product
Recommended Action: Information only; no action taken

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VII. Public Comments

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

VIII. Consent Agenda
Recommended Action: Approve Consent Agenda as presented

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

IX. Approval of Minutes

A. June 28, 2022 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove June 28, 2022 Minutes of the Regular Meeting of the Board of Directors

X. CEO Report

XI. Business Items

A. **June 2022 Financials**
Recommended Action: Approve/Disapprove

B. **Censure of Director Gaurang Pandya, MD**
Recommended Action: Approve/Deny

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XII. Announcements:

A. Regular Board of Directors Meeting – August 23, 2022 at 4:30pm

B. Ethics Training

XIII. Adjournment

SPECIAL NOTICE

Pursuant to Executive Order N-25-20 signed by Governor Newsom on March 12, 2020, and in an effort to protect public health and slow the rate of transmission of COVID-19, Sierra View Local Health Care District is allowing for electronic public participation at Regular Board Meetings. Public comments may be submitted to wwatts@sierra-view.com and will be read aloud during Public Comments as applicable, for Board consideration. Members of the public are encouraged to submit comments prior to 4:00 p.m. the day of the meeting to participate in said meeting.

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Fuentes, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 5:00 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

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MEDICAL EXECUTIVE COMMITTEE	07/06/2022
BOARD OF DIRECTORS APPROVAL	
	07/26/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
July 26, 2022 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

		Pages	Action
I.	**Policies**:		**APPROVE** ↓
	• Administration of Hepatitis B Vaccine to Employees	1-4	
	• Administration of Influenza Vaccine to Inpatients	5-7	
	• After Pharmacy Hours	8	
	• Antibiotic Stewardship Program for DP/SNF	9-13	
	• Antimicrobial Stewardship	14-18	
	• Assessment-Joint Mobility	19-20	
	• Assistive Devices	21	
	• Deaths Reportable to Coroner	22-23	
	• Documentation and Record Keeping – DP/SNF	24-25	
	• End of Life Issues	26-27	
	• Enteral Nutrition Orders	28-29	
	• Hypertonic Saline Intravenous Administration	30-32	
	• Occupational HIV Post-Exposure Prophylaxis	33	
	• Passy-Muir Speaking Valves	34-40	
	• Patient Identification and Program Engagement	41-42	
	• Pediatric Medication Administration Guidelines	43-46	
	• Prescriber Dispensing for Discharges after Community Pharmacy Hours	47-49	
	• Restraint Use – Medical/Surgical and Behavioral Restraint	50-58	
	• Sterile Hazardous Drug Handling	59-78	
II.	**Forms:**		
	• Consent to Surgery/Special Diagnostic/Therapeutic Procedure	79-81	
III.	**Advanced Privileges ED Mid-Levels:**		
	• Protocols	82-99	
	• Revised Privilege Form – Nurse Practitioner Emergency Dept.	100-102	
	• Revised Privilege Form – Physician Assistant Emerg. Dept. (Note: Approval for ED mid-level advanced privileges will be requested with Credentials on Medical Executive Committee report. Provided on Consent Agenda for convenience of advance review.)	103-105	

SUBJECT: **ADMINISTRATION OF HEPATITIS B VACCINE TO EMPLOYEES**	SECTION: **Page 1 of 4**

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

POLICY

PURPOSE: To assure that a standard procedure is in place for the administration of hepatitis B vaccine to candidate employees who meet specific criteria set by the Centers for Disease Control and Prevention (CDC) for vaccination.

A. **BACKGROUND**: Hepatitis B is one of a number of vaccine-preventable communicable diseases. Having eligible employees vaccinated against hepatitis B will greatly reduce morbidity and mortality within the hospital from the hepatitis B virus (HBV). Employee eligibility for hepatitis B vaccination is defined by the Advisory Committee on Immunization Practices (ACIP) of the CDC.

B. **PREREQUISITES**: According to the CDC, in order to be eligible for hepatitis B vaccination, the following criteria must be met:
   a. The candidate employee must be 18 years of age or older
   b. The employee has not yet received a complete hepatitis B vaccine series
   c. The employee is part of a group that has an occupational risk of infection through exposure to blood or blood-contaminated bodily fluids. This includes health care workers, public safety workers, trainees in a health professional or allied health school, housekeeping staff and others.

C. **CONTRAINDICATIONS AND PRECAUTIONS**:
   a. The candidate employee has experienced anaphylactic reactions to a prior dose of the vaccine or any of the vaccine's components. (See the manufacturer's package insert for a list of vaccine components, or visit the website www.immunize.org/fda for package inserts or vaccine product approvals.)
   b. Candidate employees with moderate or severe acute illness with or without fever should wait until resolution of the acute illness
   c. Pregnancy testing is not required before vaccination, but of the vaccines available, the following vaccines, Engerix-B, Recombivax HB or Twinrix, have data that supports safe vaccination during pregnancy. Thus, providers should vaccinate pregnant people needing hepatitis B vaccination with one of these 3 vaccines

D. RESPONSIBILITIES:
   a. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN) or a physician (MD or DO).
   b. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language, must be provided to the vaccine recipient and recorded, along with the publication date of the VIS, in the medical record or office log. (See Appendix A for a hyperlink to examples in various languages.)

PROCEDURE

A. **Assess** the employee for the need of HBV vaccination. This is accomplished by authorized personnel reviewing the employee records for vaccination status.

B. **Screen** the candidate employee for precautions and contraindications against HBV vaccination, which include but is not limited to:

   a. Precautions
      i. Moderate or severe acute illness (with or without fever)
   b. Contraindications
      i. A history of a severe allergic reaction (anaphylaxis to a vaccine component or following a prior dose of the same vaccine
      ii. A history of hypersensitivity to yeast

C. **Education**: provide the VIS form and document that the form was given (see Documentation for instructions)

D. **Prepare** materials to administer the vaccine
   a. See **Table A** to select the appropriate needle gauge, length and injection site

E. **Administer** the HBV vaccine and notify the recipient of the vaccination schedule
   a. See **Table B** for criteria and guidance on dosage, route and vaccination schedule

F. Be prepared to manage any **medical emergency** related to the administration of the vaccine. The recipient should be monitored for at least 15 minutes after administration of the vaccine. The following items should be available at the time of vaccination:
   a. A written emergency protocol specifically for vaccination reactions
   b. Equipment and or medications described in the written emergency protocol

G. **Documentation**: Document the vaccination in the medical record, if kept, the Employee Health log and complete the personal immunization record card. Items that should be documented in the medical record are:
   a. Date of vaccination and number of the series
   b. The manufacturer and lot number
   c. The vaccination site and route
   d. The name and title of the person administering the vaccine
   e. Note if the VIS was provided to the recipient. Also include the language and publication date of the VIS
   f. Record if the vaccine was not administered, record the reason(s), and discuss the need for vaccination with the candidate employee.

REFERENCES:

Weng MK, Doshani M, Khan MA, et al. Universal Hepatitis B Vaccination in Adults Aged 19–59 Years: Updated Recommendations of the Advisory Committee on Immunization Practices — United States, 2022. MMWR Morb Mortal Wkly Rep 2022; 71:477–483.
DOI: http://dx.doi.org/10.15585/mmwr.mm7113a1external icon.

State Immunization Laws for Healthcare Workers and Patients - Immunization Administration Requirements For State: CA. Retrieved May 24, 2022; Page last reviewed: November 19, 2014. https://www2a.cdc.gov/vaccines/statevaccsApp/Administration.asp?statetmp=CA

Hall E., Wodi A.P., Hamborsky J., et al., eds. Epidemiology and Prevention of Vaccine-Preventable Diseases (*The Pink Book*). 14th ed., P 143 – 164. Centers for Disease Control and Prevention. Washington, D.C. Public Health Foundation, 2021.

Vaccine Information Statements (VISs), Current VISs. Vaccine Information Statements Website, Centers for Disease Control and Prevention. Last reviewed June 2, 2022. Available on the internet at: https://www.cdc.gov/vaccines/hcp/vis/index.html

Roush, S.W., Baldy, L.M., Hall, M.A.K., eds. Centers for Disease Control and Prevention. Manual for the surveillance of vaccine-preventable diseases. Retrieved May 24, 2022; page last reviewed: April 1, 2014; originally published in 1996. Centers for Disease Control and Prevention, Atlanta, GA. Available on the internet at: www.cdc.gov/vaccines/pubs/surv-manual/

Shefer, A., Atkinson, W., Friedman, C., et al. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Recommendations and Reports, MMWR Morb Mortal Wkly Rep 2011; 60(RR07);1-45. Retrieved May 24, 2022; Available on the internet at: https://www.cdc.gov/mmwr/indrr_2011.html

Immunize.org for Professionals. Standing Orders for Administering Hepatitis B Vaccine to Adults, 2009. Available on the internet at: www.immunize.org/catg.d/p3076.pdf item #P3076 (retrieved 4/22).

California Code of Regulations: 22 CCR 5 § 70739 Licensing and Certification of Health Facilities, Home Health Agencies, Clinics and Referral Agencies, Chapter 1, General Acute Care Hospitals.

TABLES:

Table A – Prepare to Administer Vaccine, guide to choose the needle guage, needle length and injection site according to the following chart (Modified from *Standing Orders for Administering Hepatitis B Vaccine to Adults*)

Gender & Weight	Needle Gauge	Needle Length	Injection Site
Female or male 130 – 200+ lbs	22 – 25	1" – 1 ½"	Deltoid muscle of arm
Female or male Any weight	22 – 25	1" – 1 ½"	Anterolateral thigh muscle

Table B – Recommended doses and schedules of hepatitis B vaccine, Engerix-B, for adults >18 years and persons between 11-19 years (Modified from *MMWR, Vol. 71, No.13, 2022*.)

HepB vaccine/Age	Dose (ug)	Vol (mL)	Schedule
Engerix-B			
11 – 19 years	10	0.5	3 doses: 0, 1, 6 mos
≥ 20 years	20	1.0	
Adults: HD and IC*	40	2.0	4 doses: 0, 1, 2, 6 mos

* Adults ≥ 20 years, HD = hemodialysis; IC = immunocompromised

APPENDIX A

To find the most current VISs in different languages go to the CDC or Immunize.org websites via the following hyperlinks:

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.html

https://www.immunize.org/vis/

SUBJECT:	SECTION:
ADMINISTRATION OF INFLUENZA VACCINE TO INPATIENTS	***Surveillance, Prevention, Control of Infection (IC)***

POLICY:

1. Function(s): Administration of influenza vaccine to all inpatients who meet criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

2. Circumstances:

   a. Setting: Any inpatient meeting criteria (as stated below)

   b. Condition/Contraindications: Any inpatient in need of influenza vaccine, meeting criteria (as stated below). See procedure for contraindications.

   c. Other: None

PROCEDURE:

1. Definition: Nurses that have met initial and annual internal competencies will utilize the following parameters to identify inpatients in need of influenza vaccine and subsequently vaccinate these patients.

2. Data Base: (October 1st thru March 31st only)

   a. Subjective: N/A

   b. Objective:

      - All patients > or = 6 months of age
      - Patient with chronic medical disorders

3. Screen for contraindications and precautions to influenza vaccine:

   a. Serious reaction (e.g. anaphylaxis) after ingesting eggs or after receiving a previous dose of influenza vaccine or an influenza vaccine component.

   b. Already immunized this flu season

   c. Admitted from long-term care facility that routinely immunizes residents

   d. Fever (38 C/100.4 F or above)

   e. History of Guillain-Barre Syndrome

   f. Physician orders to withhold influenza vaccine

g. Patient Refused—NOTIFY PHYSICIAN

4. Plan: Vaccinate all inpatients who meet criteria with influenza vaccine

a. Treatment:

- Screen all adults for contraindications and precautions to influenza vaccine
- For age 9 and older, administer manufacturer's recommended dose of injectable quadrivalent inactivated influenza vaccine IM (22-25g, 1-1 ½" needle) in the deltoid muscle. For ages 6 months to 8 years, please see manufacturer's recommendations on dosage and administration for pediatrics.
- Monitor for serious side effects (i.e. anaphylaxis)
- Consultation Required: None

b. Education: Provide a copy of the most current federal Vaccine Information Statement (VIS). You must document in the patient's medical record or office log, the publication date of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language, if available. These can be found at www.immunize.org/vis.

c. Follow-up: Reassess patient in 30 minutes or less as needed. Annual vaccinations of influenza vaccine are needed to ensure adequate protection from influenza.

5. Documentation:

a. **Electronic Medical Record:** Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal).

STAFF AUTHORIZED TO PERFORM THE VACCINATION: **Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician Assistant (PA), Physician (MD or DO)**

REQUIREMENTS FOR ADMINISTRATION:

1. Education: Licensed Personnel (LVN, RN, FNP, PA, MD)

2. Training: As required by initial and annual internal competencies

3. Experience: N/A

4. Initial Evaluation: Review of CDC immunization criteria

5. Continuing Evaluation: Annually

DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

A. **Method:** Infection Prevention Committee, Infection Prevention Manager, and Medical Director of Infection Prevention.

B. **Review Schedule:** Yearly

REFERENCES:

- Centers for Disease Control and Prevention (CDC) (2017). Seasonal Influenza Vaccine Dosage and Administration. Retrieved from www.cdc.gov/flu/about/qa/vaxadmin.htm . ~~Page last reviewed: November 16, 2020.~~ Page last reviewed: November 16, 2020.

- Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices— United States, 2020–21 Influenza Season. (2020, August 21). Retrieved from Centers of Disease Control and Prevention: https://www.cdc.gov/mmwr/volumes/69/rr/rr6908a1.htm?s_cid=rr6908a1_w . ~~Page last reviewed: August 20, 2020.~~ Page last reviewed: August 20, 2020.

- Seasonal Influenza Vaccination Resources for Health Professionals. (2020, January 3). Retrieved from CDC: Centers for Disease Control and Prevention: https://www.cdc.gov/flu/professionals/vaccination/index.htm . ~~Page last reviewed: September 16, 2021.~~ Page last reviewed: September 16, 2021.

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SUBJECT: **AFTER PHARMACY HOURS**	SECTION: **Page 1 of 1**

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PURPOSE:

To define the procedure to be followed during the hours when the inpatient pharmacy is closed.

POLICY:

The Department of Pharmacy will provide pharmaceutical care during the hours when the pharmacy is closed.

AFFECTED AREAS/PERSONNEL: *NURSING; PHARMACY*

PROCEDURE:

A. Medication Orders when the pharmacy is closed

1. Tele-pharmacy services will review and process orders for medications when Sierra View's pharmacy is closed.

2. Tele-pharmacy will be available to answer questions related to medication orders that were processed and call the nurse caring for the patient for questions and or the prescriber for clarification regarding the medication order.

3. Sierra View will have a staff pharmacist on-call to come into the hospital as needed or to provide consultative services as needed while the pharmacy is closed.

4. At the conclusion of the tele-pharmacy shift a "End of Shift Hand Off Report" will be delivered to the oncoming SVMC pharmacy staff so that unresolved patient care issues, consults, etc., will be received and follow up can occur.

B. Medication Disposition

1. On a daily basis, the pharmacist will review the medication override list and follow the procedure found in PYXIS MEDICATION OVERRIDES AND DISCREPANCY .

2. The Pyxis will record name of drug, strength, amount removed, date and time, the name of the patient to whom the drug was administered and name of nurse removing the drug.

REFERENCES

- Pharmacy Law: California Edition. (2019) San Clemente, California: Law Tech Publishing Group.

SUBJECT: **ANTIBIOTIC STEWARDSHIP PROGRAM FOR DP/SNF**	SECTION: **Page 1 of 5**

PURPOSE:

Sierra View Medical Center (SVMC) is committed to optimizing antimicrobial therapy while minimizing unintended outcomes, including medication toxicity, increased antimicrobial resistance, and unwarranted costs.

DEFINITIONS:

Antimicrobial Stewardship: A program with the intentions to comply with mandated California Senate Bill 739, and program requirements for Long Term Care facilities by California Department of Public Health (CDPH) and Centers for Disease Control and Prevention (CDC). The Antimicrobial Program is an organizational priority to improve the process of appropriate selection, dosing, route of administration and duration of antimicrobial therapy. A multidisciplinary approach is utilized to collect and analyze data in an effort to slow the emergence of antimicrobial resistance and transmission of resistant pathogens.

ANTIMICROBIAL STEWARDSHIP COMMITTEE:

The DP/SNF has an Antibiotic Stewardship Committee that meets & reports quarterly during the Infection Control Committee meeting. Antibiotic Use is being reported on a weekly basis by the DP/SNF Infection Control Officer to the Interdisciplinary Team (IDT) during the IDT meeting. This Committee is a subcommittee of the Pharmacy &Therapeutics (P&T)/Infection Control Committee of the Hospital with the intention to develop and implement a Centralized Antimicrobial Stewardship Program. The program will strive to foster collaboration between the DP/SNF and SVMC Pharmacy and Medical Staff in the appropriate utilization of antibiotics.

Members of the DP/SNF Antimicrobial Stewardship Team may include but are not limited to:

- Infection Control Officer (Designated Team Leader)
- Medical Director/Physician
- Director of DP/SNF
- Clinical Manager
- DP/SNF Pharmacist (Model Drug Pharmacy)
- Nurses

The P&T/Infection Control Committee is chaired by an infectious disease physician who will work closely with other committee members including clinical pharmacists, pharmacy administration, the Infection Prevention Department and the Department of Microbiology to provide guidance and education on the appropriate use of antimicrobials.

Members of the Housewide Antimicrobial Stewardship Team may include but are not limited to:

- Infectious Disease Physician
- Clinical Pharmacist (SVMC)
- Infection Prevention
- Clinical Microbiologist
- Clinical Information System Analyst
- Primary Nurse
- Dietitian

Antibiotic Stewardship Meetings by P&T/Infection Control Committee will be held at a minimum of annually to review analyzed data and discuss agenda items that will assist in meeting the following Antimicrobial Stewardship goals.

SUMMARY OF CORE ELEMENTS OF HOSPITAL ANTIBIOTIC STEWARDSHIP PROGRAMS

- Leadership Commitment: Dedicating necessary human, financial and information technology resources
- Accountability: Appointing a single leader responsible for program outcomes. Experience with successful programs show that a physician leader is effective.
- Drug Expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use.
- Action: Implementing at least one recommended action, such as systemic evaluation of ongoing treatment need after a set period of initial treatment (i.e. "antibiotic time out" after 48 hours)
- Tracking: Monitoring antibiotic prescribing and resistance patterns
- Reporting: Regular reporting information on antibiotic use and resistance to doctors, nurses and relevant staff
- Education: Educating clinicians about resistance and optimal prescribing

Goals

- Promotion of appropriate use of antimicrobials
- Minimization of antimicrobial resistance

- Prevention of antimicrobial toxicity
- Improvement of patient outcomes
- Utilization of education to expand Antibiotic Stewardship practices to all healthcare employees, patients and their families.

POLICY COMPLIANCE / KEY ELEMENTS:

The Clinical Pharmacists will work with the interprofessional team to optimize the utilization of antimicrobials and to avoid the potential consequences of inappropriate antimicrobial therapy. This includes, but is not limited to:

- The selection of appropriate antimicrobials including empiric regimens based on evidence-based national guidelines site.
- The timely initiation, escalation, de-escalation and duration of antimicrobial therapy.
- The proper dosing, frequency, route and administration time of antimicrobial agents.
- The monitoring and tracking of related labs, cultures, drug-bug mismatch, and sensitivity in assessing optimization of antimicrobial therapy.
- The avoidance of toxicity.
- The avoidance of emergence of antimicrobial resistance or the development of hospital acquired infections (HAI).
- The prevention of increased morbidity and mortality.
- Identification of redundant therapy.
- The annual education of staff involved in antimicrobial ordering , dispensing, administration, and monitoring about antimicrobial stewardship practices through hospital-wide competency program.
- The education of patients and their families regarding the appropriate use of antimicrobial medications.

AFFECTED PERSONNEL/AREAS: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

The Clinical Pharmacist will employ antimicrobial stewardship practices that include the appropriate selection, dosing, route of administration and duration of antimicrobial therapy. Examples of strategies to be employed include, but are not limited to, the following:

- Vancomycin and aminoglycoside dose adjustments as allowed per policy.
- IV to PO conversion when appropriate, as allowed per policy.
- Renal dosage adjustments/recommendations, as allowed per policy.
- A seven days auto-stop implementation for duration of antimicrobial therapy, which may be extended if therapeutically warranted after a renewal re-assessment by the prescriber and pharmacist's verification.
- Avoid delays in initiation of appropriate antimicrobial therapy when ordered by the prescriber.
- Collaborate with the Infection Preventionist on monitoring drug-bug mismatches in cultures and susceptibilities and notifying the prescriber if a change in antimicrobial therapy is indicated.
- Direct interaction and feedback with the prescribers, nursing, lab and infection prevention.
- Documentation of monitoring, adjustments and interventions performed by pharmacy.

TRACKING AND REPORTING:

Pharmacists:

- Over the following year, pharmacy will track interventions/recommendations made to prescribing physicians and percent accepted will be calculated.
- The results will be analyzed and reported at Antibiotic Stewardship Committee and P&T Committee quarterly.

Infection Prevention:

- Infection Preventionist (IP) will conduct monitoring and prevention of hospital-associated infection and will analyze and report outcomes. Specifically, MDROs will be tracked to identify trends and report results to P&T and IP.
- IP will educate staff on strategies to optimize the use of antibiotics.

REFERENCES:

- ASHP Midyear 2016 , Emerging Issues in Antimicrobial Resistance, , American Society of Health-System Pharmacists, Inc.
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- Silvers J, Martinez C., Antimicrobial Stewardship Program Development. March 26, 2015.

- World Health Organization (WHO) Antimicrobial Resistance. Fact Sheet. Retrieved on July 31, 2020 ~~June 30, 2015~~ from http://www.who.int/mediacentre/factsheets/fs194/en.

CROSS REFERENCES:

- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. IV to PO Dosage Form Conversion Protocol
- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. Renal Dosage Adjustment Protocol
- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. Aminoglycoside Protocol Per Clinical Pharmacist
- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. Vancomycin Protocol Per Clinical Pharmacist

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SUBJECT:	SECTION:
ANTIMICROBIAL STEWARDSHIP	***Medication Management (MM)*** **Page 1 of 5**

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

PURPOSE:

Sierra View Medical Center is committed to optimizing antimicrobial therapy while minimizing unintended outcomes, including medication toxicity, increased antimicrobial resistance and unwarranted costs.

DEFINITIONS:

Antimicrobial Stewardship: A program with the intentions to comply with both the mandated California Senate Bill 739, and The Joint Commission Standard MM.09.01.01. The Antimicrobial Stewardship program is an organizational priority to improve the process of appropriate selection, dosing, route of administration and duration of antimicrobial therapy. A multidisciplinary approach is utilized to collect and analyze data in an effort to slow the emergence of antimicrobial resistance and transmission of resistant pathogens.

ANTIMICROBIAL STEWARDSHIP COMMITTEE:

The Antimicrobial Stewardship Committee is a subcommittee of the P&T/Infection Prevention Committee with the intention to develop and implement the Antimicrobial Stewardship program. The program will strive to foster collaboration between the Pharmacy and Medical Staff in the appropriate utilization of antibiotics.

The Committee is chaired by an infectious disease physician who will work closely with other committee members including clinical pharmacists, pharmacy administration, the Infection Prevention department and the department of Microbiology to provide guidance and education on the appropriate use of antimicrobials.

Meetings will be held at a minimum of annually to review analyzed data and discuss agenda items that will assist in meeting the following Antimicrobial Stewardship goals.

Goals:

- Promotion of appropriate use of antimicrobials
- Minimization of antimicrobial resistance
- Prevention of antimicrobial toxicity
- Improvement of patient outcomes
- Utilization of education to expand Antibiotic Stewardship practices to all healthcare employees, patients and their families

Members of the antimicrobial stewardship team may include but are not limited to:

- Infectious Disease Physician
- Clinical Pharmacist
- Infection Preventionist
- Clinical Microbiologist
- Clinical Information System Analyst
- Primary Nurse
- Dietitian

POLICY COMPLIANCE: KEY ELEMENTS:

The Clinical Pharmacists will work with the interprofessional team to optimize utilization of antimicrobials and to avoid the potential consequences of inappropriate antimicrobial therapy. This includes, but is not limited to:

- The selection of appropriate antimicrobials including empiric regimens based on evidence-based national guidelines and the organization's most recent antibiogram, which is available via link on the organization's Intranet site.
- The timely initiation, escalation, de-escalation and duration of antimicrobial therapy.
- The proper dosing, frequency, route and administration time of antimicrobial agents.
- The monitoring and tracking of related labs, cultures, drug-bug mismatch, and sensitivities in assessing optimization of antimicrobial therapy.
- The avoidance of toxicity.
- The avoidance of emergence of antimicrobial resistance or the development of hospital acquired infections (HAI).
- The prevention of increased morbidity and mortality.
- Identification of redundant therapy.
- The minimization of hospital length of stay and healthcare costs.
- The annual education of staff involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial stewardship practices.

- The education of patients and their families regarding the appropriate use of antimicrobial medications.

AFFECTED PERSONNEL/AREAS: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

- The clinical pharmacist will employ antimicrobial stewardship practices that include the appropriate selection, dosing, route of administration and duration of antimicrobial therapy. Examples of strategies to be employed include but are not limited to the following:
    - Vancomcyin and aminoglycoside dose adjustments as allowed per policy.
    - IV to PO conversion when appropriate as allowed per policy.
    - Renal dosage adjustments/recommendations as allowed per policy.
    - A seven days auto-stop implementation for duration of antimicrobial therapy, which may be extended if therapeutically warranted after a renewal re-assessment by the prescriber and pharmacist's verification.
    - Will work with ACS in the development and maintenance of evidence-based (most recent organizational antibiogram & current IDSA guidelines) infectious disease order sets.
    - Avoid delays in initiation of appropriate antimicrobial therapy when ordered by the prescriber.
    - Collaborate with the Infection Preventionist on monitoring daily reports for drug-bug mismatches in cultures and susceptibilities and notifying the prescriber if a change in antimicrobial therapy is indicated.
    - Direct interaction and feedback with the prescribers, nursing, lab and infection prevention.
    - Documentation of monitoring, adjustments and interventions performed by pharmacy.
    - Pharmacists may order the following when criteria is met;
        - MRSA nasal screen- for patients on pharmacy to dose vancomycin protocol for a pneumonia indication. This may direct pharmacists to recommend discontinuation to prescribing MD.
        - Procalcitonin- To guide pharmacists recommendation to MD's for antibiotic therapy based on the following inclusion/exclusion criteria:
            - Inclusion criteria: Sepsis (SIRS, sepsis, severe sepsis, septic shock), Lower respiratory tract infections (pneumonia, COPD exacerbations, bronchitis)
            - Exclusion criteria: ESRD/HD, trauma, post-surgery, cardiac shock, pancreatitis, neoplasm of thyroid, small cell lung CA, neonates (<72hrs), recent IVIG therapy

TRACKING AND REPORTING:

Pharmacists:

- Pharmacy will track interventions/recommendations made to prescribing physicians and percent accepted will be calculated.
    - Tracking and Analysis of data will be performed using Clinical Surveillance software
- The results will be analyzed and reported at antibiotic stewardship committee and P&T quarterly.
    - Infection Prevention
    - Infection Preventionists (IP) will conduct monitoring and prevention of hospital-associated infection and will analyze and report outcomes. Specifically, MDROs will be tracked to identify trends and report results to P&T/IP.
    - IP will educate staff on strategies to optimize the use of antibiotics.
- Clinical Pharmacist will document antimicrobial stewardship interventions. These interventions are evaluated for subsequent reporting to the appropriate committees and will be analyzed to aid in the development of future performance improvement initiatives.

Institutional Reporting:

- SVMC will upload monthly antibiotic utilization data to the Center for Disease Control's National Healthcare Safety Network. This data will be void of any identifiable patient information and shall be reviewed by a pharmacist and a quality improvement analyst prior to submission.

REFERENCES:

- ASHP statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control. Copyright ©2009, American Society of Health-System Pharmacists, Inc. Pgs. 228-230.
- California Department of Public Health. Healthcare-Associated Infection (HAI) Program. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialStewardshipLandingPage.aspx. Accessed March 21, 2022.
- CDC. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2019. http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html. Accessed March 21st, 2022.

- E. Kastango, K. St John, D. Weber, Pharmacy Services. APIC Text of Infection Control and Epidemiology Copyright © 2009, Association for Professionals in Infection Control and Epidemiology, Inc. Pgs. 61-1 thru 61-7. 2)
- Infectious Diseases Society of America. Infection prevention and control of health care-associated infection. http://www.idsociety.org/Infection_Control_Policy/. Accessed 30JUN17.
- The Joint Commission. National-Hospitals Standards Manual. https://powerdms.com/manuals/publication/83753?tabid=general&nodeid=20985652. Accessed March 21, 2022.
- Schuetz, Philipp. Et al. Procalcitonin (PCT)- guided antibiotic stewardship: an international experts consensus on optimized clinical use. https://pubmed.ncbi.nlm.nih.gov/30721141/. Accessed April 7th, 2022.
- Predictive value of MRSA nasal swab in PCR assay in MRSA pneumonia. https://www.ncbi.nlm.nih.gov/pubmed/24277023. Accessed March 21, 2022.
- World Health Organization (WHO) Antimicrobial resistance. Fact sheet. http://www.who.int/mediacentre/factsheets/fs194/en. Accessed 30JUN15.

CROSS REFERENCES:

- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. IV to PO Dosage Form Conversion Protocol
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SUBJECT:	SECTION:
~~ASSESSMENT- JOINT MOBILITY~~ ~~ASSESSMENT- JOINT MOBILITY~~	**Page 1 of 2**

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PURPOSE:

To determine a resident's range of motion for all major joints and to implement plans of care to increase, maintain, or prevent deterioration of joint mobility.

POLICY:

It is the policy of this facility to assess all residents for joint mobility limitations upon admission and at a minimum of every three months thereafter.

AFFECTED PERSONNEL/AREAS: *PHYSICAL THERAPIST, REGISTERED NURSE (RN)*

PROCEDURE:

1. Upon admission, each resident will be assessed for limitations in joint mobility by a licensed nurse.

2. Limitations in joint mobility will be defined in the following terms:

   a. FRM – full range of motion/no limitation

   b. Minimal – represents a decrease in joint mobility of approximately 1 to 40% of the normal range of motion

   c. Moderate – represents a decrease in joint mobility greater than 50% to approximately 75% of the normal range of motion

   d. Severe – represents a decrease in joint mobility greater than 75% to approximately 100% of the normal range of motion

3. The Physical Therapist will assess each joint for range of motion and document findings on the Joint Mobility section in PCS. For each joint, indicate the degree of mobility. Date and then update reassessment and changes. This will show progress or lack of progress.

4. The information is used to assist in developing or modifying a plan of care, especially in the areas of physical functioning such as positioning, locomotion, and activities of daily living (dressing, grooming, and eating).

5. The RN will assess the effectiveness of the plan of care and the resident's response to treatment on a weekly basis in the licensed weekly summary.

6. The mobility assessment is then used to reassess the overall joint mobility of each resident on an as needed and/or quarterly basis.

7. Resident care plans are updated as necessary.

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8. Assessments or evaluations may be requested if interventions prove ineffective or complications occur requiring therapy expertise.

REFERENCES:

- Med Pass, Inc., (updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25. United States of America, Med Pass Inc.
- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, -22 CCR § 72403, 22 CA ADC § 72403, San Francisco, California, Title 22. ~~(This database is current through 1/29/21 Register 2021, No. 5)~~

SUBJECT:	SECTION:
ASSISTIVE DEVICES~~ASSISTIVE DEVICES~~	Page 1 of 1

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PURPOSE:

To compensate for patients inability to handle standard utensils, cups or plates; adaptive equipment is provided.

POLICY:

The hospital will provide assistive eating devices for residents who require them.

AFFECTED PERSONNEL/AREAS:

OCCUPATIONAL THERAPIST, SPEECH THERAPIST, DIETICIAN, NURSING

PROCEDURE:

1. Upon the recommendation of the Interdisciplinary Team, an Occupational Therapist, Speech Therapist, or Dietician will evaluate, recommend and order adaptive equipment.
2. Food and Nutrition Services will wash and track adaptive equipment.
3. Plan of care will be developed specific to each resident's needs and will be reviewed on an ongoing basis by the Interdisciplinary Team.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 22 CCR § 72419, § 87608~~ 22 CA ADC~~ § 72419, San Francisco, California, Title 22.~~ (This database is current through 1/29/21, Register 2021, No.5)~~

SUBJECT: **DEATHS REPORTABLE TO CORONER**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a procedure for notifying the Coroner's office of a reportable death in the Distinct Part Skilled Nursing Facility (DP/SNF).

POLICY:

It is the policy of this facility that the Coroner's office will be notified of a death as required by State law.

AFFECTED PERSONNEL/AREAS: *RN, LVN*

PROCEDURE:

1. A resident death that fits any category of Section 27491 of California State Law will be reported to the Coroner's office.

2. The Coroner's office telephone number is available at the nurse's station of DP/SNF.

3. The officer will ask for certain information regarding the deceased and will give a case referral number.

4. The officer will give information regarding the disposition of the deceased (i.e., can be released to mortuary or hold for coroner visit).

5. Document on the licensed progress notes when the Coroner's office was notified, the name of the officer, the deceased assigned case number and the disposition of the case.

6. NOTE: Government Code, State of California, Section 27491, directs the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths, which are immediately reportable:

   a. No physician in attendance

   b. Medical attendance less than 24 hours

   c. Wherein the deceased has not been attended by a physician in the 20 days prior to death

   d. Physician unable to state the cause of death

   e. Known or suspected homicide

   f. Known or suspected suicide

   g. Involving any criminal action or suspicion of a criminal act

h. Following an accident or injury (primary or contributory, occurring immediately or at some remote time)

i. Fire, hanging, gunshot, stabbing, cutting, exposure, alcoholism, drug addiction, strangulation, or aspiration

j. Accidental poisoning (food, chemical, drug, therapeutic agents)

k. Occupational diseases or occupational hazards

l. Known or suspected contagious disease, constituting a public hazard

m. All deaths where a resident has not fully recovered from an anesthetic, whether in surgery, recovery room or elsewhere

n. All solitary deaths (unattended by physician or other person in the period preceding death)

o. Recent admission with hip fracture

REFERENCES:

- California Legislative Information (January 1, 2016). California Governmental Code Section 27491. Retrieved from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=27491.

- Centers for Disease Control and Prevention (2019). Investigations and Autopsies. Retrieved from https://www.cdc.gov/phlp/publications/coroner/investigations.html.

SUBJECT:	SECTION:
DOCUMENTATION AND RECORD KEEPING - DP/SNF	*Social Services* **Page 1 of 2**

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

PURPOSE:

To assure the timely and appropriate completion of all Social Service documentation requirements necessary for regulatory compliance and to meet the psychosocial needs of residents/families residing in the DP/SNF.

POLICY:

Social Service designee will assure that all pertinent data related to the emotional and social needs and the overall well-being of the resident and family shall be recorded in the electronic medical record. Information entered into the resident's electronic medical record will be kept confidential and shall be utilized by team members in executing the resident's comprehensive plan of care.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES DESIGNEE*

PROCEDURE:

1. Psychosocial assessment is documented in medical records within 48 hours of resident's weekday admission to the unit, reviewed within 30 days, and re-evaluated annually or at changes in resident's status.

2. Initial discharge planning assessment is to be documented in records within 48 hours of admission, with the plan reviewed during weekly Interdisciplinary Team conference for short-term or transitional residents and monthly for long-term or DP/SNF residents. The assessment is updated quarterly, annually and upon change in resident or responsible party status. The discharge planning goal is entered in the residents' plan of care within 7 days of admission. The discharge/transfer notification and designated portion of the Post Discharge Plan of Care Form is completed as appropriate for eminent discharge.

3. Weekly Social Service progress notes. These may be written more often as needed, inclusive of concerns related to physical, psychological, financial, spiritual, emotional and concrete needs of resident.

4. Goals and treatment for resident's plan of care are to be included in the psychosocial assessment and the resident care plan. Updating of plan of care goals is done on monthly, quarterly and annual basis.

5. Monthly Interdisciplinary Team conference reports, quarterly reviews, documentation of resident/family invitation, and attendance at meetings, and minutes of meeting.

6. Completion of designated portions of the Minimum Data Set (MDS)
consents and acknowledgements obtained from facility admission agreement within 24 to 48 hours of admission

7. Quarterly summary of progress updates and report of the resident's status, needs, and support interventions provided.

8. Completion of the entire admission process within 48 hours of admission, including psychosocial and discharge planning assessments within above timelines, and the admission agreement.

REFERENCE:

- National Association of Social Workers (2019). Retrieved from https://www.socialworkers.org.
- 42 CFR 483.15-483.65 (2017). Admission, transfer, and discharge rights. Retrieved from https://www.law.cornell.edu/cfr/text/42/483.15.

SUBJECT:	SECTION:
END OF LIFE ISSUES~~END OF LIFE ISSUES~~	Page 1 of 2

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POLICY:

It is the policy of the DP/SNF unit to assist those residents who are facing end of life conditions to proceed through the death process with comfort, dignity and respect. As death is viewed as the final act of living, generated from within the person, all efforts will be set forth by the organization to identify, address and positively respond to the resident's needs, related to all primary and secondary diagnoses and symptoms, and those of their families as they relate to psychological, social, emotional and spiritual issues.

AFFECTED PERSONNEL/AREAS:

SOCIAL SERVICES; PHYSICIANS, ALL DPSNF STAFF, PASTORAL CARE STAFF

PROCEDURE:

1. Every effort is made by the members of the healthcare team to identify and respond to the resident's belief and value systems, including those that are cultural and spiritual. This effort is made for all residents throughout the facility to ensure the appropriate level of care.

2. For those residents who require specialized interaction due to belief and value systems, the direct resident care provider will contact the Social Services Department and/or the Pastoral Care Department for direction and participation in the resident's care.

3. For those residents who are facing end of life issues, emphasis on therapeutic communication will be in place to allow for identification of end of life issues as they relate to belief and value systems, psychosocial, emotional and spiritual issues. Identification of these issues will be made with the assistance of the Social Services Department and the Pastoral Care Department.

    a. The Social Services and Pastoral Care Departments will be notified via the computer system by the direct resident care provider of those residents admitted with a terminal illness.

    b. The Social Services and Pastoral Care Departments will be notified by the direct resident care provider via the computer system of those residents for whom a diagnosis of terminal illness, either short term or long term, has been identified and documented as a definitive primary or secondary diagnosis.

4. Direct resident care providers will defer to the Social Services and/or Pastoral Care Departments in their psychosocial interventions based on those departmental members' specialized interactions with the resident and family. Direction will be taken from the Social Services and/or Pastoral Care Department members as to management of the resident/family end of life issues as they relate to belief and value systems, cultural, spiritual, emotional and psychosocial issues.

5. Resident care staff will be educated and trained regarding the unique needs of the resident facing end of life issues. Staff will be educated how to best assist the resident and their family members through the end of life process while maintaining the resident's comfort, dignity and respect.

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REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 United States of America, Med Pass Inc.
- National Institute on Aging, January 2022, Different Care Settings at the End of Life, US Department of Health and Human Services, retrieved from: caringinfo@nhpco.org

SUBJECT: **ENTERAL NUTRITION ORDERS**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose of this policy is to write a clear, concise, compliant order for enteral administration of formula and water.

POLICY:

Enteral orders must include the following:

1. Type of formula, amount, total calories, protein.
2. How often/rate it is to be given.
3. Method of administration (intermittent gravity, bolus or pump).
4. Amount of water flush to be given and how often.
5. Amount of water to be used for flushing before and after medications.
6. The type of feeding tube (NG, G, or J tube)
7. How often feeding tube is to be changed.
    a. Feeding tubes will be changed with every formula bottle change/every 24 hours and PRN by licensed nursing staff
8. Specific orders for elevation of HOB, tube care, residual checks, and site care.

AFFECTED PERSONNEL/AREAS: *PHYSICIAN, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), DIETITIAN*

PROCEDURE:

1. Determine the specific orders from the physician – have the physician write them, or the RN may write them as a verbal/telephone order.
2. ENTERAL NUTRITION ORDER FORMAT FOR LONG TERM CARE

    TUBE FEEDING: _____

    TOTAL: _____Vol /24 hours

    TO PROVIDE: _____Kcals

    _____Protein

Method of administration: _____ (bolus, intermittent, continuous gravity or pump).

Administer via pump:

Run at _____cc/hour over_____ hours

FREE WATER in addition to formula: _____CC/24 hours minimum or maximum, whichever the doctor writes.

- Elevate HOB 35-45 degrees at all times while feeding is administered; and for one hour after feeding if bolus or intermittent.
- Flush feeding tube with water a minimum of once per shift, and after administering medications as per flush order by MD.
- Flush GT with 30ml H_2O prior to medication administration. Flush with 15ml in between each medication given and complete medication pass with a flush of 30 ml H_2O.
- Check residual every shift, and PRN gastric distress; hold tube feeding for 1 hour if residual is greater than 250ml.
- If residuals remain over 250ml after 1 hour, hold tube feeding and recheck residuals hourly. If tube feeding held greater than 24 hours, notify MD and obtain a dietary consult. If residuals are less than 250ml, resume tube feeding at previous rate.
- Tube site care with soap and water as needed for excessive drainage. Leave site open to air if the skin is intact. (Please indicate specific orders for skin care if needed.)

REFERENCES:

- ASPEN Safe Practices for Enteral Nutrition Therapy, Joseph I. Boullata PharmD, RPh, BCNSP, FASPEN, FACN, November 4, 2016. https://aspenjournals.onlinelibrary.wiley.com.
- Enteral feeding: Indications, complications, and nursing care. Jan 11, 2017. www.myamericannurse.com.
- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.40 (a) United States of America, Med Pass Inc.

SUBJECT:	SECTION:
HYPERTONIC SALINE INTRAVENOUS ADMINISTRATION	*Medication Management (MM)* **Page 1 of 3**

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

PURPOSE:

To give guidance for 3% Hypertonic Saline in treating hyponatremia at Sierra View Medical Center.

POLICY:

A. This policy addresses the administration and monitoring of 3% Hypertonic Saline use in correcting moderate to severe hyponatremia. 3% Hypertonic Saline has a variety of off-label clinical indications that should be monitored in a similar way. The following is not an all-inclusive list:

1. Refractory elevated Intracranial Pressure (ICP) due to various etiologies

2. Subarachnoid hemorrhage with hyponatremia (ie, ≤135 mEq/L) to enhance cerebral perfusion

3. Traumatic brain injury with elevated ICP

AFFECTED PERSONNEL/AREAS: *ICU, ED, OR, TELE, PHARMACY*

EQUIPMENT:

- Alaris Guardrails Smart Pump

PROCEDURE:

A. Principles of Treating Moderate to Severe Hyponatremia

1. In hyponatremic patients who are treated to increase the serum sodium, we recommend that the serum sodium initially be increased by 4 to 6 meq/L during the first 24 hours andthe recommended maximum rate of correction should be 8 mEq/L in any 24-hour period... This rate of correction can be repeated until the sodium is normal or near normal. In patients who require emergency therapy, the goal of a 4 to 6 meq/L increase should be achieved quickly, over six hours or less; thereafter, the serum sodium can be maintained at a constant level for the remainder of the 24-hour period to avoid overly rapid correction. In patients who require non-emergency therapy, this goal can be achieved slowly.

2. Orders will be entered in a non-titratable fashion. Any need for increase in rate to achieve a goal will require a new order with the updated rate, done in small increments recommended at 5 to 10 mL/hr.

B. Treatment Regimens

1. Bolus orders (First six hours of therapy goal correction of 4 to 6 mEq/L):

   a. Symptomatic hyponatremic patients which are experiencing symptoms that may be related to increased intracranial pressure (seizures, obtundation, coma, respiratory, arrest, headache, nausea, vomiting tremors, gait or movement disturbances or confusion) may be treated with a 100 mL bolus of 3 percent saline, over 10 minutes to attempt to achieve a rapid correction of 4 to 6 mEq/L over a few hours to alleviate symptoms and prevent herniation. If initial bolus fails to resolve symptoms up to two additional 100 mL doses (to a total of 300mL) may be given. [1]

   b. Asymptomatic acute hyponatremic patients with serum <130 mEq/L may be treated with a 50 mL bolus of 3 percent saline over ten minutes to prevent sodium from falling further. Further correction strategies should be driven by further sodium checks.

   c. Bolus orders shall be restricted to ICU/ED/OR with cardiac monitoring or in emergency situations when moving from non-approved area to ICU/ED/OR would potentially delay life-saving therapy. If moving patient is not immediately possible then the physician must be at bedside during administration.

2. Continuous infusions

   a. Asymptomatic patients with severe hyponatremia (serum sodium <120 mEq/L) may have 3% saline with a recommended starting rate of 15 to 30 mL/hour, which may be administered via a large bore peripheral vein with cardiac monitoring.

   b. For patients with a moderate hyponatremia (serum sodium 120 to 129 mEq/L) it is recommended to take normal measures to identify and correct cause, while limiting water intake, before initiating a continuous infusion.

C. Administration

1. **Administration through a central line is recommended due to high osmolarity and tonicity.** If peripheral line must be used rate should not exceed 40 ml/hr & a large bore vein is recommended, but a central line should be placed as soon as possible. If greater than 24 hour therapy of continuous infusion is needed a central line should be placed.

2. Any signs of phlebitis or infusion site intolerance with peripheral use will result in patient requiring a central line for further treatment, so long as it does not prevent lifesaving therapy.

D. Lab monitoring & Calculations

1. Patients receiving emergency bolus therapy should have their serum sodium measured every one to two hours to ensure that it has increased at the desired rate and prevent overcorrection. Other patients who are treated for chronic hyponatremia in the hospital should have their serum sodium measured often enough to ensure an appropriate rate of correction and to allow the clinician to react quickly to impending overly rapid correction (eg, every four hours). The urine output should also be monitored.

2. Utilize the following Hypertonic and Normal Saline Infusion Calculator to double check that the prescribed infusion rate is appropriate. Consult pharmacy as needed for rate/projected volume.

REFERENCES:

- Jones G.M., Bode L, Riha H, Erdman MJ. Safety of Continuous Peripheral Infusion of 3% Sodium Chloride Solution in Neurocritical Care Patients. Am J Crit Care 2016; 26:37.
- Stearns, Richard. Overview of the Treatment of Hyponatremia in Adults. In: Post TW (Ed), Waltham, MA. (Accessed on August 11, 2017March 27, 2019) https://www.uptodate.com/contents/overview-of-the-treatment-of-hyponatremia-in-adults
- Sodium Chloride, Lexicomp Online (Accessed on August 11, 2017)

SUBJECT: **OCCUPATIONAL HIV POST-EXPOSURE PROPHYLAXIS**	SECTION: **Page 1 of 1**

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

POLICY:

The hospital pharmacy will provide medications to employees and non-employees exposed to blood and body fluids of an HIV positive individual within or being transferred to or from our hospital. Exposure may occur through three routes: percutaneous, mucous membrane, or topical exposure to skin.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

1. Upon potential exposure, each patient is to be admitted to the ED and evaluated by a physician for the relative risk factor as outlined in the **Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post exposure Prophylaxis**
   - https://doi.org/10.1086/672271
2. Pharmacy will provide a pre-packaged 72-hour supply of the following medications:
   - Truvada (emtricitabine 200 mg and tenofovir 300mg) one tablet by mouth daily.
   - Isentress (raltegravir 400 mg) one tablet by mouth twice daily.
3. As part of the treatment, employees may receive with their specific drugs, copies of monographs for their education. Additional copies may be made from the original provided with the exposure kits. Any questions may be forwarded to the pharmacist during normal business hours.
4. The Pharmacy will be contacted whenever this medication is deemed necessary.

REFERENCES:

- Kuhar DT, Henderson DK, Struble KA et al., US Public Health Service Working Group. Updated US public health service guidelines for the management of occupational exposures to human immunodeficiency virus and recommendations for postexposure prophylaxis. Infect Control Hosp Epidemiol. 2013 34: 875– 892. Available from: http://www.jstor.org/stable/10.1086/672271. Accessed on September 30, 2019.
- 2022 Lawbook for Pharmacy. The Pharmacy Law (Business and Professions Code 4000 et seq.
- Zachary K. Management of health care personnel exposed to HIV. Updated Jun 07, 2019. (Accessed on September 30th, 2019).

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SUBJECT: **PASSY – MUIR SPEAKING VALVES**	SECTION: **Page 1 of 7**

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

PURPOSE:

To provide a consistent method of utilizing the Passy – Muir™ valve to ensure maximal patient safety.

POLICY:

A Passy-Muir Valve (PMV) is indicated to allow patients with artificial airways to talk. This valve can only be inserted with a physician's order.

AFFECTED AREAS/PERSONNEL: *RESPIRATORY CARE PRACTITIONERS, SPEECH THERAPY*

PROCEDURE:

A. Patient Education

Each PMV comes with a patient care kit. The kit contains the following:

1. **PMV** – One of the following: PMV 005 (White) Tracheostomy and Ventilator Speaking Valve, PMV 007 (Aqua) Tracheostomy and Ventilator Speaking Valve, PMV (Clear) Low Profile Tracheostomy and Ventilator Speaking Valve, or PMV 2001 (Purple) Low Profile Tracheostomy and Ventilator Speaking Valve.

2. **PMV Storage Container** – a small plastic cup to allow you to store your clean PMV when it is not being used.

CAUTION

PMV must be completely clean and dry before placing it in container to prevent growth of bacteria that can cause respiratory infection. Container should also be cleaned occasionally to prevent bacterial growth.

3. **Instruction Booklet** – a clinician's guide to use of the PMV. Contains comprehensive technical information for use of the PMV both on and off the ventilator as well as cleaning guidelines.

4. **Chart Warning Labels (two)** – these adhesive labels can be placed in your medical chart or care plan to alert all caregivers that you are currently using a PMV.

5. **Bedside Label** – this non-adhesive durable label is designed to be near you, the PMV user (i.e. at the head of the bed or on the wall). It provides important information to caregivers about the PMV.

6. **Pilot Balloon Labels (two)** – if you have a cuffed tracheostomy tube, these small durable stickers must be applied to the pilot balloon of your tracheostomy tube as a reminder that

the cuff of your tracheostomy tube must always be completely deflated before wearing the PMV.

7. **Patient Parameters Chart Label** – this adhesive label is used in your medical chart or care plan to alert all caregivers to your use of the PMV (i.e. how long you wear it, if oxygen or ventilator is used, level of supervision needed, etc.).

8. **Patient Handbook** – the instruction booklet you are now reading on use, care and cleaning of the PMV. Designed for patient, family and caregiver use.

9. **PMV Secure-It™** - (PMV 2000 (Clear) and PMV 2001 (Purple) only). A clear, flexible, rubber attachment that connects the PMV to the tracheostomy tube tie to prevent PMV loss. (Use of the PMV Secure-It™ is optional).

B. Placement of the PMV

WARNING

Each patient must be evaluated and monitored by a Respiratory Care Practitioner when trying the PMV for the first time to ensure safety and proper use of the PMV.

1. Positioning

   a. Before putting the PMV on the tracheostomy tube, place the patient in a comfortable position as this will help air move freely around the tracheostomy tube. The tracheostomy tube should be positioned straight in the airway. This will promote good airflow and should help to make you comfortable.

2. Checking Vital Signs

   a. It is important to take the following measurements before, during and after PMV placement. This will help alert you to any possible problems you may be having before they become serious. The following are some of the vital signs that should be monitored:

      - **Heart Rate** (number of beats per minute)
      - **Respiratory Rate** (number of breaths per minute)
      - **Oxygen Saturation** (measured with a **pulse oximeter** if available)
      - **Color of Skin** (especially around the eyes and mouth)
      - **Work of Breathing**

3. Suctioning

   a. **Suction the tracheostomy tube and mouth** (as needed) to remove excess secretions before placing the PMV. Removing excess secretions from the airway before using the PMV will allow air to move more freely around the tracheostomy tube and will make the patient feel more comfortable while wearing the PMV. These secretions can cause breathing difficulties and may cause excessive coughing if not removed.

4. Deflating the Cuff

   a. **If you have a cuffed tracheostomy tube**, please read the following very carefully, as the cuff must be completely deflated before using the PMV. A deflated cuff will allow air to be exhaled around the tracheostomy tube and out of the mouth and nose when the PMV is being used. Attach the Pilot Balloon Label to the pilot balloon line of the tracheostomy tube, if not already in place. If a cuffed tracheostomy tube you might wish to consider asking your doctor to evaluate you for a cuff deflation will be eliminated when using the PMV.

WARNING

Tracheostomy tube cuff must be completely deflated before placing PMV. An inflated cuff will block the space in the airway around the tracheostomy tube and prevent PMV user from exhaling. PMV user will be unable to breathe if cuff is not completely deflated to allow air to be exhaled around the tracheostomy tube and out of the mouth and nose.

b. Suctioning may be needed before and after cuff deflation both through the tracheostomy tube and in the mouth. Secretions can build up around the cuff of a tracheostomy tube when deflated these secretions drop into the airway and may cause breathing difficulties and / or persistent coughing if not removed.

c. For Ventilator Use: When a cuffed tracheostomy tube is present and the tracheostomy tube cuff is deflated, the seal that the cuff provided is lost and some of the air that is delivered by the ventilator may escape around the tube. To avoid large leaks, always deflate the cuff slowly over 2 – 3 minutes which will allow your airway time to adjust to the airflow. Frequently, ventilator changes can be made to compensate for the escaping air so that you will continue to receive the same amount of support from the ventilator as you do when the PMV is not being used. Each patient's needs are different. The doctor will determine what ventilator adjustments (if any) should be made.

WARNING

Any adjustments to the ventilator must be approved by a doctor.

5. PMV Placement

a. Attaching the PMV to the Tracheostomy Tube: Attach the PMV to the end of the tracheostomy tube (hub) using a firm ¼ twist clockwise motion with one hand holding on to the neckplate of the tracheostomy tube with the other hand. The ¼ twist provides friction to help prevent the PMV from popping off.

CAUTION

Do not place the PMV forcefully onto the tracheostomy tube as that may make it difficult to remove the PMV and may cause the PMV membrane to stick.

b. After the PMV has been placed on the tracheostomy tube, changes in vital signs should be checked. Record the vital signs.

WARNING

If the patient is having difficulty breathing, remove the PMV immediately and contact the doctor and / or healthcare professional.

WARNING

Patients are not to wear PMV while sleeping.

CAUTION

Remove the PMV before giving medicated nebulizer treatments. If the PMV is accidentally used during a treatment is should be removed and rinsed thoroughly to remove medication residue. If this is not done, residue from medication may cause the PMV to stick.

c. For Ventilator Use: Placing the PMV In-line with the Ventilator

Ventilator Connections:

A few things to keep in mind when placing the PMV in-line with the ventilator:

- The PMV should be placed near the tracheostomy tube either directly on the hub of the tracheostomy tube or on a swivel adapter or attached to a closed suctioning system. The PMV should not be placed further down

in the tubing away from your tracheostomy tube because condensation (water) that builds up in the ventilator tubing could interfere with the function of the PMV. Also, placing the PMV down-line in the tubing instead of up close to the tracheostomy tube creates more dead space in the tubing. This deadspace can make it harder to breathe because it is filled with air that you have already exhaled and since it is still in the tubing, you will re-breathe it.

C. Removing the PMV

1. When removing the PMV from the tracheostomy tube, place one hand on the tracheostomy tube neckplate to keep the tracheostomy tube from moving and with the other hand gently twist the PMV clockwise off of the hub of the tube. Record the vital signs.

D. Troubleshooting

The following are common questions you may have regarding PMV use:

1. When the PMV was put on the tracheostomy tube, it seemed to be harder to breathe, what do I do?

   a. Check the patient's position and the position of the tracheostomy tube. Sit upright in a chair or bed as this generally most comfortable and will allow for full movement of the diaphragm and other respiratory muscles. Also, make sure that the tracheostomy tube is not sitting crooked at the neck as this can mean that it is crooked in the airway.

   b. Check to be sure that the tracheostomy tube cuff is completely deflated.

   c. Suction airway through the tracheostomy tube and also the mouth again if needed.

   d. Check the amount and type of secretions coming from the tracheostomy tube.

   e. Anxiety

2. When the PMV is on the tracheostomy tube, the patient seems to start coughing and sometimes the PMV will pop right off of my tracheostomy tube.

   a. This is because the air being exhaled is going through the throat instead of the tracheostomy tube and they are feeling secretions that are in the throat. Sometimes they will cough hard enough that the PMV will pop off of the

tracheostomy tube. When this happens, check to see if suctioning through the tracheostomy tube and / or mouth is needed. After suctioning, place the PMV back on the tracheostomy tube. Be sure to put the PMV on the tracheostomy tube using a firm ¼ twist as described in PMV Placement.

3. The PMV is making a "honking" noise.

   a. If you have been using the PMV for two months or more, this sound indicates that it is time to replace the PMV. If you have been using the PMV for less than two months, put it through one cleaning cycle.

4. No voice or very little voice is being produced while the PMV is being worn.

   a. Airflow through the vocal cords is responsible for producing speech and sound. The vocal cords may be weak from not using them if the tracheostomy tube has been in place for a while. In addition, there may be weakness of the diaphragm, which can reduce the amount of breath support you have when you speak which can make your voice sound soft and weak. If this is the first time the PMV is being used, remember that sometimes it takes time and practice to coordinate breathing with voicing. The following exercises may be helpful to get the patient started:

      - Have the patient take a breath in through the tracheostomy tube while your PMV is on and then open your mouth and say "ahhhh" while you exhale. Try this a few times.

      - Count slowly from one to five, taking a breath before saying each number. Try this a few times.

5. If no voice can be produced, an evaluation of the vocal cords by the patient's physician may be needed to rule out vocal cord damage and / or assess the tracheostomy tube size to consider putting a smaller tube in the airway to allow more air to reach the vocal cords.

E. Cleaning, Care and Lifetime of the PMV

1. It is recommended that you have two PMV's, so that one can be cleaned while the other is being used. The PMV and PMV Secure-It™ (if used) should be cleaned daily after wearing.

WARNING

The PMV and PMV accessories are for <u>single</u> patient use only.
They can be used by only one person and cannot be shared.

2. Cleaning Procedures

a. Swish PMV in pure, fragrance-free soap and warm (not hot) water.

b. Rinse PMV very thoroughly in warm running water.

c. Allow PMV to air dry thoroughly before placing in storage container. Do not apply heat to dry PMV.

d. **DO NOT** use hot water, peroxide, bleach, vinegar, alcohol, brushes or Q-tips to clean PMV.

F. Indications

1. Criteria for a Speaking Valve
   a. Stable heart rate, respiratory rate and SpO2 > 92%

   b. Patient is alert and co-operative

   c. Patient meets CMV weaning criteria (may have a physician's order to bypass this requirement)

2. To enable the patient to speak louder and longer sentences without having to cover the tracheostomy tube with their finger.

G. Assessment of Outcome

1. The should have an improvement in the following:

   a. Swallowing

   b. Secretion management

   c. Assist in ventilator weaning

   d. Assist in weaning from the tracheostomy tube

   e. Taste and smell

REFERENCES:

- The Passy Muir® Valve. (n.d.). Retrieved from http://passy-muir.com/ Accessed 2018

SUBJECT:	SECTION:
PATIENT IDENTIFICATION AND PROGRAM ENGAGEMENT	***POST ACUTE CARE TRANSITIONS***

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

PURPOSE:

To establish a method of identifying the target population for the Post-Acute Care Transitions Program (PACT) at Sierra View Medical Center.

DEFINITIONS:

1. Care Transition Social Worker: MSW assigned to patient as part of the Post Acute Care Transitions Program.

2. PACT: Post Acute Care Transition Program.

POLICY:

Following admission, the Bridge Services Engagement Specialist, PACT RN Case Manager or Care Transitions Social Worker, Bridge Services Pharmacist, or other staff assigned the duty of patient identification and engagement will use the procedure defined below to determine if a patient is eligible for participation in the PACT program to receive outpatient care transition and educational services.

AFFECTED PERSONNEL/AREAS: *BRIDGE SERVICES*

PROCEDURE:

A. The following Cohort will be identified as potential PACT patients, to include those with the following primary diagnoses: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, or Pneumonia. Patients with another primary diagnosis, who are also treated for Congestive Heart Failure or Chronic Obstructive Pulmonary Disease during their admission may also be considered. Those patients who meet criteria and are able to show readiness to participate, via the engagement survey screening tool, will be eligible to participate in the program.

   a. Exclusions:
      - Any patient who is currently a resident of a skilled nursing facility or long term acute care facility are disqualified.
      - Any patient who is discharged to skilled nursing facility, long term acute care facility or hospice are disqualified.
      - Three attempts will be made to contact the patient/family to participate in the engagement survey screening tool. Any patient/family who does not respond to requests for screening will not be accepted into the program at that time.

   b. Special Inclusions: Any patient that is specifically requested by the hospitalists/resident team to participate in PACT will be assessed by the PACT team for inclusion. The prior exclusion criterial applies.

SUBJECT:	SECTION:
PATIENT IDENTIFICATION AND PROGRAM ENGAGEMENT	***POST ACUTE CARE TRANSITIONS***

REFERENCES:

CMS.gov (n.d.). *Hospital readmission reduction program.* Centers for Medicare &Medicaid Services. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

SUBJECT:	SECTION:
PEDIATRIC MEDICATION ADMINISTRATION GUIDELINES	**Page 1 of 4**

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

PURPOSE:

The policy defines the guidelines for medication management in the Pediatric Department. The guidelines also address how to safely and accurately administer medication to a child, taking into account their weight, surface area, and the ability of the child to absorb, metabolize, and excrete the medication.

POLICY:

Medications shall be administered based on a physician order and the necessity of care the patient requires.

1. Those involved in the medication management process shall determine the following, but not limited to:
   a. Age
   b. Sex
   c. Current medications
   d. Diagnosis and co-morbidities
   e. Relevant laboratory data
   f. Allergies and past sensitivities
   g. Weight and Height as appropriate
   h. Pregnancy and lactation status as appropriate
   i. Any other information required for safe medication management
2. To avoid medication errors, always follow these five steps in preparing and administering medication to a pediatric patient.
   a. RIGHT CHILD. Always check the identification band of the child before administering the medication. Never assume that the child in the bed is the child assigned to that bed. If the identification band is missing, the nurse must identify the child by asking a parent, guardian or the child, and then replace the band immediately.
   b. RIGHT DRUG. Check the label on the medication. If the label is not clear or confusing, do not give the medication. Call the pharmacist and have the drug relabeled. Check the drug's expiration date; do not administer outdated drugs. Check the consistency and color of the drug and be aware of the signs of deterioration.

c. RIGHT DOSE. If in doubt about how much medication is an appropriate dose, check a reference before administering it. Always clarify poorly written orders. Check drug references before mixing any medications to determine the compatibility of the drugs.

d. RIGHT ROUTE. Some drugs are never given by certain routes because the route would hinder the action of the drug.

e. RIGHT TIME. Always make a note of when the medication is to be given.

f. RIGHT ED RIGHT EDUCATION. Education must be given to the patient (if age appropriate) and family on the following: the name of the medication being administered, common usages, contraindications, side-effects, toxic effects, and the side effects the child's parents or caregiver should be aware of.

g. RIGHT DOCUMENTATION. Always double check all documentation and save in the EMAR this should include verification process.

3. Pediatric patient weights shall be documented on admission in kilograms (kg).

4. The nurse's manner of approach should indicate that she firmly expects the child to take the medication. This manner convinces the child of the necessity of the procedure. Establishing a positive relationship with the child will allow him to express feelings, concerns, and fantasies regarding medication.

5. Never give a child a choice of whether or not to receive the medicine.

6. Explanation about the medication should appeal to the child's level of understanding (i.e., color, comparison to something familiar).

7. Never lie. Do not tell a child that a shot will not hurt.

8. It is often necessary to mix distasteful medications or crushed pills with a small amount of applesauce or juice.

9. Never threaten a child with an injection if he refuses an oral medication.

10. Medication should not be mixed with large quantities of food or with any food that is taken regularly (e.g., milk).

11. Medication should not be given at mealtime unless specifically prescribed.

12. The nurse must know the following about each medication that he/she is administering: common usages and dosages, contraindications, side-effects, and toxic effects and explain the side effects to the child's parents or caregiver.

13. Assure the child that it is all right to be afraid and that it is okay to cry.

14. Do not talk in front of the child as if the child were not there. Include the child in the conversation when talking to parents.

15. Obtain parental cooperation. Parents may be able to calm a frightened child, persuade the child to take the medication and achieve cooperation for care.

16. As a safe practice, medications shall not be left at the patient's bedside.
17. Medications require a second licensed person to verify the correct dose. The second licensed person will check the dosage calculation, as applicable, and the dose that is prepared properly. Both licensed persons, one of which is an RN, will contest in the EMAR that the calculation and dose given was correct and verified. ~~initial and sign the patient's Medication Administration Record (MAR).~~ The following doses require two (2) licensed verifications and signatures:

    a. Pediatric/neonatal medications that are High-Alert, IV and IM doses excluding Vitamin K and immunizations; multidose vials, topicals.

AFFECTED PERSONNEL/AREAS: *RNs*

PROCEDURE:

1. Allergies will always be checked before the administration of medications.

2. Identifying the patient:
   Always check a child's identification bracelet using BMV (bedside medication verification) process before administering a medication.

3. Buretrols will be used on all pediatric patients under the age of 13 years old when an IV is running.

4. **Nursing will refer to the book "Pediatric Nursing Procedures" written by Bowden and Greenberg for specific administration processes such as oral, rectal, subcutaneous, intramuscular, etc.**

DOCUMENTATION:

1. ~~The~~ The nurse/pharmacists~~RN and~~ that verifies the dosage prior to the administration of the drug shall document in the EMR (electronic medical record) his/her electronic signature in the patient's EMAR (electronic medication administration record).

2. The Administering RN will document in the EMAR the time, route and dosage of the medication.

3. If giving the child immunizations, the lot number and expiration date of the vaccine, along with the most recently updated VIS (Vaccine Information Sheet) will be documented.

REFERENCES:

- Bowden, Vicky, & Smith Greenberg, Cindy. (2015~~2~~). Pediatric Nursing Procedures 4th ~~Third~~ Edition. Philadelphia, PA, Lippincott Williams & Wilkins.

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CROSS REFERENCES:

MEDICATION ADMINISTRATION

SUBJECT:	SECTION:
PRESCRIBER DISPENSING FOR DISCHARGES AFTER COMMUNITY PHARMACY HOURS	**Page 1 of 3**

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

PURPOSE:

To provide a policy and procedure for post-surgical, or other discharged patients to receive- limited and specified, medications when discharged during hours in which all community pharmacies within the local area are closed.

POLICY:

A small supply of a limited number of prepackaged medications may be dispensed directly to a discharged patient by the prescribing physician. Dispensing and labeling is done in accordance with applicable laws and regulations and meets all requirements for prescriber dispensing as required within those applicable laws and regulations.

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

PROCEDURE:

1. Late surgery – anticipated discharge: Whenever possible, a prescription for anticipated medications (i.e., pain, antibiotics, etc) should be given to the patient's family to be filled at a local, community pharmacy during business hours, PRIOR to discharge of the patient.

2. Dispensing from SVMC: To assure that when medications are dispensed directly to the patient by Physicians during the hours in which all community pharmacies are closed;- dispensing and labeling is done in accordance with applicable laws and regulations and meets all requirements for prescriber dispensing as required within those applicable laws and regulations. The following conditions must be met:

   a. The physician has examined the patient.

   b. It is documented in the patient s record that the medication is necessary in the treatment of the condition presented to the physician.

   c. Circumstances preclude the patient obtaining the medication from an outside pharmacy (i.e.- patient s condition, all community pharmacies are closed).

   d. The Physician dispenses only properly- labeled prescriber dispensing packs (as described in the procedure below)- to include:

      - Name of the medication
      - Name of the manufacturer
      - Directions for the use of the medication

- Patient's name
- Physician's name
- Date of issue
- Name, address, and telephone number of the hospital emergency department
- Strength of the medication or medications
- Quantity of the medication
- Expiration date
- Condition (e.g.: "for pain")

e. The medication is not furnished by a nurse or attendant, but directly by the Physician. However, the nurse is required to sign out the appropriate medication from the Pyxis inventory, inclusive of all information and documentation required, to give to the Physician for dispensing to the patient.

f. The Physician offers to give the patient a written prescription for the medication to be filled at a pharmacy of the patient's choosing.

g. Documentation will be present in the electronic health record that indicated that the patient acknowledges:

- The fact that they could go to any pharmacy, when the pharmacy reopens
- That they have been counseled by the physician

h. Upon request of the patient or patient's representative, a translated directions for use will be provided on a supplemental document.

i. The prescriber will also verbally counsel the patient on the medication's indication, directions, side effects, precautions, interactions, and storage.

j. The quantity dispensed shall not exceed 72 hours.

k. Prescriptions dispensed will be in child-proof containers. If non-safety caps are used, provider is to document in the Medical Record.

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k. Pharmacy will keep all records of dispensing to PDMP. Dispensations will be reported to PDMP/CURES within 24hrs.

l. Any discrepancies or lack of proper documentation shall be reported immediately to the pharmacist-in-charge and the Chief Nursing Officer. -see Controlled Substances Policy.

m. Pharmacy to input discrepancies & errors into electronic reporting system. Pharmacy will also investigate and document to report to the Board of Pharmacy as part of Quality Assurance requirements for ADDS License.

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n. Pharmacy personnel perform monthly inspection for expiration, blind counts, and cleanliness.-see Medication Procurement, Storage, Distribution and Control Policy.

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~~m.~~o. Personnel with access to Pyxis will be trained on system use on new hire & annually.

~~n.~~p. Medication will only be dispensed from a validly licensed ADDS Pyxis machine. Copy of valid license & policy will be displayed by AUD.

(a) Currently licensed Pyxis machines: EDEA-DT

REFERENCE:

- **Automated Drug Delivery System License Application. California State Board of Pharmacy. https://www.pharmacy.ca.gov/forms/adds_app.pdf. Accessed August 16, 2021.**
- **Direct Dispense Application. California Prescription Drug Monitoring Program (PDMP). https://www.aaicures.com/login.again.php. Accessed August 16, 2021.**
- **Pyxis Access. Medication Management. Patient Care Services Policy & Procedure Manual.**
- **https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=%28sc.Default%29. Accessed August 16, 2021.**
- **https://leginfo.legislature.ca.gov/. Accessed August 16, 2021.**
- California Business & Professions Code, Article 12, Section 4170 (a – c). Retrieved from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4170.&lawCode=BPC.

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SUBJECT:	SECTION:
RESTRAINT USE –MEDICAL/SURGICAL AND BEHAVIORAL RESTRAINT	***Provision of Care, Treatment and Services (PC)*** **Page 1 of 9**

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

PURPOSE:

To guide the application of ***Medical/Surgical and Behavior*** restraint in all settings with the goal of minimizing the frequency/duration of restraint use to that which is absolutely necessary for patient care and patient and provider safety.

SCOPE:

The following are not considered restraint under this policy:

- Standard healthcare practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes;
- Adaptive support in response to assessed patient need;
- Forensic or correctional restrictions used for security purposes.
- Four side rails for seizure precautions
- All beds in the Intensive Care Unit are designated as therapeutic care and the use of these side rails are not subject to the requirements of the standard.

POLICY:

1. Seclusion will not be employed on inpatient units.
2. Physical restraint may be used according to his policy when warranted by the patient's condition and therapy and when less-restrictive means of protecting the patient are not indicated.
3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence.
4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint.

AFFECTED PERSONNEL/AREAS: *ALL ACUTE INPATIENT UNITS; EXCLUDES DPSNF*

PROCEDURE:

MEDICAL/SURGICAL RESTRAINT

1. ***Definition***

   Medical/Surgical restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g.,

magnetic resonance imaging, surgery, etc.) is not considered restraint. *(See Appendix for examples of **medical/surgical restraint**).*

2. ***Indications***

Prior to the initiation and continuation of a medical/surgical restraint, the patient must be assessed to determine whether he/she requires restraint to prevent interference with his/her treatment plan.

3. ***Consideration of less-restrictive means***

Prior to the initiation and continuation of restraint, alternative means of protecting the patient will be considered. *(See Appendix for examples of Alternatives to Use of Restraint. These alternative methods should be documented in the EMR.)*

4. ***Conversation with Patient and Family***

To the extent practical, the issue of restraint will be discussed with the patient and family around the time of its use. Patient/family education will be documented.

5. ***Orders***

Restraint will be initiated or continued at the order of a treating physician with current privileges at SVMC. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted.

6. ***Initiation Without Orders***

If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.

7. ***Initial In-Person Physician Assessment within 24 hours of Initiation***

The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate. The physician will re-order or discontinue restraint at the time of that evaluation.

8. ***Ongoing In-person Physician Assessments and Continuation of Restraint Orders***

The treating physician will perform in-person assessments of a restrained patient at least once every 24 hours at which time restraint will be either reordered or discontinued as necessary.

9. ***Early Discontinuation of Restraint***

Restraint will be discontinued as soon as it is no longer warranted by the patient's actions or the nature of the patient's treatment plan. Documentation of restraint discontinuation is mandatory.

10. ***Patient Monitoring***

Monitor restrained patients as often as necessary to ensure safety and dignity and to attend to comfort needs. Patients will be observed at least every two *(2)* hours to ensure that restraint remains necessary, that restraining devices remain safely applied, and that the patient remains as comfortable as possible. Such monitoring will be documented every 2 hours.

11. ***Documentation***

The following will be documented in the medical record whenever medical restraint is applied:

a. The patient's actions or condition that indicated the initial and continued use of restraint;

b. The less-restrictive alternative(s) to restraint considered;

c. Restraint orders;

d. Patient monitoring;

e. Significant changes in the patient's condition;

f. Discussions and education with the patient and family (as appropriate) regarding restraint;

g. The patient's plan of care will be updated any time a restraint is used;

h. Removal of all restraints.

BEHAVIOR RESTRAINT

1. ***Definition***

Behavior Restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger.

2. ***Consideration of Less-Restrictive Means***

Prior to the initiation and continuation of ***behavioral*** restraint, alternate means of protecting the patient and others will be considered. *(See Appendix)*

3. ***Conversation with Patient and Family***

To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate.

4. ***Discontinuation of Restraint***

Behavioral restraint will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.

5. ***Orders***

Behavioral restraint will be initiated or continued upon the order of a treating physician with current privileges at this institution. The order for restraint will include the type of restraint to be applied and will be based on specific violent/self-destructive behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. ***Behavioral*** restraint may not be ordered for longer than four (4) hours for adult patients, two (2) hours for children between nine and 17 years old, and one (1) hour for children eight years old or younger.

6. ***Initiation Without Orders***

An RN may initiate ***behavioral*** restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one ***(1)*** hour of its application.

7. ***Renewal of Restraint Orders***

Before the expiration of the original order, a ***behavioral*** restraint may be reordered by the treating physician based on the assessment of the RN. However, the physician must perform an in-person assessment at least every eight (8) hours for adults and at least every four (4) hours for patients 17 years old or younger.

8. ***Notification of the Nurse Manager/House Supervisor***

The nurse manager or house supervisor on duty will be notified:

a. of any ***behavioral*** restraint that continues to be applied for more than eight hours; and

b. any reapplication of behavioral restraint within 12 hours after discontinuation.

9. ***Patient Monitoring***

Patient will be placed in ICU where staff will continuously observe patients in ***behavioral*** restraint. Such monitoring will be documented at least every 15 minutes.

10. ***Documentation***

Document the following in the medical record whenever ***behavioral*** restraint is applied:

a. The patient's actions or condition that indicated the initial and continued use of restraint;

b. The less-restrictive alternative(s) to restraint considered;

c. Restraint orders;

d. Patient monitoring;

e. Significant changes in the patient's condition;

f. Discussions and education with the patient and family (as appropriate) regarding restraint.

g. The patient's plan of care will be updated any time a restraint is used

CHEMICAL RESTRAINT

1. ***Definition***

A chemical restraint is any medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement that is not a standard treatment or dosage for the patient's condition. Therefore, administration of an antianxiety or antipsychotic drug to alleviate symptoms of mental illness need not be considered a chemical restraint. Routine scheduled use of medications or PRN use, either oral or IM, of these same medications for approved indications does not need to be considered a chemical restraint.

On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of ***behavioral*** restraint. The protections afforded the patient for this physical restraint *(See behavioral restraint above)* also ensures the patient's rights for chemical restraint.

REPORTING DEATHS RELATED TO RESTRAINT

As per 42 Code of Federal Regulations (CFR) 482.13 (e)-(g)

Staff will promptly notify management of the death of any patient during or within 24 hours of the end of an episode of restraint.

Management, in consultation with the department of Quality and Regulatory Affairs, will notify the California Department of Public Health (CDPH) (on behalf of the Centers for Medicare & Medicaid Services [CMS]) of any patient who dies during or within 24 hours of the end of restraint no later than by close of the next business day the discovery of:

- Each death that occurs while a patient is in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of the restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

Hospital staff do not need to report the death to CMS but must record the death in an internal log or other system only for deaths that occur when:

- No seclusion has been used, and
- The only restraints used on the patient were applied to the patient's wrist(s) and composed solely of soft, non-rigid, cloth-like materials.

STAFF EDUCATION:

1. During the initial orientation period, all levels of staff who have direct patient care responsibilities are oriented to this policy and procedure and trained in the proper and safe application and use of restraints.
2. Competency validation related to the proper and safe application and use of restraints is documented prior to the independent performance of the application or monitoring of a patient requiring restraint and then annually.
3. Only Registered Nurses (RN), who have demonstrated competence or physicians may apply restraints in an emergency situation.
4. Contract/agency staff with direct patient care responsibilities have documented competency in the hospital's restraint policies and procedures prior to caring for patients in restraints.

PERFORMANCE IMPROVEMENT:

It is the policy of Sierra View Medical Center to make every effort to reduce the use of restraints. Performance improvement activities will focus on reduction in the use of restraints with data collected on each episode until a baseline of aggregate data has been established and assessed. Once a baseline is established, targeted monitoring will be employed.

REFERENCE:

- The Joint Commission. (2021). Hospital Accreditation Standards. PC.01.03.05, PC.03.05.01, PC.03.05.03, PC.03.05.05, PC.03.05.07, PC.03.05.09, PC.03.05.11, PC.03.05.13, PC.03.05.15, PC.03.05.17, PC.03.05.19. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- Appendix A: Restraint Alternatives

Appendix A

Alternatives to the Use of Restraints

PHYSICAL MEASURES	**SPIRITUAL NEEDS**
Exercise & activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books & magazines)	Contact patient's pastor, minister, priest, rabbi
Anticipate & provide for basic needs of hunger (snacks), thirst & toilet	Offer sacraments of Communion, Reconciliation and Anointing of the sick as appropriate
Promote normal sleep patterns	Use sitter or volunteer to read to patient
Relaxation techniques	Use audio tapes
Use of lap/seatbelt in chair as a reminder	
Provide glasses, hearing aid, dentures	
Tape foley to abdomen of male patient	
Use busy vest or busy activity such as folding towels	
PSYCHOLOGICAL MEASURES	**ENVIRONMENTAL MEASURES**
Explain all procedures, be aware of fear of the unknown	1:1 communication to inform patient of safety precautions & orient to environment
Orient patient to reality often	Use of cushions/pads to maintain safety
Provide for companionship: family, friends, church members, volunteers, sitters	Locate patient next/close to nurse's station
Holding/cuddling infants & young children	Use appropriate lighting-nigh light, increase or decrease light in room depending on patient's eyesight or medical condition
Use TV, radio or music as diversion	Use of Geri chair
Allow patient to wear street clothes, underwear or shoes	Use bed alarms, door alarms as available
PHYSIOLOGICAL MEASURES	Decrease or control noise level
Review medications for side effects & interactions	Call light within reach
Review lab results for abnormal values	Floor or room uncluttered
Collaborate with other healthcare team members & evaluate treatment plan	Urinal or bedpan within reach
Initiate frequent bathroom rounds	Position tubes/drains out of site
Provide adequate pain medication	Control activity level (visitors, coordinate activities/treatments)
Eliminate itch (if scratching)	Schedule family/friends to stay with patient

Patient actions to be considered in the application of restraints

ACTION	EXAMPLE OF DEVICE	TYPE OF RESTRAINT
Patient severely combative or violent due to mental state	4 point soft restraints	Behavioral
Restricting movement of confused patient from removing medical device (IV, endotracheal tube, catheter, drains, etc)	Soft wrist ties Mittens	Medical/Surgical
Confused patient attempting to climb out bed	Bed Alarm, use of Three side rails	NOT Restraint
Post-op patient needs to lay on her side without rolling out of bed	Bed rails	NOT Restraint
Patient with poor posture while sitting in chair	Seat belt/lap belt	NOT Restraint
Patient sliding out of chair	Over bed portable table (not placed under chair legs) Lap belt	NOT Restraint
Patient immobilized during MRI, circumcision, operative procedure	Soft wrist restraints Safety belt	NOT Restraint
Protection of patient from falling out of bed, using side rails	Bed rails (X2)	NOT Restraint
Patient transported via gurney or wheelchair	Safety belt	NOT Restraint
Patient under arrest, being guarded by Deputy Sheriff	Handcuffs	NOT Restraint

SUBJECT:
STERILE HAZARDOUS DRUG HANDLING

SECTION:

PURPOSE:

To provide practice and quality standards for handling hazardous drugs (HD's), to promote patient safety, worker safety, and environmental protection. In addition, providing for the safe receipt, storage, compounding, dispensing, administration, and disposal of sterile hazardous products and preparations at Sierra View Medical Center (SVMC).

DEFINITIONS:

A. Hazardous Drugs- Medications that in small quantities can produce severe adverse physiological effects. This category can be further subdivided into antineoplastic, non-antineoplastic, reproductive risk only.

B. USP 797- Refers to a chapter from the United States Pharmacopeia publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile intravenous products.

C. USP 800- Refers to a chapter from the United States Pharmacopeia (USP) publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile intravenous products.

D. Compounding Aseptic Containment Isolator (CACI)- A unidirectional HEPA filtered airflow CACI is designed to provide worker protection from exposure to undesirable levels of airborne drug throughout the compounding and material transfer process and to provide an aseptic environment for compounding sterile preparations.

E. ISO Class 5- A reference to a space of air that contains no more than 3,520 particles per cubic that are 0.5 microns or larger.

F. PPE- Personnel Protective Equipment includes chemotherapy rated gloves, gowns, eye, face, head, shoe, sleeve coverings that are intended to prevent exposure to hazardous drugs.

G. Category 1 Compounded Sterile Product (CSP)- Category 1 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring. It assigns a BUD of 12 hours at room temperature and 24 hours refrigerated. CTC Suite A will have a max BUD of 12 hours.

H. BUD- Beyond Use Date is either the date or hour after which a CSP must not be used or administration must not begin. The BUD is determined from the date and time that preparation of the CSP is initiated.

POLICY:

It is the policy of SVMC that all injectable hazardous medications will be prepared in the Cancer Treatment Center in a negative pressure CACI/Hood by properly trained personnel who will practice safe established preparation techniques and proper handling procedures as outlined in USP 797, USP 800 and California State Board of Pharmacy regulations.

AFFECTED PERSONNEL/AREAS: *PHARMACY, CANCER TREATMENT CENTER, NURSING*

A. PERSONNEL PREPARATION:

1. All activities not requiring a sterile environment (e.g., checking labels, doing calculations) should be completed before accessing the CACI/Hood.

2. Hand washing is a critical component to ensuring IV admixtures are aseptically prepared as well as reducing chemotherapy trace contamination of both product and personnel.

   a. Wash hands before and after cleaning hood or preparing chemotherapy products.

   b. Wash hands for 30 seconds using chlorhexidine, digital timer provided . Wash to elbows when possible.

   c. Utilize bactericidal soap.

   d. Pay particular attention to under fingernails and between fingers. Use nail picks to remove debris from underneath fingernails.

   e. No jewelry (rings, watches, etc.) may be worn during compounding.

   f. No nail polish, artificial nails, or cosmetics may be worn during compounding.

   g. After washing, use a lint-free (non-shedding) cloth or paper towel to dry hands.

   h. Prior to donning first pair of sterile HD certified gloves, after washing hands as above, apply Sterillium© and allow contact time of at least 3 minutes.

3. Utilize gowns that are certified for use in the preparing of hazardous drugs. This will help protect both you as well as others from trace chemo contamination. Gowning will help protect you from any gross chemotherapy spills that could occur. Wearing protective garments (gown and gloves) is required when preparing, compounding, handling, cleaning and disposing of chemotherapy.

   a. After washing hands and applying Sterillium, don first (interior) set of sterile HD gloves

   b. Sanitize outside of the gloves with 70% isopropyl alcohol, allow alcohol to dry.

c. Don protective chemotherapy-approved gown.

d. First set of gloves should be tucked under/inside the cuff of the gown.

e. Don second set of chemotherapy approved sterile gloves (double gloves are recommended for hazardous drugs as permeability varies with material, thickness, and exposure duration).

f. Extend outer glove over the cuff of gown.

g. Sanitize outer HD glove with 70% isopropyl alcohol, and allow alcohol to dry.

h. Change gloves if they become contaminated, torn or punctured.

i. Change outer gloves whenever you must exit and re-enter the Glove Box by opening the face of the Glove Box for cleaning, decontamination.

j. Gowns are not to be worn outside of buffer area.

k. TWO sets of booties must be worn while compounding.

B. CHEMOTHERAPY PREPARATION TECHNIQUE:

1. Nothing should interrupt the flow of air between the HEPA filter and the sterile object. To maintain sterility, nothing should be placed above the work surface. Objects should be placed at least six inches from the sides and front edge of the hood without blocking air vents. Hands should also be positioned to assure that airflow in the critical area of the HEPA filter and the sterile objects is not blocked.

2. Vertical flow hoods (BSC) must be operated continuously 24 hours a day and must be inspected and certified by qualified personnel every six months.

3. Nothing should be stored on the top of the vertical flow hood.

4. Clean the drug preparation area, left to right and top to bottom, with an approved sterile water, 70% isopropyl alcohol, and Peridox© (with a dwell time of at least 3 minutes). This will be done at the beginning and the end of the shift, when there is a spill or as needed.

5. Keep the area free of solutions, additives, and equipment that are not required to prepare the product.

6. All products necessary for preparing the admixture or batch should be gathered and sanitized with sterile 70% alcohol and readied for placement in the CACI or Hood. Obtain the basic parenteral solutions, additive drugs, syringes, needles, swabs, labels,

chemo transport bag, etc.

7. When using a CACI, place the label inside the chemo transport bag designated to hold the final preparation and place this bag on the tray inside the pass-through. Then, place the remaining sanitized supplies on top of the chemo transport bag. Close the pass through and initiate the airlock purge.

8. After the 2 minute purge, transfer the supplies into the main chamber, but leave the chemo transport bag and label within the airlock.

9. If an infusion container (IV bag) will be utilized, attach the IV tubing and completely prime the tubing in the hood, making sure it is free of all air bubbles.

10. Prime tubing with fluid from container PRIOR to adding chemotherapy agent whenever possible.

11. Clean diaphragms and injection ports with sterile 70% alcohol swab prior to needle puncture.

12. The safe handling of hazardous drug solutions in vials or ampoules requires the use of a syringe that is no more than three-fourths full when filled with the solution. This minimizes the risk of the plunger separating from the syringe barrel.

13. Ensure that the syringe is the appropriate volume and needle is the appropriate gauge and length.

14. Use CSTD (ONGUARD system) for all compounding in the CACI/Hood.

15. When reconstituting, the syringe should remain in the CSTD, and the contents should be swirled carefully until dissolved.

16. With the vial inverted, the proper amount of drug solution should be withdrawn in small aliquots (e.g., 1/4th to 1/5th of total volume in each aliquot) while equal volumes of air are exchanged for solution. The exact volume needed must be measured while the syringe is in the CTSD and any excess drug should remain in the vial.

    - If the preparation is to be administered in a syringe then it may be capped and labeled at this point in the procedure. If the final dosage form is a IV bag then continue with the following procedure.

17. When transferring drug to the IV bag, attach the CSTD to the IV bag containing the base solution and avoid puncturing the sides of the port or bag.

18. Attach the syringe with the drug to the CSTD on the IV bag and slowly inject.

19. After the drug solution is inserted into the IV bag; the IV port, container, set, and gloves

of the fixed-glove assembly should be surface decontaminated with sterile alcohol 70%., preferably.

20. The injection port of the final product should then be covered with a protective shield and chemotherapy.

21. The final preparation should then be placed into the pass-through, inner airlock door closed, hands removed from fixed-glove assembly, and the clean inner gloves should be used for labeling and placement into the chemotherapy transport bag.

22. When using a negative pressure hood, all items must be wiped down with 70% sterile alcohol prior to being placed in the hood. The items must be at least 6 inches in the hood and placed in the hood so that turbulent airflow is not created.

C. INSPECTION OF FINAL PRODUCT:

After completion of preparation, the pharmacist will notify the Cancer Treatment Center (CTC) nursing staff. One of the licensed registered chemo-certified nurses and the pharmacist will verify that the final product is free from visible particulate, turbidity or discoloration. At this point the final preparation is ready for administration to the patient. It will be taken by the nurse, sealed in a chemotherapy transport bag.

D. LIST OF HAZARDOUS DRUGS

1. A list of hazardous drugs that are handled at Sierra View Medical Center will be maintained by the pharmacy (PIC) and reviewed against the NIOSH list for changes annually.

~~2. See attached 2020 list.~~

E. RESPONSIBILITIES OF PERSONNEL HANDLING HAZARDOUS DRUGS

1. The pharmacist in charge will be responsible for developing and implementing appropriate procedures; overseeing entity compliance with USP 800.

   a. Program integrity will be assured through:

      - Testing of product, environment and personnel.
      - Acting upon results when necessary.
      - Hand hygiene and use of PPE shall be employed at each phase of hazardous drug (HD) handling, e.g., receipt, transport, compounding, administration, spill, and disposal.

F. FACILITIES AND ENGINEERING CONTROLS

1. Designated areas for handling HDs

   a. Segregated Compounding Area and Suite B, both located at Cancer Treatment Center

      - A sign designating "hazard" must be displayed.
      - Access to HD preparation area must be restricted to authorized personnel.
      - Located away from break rooms or areas for patients, visitors.

   b. Receipt and Unpacking of HD located at Cancer Treatment Center

      - A pharmacist will receive the HD order from the wholesaler.
      - A properly garbed pharmacist will unpack the HD shipment in the compounding area.

   c. Storage at Cancer Treatment Center

      - HDs will be stored in the segregated compounding room, behind a locked door.
      - HDs will be stored as per manufacturer's recommendations and monitored as per SVMC policy MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL.

   d. Hand washing shall occur after handling and PPE has been doffed.

   e. Designated Administration Areas

      - Cancer Treatment Center
      - Clinical Decision Unit, Operating Room- Bladder Instillation

G. RECEIPT

1. Antineoplastic HDs must not be unpacked (removal from shipping containers) from their external shipping containers in positive pressure areas.

   a. If the shipping container appears damaged:

      - Seal the container without opening and contact the supplier.

- If the unopened package is to be returned to the supplier, enclose the package in an impervious container and label the outer container "Hazardous".
- If the supplier declines return, dispose of as hazardous waste.

b. If a damaged shipping container must be opened:

- Seal the container in a plastic or an impervious container.
- Transport it to a negative pressure CACI/Hood and place on a plastic-backed preparation mat.
- Open the package and remove undamaged items.
- Wipe the outside of the undamaged items with a disposable wipe.
- Enclose the damaged item(s) in an impervious container and label the outer container "Hazardous."
- If the supplier declines return, dispose of as hazardous waste.
- Deactivate, decontaminate, and clean the CACI/Hood and discard the mat and cleaning disposables as hazardous waste.
- Hand washing shall occur after handling and PPE has been doffed.

H. STORAGE

1. HDs must not be stored on the floor.
2. HDs must be stored on secured shelves with raised front lips.
3. Antineoplastic HDs must be stored separately from non-HDs in a manner that prevents contamination and exposure.
4. Refrigerated antineoplastic HDs must be stored in a dedicated refrigerator.
5. After stocking, hand washing shall be completed.

I. COMPOUNDING

1. One licensed registered chemotherapy nurse will double check, and initial, the pharmacist's calculations prior to compounding.
2. Hand washing is a critical component to ensuring IV admixtures are aseptically prepared as well as reducing chemotherapy trace contamination of both product and personnel.

a. Wash hands before and after cleaning hood or preparing chemotherapy products.
b. Wash hands for 30 seconds, digital timer provided. Wash to elbows when possible.

c. Utilize bactericidal soap.

d. Pay particular attention to under fingernails and between fingers, use a nail pick for debris under fingernails.

e. No jewelry (rings, watches, etc.) may be worn during compounding.

f. No nail polish, artificial nails, or cosmetics may be worn during compounding.

g. After washing, use a lint-free (non-shedding) cloth or paper towel to dry hands.

h. Apply sterillium to bare hands prior to donning first pair of HD gloves.

3. Gowning will help protect both you as well as others from trace chemo contamination. Gowning and gloving is required when preparing, compounding, handling, cleaning and disposing of HDs.

a. After washing hands, don first (interior) set of HD gloves.

b. Sanitize HD gloves with 70% isopropyl alcohol.

c. Don protective chemotherapy-approved gown.

d. First set of gloves should be tucked under/inside the cuff of the gown.

e. Don second set of chemotherapy approved gloves (double gloves are recommended for hazardous drugs as permeability varies with material, thickness, and exposure duration).

f. Extend outer glove over the cuff of gown.

g. Sanitize and or soak outer glove with 70% isopropyl alcohol and allow product to dry.

h. Change gloves if they become contaminated, torn or punctured.

i. Change outer gloves whenever you must exit and re-enter the Glove Box by opening the face of the Glove Box for cleaning, decontamination.

j. Gowns are not to be worn outside of preparation/buffer area

4. Head, Hair, Shoe Covers

   a. A second pair of shoe covers must be worn when compounding HDs and when entering the compounding area and removed before leaving that area.

   b. Head covers/Bouffants will be worn while compounding HDs.

5. Doffing of PPE after HD compounding

   a. Remove outer pair of HD gloves and place in HD waste container in buffer area.
   b. Remove outer pair of booties and place in yellow HD waste container, in buffer area.
   c. While in the HD buffer area, remove the HD gown and place in yellow HD waste container.
   d. Remove inner pair of HD gloves, while in buffer area.
   e. Exit HD Buffer and enter clean side of ante room and go to the sink.
   f. Remove bouffant/mask and place in yellow HD waste container found under sink.
   g. Wash hands as stated above.
   h. Remove inner booties and step across LOD.
   i. Use Sterillium gel.

6. Eye and Face Protection

   a. Must be worn when there is a risk of splash or spills outside of CACI/Hood, i.e., cleaning a spill, or working above eye level.

   b. Goggles must be used, not eye glasses.

   c. Goggles plus face shield provide full protection.

7. Respiratory Protection

   a. Shall be worn when unpacking HD's that are NOT contained in plastic bags.

   b. A N95 surgical respirator provides barriers to splashes, droplets, and sprays but not to vapors or gas.

   c. A full face-piece, chemical cartridge-type respirator should be worn when risk of exposure to vapor or:

      - Attending HD spills larger than what can be contained with a spill kit.
      - Deactivating, decontaminating, and cleaning underneath work surfaces.

- Known or suspected airborne exposure to powders or vapors.

8. Engineering Controls

   a. Primary Control – A CACI/Hood will be used for all phases of compounding that provides an ISO Class 5 or better air quality.

   b. Supplemental Control- A closed system transfer device will be used in compounding and administering HD.

9. CACI/Hood

   a. Must operate continuously 24 hours a day 7 days a week.

   - Will be recertified every 6 months.
   - If there is any loss of power, if repair or moving occurs:
     - All activities in CACI/Hood must be suspended
   - Upon return of power
     - Decontamination, cleaning and disinfection must occur and the CACI must be given the manufacturer specified time to recover before compounding resumes.
   - A sink must be available for hand washing.
   - An eyewash station must be readily available.
   - Water sources and drains must be located at least 1 meter away from CACI/Hood.
   - CACI/HD hood must be externally vented.
   - Must provide an ISO Class 5 or better environment.

10. STERILE COMPOUNDING

   - All sterile NON- HD compounding must follow USP 797 standards.
   - LABELING
     - HDs shall be labeled "Caution Chemotherapy-Dispose of properly" or "hazardous- dispose of properly" and "Prepared in this Pharmacy".

- All product labels shall include:
- Name of pharmacy
- Name of medication, strength, volume
- For IV admixed medications, it shall include the solution used.
- Instructions for storage, handling, and administration, rate of infusion.
- Beyond use date (Shall not exceed 12 hours)
- Date of compounding
- Lot number or pharmacy reference number

All compounded HDs will undergo visual inspection for particulate matter, turbidity, and evidence of contamination. Products with suspected adulterants will be discarded into the yellow HD waste container after the patient information has been removed and destroyed.

11. SVMC Policy IV PREPARATION AND DISPENSING shall be applied, HD guidelines from USP 800 shall supersede non HD procedures where conflict exists.

12. Hand washing and proper PPE shall be donned before compounding and hand washing shall occur after doffing PPE.

A. TRANSPORT OF HD'S

1. LABELING

   a. HDs must be clearly labeled as per USP 797 at all times during transport and include labels of "Chemotherapy-dispose of properly" or "Hazardous drugs-dispose of properly."

2. PACKAGING

   a. A designated HD transport tote will be labeled "Hazardous Drugs" will be used solely for the HDs.

   b. The transport tote will be cleaned before and after transport of HDs by properly garbed pharmacy technicians.

   c. Hand washing shall occur after PPE has been doffed.

B. ADMINISTERING

1. Sterile intravenous HDs will be administered via needleless closed system transfer device.

2. PPE used when administering HDs will be disposed of in a chemotherapy waste receptacle.

3. Hand washing shall occur after proper PPE has been doffed.

C. DISPOSAL

1. All personnel who perform custodial waste removal and cleaning activities will be trained to prevent and protect themselves from accidental exposure and contamination of the environment.

2. Hand washing shall occur after proper PPE has been doffed.

D. DISPENSING OF FINAL DOSAGE FORMS

1. Any oral dosage form HDs that do not require any further manipulation other than counting or repackaging of the final dosage form must not be placed into an automated counting machine.

E. DEACTIVATING, DECONTAMINATIONG, CLEANING, AND DISINFECTING

1. All personnel who perform deactivation, decontamination, cleaning and disinfection activities in HD handling areas will be:

   a. Trained annually.

   b. All personnel performing these activities will wear impervious personnel protective equipment, double glove with chemotherapy gloves, and use eye protection if splashing is likely.

2. CACI/Hood MAINTENANCE

   a. Do not use a spray bottle. Lint free wipes shall be used.

   b. Disposal meets FDA regulations

   c. All cleaning activities will be documented

3. Deactivation

a. Shall occur daily, after a spill, or as deemed warranted.

b. A process whereby the HD compound is rendered inert, SVMC will use Peridox©

4. Decontamination

a. Performed prior to any compounding, in between compounding different HD's, at the end of a shift, when a spill occurs, before and after certification, voluntary interruption and if ventilation tool moved.

- Removal of HD residue
  - Sterile Alcohol 70%

5. Cleaning

a. Shall occur prior to any compounding, in between compounding different HD's, at the beginning and end of a shift, when a spill occurs, before and after certification, voluntary interruption, at least every 30 minutes when compounding involving human staff is occurring, and if ventilation tool moved.

- Removal of organic and inorganic material

SVMC will use Peridox© with a contact time of 3 minutes when agent is visibly wet.

6. Disinfecting

a. A process of inhibiting or destroying microorganisms, shall be performed prior to any compounding, in between compounding different HD's, at the end of a shift, when a spill occurs, before and after certification, voluntary interruption, and if ventilation tool moved. SVMC will use Peridox© with a contact time of at least 3 minutes.

b. Must occur after surfaces are cleaned using sterile 70% alcohol

c. SVMC Policy: STERILE PRODUCTS: STERILE PRODUCT ENVIRONMENTAL STANDARDS shall be applied and followed

7. Spill Control

a. Pharmacy personnel involved in handling HDs will receive annual training in use of personnel protective equipment and respirator.

b. Spills must be contained and cleaned immediately by qualified personnel with appropriate PPE.

c. Signs must be used to restrict access to spill.

d. Spill kits must be available at all times while HD's being handled, in all areas where routinely handled.

e. All used spill kit items must be disposed of as hazardous waste.

f. Spill kits are located in CTC HD Pharmacy and Main Pharmacy.

g. Face pieces must be used if capacity of kit is exceeded or if vapors are known or suspected.

h. Material Safety Data Sheets are accessible 24 hours a day via the SVMC intranet.

i. When a spill occurs, protect the patients or employees who had cytotoxic drugs spilled on them.

a. If skin is exposed, wash the affected areas with copious amounts of non-medicated soap and water for 20 minutes

b. If mucous membranes are exposed (i.e. eyes), rinse with copious amounts of clean water for at least 15 minutes.

8. Spills should be cleaned up immediately by the person responsible. An Environmental Services Supervisor is available during business hours. Call the Supervisor to assist if the spill is complicated (i.e., >50ml or >12 inches in diameter, or difficult to contain, for example liquid mercury spills) or the area is difficult to clean. The supervisor may also be called as an information resource on cleaning spills.

9. A written procedure for spill management is included in each spill kit. Components of a spill kit include (but may not be limited to)

a. 2 pairs disposable HD gloves

b. Low permeability gown and shoe covers

c. Goggles or face shield

d. Respirator mask (unless included in face shield)

e. Plastic backed absorbent sheets or spill pads (sufficient to absorb a spill of up to 1000mL).

f. Disposable towels or swabs for absorbing and cleaning liquid spills

g. At least 2 sealable plastic waste bags "Cytotoxic Waste"

h. Disposable scoop for collecting glass fragments

i. Puncture-resistant container for glass fragments, clearly labeled as cytotoxic waste container

j. Cleaning solution for cleaning and decontamination of area

k. Instructions on the management of a cytotoxic chemotherapy spill.

l. Warning signs to alert other staff to the hazard and isolate the area of the spill.

F. General clean-up procedure:

1. Assess the size and scope of the spill.
2. Spills that cannot be contained by two spill kits may require outside assistance and supervisor should be alerted.
3. Post signs to limit access to spill area.
4. Obtain spill kit.
5. Don PPE, including inner and outer gloves and mask.
6. Once fully garbed, contain spill using spill kit.
7. Carefully remove any broken glass fragments and place them in a puncture-resistant container.
8. Absorb liquids with spill pads.
9. Absorb powder with damp disposable pads or soft toweling.
10. Spill cleanup should proceed progressively from areas of lesser to greater contamination.
11. Completely remove and place all contaminated material in the disposal bags.
12. Rinse the area with water and then clean with detergent, sodium hypochlorite solution/wipes and neutralizer.
13. Rinse the area several times and place all materials used for containment and cleanup in disposal bags. Seal bags and place them in the appropriate final container for disposal as

hazardous waste.

14. Carefully remove all PPE using the inner gloves. Place all disposable PPE into disposal bags. Seal bags and place them into the appropriate final container.

15. Remove inner gloves; contain in a small, sealable bag; and then place into the appropriate final container for disposal as hazardous waste.

16. Wash hands thoroughly with soap and water.

17. Once a spill has been initially cleaned, have the area re-cleaned by housekeeping, janitorial staff, or environmental services.

G. After the spill has been cleaned up and the people who came in contact with the cytotoxic drugs have washed the involved skin areas for 20 minutes, consider the following:

1. If the spill is on a patient, notify the physician.

2. If the spill is on an employee:

   a. Call Employee Health Services during working hours or the emergency room for further instructions. The Employee Health nurse or emergency room physician will assess for injury related to the exposure with particular attention to the skin, eyes, and mucous membranes. If a baseline CBC has not been drawn, a CBC with differential will be done.

   b. A CBC with differential and follow-up exam will be done by the Employee Health Service nurse at the time of the expected nadir (the lowest point of circulating blood counts (e.g., WBCs and RBCs)) of the drug.

3. Complete an incident report if a spill occurs anywhere or if a spill occurs on a patient or employee.

H. DOCUMENTATION AND STANDARD OPERATING PROCEDURES

1. Must be reviewed by the pharmacist in charge every 12 months.

2. Any changes to policy or records must be communicated and documented to all personnel handling HD's.

I. MEDICAL SURVELLIANCE

1. Pharmacy personnel involved in routine handling of HD's will be enrolled into SVMC's medical surveillance program which is administered through employee health.

2. All employees with potential exposure to cytotoxic drugs will be informed by their

department of the potential risks and the need to follow the procedures related to handling of chemotherapy. Training in the policies will be provided as appropriate for the department involved.

3. Employees will be informed by their department of the potential reproductive hazards and if they so request, staff members who are pregnant or breast-feeding, will be transferred to comparable duties that do not involve handling cytotoxic drugs.

4. ACTIONS IN RESPONSE TO EXPOSURE-RELATED HEALTH CHANGES

   a. Post-exposure examination tailored to type of exposure.

   b. Compare performance of controls with recommended standards.

   c. Conduct environmental wiping samples.

   d. Verify that all engineering controls are operating properly.

   e. Verify and document that employee complied with existing policies.

   f. Develop and document a plan of action that will prevent future exposure.

   g. Ensure a confidential two way communication between employee and employee health regarding notification of a change in health condition.

   h. Provide and document a follow-up medical survey to demonstrate actions that are effective.

   i. Ensure that any exposed employee receive notification of any adverse health effect.

   j. Provide ongoing medical surveillance of all employees that handle HD's to ensure plan implemented is effective.

J. TRAINING

1. Personnel will be trained annually

   a. According to OSHA standards 1910.120 Hazardous Waste Operations Emergency Response

   b. USP 797

   c. USP 800

   d. California State Law. CCR 1735, CCR 1751.

e. Sierra View Medical Center Policy and Procedures related to USP 797, USP 800.

f. Chemo Check Workbook ™

g. Environmental Services, Nursing, and Pharmacy shall read and sign "hazardous Drug Risk" form that acknowledges risk of HD's to employees.

K. QUALITY ASSURANCE PROGRAM

1. Quality Indicators found in SVMC policy COMPOUNDED STERILE PREPARATION:QUALITY ASSURANCE PROGRAM that shall be followed include:

a. Personnel Performance

b. Equipment and Facilities

c. Product and Environment

- At a minimum of every 6 months, or as needed to verify containment, the following shall be done upon the interior of CACI, pass thru chambers, surfaces in staging or work areas near CACI, areas adjacent to CACI, areas immediately outside buffer area, patient administration areas:
  - Environmental Wipe Sampling for Trace Chemo:
- In the event of a positive result, the pharmacist in charge shall:
  - Identify, document and contain the cause of contamination.
  - Reevaluate the workplace practices.
  - Re-train personnel.
  - Perform deactivation, decontamination, cleaning and improving engineering controls.
  - Repeat wipe sampling to validate decontamination complete.

End Product Sampling
Sterile Product Analysis
Potency Analysis

L. HAZARD COMMUNICATION PROGRAM

1. Standards of handling HDs shall be implemented and evaluated thru annual employee

competencies.

2. All containers of HDs shall be labeled with the identity of the material and appropriate hazard warning.

3. Material Data Sheets are available for all employees 24 hours a day via the SVMC intranet.

4. Personnel shall receive training on exposure prior to handling HDs or when there are hazard changes.

5. Personnel of reproductive capability shall confirm in writing that they understand the risk of handling HDs.

M. CONTAINMENT REQUIREMENTS

1. For dosage forms (tablets or capsules, solid intact medications) that are administered to patients without modification shall be handled as per a risk facility risk assessment.

2. The selected containment strategy (handling precautions) will be communicated to staff via Electronic Medical Record and auxiliary stickers or pharmacy labels.

3. The facility risk assessment shall be reevaluated annually.

N. In the event of a drug recall, the procedure found in SVMC policy DRUG RECALL PROCEDURE shall be followed.

O. The pharmacy maintains written policies and procedures for compounding and understands any material failure to follow the pharmacy's policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

P. All medications used for compounding sterile products, both hazardous and nonhazardous, will be procured from a registered wholesaler or from an FDA registered manufacturer.

Q. Documentation Retention

1. All records of compounding and materials used to compound sterile preparations shall be maintained in a readily retrievable form for three (3) years from the date the record was last in effect.

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

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

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

R. A pharmacy technician may, at the discretion of the pharmacist, remain in the pharmacy but may only perform nondiscretionary tasks. The pharmacist will be responsible for reviewing any tasks completed in the temporary absence, i.e., restroom break etc.

REFERENCES:

- USP 800 Hazardous Drugs- Handling in Healthcare Settings (2017). Retrieved from http://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/general-chapter-800.pdf. Accessed 6/24/2020.
- "ASHP Guidelines on Handling Hazardous Drugs." *American Journal of Health-System Pharmacy* 63, no. 12 (June 15, 2006): 1172–1191. doi:10.2146/ajhp050529. Accessed: November 6, 2018.
- Occupational Safety and Health Administration (OSHA) Guidelines for Controlling Occupational Exposure to Hazardous Drugs Accessed 6/24/20.https://www.osha.gov/SLTC/hazardousdrugs/index.html
- 2022 Lawbook for Pharmacy, Business and Professions Code 4000 https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf Accessed 3/2/2022.

CROSS REFERENCES:

- MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL
- IV PREPARATION AND DISPENSING
- COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM
- DRUG RECALL PROCEDURE

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Field Code Changed

1. Your doctor(s) have recommended the following operation or procedure:

   _____

   _____

   and the following type of anesthesia: _____

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, or newly discovered information will be performed on you. The operations or procedures will be performed by the doctor(s) named below (or in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists of Sierra View Medical Center to whom the doctor(s) performing the procedure may assign designated responsibilities.

2. Name(s) of the practitioner(s) who is/are performing and/or assisting with the procedure or administration of medical treatment: _____.

   The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, the persons in attendance for the purpose of performing specialized medical services such as your doctors, surgeons, and anesthesiologists, radiologists, or pathologists are not employees or agents of the hospital or of doctor(s) performing the procedure. They are independent medical practitioners.

3. All operations and procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

   - The nature of the operation or procedure, including other care, treatment or medications;
   - Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur with the anesthesia to be used and during recuperation;
   - The likelihood of achieving treatment goals;
   - Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
   - Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

   Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

4. If your doctor determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the various options for blood transfusion including pre-donation by yourself or others.

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PATIENT'S LABEL

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You also have the right to have adequate time before your procedure to arrange for pre-donation, but you can waive this right if you do not wish to wait. Transfusion of blood or blood products involves certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV), and you have a right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your doctor.

5. You authorize the pathologist to use their discretion in disposition or use of any cells, tissue, body part, hardware or foreign object removed from your person during the operation or procedure set forth above, subject to the following conditions (if any): _____

6. Any patient receiving a medical device that is subject to tracking under 21 U.S.C. Section 360i(e), may under CFR Section 821.55 refuse to have their name, address, telephone number, social security or other identifying information released to the device manufacturer.
Please initial if you DO NOT want this information released._____

7. Cardiac procedures are performed without on-site surgical back-up. In the event there is an emergent cardiac need, you will be transferred to another hospital for surgical intervention. We have a written plan with a contracted facility, in the event of a transfer. There is a possibility of risks related to transfer.

8. The hospital promotes the continuing education and advancement of the healthcare field by providing training opportunities for students of health professions. The students are supervised by hospital and non-hospital staff. You have the right to decide whether to agree to a student observing or participating during this procedure.
Please initial if you DECLINE student observation and/or participation as above. _____

9. Your signature on this form indicates that:
   - You have read and understand the information provided in this form;
   - Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and alternatives, and the other information described above in this form;
   - You have had a chance to ask your doctors questions;
   - You have received all of the information you desire concerning the operation or procedure and the anesthesia;
   - You authorize and consent to the performance of the operation or procedure and the anesthesia.

Date: _____ Time: _____AM/PM Signature: _____
(patient/legal representative)

If signed by other than patient, indicate name and relationship: _____
(patient/legal representative)

Date: _____ Time: _____AM/PM Witness: _____
(employee signature)

Witness: _____
(print name)

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

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PHYSICIAN CERTIFICATION FOR SURGERY/ SPECIAL PROCEDURE

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The risks and benefits of the procedure;
- Any adverse reactions that may reasonably be expected to occur;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
- The potential problems that may occur during recuperation; and
- Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 1 and 2 above. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____AM/PM Signature: _____
(physician)

Telephone witness of informed consent discussion between the consent giver and physician:

Witness:_____ Date:_____ Time: _____ AM / PM
(employee signature)

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (patient or patient's legal representative) in the patient's or legal representative's primary language (identify language) . He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my pres-

Date: _____ Time: _____AM/PM Signature: _____
(interpreter or remote interpreter's number)

Name: _____
(print)

PATIENT'S LABEL

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Procedure Checklist

Adult Intubation

Sierra View Medical Center

1) Identify the need for endotracheal intubation in the patient. If mid-level provider, consult with attending physician as soon as possible if he/she is available.

2) Obtain verbal or written (preferred) consent from the patient if not emergent. Explain the need for intubation, risks and benefits, brief description of procedure, etc.

3) Inform the nurse of intent to intubate the patient.

4) Inform the unit clerk to notify Respiratory Therapy to come to the ER with a ventilator

5) Request the Glidescope to be brought to the bedside. The Glidescope should preferably be used on all intubations as possible.

6) Provider to obtain and don PPE (goggles, mask, gloves, and gown (if indicated)

7) Insure suction with Yankauer catheter is set up and properly functioning at bedside

8) Insure Bag-Valve-Mask is set up, hooked to high-flow oxygen, and at bedside

9) Place orders for RSI medications if indicated (any combination of sedation and paralytic listed below but highlighted are preferred)

    a. Versed 1-2mg IVP
    b. Etomidate .3mg/kg IVP
    c. Ketamine 1 mg/kg IVP
    d. Propofol 2mg.kg IVP
    e. Fentanyl 50-100 mcg IVP
    f. Succinylcholine 1mg.kg IVP
    g. Rocuronium .6mg/kg
    h. Vecuronium 80-100 mcg/kg IVP (not for RSI induction, only after intubation)

10) Position patient in favorable position for intubation.

11) Insure there are sufficient staff in the room and no additional personnel

a. Intubating Provider
b. Respiratory Therapist
c. Medication Nurse
d. Recording Nurse

12) Insure the patient is on the cardiac monitor, blood pressure cuff, pulse oximetry

13) Insure the proper equipment is present and ready.

a. Glidescope or Laryngoscope with proper blade
b. Endotracheal tube with a back-up on size lower
c. Stylet
d. Nasogastric tube (18 Fr preferred)
e. 10cc syringe
f. 60cc NG syringe
g. Tube Securing device
h. Suction with Yankauer Catheter
i. Adult Bag-Valve-Mask
j. End-Tidal CO2 Detector device
k. Stethoscope

14) Check the Glidescope is working properly, proper size ET Tube (8.0 preferred) with no leaks in the cuff.

15) Give the order for RSI medications

16) Once the patient is sufficiently sedated, use the Glidescope or Laryngoscope to perform direct laryngoscopy to visualize the vocal cords. Once the vocal cords have been visualized, pass the endotracheal tube through the cords to approximately 22-24 cm depending on the patient's body size.

17) Withdraw the stylet while maintaining control of the endotracheal tube until the respiratory therapist takes control of the endotracheal tube

18) Insert the nasogastric tube under direct laryngoscopy into the esophagus to a proper depth (usually 55-70 cm)

19) Auscultate bilateral lung sounds and then epigastric confirmation of the NG tube.

20) Turn over control of the ET and NG tube to the RT for securing.

21) Order a STAT chest xray, abdominal film, and ABG. Confirm vital signs are stable.

22) Give ventilator settings to respiratory therapist

a) Mode (Assist Control, SIMV, IMV)
b) Tidal Volume (5-7ml/kg of Ideal Body Weight)
c) FIO2 (usually 100% unless pt is oxygenating well and for airway protection)
d) Peep (5-7 mmHg)
e) Rate (12-14 usually, higher if CO2 is elevated or increased ICP)

23) Give orders for maintenance sedation and RASS/Ramsey parameters.

RASS Scale (-3/-4 preferred)

+4 = Combative
+3 = Very Agitated
+2 = Agitated
+1 = Restless
0 = Awake and Calm
-1 = Drowsy
-2 = Light Sedation
-3 = Moderate Sedation
-4 = Deep Sedation
-5 = Unarouseable

Ramsay Scale (4-6 preferred)

1 = Awake and Alert, no impairment
2 = Awake but Tranquil, can converse
3 = Asleep, responds to normal verbal
4 = Asleep, responds to loud verbal
5 = Asleep, Sluggish to loud verbal
6 = Asleep, Sluggish to painful stimuli
7 = Asleep, Withdraws to pain
8 = Unresponsive

Sedation Medications

Fentanyl Drip: Start at 75mcg/hr and titrate up prn AND
Versed Drip: Start at 2mg/hr and titrate up prn

Diprivan Drip: Start at 100mcg/kg/min and titrate up prn

24) Check chest xray for verification of endotracheal tube and nasogastric tube positioning

25) Write procedure note and intubation sign-off sheet (if MLP performing procedure)

ADVANCED PROCEDURE CERTIFICATION

Sierra View Medical Center utilizes advanced care practitioners in the Emergency Department as primary providers under the direct supervision of the emergency room attending (ED MD) and ultimately under the site medical director (SMD) and at times these providers are required to interact with critical patients due to the staffing model incorporated at the hospital and the occasional circumstances where an ER MD is not available for various reasons.

Examples of unavailability of the ER MD could be as follows:

-ER MD called to the floor or ICU in the evening for a code blue

-ER MD called to intubate a patient due to Hospitalist inability to perform this procedure

-ER MD is indisposed of (restroom break)

-ER MD is dealing with another critical patient that requires him/her to be at bedside

-Mass Casualty Incident

It has been identified by both the administration at SVMC and NES Leadership team that the current staffing model dictates that mid-level providers should be credentialed in certain advanced procedures due to the critical nature and time-sensitive situations that arise in the emergency room when an ER physician may not be immediately available.

Any Mid-Level Provider (NP or PA) wishing to be credentialed for advanced procedures at SVMC will need to complete the following requirements for the requested procedure as follows:

1) Endotracheal Intubation:

-ACLS or FCCS (preferred) course with current certification

-5 successful intubations in the last two years OR 5 successful intubations in the OR or 5 successful intubations under the direct supervision of the ER medical director or his designated ER attending physician

-Pediatric intubations should be handled by the ER attending physician in ALL cases except when in an emergency situation where the ER physician is handling another critical patient requiring his/her present.

-PALS and/or NALS is required for pediatric intubation credentialing

-3 pediatric intubations within the last 2 years or successful intubations under the direct supervision of the ER medical director or his designated ER attending physician

-Sign off by Chief of Anesthesia

-Sign off by Emergency Department Medical Director

-Apply for Credentialing with Medical Staff Office with above documentation

-Recertification by procedure log is acceptable

-5 intubations in two years either in the ER or in the OR to maintain privileges

-Alternatively, the SMD or Chief of Anesthesia may sign off on re-credentialing based on direct observation of a successful intubation if the MLP was not able to achieve the minimum amount of intubations

-Successful completion of SVMC Conscious Sedation test

2) Central Venous Line Insertion:

-FCCS course with current certification

-5 successful CVL insertions in the last two years OR five successful insertions under the direct supervision of the ER medical director or his designated ER attending physician

-Successful completion of a Vascular Ultrasound course for CVL insertion OR certification by the SMD having observed and verified competence in US use and guidance

-Sign off by Emergency Department Medical Director

-Recertification by procedure log is acceptable

-5 CVL in two years either in the ER or completion of FCCS renewal course to maintain privileges

- Alternatively, the SMD may sign off on re-credentialing based on direct observation of a successful CVL insertion if the MLP was not able to achieve the minimum amount of procedures

3) Chest Tube Insertion:

- ATLS course with current certification
- -3 successful chest tubes in the last two years or 3 successful chest tube insertions under the direct supervision of the ER medical director or his designated ER attending physician
- Ability to setup and troubleshoot a pleuravac
- Recertification by procedure log is acceptable
- 3 thoracostomies in two years either in the ER to maintain privileges
- Alternatively, the SMD may sign off on re-credentialing based on direct observation of a successful chest tube insertion if the MLP was not able to achieve the minimum amount of procedures
- ATLS successful re-certification will also serve as evidence of competence in chest tube insertion and can be substituted for case log and SMD direct observation,
- Successful completion of SVMC Conscous Sedation Test.

Certification by Lab or Mannequin Experience

In the event that procedures are performed in a lab or with Mannequin experience:

A. 10 Adult intubations (age > 6 years old or at the discretion of the SMD)

B. 10 Pediatric Intubations (age < 6 at the discretion of the SMD_

C. 10 Central Venous Cannulation(s)

D. 5 Chest tubes

Upon completion of the above requirement(s) you are authorized to perform these procedures after written approval by the SMD.

After 2 years you may be recertified (based on procedure log, or repeat of the above).

Supervision of Procedures

Any procedures that are performed under direct supervision of a supervising physician must have individual completion forms completed by and signed by the attending physician who performed direct supervision. (See Appendix B)

Each APP must maintain procedure records that are available for review by any attending physician at any time as well as a copy of his/her credentialing paperwork that indicates approval of hospital credentials for said procedure

NES/~~SVMC will issue an identification badge with the MLP name and advanced procedures that they are allowed to perform for easy recognition by nursing and administrative staff. This badge must be attached to their hospital identification badge and available at all times (see Appendix A)~~

Direct supervision by an attending physician is always preferable for all advanced procedures, except in cases of emergency where delay would be detrimental to patient care.

Each procedure, upon completion of the minimum requirements, must be reviewed and authorized by the SMD

The SMD may, at his/her discretion require additional numbers of procedures to be performed by the MLP prior to signing off on independent performance.

The SMD may at his/her discretion or temporarily suspend or revoke a MLP's authorization to perform advanced procedures if in the opinion of the SMD the MLP is not proficient, following proper protocols, maintain required documentation, or otherwise breaching agreed upon guidelines for having the privilege to perform advanced procedures

Authorization of 2 year procedure review, compliance and completion, is the responsibility of the SMD. Any change in privilege status will be reported to medical staff office.

Management of Complications or Adverse Events

A complication is defined as a possible, though uncommon, anticipated outcome of a procedure that can result from normal performance and technique during a procedure. These complications are usually explained to the patient during the consent process.

Common Complications include the following:

Endotracheal Intubation

-Aspiration due to vomiting

-Rupture of Balloon on ET tube during passage of tube

-Failure or Intubation due to patient habitus or size

-Dental fracture

-Cessation of procedure due to equipment failure

-Transient hypotension secondary to RSI medications

CVL Insertion

-Pneumothorax

-Arterial puncture of Subclavian, Internal Jugular, or Femoral artery with hematoma

-Cessation of procedure site due to inability to advance wire

-Bleeding or oozing at the site, especially if on blood thinners

-Misplacement of the catheter into the IJ from the subclavian vein

-CRBSI (decreased with sterile precautions)

Chest Tube Insertion

-Bleeding at the site

-Hemothorax

-Infection at the site

-Inability to evacuate blood or fluid due to loculations

An adverse event is defined as an event that is not anticipated or considered an expected or potential outcome of a procedure. It usually occurs due to deviation from protocol, poor technique, or lack of confirmation of procedural success.

Potential Adverse Events will include the following:

Endotracheal Intubation

-Intubation of the esophagus

-Significant dental damage from laryngoscope technique

-Inappropriate ventilator settings

-Unidentified right mainstem intubation

CVL Insertion

-Unrecognized arterial cannulation

-Infection due to lack of sterile technique in a non-emergent situation

-Significant bleeding due to lack of checking for blood thinners or PT/INR in a non-emergent situation

-Tension or undiagnosed pneumothorax due to failure to obtain or check chest xray

-Poor positioning of CVL due to failure to obtain or check chest xray

Chest Tube Insertion

-Failure to place tube in correct position due to failure to check chest xray

-Infection due to lack of sterile precautions in a non-emergent placement

-Failure to recognize and troubleshoot lack of re-expansion of lung

-Placement of chest tube on wrong side

Process for Addressing Complications

All potential complications must be explained to the patient in non-emergent situations and a consent form signed. A nurse should be present to witness the consent.

Any complications must be immediately reported to the attending physician on duty and as soon as possible but a maximum of within 24 hours to the Site Medical Director.

Complications must be properly documented in the chart as well as any corrective action taken to address the complication.

The attending physician will discuss the complication with the mid-level provider and together will address the complication with the patient as well as any corrective action / procedure needed to fix the complication.

The attending physician will assume immediate co-management or take over care of the patient depending on the gravity of the situation and the patient's wishes.

A copy of the patient chart, the procedure note, and a written statement of the events will be prepared and forwarded by secure NES email to the SMD within 24 hours.

The SMD will review the chart and determine if a breach of protocol or avoidance or technique led to the complication or if the complication was unavoidable.

In the event that the complication was unavoidable, the matter will be closed and no further action.

In the event that the complication was potentially avoidable, the procedure privilege will be temporarily suspended pending a discussion with the SMD and review of the chart and complication. The case will automatically be forwarded to the peer review committee for consideration.

The SMD will have the discretion to restore the privilege once any remediation or education is met or after discussion and satisfactory resolution with the MLP regarding the case.

Process for Addressing Adverse Events

All potential complications must be explained to the patient in non-emergent situations and a consent form signed. A nurse should be present to witness the consent.

Any adverse events must be immediately reported to the attending physician on duty and immediately to the Site Medical Director.

The adverse event must be properly documented in the chart as well as any corrective action taken to address fix the adverse event..

The attending physician will discuss the adverse event with the mid-level provider and together will address the adverse event with the patient as well as any corrective action / procedure needed to fix the issue.

The attending physician will assume immediate management and take over care of the patient. The MLP will sign over care of the patient immediately.

A copy of the patient chart, the procedure note, and a written statement of the events will be prepared and forwarded by secure NES email to the SMD within 24 hours.

The SMD will review the chart and determine the root cause of the adverse event and will immediately temporarily suspend the specific procedure pending investigation and outcome.

The SMD and review of the chart and adverse even and discuss the case with the MLP and attending physician on duty at the time to fully understand the circumstances;. The case will automatically be forwarded to the peer review committee for consideration.

The SMD will have the discretion to restore the privilege once any remediation or education is met or after discussion and satisfactory resolution with the MLP regarding the case.

Temporary suspension and reinstatement of the privilege will be reported to the medical staff office (MSO) but no further action will be required by the MSO.

ADVANCED PRACTITIONER ADVANCED PROCEDURE AUTHORIZATION CARD

NAME_____

TITLE_____

Endotracheal Intubation YES NO

Date Effective_____Date Expires_____

Central Venous Line Insertion YES NO

Date Effective_____Date Expires_____

Chest Tube Insertion YES NO

Date Effective_____Date Expires_____

_____

Medical Director Signature

APPENDIX A

INTUBATION SIGN OFF SHEET

PT Sticker

___ PT identified appropriately as needing intubation (emergent, elective).

___ RN notified and order for appropriate medications given and RT summoned.

___All appropriate staff at bedside. Glidescope at bedside. Suction available.

___All equipment checked and verified to be working. Correct med doses at bedside.

___Correct and appropriate doses of RSI medications and maintenance drips ordered.

___Communicate start of procedure and time-out if indicated for elective procedure.

___ Appropriate medications given and Glidescope / Laryngoscope introduced.

___ Intubation (vocal cord visualization and passing of ETT Tube)

1st 2nd 3rd attempt (Circle one)

___Nasogastric Tube placed Depth_____ cm

___Confirmation of ETT and NG tube placement and securing (at least 4 methods)

___ CXR, ABG, ventilator settings, and maintenance drips ordered to appropriate RASS

___ Review of CXR, ABG, and RASS level to assure correct placement and sedation.

___ Procedure note completed and reviewed with ER Attending

Anesthesia and Sedation (filled out by MLP and confirmed by MD)

__ Mallampati score 1 2 3 4 (circle one)

__ ASA score 1 2 3 4 5 6 (circle one)

__RASS score 0 -1 -2 -3 -4 -5 (circle one)

__RSI Agents Ketamine 1mg/kg Etomidate .3mg/kg

(circle all) Versed .3mg/kg Propofol 2mg/kg

Succinylcholine 1mg/kg Vecuronium 80mcg/kg

Fentanyl 100 mcg

Sedation Maintenance: Fentanyl Versed Propofol Ketamine

Placement Confirmation: CXR SPO_2 > 95% Bilat Lung Sounds $ETCO_2$ Color

$ETCO_2$ 28-32 (-) air in epigastrum Direct Visualization

Ventilator Settings (filled out by MLP and confirmed by MD)

Mode_____VT_____Rate_____FIO_2_____PEEP_____PS_____

Complications: _____

_____ _____

Name (Mid-Level Provider) Signature (Mid-Level Provider)

_____ _____

Name (Attending MD) Signature (Attending MD)

_____

Signature (Emergency Department Medical Director)

CVL INSERTION SIGN OFF SHEET

PT Sticker

___ PT identified appropriately as needing CVL Access (emergent, urgent, elective).

___ Consent with Risks/Benefits explained and signed.

___PT/INR, PTT, and Blood Thinners status checked

___Pt placed in appropriate position and all non-essential personnel evacuated.

___Ultrasound at bedside and used during the procedure as indicated

___Communicate start of procedure and time-out if indicated for elective procedure.

___ Provider in sterile gown and attire and patient draped in sterile fashion

___ Needle puncture, wire introduced, wound dilated, and catheter introduced

___CVL sutured in and Biodisk / Tegaderm dressing applied after all 3 ports flushed

___Stat CXR for Subclavian and IJ procedures ordered and obtained

___ Proper placement verified via CXR and RN communicated OK to use CVL

Complications: _____

_____ _____

Name (Mid-Level Provider) Signature (Mid-Level Provider)

_____ _____

Name (Attending MD) Signature (Attending MD)

Signature (Emergency Department Medical Director)

CHEST TUBE INSERTION SIGN OFF SHEET

PT Sticker

___ PT identified appropriately as needing thoracostomy (emergent, urgent, elective).

___ Consent with Risks/Benefits explained and signed.

___PT/INR, PTT, and Blood Thinners status checked

___Pt placed in appropriate position and all non-essential personnel evacuated.

___Verify Pleurevac is hooked up to suction and functional

___Communicate start of procedure and time-out if indicated for elective procedure.

___ Provider in sterile gown and attire and patient draped in sterile fashion

___ Administer sedation with 1mg/kg of Ketamine to RASS -2

___Minimal incision made and appropriate location

___Indroduction of appropriate size chest tube with Kelly Forceps or Trochar

___Hook up Chest Tube to Pleurevac and insure no air leak and good seal

___Stat CXR ordered and placement verified via CXR

Complications: _____

_____ _____

Name (Mid-Level Provider) Signature (Mid-Level Provider)

_____ _____

Name (Attending MD) Signature (Attending MD)

NAME: _____

SIERRA VIEW MEDICAL CENTER

CLINICAL PRIVILEGES FOR NURSE PRACTITIONER – EMERGENCY DEPARTMENT

❑ **NEW APPLICANT** ❑ **REAPPOINTMENT**

PRIVILEGE/CATEGORY	EDUCATION/TRAINING/QUALIFICATIONS/ REQUIREMENTS	EXPERIENCE	REAPPOINTMENT REQUIREMENTS	PRIVILEGES	
				GRANTED	NOT GRANTED
Family Nurse Practitioners in the emergency department (ED) are licensed practitioners who practice emergency care **in collaboration with the** physician ❑ **Family Nurse Practitioner Core Privileges – Emergency Department** Core privileges for NPs in the ED include, but are not limited to the following: ▪ Take patient histories and perform physical examinations, including MSEs ▪ Record or dictate the information into the patient chart ▪ Perform or assist in the performance of laboratory and patient screening procedures ▪ Perform diagnostic and therapeutic studies ▪ Order and interpret diagnostic laboratory tests and radiological studies ▪ Order medications and other therapies ▪ Perform procedures that include but are not limited to the following: o Suturing o wound care o splinting of extremity fractures o reduction of joint dislocations o I&D (incision and drainage) of abscesses o foreign body removal o lumbar punctures o reduction of fractures	Basic Education: Master's degree Minimum Formal Training: Demonstrate completion of an accredited RN program. In addition, an NP should meet the following requirements: Successful completion of an accredited NP program and completion of training in the ED procedures for which privileges are sought. A current state RN license and NP license. A current state NP furnishing license and DEA certificate. Current ACLS and PALS certification. Evidence of adequate professional liability insurance secured either through the NP's employer or held by the NP. Employment by or agreement with a physician group currently contracted with hospital.	Applicants must be able to demonstrate that they have provided patient care services for at least 50 patients in the past 12 months or are a recent graduate of an accredited NP program.	Demonstrate maintained competence by showing evidence that ED services have been provided for at least 50 patients annually over the preceding two years.		

NAME: _____

PRIVILEGE/CATEGORY	EDUCATION/TRAINING/QUALIFICATIONS/ REQUIREMENTS	EXPERIENCE	REAPPOINTMENT REQUIREMENTS	PRIVILEGES	
				GRANTED	NOT GRANTED
Advanced Privileges Requested: ❑ **Endotracheal Intubation** Note: Pediatric intubations should be handled by the ER attending physician in **ALL** cases except when in an emergency situation the ER physician is handling another critical patient requiring his/her presence.	ACLS or FCCS (preferred) course with current certification. Successful completion of SVMC Procedural Sedation Exam.	5 successful intubations in the last two years. This can be in the OR or under the direct supervision of the ED Medical Director or his designated ER attending physician. 3 pediatric intubations in the last two years. Sign off by Chief of Anesthesia or Emergency Department Medical Director.	5 intubations in two years either in the ER or OR. (Procedure log will be accepted) OR ED Medical Director or Chief of Anesthesia may sign off based on direct observation of a successful intubation.		
❑ **Central Venous Line Insertion**	FCCS course with current certification. Successful completion of a vascular ultrasound course for CVL insertion OR certification by the ED Medical Director having observed and verified competence in US use and guidance.	5 successful CVL insertions in the last two years OR 5 successful insertions under the direct supervision of the ED Medical Director or his designated ER attending physician. Sign off by ED Medical Director.	5 CVL insertions in two years in the ER or completion of FCCS renewal course. OR ED Medical Director may sign off based on direct observation of a successful CVL insertion.		
❑ **Chest Tube Insertion**	ATLS course with current certification. Successful completion of SVMC Procedural Sedation Exam.	3 successful chest tubes in the last two years or 3 successful chest tube insertions under the direct supervision of the ED Medical Director or his designated ER attending physician. Ability to setup and troubleshoot a pleuravac.	3 thoracostomies in two years. (Procedure log will be accepted) OR ED Medical Director may sign off based on direct observation of a successful chest tube insertion OR ATLS successful recertification		

Department of Emergency Medicine Review: 08/18/2015Draft 06.16.22
IDP/Credentials Committee Review: 03/24/2014
Medical Executive Committee Review: 09/02/2015
Board Review: 9/22/2015

NAME: _____

I hereby attest that I have personally reviewed these categories and have met the training, certification and experience, and understand that falsification is grounds for suspension.

Print full name	Signature	Date
_____	_____	_____

I hereby attest that I have reviewed this application for privileges and determined that the applicant has met the training, certification and experience to perform these procedures.

	Print full name	Signature	Date
VPPCS/Chief Nurse Exec:	_____	_____	_____
Department Chair:	_____	_____	_____

DATES OF APPROVALS:

Credentials Committee	Medical Executive Committee	Board of Directors
_____	_____	_____

201

Department of Emergency Medicine Review: 08/18/2015Draft 06.16.22
IDP/Credentials Committee Review: 03/24/2014
Medical Executive Committee Review: 09/02/2015
Board Review: 9/22/2015

NAME: _____

SIERRA VIEW MEDICAL CENTER

CLINICAL PRIVILEGES FOR PHYSICIAN ASSISTANT – EMERGENCY DEPARTMENT

☐ **NEW APPLICANT** ☐ **REAPPOINTMENT**

PRIVILEGE/CATEGORY	EDUCATION/TRAINING/QUALIFICATIONS/ REQUIREMENTS	EXPERIENCE	REAPPOINTMENT REQUIREMENTS	PRIVILEGES	
				GRANTED	NOT GRANTED
Physician Assistants (PA) in the emergency department (ED) are licensed practitioners who practice emergency care under physician supervision. ❑ **Physician Assistant Core Privileges – Emergency Department**					
Core privileges for PAs in the ED include, but are not limited to the following: ▪ Take patient histories and perform physical examinations, including MSEs ▪ Record or dictate the information into the patient chart ▪ Perform or assist in the performance of laboratory and patient screening procedures ▪ Perform diagnostic and therapeutic studies ▪ Order and interpret diagnostic laboratory tests and radiological studies ▪ Order medications and other therapies ▪ Perform procedures that include but are not limited to the following: o Suturing, wound care, splinting of extremity fractures, reduction of joint dislocations, I&D (incision and drainage) of abscesses, foreign body removal, lumbar punctures, reduction of fractures	Basic Education: Master's, baccalaureate, or associates degree. Minimum Formal Training: Demonstrate completion of an accredited PA program. In addition, a PA should meet the following requirements: Successful completion of an accredited postgraduate PA program in emergency medicine or completion of training in the ED procedures for which privileges are sought. Successful completion of the national certifying examination given by the NCCPA. A current state license and a current DEA certificate. Evidence of adequate professional liability insurance secured either through the PA's employer or held by the PA. Employment by or agreement with a physician group currently contracted with the hospital. Physician supervisor appointed to the medical staff of the hospital.	Applicants must be able to demonstrate that they have provided patient care services for at least 50 patients in the past 12 months or are a recent graduate of an accredited PA Program.	Demonstrate maintained competence by showing evidence that ED services have been provided for at least 50 patients annually over the preceding two years.		

Approved by the Emergency Medicine Department: 10/07, Revised 06/22/2013, 08/18/2015 Draft 06.16.22
Approved by the MEC: 11/07, Revised: 07/01/2013, 09/02/2015
Approved by the Board of Directors: 12/07, Revised: 07/23/2013, 09/22/2015

NAME: _____

PRIVILEGE/CATEGORY	EDUCATION/TRAINING/QUALIFICATIONS/ REQUIREMENTS	EXPERIENCE	REAPPOINTMENT REQUIREMENTS	PRIVILEGES	
				GRANTED	NOT GRANTED
Advanced Privileges Requested: ❑**Endotracheal Intubation** Note: Pediatric intubations should be handled by the ER attending physician in ALL cases except when in an emergency situation the ER physician is handling another critical patient requiring his/her presence.	ACLS or FCCS (preferred) course with current certification. Successful completion of SVMC Procedural Sedation Exam.	5 successful intubations in the last two years. This can be in the OR or under the direct supervision of the ED Medical Director or his designated ER attending physician. 3 pediatric intubations in the last two years. Sign off by Chief of Anesthesia or Emergency Department Medical Director.	5 intubations in two years either in the ER or OR. (Procedure log will be accepted) OR ED Medical Director or Chief of Anesthesia may sign off based on direct observation of a successful intubation.		
❑ **Central Venous Line Insertion**	FCCS course with current certification. Successful completion of a vascular ultrasound course for CVL insertion OR certification by the ED Medical Director having observed and verified competence in US use and guidance.	5 successful CVL insertions in the last two years OR 5 successful insertions under the direct supervision of the ED Medical Director or his designated ER attending physician. Sign off by ED Medical Director.	5 CVL insertions in two years in the ER or completion of FCCS renewal course. OR ED Medical Director may sign off based on direct observation of a successful CVL insertion.	----------	----------
❑**Chest Tube Insertion**	ATLS course with current certification. Successful completion of SVMC Procedural Sedation Exam.	3 successful chest tubes in the last two years or 3 successful chest tube insertions under the direct supervision of the ED Medical Director or his designated ER attending physician. Ability to setup and troubleshoot a pleuravac.	3 thoracostomies in two years (Procedure log will be accepted) OR ED Medical Director may sign off based on direct observation of a successful chest tube insertion OR ATLS successful recertification	----------	----------

NAME: _____

I hereby attest that I have personally reviewed these categories and have met the training, certification and experience, and understand that falsification is grounds for suspension.

Applicant:

_____	_____	_____
Print full name	**Signature**	**Date**

I hereby attest that I have reviewed this application for privileges and determined that the applicant has met the training, certification and experience to perform these procedures.

Department Chair: _____ _____ _____

Print full name	**Signature**	**Date**

DATES OF APPROVALS:

_____	_____	_____
Credentials Committee	Medical Executive Committee	Board of Directors

Approved by the Emergency Medicine Department: 10/07, Revised 06/22/2013, 08/18/2015 Draft 06.16.22
Approved by the MEC: 11/07, Revised: 07/01/2013, 09/02/2015
Approved by the Board of Directors: 12/07, Revised: 07/23/2013, 09/22/2015

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Senior Leadership Team	7/26/2022
Board of Director's Approval	
_____ Bindusagar Reddy, MD, Chairman	7/26/2022 Date

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
July 26, 2022
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	**Action**
Policies:		Approve ↓
1. Chart Thinning	1	
2. Civil Disturbance Plan	2-3	
3. Equal Employment Opportunity	4-5	
4. Hospital Service Teams – Participation and Guidelines	6-7	
5. Worker's Compensation	8-12	
Forms:		
1. Patient Rights	13-18	
Reports:		
1. Human Resources Annual Report	19-26	
2. Marketing Report Q2	27-48	

SUBJECT: **CHART THINNING**	SECTION: **Page 1 of 1**

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

POLICY:

Charts shall be thinned by the nursing staff in order to reduce bulk of the medical records.

PROCEDURE:

1. The following documentation is to be retained on each patient medical record currently in the hospital unless the physician electronically signs his dictated report:

    a. Admission Assessments

    b. History and Physical

    c. Consultation

    d. Operative Reports

    e. Request for Photographs Documentation

    f. Approximately one (1) week of:

    - Progress Notes
    - Pressure Ulcer Flow Sheet
    - Graphics
    - Clinical Laboratory Reports

2. All forms removed from the chart shall be secured and labeled with patient name, medical record number and "thinned chart" indicator. The chart shall then be forwarded to the Health Information Management Department by the unit clerk. The Assembler shall then assemble the chart in the Health Information Management Department until the patient is discharged. At that time the current chart shall be combined with the thinned chart.

REFERENCES:

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

SUBJECT: **CIVIL DISTURBANCE PLAN**	SECTION: ***Special Circumstances*** **Page 1 of 2**

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

POLICY:

The hospital must be prepared to respond to civil disturbances, riots, or other security threats so that patients, staff, and visitors may be safe from harm and patient care may continue to be delivered.

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

PROCEDURE:

1. Any person or group of persons on the premises who are determined or suspected to have no official business or medically related reason for being in the hospital shall be challenged by staff and escort arranged with Security/Engineering out of the building as discreetly as possible. Assistance will be sought from the Police Department if needed.

2. In the event of a potentially violent situation, Security/Engineering will be notified immediately to respond. The Police Department will be called if needed or if the threat is significant (large group, brandishing lethal weapons, etc.) In the case of an organized group attempting to reach a patient or member of the hospital staff with intent to harm, the Police Department must be called immediately. If there is any doubt, it is better to inform them too early rather than too late as the situation can often be resolved before violence occurs.

3. If not already inside the facility, every effort shall be made to secure all entrances to prevent entry to the facility.

4. Security/Engineering may direct the Switchboard to page: "Code Gray" – Visitor or patient out of control or "Situation W" – Person in house with weapon. All available Security and Engineering personnel will respond to the designated location. All other personnel must remain away from the area.

5. Special attention should be given to protect the liquid oxygen storage area, generators, and boiler room from intruders.

6. Other options:

    a. Initiate "Triage Code 1" internal disaster plan (can be initiated by Chief Executive Officer, Administrator on Call, Safety Officer, or designee).

    b. Divert ambulance traffic if Emergency Department is affected, with the exception of serious emergencies.

    c. Post guard at the Emergency Department entrances.

    d. Depending upon the particular incident and its seriousness, consider securing vital records or transporting them to safe locations outside the facility.

e. Special attention should be given to safeguarding computer equipment and systems.

REFERENCES:

- Title 22: Section 70741, 70743, 70745, 70746
- The Joint Commission (2022) Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL. EC.02.01.01 EP9

CROSS REFERENCES:

- SVMC Policy and Procedure – Code Gray – Visitor or Patient Out of Control
- SVMC Policy and Procedure – Code Silver Person with a Weapon or Active Shooter
- SVMC Policy and Procedure – Standardized Emergency Codes

SUBJECT:	SECTION:
EQUAL EMPLOYMENT OPPORTUNITY	*Human Resources*
	Page 1 of 2

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

PURPOSE:

To ensure compliance with all applicable laws providing equal employment opportunities to all qualified individuals and protection from unlawful discrimination.

POLICY:

Sierra View Medical Center (SVMC) is an equal opportunity employer and makes employment decisions on the basis of merit, qualifications, potential and competency. SVMC policy prohibits unlawful discrimination based on race, color, creed, gender (including gender identity and gender expression), religion (all aspects of religious beliefs, observance or practice, including religious dress or grooming practices) marital status, registered domestic partner status, age, national origin or ancestry, physical or mental disability, medical condition (including cancer or a record or history of cancer, and genetic characteristics), sex (including pregnancy, childbirth, breastfeeding or related medical condition), genetic information, sexual orientation, veteran status or any other consideration made unlawful by federal, state, or local laws. It also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. Discrimination can also include failing to reasonably accommodate religious practices or qualified individuals with a disability where the accommodation does not pose an undue hardship. All such discrimination is unlawful.

SVMC is committed to complying with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in the operations of SVMC and prohibits unlawful discrimination by any employee of SVMC.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES/INTERNS/VOLUNTEERS/JOB APPLICANTS*

PROCEDURE:

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, SVMC will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant, an employee, unpaid intern or student volunteer unless undue hardship would result. For additional detail, please refer to the policy titled "Reasonable Accommodations."

Any reports or complaints concerning a violation of this policy will be promptly investigated. If SVMC determines that unlawful discrimination has occurred, prompt and effective remedial action will be taken. Appropriate action will also be taken to deter any future discrimination. Whatever action is taken will be made known to the victim of any discrimination, and SVMC will take appropriate action to remedy any losses suffered due to discrimination.

SVMC will not retaliate against any applicant, employee, or unpaid intern or volunteer for filing a good faith complaint, participating in an investigation and/or testifying or assisting in any proceeding involving

allegations of discrimination, and SVMC will not tolerate retaliation by a member of management or fellow staff members, interns or volunteers.

Applicants, interns, volunteers or employees shall report all incidents of alleged discrimination to the Human Resources Department.

The Human Resources Department is responsible for ensuring that these requirements are being followed in the hiring and placement of employees and in all other formal actions or events regarding personnel administration.

REFERENCES:

- Title VII of the Civil Rights Act of 1964
- The Age Discrimination in Employment Act of 1967
- The Americans with Disabilities Act of 1990
- The ADA Amendments Act of 2008
- The Immigration and Nationality Act
- AB 1443- Fair Employment and Housing Act Anti-Discrimination and Anti-Harassment Provisions

CROSS REFERENCES:

- REASONABLE ACCOMODATIONS
- ANTI-DISCRIMINATION, HARASSMENT & NON-RETALIATION

SIERRA VIEW MEDICAL CENTER

SUBJECT: **SERVICE EXCELLENCE TEAMS**	SECTION: ***Housewide Policy*** **Page 1 of 2**

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

PURPOSE:

To identify the purpose and criteria for employee participation on SVMC's hospital service excellence teams. Service Excellent Teams (SET) include the Awards and Recognition Committee, The Culture Team, The EPPEC Team and The Wellness Committee.

POLICY:

Service Excellence Teams are designed to enhance the overall morale and offer staff a fun, engaging and healthy workplace. Each SET will focus on events, activities, and initiatives which support SVMC's mission, vision and values. Each SET will have a VP-level executive sponsor.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

To be eligible to participate on a SVMC SET staff members must meet the following criteria:

- Newly hired staff must complete at least six months of employment.
- Staff must be able to demonstrate success in their position and be viewed as a role-model of SVMC's values to be considered to participate on a service team. If a staff member is placed on a written-level notice of corrective action, the Director/Manager will ask their staff member to step down from their respective SET team and the Director/Manager will notify the SET executive sponsor. The staff member, if no further notice of corrective actions are issued can be re-considered for a SET after six (6) months from the NOCA.
-
- Staff can self-select to join a team if they meet the above criteria with leadership approval and/or be recommended to join a team from their leadership team member.
-
- Existing staff serving on a service team who transfer into a new position Can remain on the SET with the approval of their new department leadership.
- Service on a team is not established for any certain period of time. As long as the staff member remains in good standing and continues to want to serve, they are afforded this opportunity.
- Staff may only serve on one (1) service team at a time.

At any point during the employee's tenure on a team, if any of the above listed criteria have not been met, the employee's membership will be withdrawn from the service team. This will be done discreetly and confidentially, with the assistance of the staff member's SET executive sponsor.

6

Time spent by employees performing tasks for their respective teams will be considered to be "hours worked" and employees will be paid at their base rate of pay. Service on a SET is not intended to result in receiving overtime pay. To avoid working greater than 40 hours in a work week, employees may be permitted to flex their scheduled hours, with prior authorization from the employee's respective department Director/Manager, based on the needs of the department.

REFERENCES:

- PERSONAL CONDUCT
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT
- ATTENDANCE AND PUNCTUALITY

SUBJECT: **WORKERS' COMPENSATION**	SECTION: **Page 1 of 5**

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

POLICY:

Workers' Compensation benefits are available to employees sustaining an occupational illness or injury arising out of the course of employment.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Employees shall report any occupational illness or injury immediately via the electronic incident reporting system and follow up with department leadership.

Department leaders shall prepare an action plan for each incident using the electronic incident reporting system. Department leader shall escort the employee to Employee Health Services (EHS). (See Addendum A.)

Employees failing to report work related injures with 24 hours of the occurrence jeopardize their Worker's Compensation Benefits.

Benefits will be paid for any temporary disability and medical expenses for all compensable occupational illnesses or injuries incurred while in the course and scope of employment. The rate of compensation is approximately 2/3 of the average weekly salary. Worker's Compensation benefits do not reimburse self-procure medical treatment and their expenses.

Department leaders may not discriminate or retaliate against any employee for filing a Workers' Compensation Claim or for retaining an attorney to assist them in their claim for benefits.

Department leadership, with the assistance of Employee Health Services (EHS), are responsible for investigating injuries, safety practices, and other safety issues in order to maintain a safe working environment. The Electronic Event Report shall be used for this purpose and is routed to EHS.

An employee experiencing an absence for three days or longer should be placed on a leave of absence in accordance with our leave of absence policies. See "LEAVE OF ABSENCE – FMLA/CFRA" for eligible employees. Employees whose length of service at the time of injury is less than one year should contact Human Resources (HR) for other leave options.

Time away from work due to an on the job injury/illness will generally qualify under the Family Medical Leave Act. All provisions of the Family Medical Leave Act (FMLA), including twelve (12) weeks of job and benefits protected leave, shall apply. Refer to "LEAVE OF ABSENCE – FMLA/CFRA."

Department leadership, with guidance from Human Resources (HR)/EHS, shall consider transitional return to work assignments for employees who have been released by their physician to return to work with work restrictions. Returning an employee back to work as soon as possible even if there are work restrictions resulting in modified duty considerations encourages quicker recovery for the employee. See policy "TRANSITIONAL RETURN TO WORK" when considering reasonable accommodations.

HR/EHS shall be advised immediately when light duty is not available within the employee's department. Transitional return to work assignments may be found outside the employee's home department.

Department leaders are responsible for immediately notifying the Workers' Compensation Coordinator of any time lost by an employee due to occupational injury or illness. All treatment-related documents should be forwarded to EHS.

It is the Department leader's responsibility to communicate the policy for reporting an occupational illness or injury while on duty to employees.

Determinations regarding benefit eligibility and premium contributions are deferred to applicable paragraph(s) appearing in the Benefits Policy for Worker's Compensation Claims. Benefit decisions for employees accepting employment outside the Hospital or who become eligible for Vocational Rehabilitation programs are deferred to the Benefits Policy. Employment status ceases with acceptance of employment outside of the Hospital, denial of alternative job offers made by the Hospital meeting the employee's permanent work restrictions or the acceptance or denial of Vocational Rehabilitation eligibility.

Systems:

Electronic Reporting System

Responsibility:

Employees, Department Leaders (Managers, Directors, Supervisors, etc.), Human Resources, and Employee Health Services

Addendum A:

Accident Reporting Flow Chart

REFERENCES:

- California Workers' Compensation Statutes
- Family Medical Leave Act

CROSS REFERENCES:

- BENEFITS
- LEAVE OF ABSENCE- FMLA/CFRA
- LEAVE OF ABSENCE- PERSONAL
- VACATION/HOLIDAY LEAVE

- TRANSITIONAL RETURN TO WORK

Addendum A

WHEN AND WHERE TO REPORT WORK RELATED INJURES

A. Injured Employee Responsibility:

1. Complete Electronic Event Report.
2. Notify supervisor immediately.
3. Employees will follow-up with EHS immediately or on the next business day for necessary medical treatment. If injuries are life-threatening, the employee will be taken to the Emergency Department immediately.

B. Supervisor's Responsibilities:

1. Injuries requiring medical treatment: Employee will be taken to Employee Health Services (EHS) for evaluation and treatment.
   a. Employee Health Services office hours: Monday-Friday 7:00AM to 3:30PM
   b. Injuries occurring after EHS hours that are emergent or require treatment will require that the employee be taken to the Emergency Department: this includes weekends and holidays. **Employee must follow up with EHS on their next business day.**
2. Injuries that are life threatening: take employee to the Emergency Department immediately.
3. Notify EHS as soon as possible, but no later than 24 hours after the injury occurs.
4. For Bloodborne Pathogen injuries/exposures, be sure to follow the BLOODBORNE PATHOGEN KIT instructions and complete all of the necessary forms.

C. EHS

1. Provide the injured worker with DWC-1 form and additional forms.
2. Report the claim to the Third Party Administrator.
   a. Complete the Occupational Safety and Health Administration (OSHA) log and sharps log
   b. Track all First Aid Injuries
3. Follow-up with the treating physician.

4. Follow-up with the employee.

5. Follow-up with the Department leader.

   a. Employees' work status, lost time, modified duty, returning employee back to work.

   b. Check Electronic Event Report to see if an action plan was completed.

   c. Report quarterly to the Safety Committee.

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and nonphysicians who will see you.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to access your medical records. You will recieve a separate "Notice of Privacy Practices" that explains your rights to access your records. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or nontreatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.

7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of pain with methods that include the use of opiates.

10. Receive information about how to formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
PATIENT RIGHTS
Form # 015983 REV 12/20

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

B

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.

17. Know which hospital rules and policies apply to your conduct while a patient.

18. Designate a support person as well as visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, or registered domestic partner status, unless:

    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - You have told the health facility staff that you no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of the hospital's bill regardless of the source of payment

21. Exercise these rights without regard to, and to be free of discrimination, on the basis of, sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.

22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling:
    Sierra View Medical Center
    Risk Department Designee
    465 W. Putnam Ave., Porterville, CA 93257
    559-788-6033
    The grievance committee will review each grievance and provide you with a written response within seven days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).

23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's address and phone number and is:
    California Department of Public Health
    Licensing and Certification.,
    4540 California Ave., Suite 200
    Bakersfield, California 93309
    (661)336-0543 Office
    (866)222-1902 Toll Free

24. Submit a grievance regarding quality of care or early discharge issues. The Family Centered Care (BFCC) QIO for the State of California will manage all beneficiary complaints, quality of care reviews, EMTALA, and other types of case reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families.
    BFCC QIO PROGRAM
    Livanta
    9090 Junction Drive, MD 20701
    (877)588-1123
    TTY (855)887-6668
    Fax (855)694-2929

25. File a complaint with The Joint Commission:
    Mail: Office of Quality and Patient Safety
    The Joint Commission
    One Renaissance Boulevard
    Oakbrook Terrace, IL 60181
    Fax 630-792-5636

26. File a complaint with the California Department of Fair Employment and Housing.
    CDFEH
    2218 Kausen Drive, Suite 100
    Elk Grove, CA 95758
    800-884-1684
    www.dfeh.ca.gov

27. File a complaint with the Medical Board of California.
    Medical Board of California
    Central Complaint Unit
    2005 Evergreen Street, Suite 1200
    Sacramento, CA 95815
    800-633-2322
    www.mbc.ca.gov/consumers/complaints

Usted tiene derecho a:

1. Recibir una atención considerada y respetuosa, y a sentirse cómodo. Ústed tiene derecho a ser respetado por sus valores, creencias y preferencias culturales, psicosociales, espirituales y personales.

2. Que le avisen de inmediato a un familiar (u otro representante de su elección) y a su propio médico hospital.

3. Saber el nombre del profesional de atención médica certificado que actúa en el marco de su certificación profesional y que tiene la responsabilidad principal de coordinar su atención, y los nombres y las relaciones profesionales de los médicos y empleados de salud que lo verán.

4. Recibir información acerca de su estado de salud, diagnóstico, pronóstico, tratamiento, posibilidades de recuperación y resultados de la atención (incluidos los resultados no esperados) con términos que usted pueda comprender. Usted tiene el derecho al acceso de su historial médico. Recibirá una "Notificación de Practicás Privadas" separada en la que se explica sus derechos de acceso a su historial.Tiene derecho a tener una comunicación efectiva y participar en el desarrollo e implementación de su plan de atención. También puede participar en cuestiones éticas que surjan durante su atención, incluidos temas sobre resolución de conflictos, negación a recibir servicios de resucitación, y continuación o retiro del tratamiento para mantener la vida.

5. Tomar decisiones sobre su atención y recibir toda la información sobre cualquier tratamiento o procedimiento porpuesto que pueda necesitar para dar su consentimiento informado o negarse al tratamiento. Excepto en casos de emergencia, esta información incluira una descripción del procedimiento o tratamiento, los riesgos medicamente significativos que implican, los tratamientos alternativos o no tratamientos, y los riesgos que cada uno incluye, y el nombre de la persona que realizara el procedimiento o tratamiento.

6. Solicitar o negarse a recibir tratamiento, en la medida que lo permita la ley. Sin embargo, usted no tiene derecho a exigir tratamientos o servicios inadecuados o que no sean médicamente necesarios. Tiene derecho a abandonar el hospital incluso en contra de la recomendación de los miembros del personal médico, en la medida que lo permita la ley.

7. Ser notificado si el hospital o el profesional de atención médica certificado que actúa en el marco de su certificación profesional propone participar o realizar experimentos en humanos que afecten su atención o tratamiento. Tiene derecho a negarse a participar en tales proyectos de investigación.

8. Recibir respuestas razonables a toda solicitud razonable que realice sobre los servicios.

9. Recibir una evaluación y un control adecuado de su dolor, información sobre el dolor y medidas para el alivio del dolor, y a participar en decisiones acerca del control del dolor. También puede solicitar o rechazar el uso de cualquiera o todas las modalidades para aliviar el dolor, incluidos los medicamentos opiaceos, si sufre de dolor grave persistente. El médico puede negarse a recetar medicamentos opiáceos, pero si es asi, debe informarle a usted que existen médicos que se especializan en el tratamiento del dolor con métodos que incluyen el uso de opiáceos.

10. Recibir información sobre cómo formular directivas anticipadas. Esto incluye designar a un tomador de decisiones si no puede comprender un tratamiento propuesto o si no puede comunicar sus deseos con respecto a la atención. El personal del hospital y los profesionales que brindan atención en el hospital deberán cumplir con estas directivas. Todos los derechos de los pacientes se aplican a la persona que tiene la responsabilidad legal de tomar decisiones con respecto a la atención médica en su nombre.

11. Que su privacidad sea respetada. La discusión del caso, las consultas, los exámenes y el tratamiento son confidenciales y se deben realizar con discreción. Tiene derecho a que le indiquen la razón de la presencia de cualquier persona. También tiene derecho a que las visitas se retiren antes de un examen y cuando se habla de temas relacionados con el tratamiento. Se usarán cortinas para privacidad en habitaciones semiprivadas.

12. Recibir tratamiento confidencial de todas las comunicaciones y registros relacionados con su atención y permanencia en el hospital. Usted recibirá un "Aviso Sobre Practicas de Privacidad" (Notice of Privacy Practices) por separado que explica en detalle sus derechos a la privacidad y como podemos utilizar y divulgar la información protegida sobre su salud.

13. Recibir atención en un entorno seguro, donde no haya abuso, mental, físico, sexual ni verbal, ni tampoco abandono, explotación o acoso. Usted tiene derecho a acceder a servicios de protección y defensa, lo que incluye notificarles a las agencias de gobierno sobre abandono o abuso.

14. No tener restricciones ni estar aislado de ninguna forma por decisión del personal como medio de coerción, disciplina, conveniencia o represalia.

15. Recibir una atención razonablemente continua y saber por adelantado la hora y el lugar de las citas, así como también la identidad de las personas que proporcionan la atención médica.

16. Ser informado por el médico, o un representante del médico, de los requisitos y opciones de atención médica continua luego de ser dado de alta del hospital. También tiene derecho a participar en el desarrollo e implementación de su plan para ser dado de alta. Si lo solicita, un amigo o un familiar también pueden recibir esta información.

17. Conocer qué reglas y políticas del hospital se aplican a su conducta mientras sea paciente.

18. Designar un acompañante así como también visitas que usted elija, si tiene la capacidad de tomar decisiones, independientemente de que la visita sea un familiar de sangre, por matrimonio o una pareja de hecho registrada, a menos que:

    - No se permitan visitas.
    - El establecimiento determine de manera razonable que la presencia de una visita en particular podría poner en peligro la salud o la seguridad de un paciente, de un miembro del personal del establecimiento de salud o de otras visitas en el establecimiento, o podría interrumpir de manera significativa las funciones de dicho establecimiento.
    - Usted le haya notificado al personal del establecimiento de salud que ya no desea que una persona determinada lo visite.

    Sin embargo, un establecimiento de salud puede establecer restricciones razonables para las visitas, incluidas restricciones sobre los horarios de visita y la cantidad de personas. El establecimiento de salud debe informarle a usted (o a su acompañante, cuando corresponda) sobre sus derechos de visita, incluidas las restricciones o limitaciones clínicas. El establecimiento de salud no puede restringir, limitar o, de otro modo, negar los privilegios de visita por razones de raza, color, nacionalidad, religión, sexo, identidad de género, orientación sexual o discapacidad.

19. Que sus deseos sean tenidos en cuenta si no tiene la capacidad de tomar decisiones para determinar quién lo puede visitar. El método de dicha consideración cumplirá con la ley federal y se divulgará en las políticas del hospital sobre las visitas. Como mínimo, el hospital incluirá toda persona que viva en su hogar y acompañante de conformidad con la ley federal.

20. Evaluar y recibir una explicación de la cuenta del hospital, independientemente de la fuente de pago.

21. Ejercer estos derechos sin importar su y estar libre de discriminacion basada en sexo, situación económica, nivel de educación, raza, color, religión, ascendencia, nacionalidad de origen, orientación sexual, identidad/expresión de genero, discapacidad, condición médica, estado civil, edad, concubinato registrado, información genética, ciudadanía, idioma primario, estatus migratorio, (excepto según lo requerido por ley federal) o la fuente de pago para su atención médica.

22. Presentar una queja. Si desea presentar una queja en este hospital, puede hacerlo por escrito o llamando a:
    Sierra View Medical Center
    Risk Department Designee
    465 W. Putnam Ave., Porterville, CA 93257
    559-788-6033
    El comité de quejas analizará cada queja y le dará una respuesta por escrito dentro de 7 días. La respuesta por escrito incluirá el nombre de la persona con la que debe comunicarse en el hospital, las medidas tomadas para investigar la queja, los resultados del proceso conciliatorio, y la fecha de finalización del proceso conciliatorio. Las inquietudes relacionadas con la calidad de la atención o una dada de alta prematura también pueden ser remitidas a la organización correspondiente sobre la utilización y control de calidad, Peer Review Organization (PRO).

23. Presentar una queja ante el Departamento de Salud Pública de California (California Department of Public Health), independientemente de que utilice el proceso de quejas del hospital. El número de teléfono y la dirección del Departamento de Salud Publica de California son:
    California Department of Public Health
    Licensing and Certification.,
    4540 California Ave., Suite 200
    Bakersfield, California 93309
    (661)336-0543 Oficina
    (866)222-1902 Línea gratuita

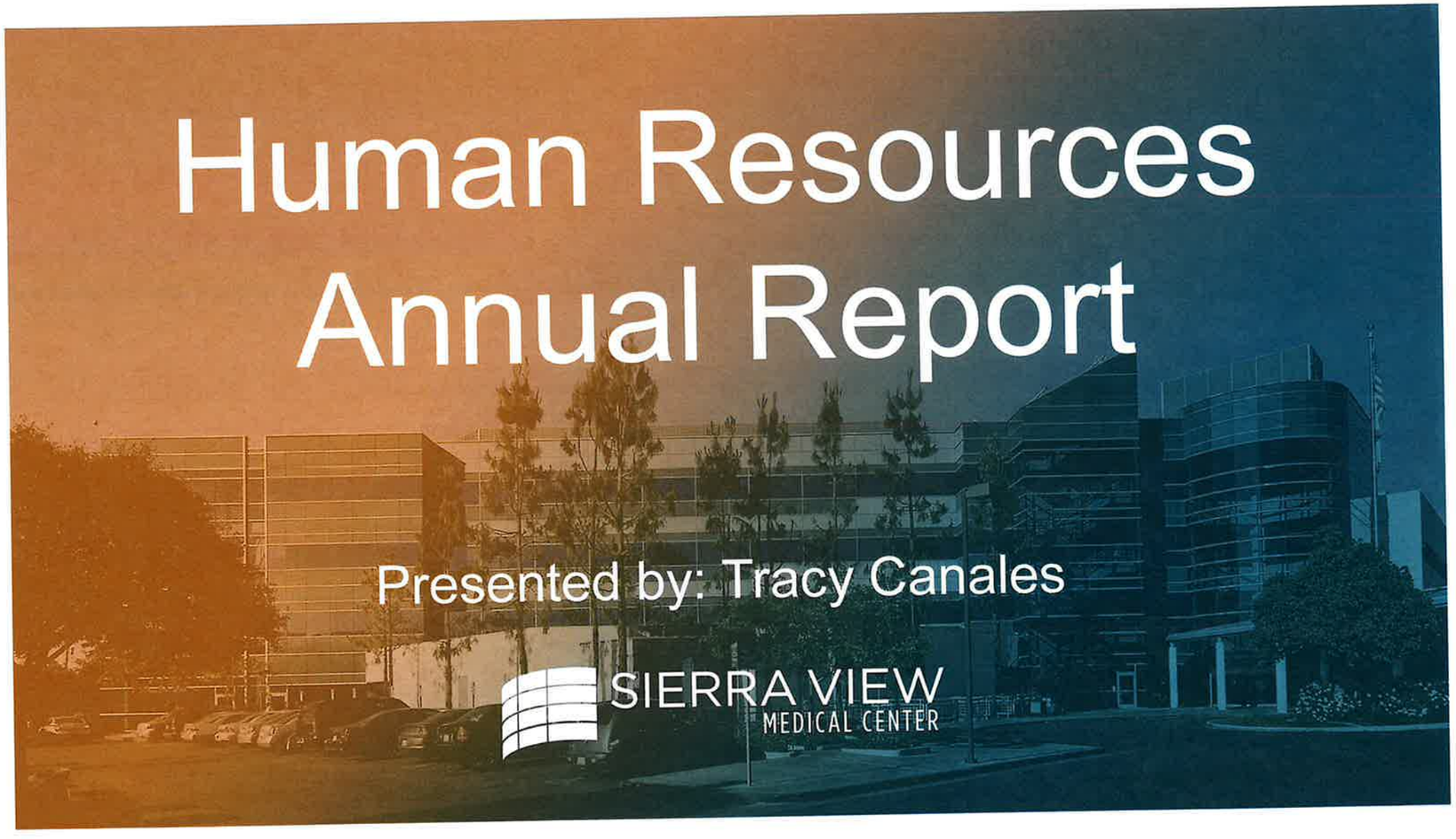
24. Presentar una queja sobre la calidad de la atención o los problemas de alta temprana. La QIO de Atención Centrada en la Familia (BFCC) para el Estado de California gestionará todas las quejas de los beneficiarios, las revisiones de calidad de la atención, EMTALA y otros tipos de revisiones de casos para garantizar la coherencia en el proceso de revisión, teniendo en cuenta los factores locales importantes para los beneficiarios y sus familias.
    BFCC QIO PROGRAM
    Livanta
    9090 Junction Drive, MD 20701
    (877)588-1123
    TTY (855)887-6668
    Fax (855)694-2929

25. Presente una queja ante la Comisión Conjunta:
    Mail: Office of Quality and Patient Safety
    The Joint Commission
    One Renaissance Boulevard
    Oakbrook Terrace, IL 60181
    Fax 630-792-5636

26. Presente una queja ante el Departamento de Empleo y Vivienda Justa de California.
    CDFEH
    2218 Kausen Drive, Suite 100
    Elk Grove, CA 95758
    800-884-1684
    www.dfeh.ca.gov

27. Presente una queja ante la Junta Médica de California.
    Medical Board of California
    Central Complaint Unit
    2005 Evergreen Street, Suite 1200
    Sacramento, CA 95815
    800-633-2322
    www.mbc.ca.gov/consumers/complaints

Human Resources Annual Report



Recruitment

Recruitment	2020	2021	% Change
New Hires	187	224	20%
Transfers	139	227	63%
Promotions	31	46	48%
Referred by an Employee	88	92	5%
No. of Requisitions	310	444	43%
No. of Applications	2,923	2,767	-5%
Vacancy Rate	3.2%	6.4%	3.2%

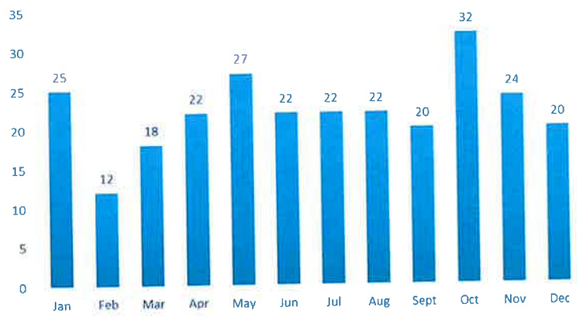
Recruitment via Geo-fencing	2020	2021	% Change
Interviews	43	69	60%
New Hires	24	50	108%
Annual Cost	$ 4,065	$ 2,250	-45%
Cost per Hire	$ 169	$ 45	-73%

Engagement & Retention - Turnover

Turnover	2020	2021	% Change
Full Time & Part Time	92	167	82%
Per Diems	118	99	-16%
Turnover Rate (FT&PT)	11.1%	20.8%	9.7%
CHA Turnover Rate (FT&PT)	11.1%	12.7%	1.6%
SVMC Variance	0.0%	-8.1%	-8.1%

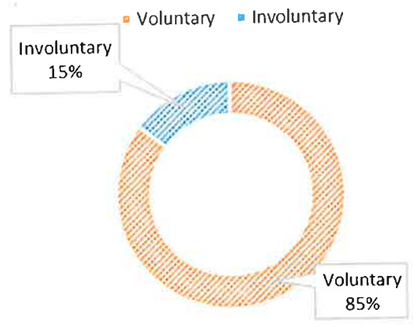
RN Turnover	2020	2021	% Change
RN Full Time & Part Time	34	52	53%
RN Per Diems	30	25	-17%
RN Turnover Rate (FT&PT)	16.3%	26.6%	10.3%
RN CHA Turnover Rate (FT&PT)	12.3%	13.8%	1.5%
RN SVMC Variance	-4.0%	-12.8%	-8.8%

2021 Terms by Month



Turnover	2020	2021	% Change
Total Terms	210	266	27%
Voluntary	162	227	40%
InVoluntary	48	39	-19%

Terms Hired in Same Year	2020	2021	% Change
Terms hired in same year	52	57	10%
Turnover Rate	28%	25%	-3%

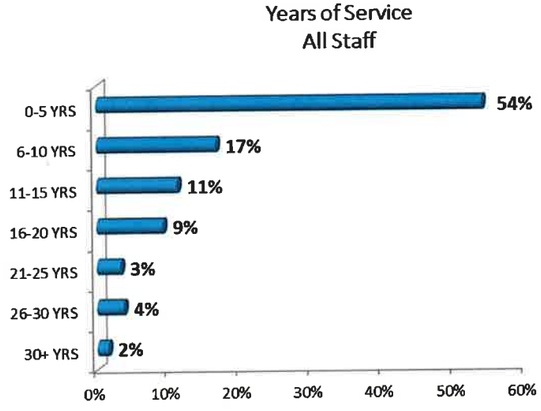


Engagement & Retention

Timely Evaluations	2020	2021	% Change
Timely Rate	85.2%	83.5%	-1.7%

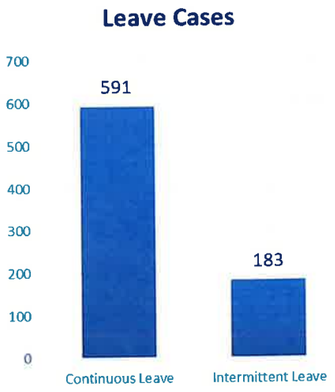
Retirement	2020	2021	Change
# of Participants	625	560	-10.4%

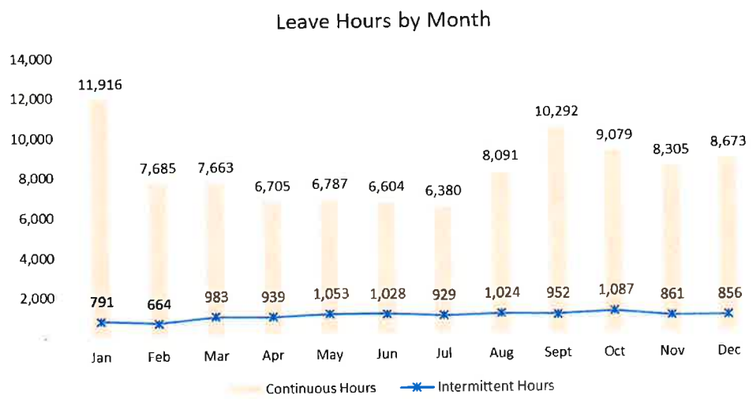
Milestone Achievements	2020	2021	% Change
Total Milestone Achievements	28	32	14%
PhD Degree	2	2	0%
MA Degree	4	6	50%
BA Degree	6	9	50%
Certification	16	15	-6%



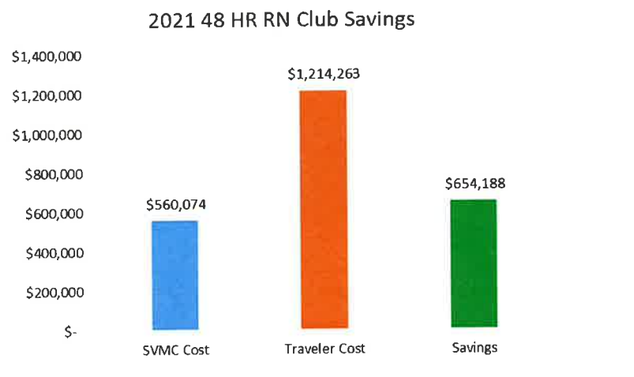
Compliance - Leaves

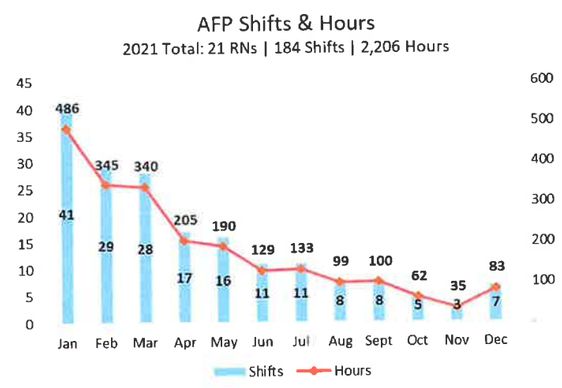
Leaves	2020	2021	% change
Leave cases opened	891	774	-13%
Total Employees (including Quarantine & Covid-19 Positive)	543	473	-13%
Total Leave Hours	117,175	109,344	-7%
Total Employees - Quarantine	214	205	-4%
Total Employees - Covid-19 Positive	142	138	-3%
SUPSL Hours	10,031	13,323	33%
SUPSL Cost	$ 288,913	$ 426,690	48%

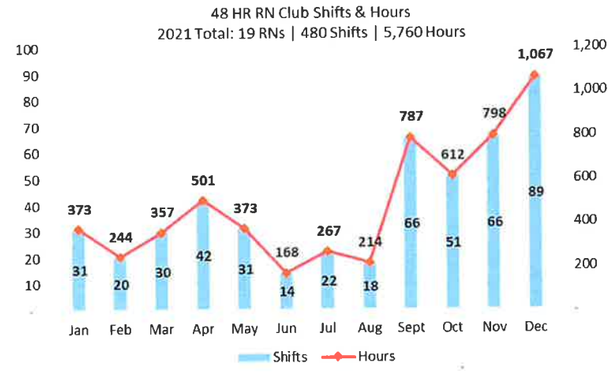




Advance Float Pool & 48 Hour Club Savings







2021 Accomplishments

- Cost Savings of over $1M utilizing internal incentive programs (AFP & 48 hour club) in lieu of Travelers
- Successfully covered 664 vacant shifts utilizing internal incentive programs (AFP & 48 hour club)
- 41% of New hires through our Employee Referral Program
- HR Implementation of GME Program for 16 resident physicians (compensation/benefits research, policy research, NHO, and onboarding.)
- Re-Design of SVMC's Interviewing Guides for both support and leadership interviews.
- Re-Structure of onboarding process
- Designed and implemented new recruitment strategies for critical to fill positions
  - Geo-fencing campaigns
  - Themed Recruitment events
  - Virtual Recruitment events
- Full Benefit Dependent Eligibility Verification (DEV) Audit
- Changed Flexible Spending Accounts (FSA) Vendors for a better employee experience and cost savings to SVMC
- Volunteer League and Pet Partners successfully returned on-site

Thank you

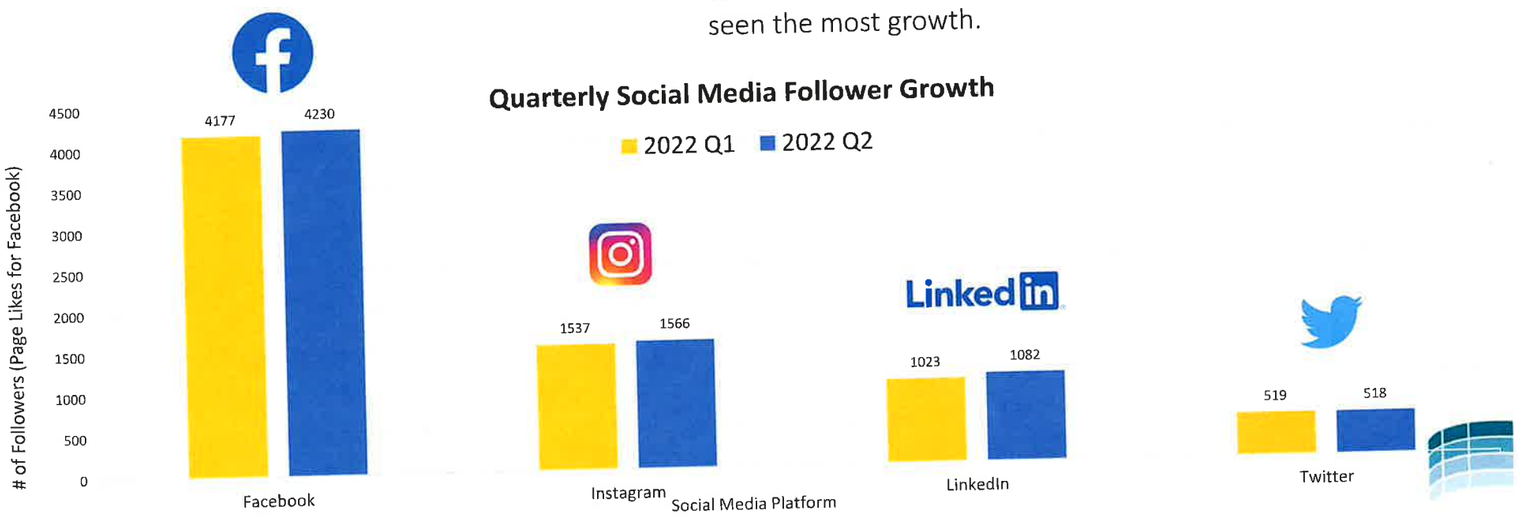

Marketing Report
2022 Q2
SIERRA VIEW
MEDICAL CENTER


SVMC Marketing
Social Media
SIERRA VIEW
MEDICAL CENTER

2022 Q1 Social Media Growth

Platform	2022 Q1	2022 Q2	% Change
Facebook	4177	4230	1.27%
Instagram	1537	1566	1.89%
LinkedIn	1023	1082	5.77%
Twitter	519	518	-0.19%

SVMC social media platforms continue to experience a steady growth. In Q2, growth was slower than Q1 but the average growth is approximately 2% across all platforms against the strategic objective of 3%. The platform with greatest area of opportunities is Twitter. Facebook continues to be our strongest social media platform and LinkedIn has seen the most growth.



Top-Performing Stories

Marketing continues to focus on a variety of key categories for social media outreach including: community, employees and patient stories.

Top-performing content on Facebook included a retirement highlight, patient stories, employee highlights and stories featuring community partners such as Sierra View Foundation, Tulare Kings Hispanic Chamber of Commerce, and Porterville Breakfast Rotary Club.

Sierra View Medical Center
Wed 6/1/2022 4:08 pm PDT

After being with SVMC for over 21 years, Maria Martinez, RN of Sierra View Medical Center's Cath Lab is retiring! We wish yo...

Total Engagements	**1,165**
Reactions	275
Comments	61
Shares	6
Post Link Clicks	27
Other Post Clicks	796

Sierra View Medical Center
Tue 4/5/2022 11:17 am PDT

Our Distinct Part Skilled Nursing Facility (DP/SNF) department is looking for new day and night shift Certified Nursing...

Total Engagements	**544**
Reactions	18
Comments	3
Shares	5
Post Link Clicks	47
Other Post Clicks	471

Sierra View Medical Center
Thu 3/24/2022 5:05 pm PDT

Sierra View is a place for healing and for learning! This week, we welcomed Psych Tech students from Porterville College as...

Total Engagements	**409**
Reactions	90
Comments	13
Shares	7
Post Link Clicks	—
Other Post Clicks	299

Sierra View Medical Center
Tue 5/24/2022 4:03 pm PDT

Today, members from Porterville Breakfast Rotary Club presented a check to Sierra View Medical Center's Roger S. Good...

Total Engagements	354
Reactions	80
Comments	10
Shares	4
Post Link Clicks	4
Other Post Clicks	256

Sierra View Medical Center
Tue 5/10/2022 5:12 pm PDT

We recently joined the Tulare Kings Hispanic Chamber of Commerce (TKHCC) as they celebrated their Annual Awards L...

Total Engagements	**334**
Reactions	87
Comments	18
Shares	1
Post Link Clicks	2
Other Post Clicks	226

Sierra View Medical Center
Mon 5/9/2022 3:51 pm PDT

It was a great day for the 2022 Run for Life! Several SVMC employees came out on top within the 5k race in both the run...

Total Engagements	**319**
Reactions	15
Comments	0
Shares	0
Post Link Clicks	—
Other Post Clicks	304

Top-Performing Stories

Top-performing content also included the Porterville Unified School District's Pathways Program and recruitment outreach including clinical leaders and HR's talent acquisition team.

Sierra View Medical Center
Fri 6/17/2022 4:43 pm PDT

Join us in celebrating our Employee of the Month for April 2022, Michelle Cacy, MSN, RN, CAPA. CPAN is the educator for all of...

Total Engagements	**270**
Reactions	78
Comments	17
Shares	2
Post Link Clicks	9
Other Post Clicks	164

Sierra View Medical Center
Thu 6/23/2022 9:45 am PDT

High school students are back at the hospital! Throughout the pandemic, we'd had to cut our student work-based...

Total Engagements	**267**
Reactions	43
Comments	2
Shares	2
Post Link Clicks	4
Other Post Clicks	216

Sierra View Medical Center
Tue 6/14/2022 11:02 am PDT

Our Talent Acquisition Partner Lance Rowell is currently at Nurses Boutique in Visalia! He and HR Manager Colleen Wilson are...

Total Engagements	**264**
Reactions	43
Comments	5
Shares	4
Post Link Clicks	—
Other Post Clicks	212

Sierra View Medical Center
Fri 4/22/2022 4:59 pm PDT

Today, several of us at SVMC showed up in blue and green to bring awareness of the importance of donate life! When we com...

Total Engagements	**254**
Reactions	20
Comments	0
Shares	0
Post Link Clicks	—
Other Post Clicks	234

Sierra View Medical Center
Thu 6/23/2022 3:52 pm PDT

This team never ceases to amaze us! Sierra View Medical Center's Wound Healing Center has earned two prestigio...

Total Engagements	**230**
Reactions	46
Comments	7
Shares	5
Post Link Clicks	7
Other Post Clicks	165

Sierra View Medical Center
Wed 5/11/2022 11:23 am PDT

Community leader and local businessman Felipe Martinez describes himself as a humble servant. He regularly volunteers...

Total Engagements	**226**
Reactions	100
Comments	17
Shares	1
Post Link Clicks	2
Other Post Clicks	106


SVMC Marketing
Public & Media Relations
SIERRA VIEW
MEDICAL CENTER

SVMC in the News Making Headlines

SVMC is making headlines locally and nationally. Recently, Administrative Director of Revenue Cycle Julie Franer was named as a recognized Revenue Cycle Management leader by Becker's Hospital Review.

SVLHD also completed their redistricting process with a successful approval of a new district map.

Becker's Healthcare Hospital ASC Spine Clinical Health IT CFO Dental Payer Podcasts Behavioral Careers

Hospital CFO Report

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Financial Management

'We have to find a better way': How 4 RCM leaders would change prior authorizations

Andrew Cass and Alia Paavola - Monday, April 18th, 2022

Save Post Tweet Share Listen Text Size Print Email

Providers and hospitals have long said the prior authorization process is problematic and cumbersome for them, as many health plans have different requirements and submission guidelines.

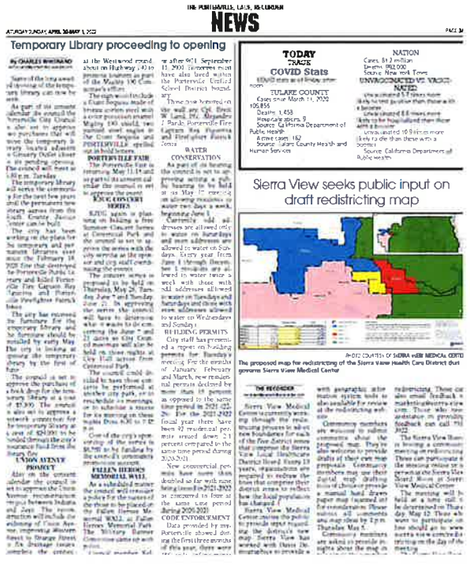
Prior authorizations are a process in which a provider, on behalf of a patient, requests approval from the patient's insurer to ensure the treatment or service will be covered. This process was designed to ensure patients are receiving care in the right setting based on efficacy and safety. Payers argue prior authorizations help lower costs for beneficiaries, while providers say they can lead to care delays and contribute to staff burnout.

This left us wondering: What would revenue cycle leaders at hospitals do to meaningfully improve the process if they could?

Here, four revenue cycle leaders share what they believe would improve the process.

Editor's note: Responses were lightly edited for length and clarity.

Julie Franer, Administrative Director of Revenue Cycle at Sierra View Medical Center (Porterville, Calif.): I think what could help is a "uniformity" among all health plans on what services require an authorization so it takes the guesswork out of who and what plan requires one. I also think having a universal evidence-based medical necessity criteria to support the need would help to streamline the process across all health plans. If all plans required the same documentation, it would help streamline the process.


THE PORTERVILLE RECORD NEWS

Temporary Library proceeding to opening

TODAY IN THE COVID Stats

Sierra View seeks public input on draft redistricting map

The proposed map for redistricting of the Sierra View Health Care District that governs Sierra View Medical Center

Press Release by Category

Press Releases are sent in a variety of categories.

The top categories include:

- Board
- Community
- Employees
- Foundation
- Leadership
- Patient Story
- Public Information (PIO)
- Quality
- Recruitment
- Service Line

Sent in 2022 Q2:

15

Sent in 2022 Q1:

19

$43,500 Donated by Porterville Breakfast Rotary Club to Cancer Treatment Center

Category: News *Posted On:* May 24, 2022