SIERRA VIEW
MEDICAL CENTER

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

AGENDA
May 23, 2023

OPEN SESSION (5:00 PM – 5:05 PM)

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

Call to Order

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

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

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

CLOSED SESSION

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

III. **Closed Session Business**

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 23-000673

D. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 23-000683

E. Conference with Legal Counsel pursuant to Gov. Code Section 54956.9(d), Ongoing Litigation in Tulare County Superior Court Case VCU291990; Exposure to Potential Litigation (d)(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)

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

1. Compliance Report – Quarter 3

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

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

I. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel: and Conference with Legal Counsel pursuant to Gov. Code Section 54956.9(d)(2), Potential Litigation

J. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel and Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item) Estimated Date of Disclosure – June 2024

K. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel: Public Employee Performance Evaluation

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. Conference with Legal Counsel Re: BETA Claim No. 23-000673
Recommended Action: Approve/Deny BETA Claim No. 23-000673

D. Conference with Legal Counsel Re: BETA Claim No. 23-000683
Recommended Action: Approve/Deny BETA Claim No. 23-000683

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

F. Quality Review

1. Compliance Report – Quarter 3

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

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

I. Discussion Pertaining to Personnel and Conference with Legal Counsel
Recommended Action: Information only; no action taken

J. Discussion Pertaining to Personnel and Trade Secret
Recommended Action: Information only; no action taken

K. Discussion Pertaining to Personnel
Recommended Action: Approve/Disapprove

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

VI. Public Comments

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

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

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

VIII. Approval of Minutes

A. **April 25, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove April 25, 2023 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. **Quarterly Foundation Report and Check Presentation**
Recommended Action: Information only; no action taken

B. **2023 Audit Entrance | Moss Adams**
Recommended Action: Information only; no action taken

C. **April 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

D. **Investment Policy and Investment Report**
Recommended Action: Approve/Disapprove

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – June 27, 2023 at 5:00 p.m.

XII. Adjournment

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PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

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

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Senior Leadership Team	5/23/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	5/23/2023

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SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
May 23, 2023
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. Air Filter Log	1	
2. Attendance and Punctuality	2-6	
3. Biomedical Equipment Repair	7-8	
4. Electrical Distribution System Preventative Maintenance	9	
5. Employee Orientation	10-12	
6. Exempt Staff Working Extra Shifts	13-14	
7. False Claims Act and Whistleblower Protection	15-20	

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SUBJECT:	SECTION:
AIR FILTER LOG	*Utility Management*
	Page 1 of 1

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

POLICY:

This instruction is developed to standardize the procedures for maintaining a record of the filter system of the hospital. Filters will be changed at intervals to maintain acceptable indoor air quality and minimize infection control exposure.

PROCEDURE:

An integral part of the Engineering Department of this hospital is the planned and programmed replacement and cleaning of the various and numbered quantities of filters for the cleanliness of the hospital.

- All filters will be cleaned or replaced in reference to the Preventative Maintenance schedules.
- A standard system has been developed identifying the quantity, location, size, frequency and the date completed.
- A Filter Log is located in the Engineering Department for the purpose of utilization and record keeping.
- A Filter Log file is located in the Engineering Department for the purpose of filing the Filter Log after the current year expires.
- The Engineering Manager is responsible for the scheduling of the filter changes.
- This instruction is referenced by the instructions on Engineering Department Logs.
- Safety measures should be taken when handling air filters removed from service to protect from airborne illnesses. Personal Protective Equipment (PPE) should be employed during filter changes by Engineering staff. Dirty filters should be disposed immediately in the facilities trash compactor.

REFERENCES:

- The Joint Commission (2023) Hospital accreditation standards. EC.02.05.05 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **ATTENDANCE AND PUNCTUALITY**	SECTION:

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

PURPOSE:

To establish a standardized procedure for the reporting and handling of absences in order to ensure the consistent and equitable treatment of employees.

POLICY:

In order to ensure quality patient care and to fulfill your job responsibilities, it is important that all employees are present at work at scheduled times and are able to perform the duties required of their job(s). In declared emergencies/disasters at the local, State, and National levels, healthcare providers are considered disaster service workers and are required to report to work. Exceptions must be approved by Human Resources.

DEFINITIONS:

1. ***Absence Occurrence*** is a failure to report to work on a scheduled day and time due to personal reasons, illness and/or family matter. Absences related to protected sick leave, bereavement leave, family or medical leave of absence, disability leave of absence or worker's compensation will not be counted as an absence occurrence. Extra shifts are considered part of the regular schedule and will have the same attendance expectations under this policy.

   If the absence is not to be considered an absence occurrence, employees must have prior written/verbal supervisory approval within a consistent time frame as determined by each Department. Approval is granted by the Department Director and is based on factors such as staffing needs, workload and the employee's attendance history.

   During times of declared emergencies/disasters or other extenuating circumstances involving emergency situations exceptions will be considered and reviewed on a case-by-case basis by Human Resources to determine if the absence(s) will be considered an absence occurrence.

2. ***Partial Absence Occurrence (arriving late/leaving early)*** – is arriving at work late or leaving work early without written or verbal supervisory approval.

   Tardy is defined as clocking in eight (8) or more minutes after the employee's scheduled start of shift and/or after the employee's 30 minute meal break, are considered a partial absence occurrence. Leaving work early is defined as clocking out eight (8) or more minutes before the end of the employee's scheduled shift and is considered a partial absence occurrence. Employees are expected to be at their workstation at the start/end time of their shift. Continued patterns of clocking in after the start time of a scheduled shift (one or more minutes late) and/or not remaining in their workstation until the end of the employee's scheduled shift (one or more minutes early)may result in disciplinary action.

   Two (2) partial absences (arriving late/leaving early) will be counted as one absence occurrence.

3. ***Consecutive Days*** – is an absence occurrence of one or more consecutively scheduled workdays missed due to the same illness.

   In a declared emergency/disaster related to a medical situation like a pandemic, a physician's note will be required after the third day of work missed.

4. ***Non-Consecutive Days*** – Non-consecutive days are considered separate and unrelated absence occurrences, except for interrupted workdays missed due to the same illness, i.e. staff who are absent two (2) days of work, return to work and are still too sick to work and go home mid-shift.

5. ***Catastrophic Injury or Illness*** – (Heart attack, trauma, stroke, major broken bones, etc.) A catastrophic injury or illness will not be considered as an absence occurrence in this policy

PROTECTED TIME OFF:

1. ***Sick Leave*** - An employee may be absent by use of available sick leave hours for the purposes noted in the Sick Leave policy and not have it count as an absence occurrence. If an employee's available sick leave hours do not cover the full time absence, the remainder of such time not covered by available sick leave will be considered a partial absence occurrence. If an employee does not have any available sick leave hours for their absence, the absence is not considered a sick leave absence and will count as a full absence occurrence.

   If the employee believes that any of the absences should not be counted as an occurrence because the absence is protected by law governing time off from work, the employee must provide information at that time, prior to the implementation of the corrective plan of action.

2. ***Chronic Medical Condition*** – If an employee has been identified as having a chronic medical condition as exemplified by the federal Americans with Disability Act (ADA) or the California Fair Employment Housing Act (FEHA) that at intermittent times keeps the employee from work, these times may not count toward an absence occurrence. It is required that an employee with a chronic illness work with both Employee Health and their health care provider to minimize, as much as possible, the impact the absences may have on the department. The employee is required to provide reasonable advance notice when she or he is able, but not when the absence is emergent. The employee is required to comply with the Hospital's normal attendance call-in and notification procedures. Employee Health, in collaboration with Human Resources, will be responsible for determining if any modifications to the employee's work schedule or duties need to be made. Where appropriate, Sierra View Medical Center shall grant the employee intermittent leave under the provisions of the applicable statutory family/medical leave acts.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

GUIDELINES FOR CORRECTIVE ACTION

The following guidelines are to be followed for absence occurrences excluding Sick Leave and other absences protected by law governing time off from work:

5 occurrences	Employee receives a Verbal, Documented
6 occurrences	Employee receives a Written Warning.
7 occurrences	Employee receives a Final Written Warning with possible demotion and reduction in pay if in a lead position or above
8 occurrences	Employee is Terminated.

To be considered for disciplinary action, the absence occurrence must have occurred during the last rolling 12-month period. Any occurrences prior to this time frame will not be considered.

In a declared emergency/disaster, Human Resources will assess occurrences on a case-by-case basis. Any employee requiring written corrective action will meet with their department head and a corrective plan of action will be determined, i.e. not allowed to sign-up for extra shifts or call time, change in status to part-time, leave of absence, etc.

Pattern Absenteeism:

Employees will be considered to have a pattern of unscheduled absences if their absences tend to occur immediately before or after previously approved scheduled days off, immediately before or after a holiday(s), the weekend, occur at regular intervals or on consistent days, occur immediately following disciplinary action, or occur on days previously requested off but not approved/or denied such request. Patterns of absences will be considered misconduct and maybe subject to disciplinary action.

Where there are parallel or overlapping incidents of absenteeism, tardiness and/or no call/no shows, the disciplinary action may be accelerated.

During the introductory period of a new employee, absenteeism or incidents of tardiness may result in disciplinary action up to and including separation of employment.

However, nothing in this policy alters the employee's at-will employment status and SVMC's ability to terminate an employee's at-will employment with or without cause at any time.

When employees are unable to report to work for the beginning of their shift, they must call their supervisor (2) two-hours before their scheduled shift. Exceptions will be considered based on how emergent the situation was that prevented the 2-hour notification.

It is the responsibility of the Department Director or Designee to track and review absence patterns of all employees in his/her department(s). Prior to final corrective action, the appropriate Vice-President and Human Resources Department must review attendance history and performance.

Directors/Managers must notify Human Resources when employees are absent for more than 3 days, as they may qualify for a protected Leave of Absence.

MAKE-UP POLICY

If the employee called off on their scheduled weekend days, they will automatically be scheduled to work the following weekend, one or both days, depending upon which one(s) they called off. *The employee may be required to work a number of weekends in a row if the employee has missed more than one weekend commitment. Exception: Those employees who regularly work every weekend and call in sick will be required to complete their "make-up day" at the discretion of the Department Director.*

If the absence is covered with the Sick leave bank or Intermittent FMLA, the employee will not be required to make up the shift.

Failure to actually work on the following scheduled weekend will result in disciplinary action. Exceptions may be pre-authorized only by the appropriate Vice-President.

REPETITIVE WRITTEN WARNINGS

Upon receiving the third corrective action for attendance within a rolling twelve (12) month period, the employee will be subject to termination of employment.

NO CALL/NO SHOW - FAILURE TO REPORT TO WORK AS SCHEDULED

It is the employee's responsibility to follow the notification procedure as designated by his/her department when reporting an unscheduled absence. Failure to report to work as scheduled is a serious offense.

A No Call/No Show will result when one of the following occurs:

- Employee fails to call in within the first fifteen (15) minutes of the start of an assigned shift
- Employee fails to call and reports to work fifteen (15) minutes or more after the start of an assigned shift
- Employee fails to report to work for assigned shift.
- First No Call/No Show is a Final Written Warning
- Second No Call/No Show is termination.

A single incident of a No/Call/No Show may escalate the disciplinary process up to and including termination when there is a documented record of occurrences for attendance. When reviewing action to be taken as a result of an employee's failure to report to work or provide appropriate notification, consideration will be given to the length of time between occurrences, as well as the number of occurrences within the rolling twelve month calendar for attendance occurrences purposes.

UNAUTHORIZED LEAVE DURING A SHIFT

Employees who report to work and leave the facility early without communication and authorization from their supervisor will receive a final written notice for leaving their shift early without prior notification and/or approval. If a second incident occurs within the rolling twelve month calendar, it would result in separation of employment.

A single incident of an incomplete shift due to an unauthorized leave may escalate the disciplinary process up to and including termination when there is a documented record of occurrences for attendance. When reviewing action to be taken consideration will be given to the length of time between occurrences and the number of occurrences.

ABANDONMENT OF POSITION

Three (3) Consecutive Days of failure to report to work without notification to the hospital will be considered job abandonment and a voluntary resignation.

REFERENCES:

- Barsook, B., Platten, C., Vendrilo, C. (2017). California Public Sector Employment Law. Retrieved from www.lexisnexis.com

CROSS REFERENCES:

- Recording Hours Worked policy
- Sick Leave Policy

SUBJECT: **BIOMEDICAL EQUIPMENT REPAIR**	SECTION: *Medical Equipment Management* **Page 1 of 2**

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

PURPOSE:

To provide for the repair of failed biomedical equipment.

POLICY:

Sierra View Medical Center will have contracted services with a biomedical equipment service provider to repair failed biomedical equipment.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

Make all necessary repairs in a timely manner. Observe all safety precautions. Observe the safety precautions indicated in the manufacturer's service manuals.

Should repair service be required, the hospital staff will complete and attach an appropriate "defective" red tag to the item and complete a Biomedical Engineering Department service request via the hospital's intranet to acquire service. The item should be placed in a secure location to prevent it from being placed back in use.

It is extremely important that clinical staff completes the "defective" red tag and indicate the work order number from the Biomedical Engineering service request, the exact symptoms and nature of the failure, as well as the conditions under use.

Extreme care should be taken to assure that all power is removed from apparatus before servicing. To prevent accidental shock from the stored energy in capacitors, discharge them to ground or short circuit the leads before touching with bear hands. High voltage capacitors should be discharged by short circuiting the leads for at least one full minute. Parts such as tubes, resistors, heat sinks, etc., remain extremely hot for some time after main power has been removed.

Wash hands for at least 30 seconds after working on soiled patient care equipment, and immediately after coming in contact with blood, body fluids or contaminated materials.

Wipe all tools that come in contact with blood, body fluids or contaminated materials with a germicidal disinfectant approved by the hospital Infection Control Committee and manufacturer's instructions for use.

Repair biomedical equipment in accordance with manufacturer's recommended procedures.

Calibrate equipment, as necessary, in accordance with the manufacturer's recommended procedures and to meet the manufacturer's specifications.

Clean biomedical equipment, as needed, with detergent and water to maintain proper function and professional appearance. Observe the manufacturer's cautions and procedures.

Perform Preventive Maintenance and electrical safety inspection if:

- The repair involved a primary power circuit
- The repair involved the output of therapeutic equipment
- It is close to or after the preventative maintenance due date.

Check the condition of lamps, displays, batteries, switches, connectors, etc., and replace or repair as necessary. Tighten loose knobs, screws, etc. Replace missing screws, feet, etc.

Check the conditions of the power cord insulation for deterioration or cuts, and for the insulation being pulled back from the power plug or strain relief. Repair or replace as necessary.

Check the condition of the power plug for damage, arcing, or excessive ware. Replace, as needed, with the following types of power plugs:

- Patient care equipment: hospital grade type;
- Surgery equipment: hospital grade type
- Buffers: moisture proof type

Check the functions of the equipment in all its operative modes, for proper and safe operation, in accordance with its manufacturer's procedures.

Delays in repair: Advise the biomedical supervisor, related department head, and/ or the person you were in contact with on the equipment repair concerning the delay.

Deliver repaired equipment to the appropriate department: Check that all cables, accessories, etc. are returned with the equipment. Make the appropriate person aware of the return of the equipment. Set up equipment for proper operation, as required. In-service staff if the problem is user related.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC.02.04.03 Joint Commission Resources. Oak
  Brook, IL.

CROSS REFERENCES:

- Life Safety Preventative Maintenance Program
-

SUBJECT:	SECTION:
ELECTRICAL DISTRIBUTION SYSTEM PREVENTATIVE MAINTENANCE	***Utility Management***

POLICY:

There is a scheduled maintenance system which is used to schedule, monitor and document the testing and maintenance of the electrical distribution system at annual intervals unless circumstances exist for more frequent testing.

PROCEDURE:

1. All electrical receptacles will be checked by an engineer within the established time frame set for the maintenance of that environmental unit.

2. Work orders are generated for other components of the electrical distribution system on predetermined intervals.

    - The work orders are assigned by the Facilities Manager.

    - The electrical distribution system is inspected and tested at predetermined intervals. The engineer will perform any preventative maintenance and corrective maintenance as necessary.

    - A scheduled maintenance work order is completed by the engineer, indicating specific preventative or corrective maintenance actions taken. The date the scheduled maintenance was completed is entered on the form and it is submitted to the Engineering Clerk for entry into the preventative maintenance (PM) system.

3. The Engineering Department will inspect the generator and batteries weekly. A generator test will be performed under actual load and operating temperature conditions for at least 30 minutes, monthly. The tests are documented and the test results are reviewed weekly by the Facilities Manager to assure the generator is performing in a reliable manner.

4. Generators will be started and brought up to normal operating temperatures without load weekly.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC.02.05.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **EMPLOYEE ORIENTATION**	SECTION:

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

PURPOSE:

To define the requirements and procedures of Sierra View Medical Center's (SVMC) orientation program for staff hired at SVMC.

POLICY:

SVMC staff members will receive information regarding policies and procedures supporting the Hospital's mission, vision and values and will be introduced to key safety topics based on their role within the organization and as defined by SVMC.

AFFECTED AREAS/PERSONNEL: *SVMC EMPLOYEES*

PROCEDURE:

INITIAL HOUSEWIDE ORIENTATION

All newly hired employees will be oriented by his/her Department Director or designee within the first shift assigned in their department. The orientation topics are defined using the Initial House-Wide Orientation Checklist and Attestation found in the new employee's education folder (See attached Checklist). Upon completion of orientation, the Attestation Form is to be signed by both the Director or designee and the new employee during their first day on the job. Once completed, the signed Attestation Form is then submitted to Education to be entered into the employee's e-learning transcript. The Attestation Form must be forwarded to the Education Department within 1 week of completion.

Employee's floating to a new department will receive a copy of the Initial House-Wide Orientation Checklist upon arrival to the new nursing unit to be oriented to only the areas specific to that unit. An Attestation Form must be completed and signed for each Unit an employee is assigned to float and forwarded to the Education Department.

It is the Department Director's responsibility to ensure new employees are properly oriented to their Unit and to discuss expectations regarding his/her job responsibilities and Standards of Performance during their initial department orientation period.

MANDATORY NEW HIRE ORIENTATION SESSION

All new employees attend a mandatory new hire session within 30-60 days of their hire date. The new hire orientation session is scheduled on a monthly basis. The orientation agenda is focused on introducing the new employee's to SVMC's culture, mission, vision, and values. The Human Resources Department is responsible for scheduling the monthly orientation and department Directors will ensure their new employees attend within the designated timeframe. New employees will sign an acknowledgement of attendance which will be filed in their employee file.

MANDATORY ELECTRONIC ORIENTATION MODULES

All staff are assigned modules through the learning management system at the time of hire and annually thereafter. Non-exempt staff must complete these modules during scheduled working hours. This orientation is mandatory and must be completed within the designated time lines as defined below:

New Hires

All new employees are required to complete the New Hire E-Learning Modules within 30-days after their first day of employment. These modules are assigned and available for completion electronically upon hire. Authorized usernames and passwords are issued to access the learning management system. Training for accessing the modules is conducted upon hire by the department in conjunction with the Information Technology (IT) Dept.

Annual Orientation

Annually, all employees will be assigned the Annual Orientation Module on the first day ofJuly each year. Employee's will have until September 30th to complete all lessons in the module. The Department Directors have responsibility for advising the employee of these requirements and allowing them time at work to complete the modules.

The Human Resources Department will monitor annually for compliance and notify Department Directors to remove the employee from their regularly scheduled duties until the orientation modules have been completed.

CLINICAL STAFF ORIENTATION

In addition to the previous mentioned orientation requirements, clinical staff will be required to complete the additional orientation programs as new employee:

- Clinical modules launched at time of hire through the learning management system. Must be completed within 30 days after their date of hire.
- Safe Patient Handling & Mobility Program including a hands-on competency check-off by the instructor. Must be completed within 30-60 days after date of hire.
- Through the Education Department, newly hired clinical staff will receive training on topics such as electronic medical record system, skills assessment of key clinical policies and nursing competencies such as glucometer testing, medication administration, Fall Risks Policy, etc. These classes are scheduled at minimum on a monthly basis and more frequently as needed.

LEADERSHIP ORIENTATION

Managers, Directors and Vice Presidents will be oriented to the facility as well as their individual departments within sixty (90) days after their date of hire.

Human Resources staff will provide the respective Vice President a Leadership Orientation Checklist for them to customize based on the new leaders role. This template will then be provided to the newly hired leader on their first day of employment by the Vice President. The newly hired leader will be responsible for scheduling one-on-one meetings with each assigned area and present the checklist for signature upon completion of the orientation session. The completed signed checklist is returned to the respective Vice President for a final signature and then the original is signed in the Education Folder and a copy provided to the new leader.

Human Resources will provide a bi-monthly new leadership orientation session for all HR-related functions for newly promoted and/or hired leaders.

Staff members are expected to complete all orientation expectations based on their role. Non-compliance of any of the required orientation programs will be subject to disciplinary measures, up to and including separation of employment.

SUBJECT: **EXEMPT STAFF WORKING EXTRA SHIFTS**	SECTION: ***Human Resources*** **Page 1 of 2**

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

PURPOSE:

To define the process for allowing exempt staff to work extra shifts and determine compensation associated with those extra shifts.

POLICY:

SVMC provides an opportunity for exempt clinicians to cover non-exempt clinical positions due to staffing vacancies, and maintain clinical skills while meeting the Hospital staffing requirements, by working additional clinical non-exempt shifts for designated positions under structured terms and conditions at the discretion of the President/CEO or respective Vice President.

AFFECTED PERSONNEL/AREAS: *CLINICAL AND ANCILLARY EXEMPT MANAGEMENT STAFF*

PROCEDURE:

Upon approval by the President/CEO or the respective Vice President, clinical and ancillary exempt management staff may be offered the opportunity to work additional hours to provide direct patient care services with extra compensation.

1. A Vice President or Administrative Director will not be eligible for extra compensation.

2. To be eligible for extra compensation, the following criteria must be met:

   a) The President/CEO must designate the clinical/ancillary position as eligible for exempt staff participation as non-exempt staff additional compensation.

   b) The clinical/ancillary shift(s) must be scheduled outside of the normal hours of the staff member's regular hours of responsibility of the exempt position. (*For example: If the exempt employee typically works during the day shift, the extra non-exempt shift must be performed during hours outside of the exempt manager's normally scheduled day shift.)*

   c) The exempt employee must have a secondary job code and department designation assigned to their Kronos timekeeping record so hours and compensation for the non-exempt pay code can be tracked appropriately.

   d) The exempt employee may not use unscheduled Vacation/Holiday or unprotected Sick Leave during the 7-day work week in which the clinical shift is worked.

   e) No more than 24 hours per pay period will be compensated under this policy.

   f) The exempt employee, when working an extra shift under the secondary job code as a clinician must clock "in" and "out" for each extra shift worked, and must follow the meal period and rest period policy

3. Clinical/ancillary management staff will be compensated at a rate equivalent to time and one-half their "hourly rate of pay" when working the extra shift on the floor. The "hourly rate of pay" shall be calculated by dividing their weekly compensation by the number of hours they are expected to work in a normal work week.

4. All hours worked are to be coded to the department and the job code of the position for which they are covering.

5. Performance of duties in the exempt position shall remain the employee's primary responsibility. A decline in performance of these responsibilities, as determined by the responsible Vice President or Administrative Director, may result in the employee's ineligibility to work clinical shifts.

6. Clinical/ancillary extra shift opportunities will be made available at the Hospital's discretion based on staffing requirements and other criteria.

7. No clinical shift will be scheduled for exempt licensed staff until at least 72 hours prior to the start of the shift.

In a declared emergency, the CEO may approve discretionary pay for exempt staff who are working extra shifts specifically in relation to the emergency.

CROSS REFERENCES:

- Employment Status Policy
- Sick Leave Policy
- Meal Periods and Rest Periods Policy

SUBJECT: **FALSE CLAIMS ACT AND WHISTLEBLOWER PROTECTION**	SECTION: **Page 1 of 6**

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

PURPOSE:

To provide a summary of federal and state law regarding the False Claims Act (FCA), whistleblower protection as it relates to healthcare organizations, and specific policies and procedures on how Sierra View Medical Center (SVMC) prevents false claims.

POLICY:

Sierra View Medical Center (SVMC) employees, contractors and agents each have a responsibility to ensure their actions and those of their co-workers are in compliance with all federal and state laws and regulations. Particularly important are the provisions of the FCA, the most heavily penalized form of healthcare-related misconduct, which warrants special attention.

To ensure that healthcare organizations have strong incentives to police their own actions, the government provides special protection to whistleblowers who provide incriminating evidence of their company's misconduct to the government. Employees are encouraged to report any observations regarding potential violations to their supervisor, the Compliance Officer or through the Compliance Hotline (559)791-4777.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES, CONTRACTORS AND AGENTS.*

DEFINITIONS:

Claim: Any request or demand for money submitted for reimbursement to the U. S. Government or its contractors.

Liability: Health care providers and suppliers (persons and organizations) who violate the FCA can be subject to civil monetary penalties for each false claim submitted. In addition to this civil penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government. If a provider or supplier is convicted of a FCA violation, the Office of Inspector General may seek to exclude the provider/supplier form participation, in government health care programs.

Knowing/Knowingly: A person, with respect to information, that:

- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

Person: Any employee, contractor, agent, department, or group of employees of or representing SVMC.

Qui Tam Action: An action that is brought by a person on behalf of a government against a party alleged to have violated a statute especially against defrauding the government through false claims and

that provides employment protection and for part of a penalty to go to the person bringing the action. Also known as Whistleblower protection.

STATE PROVISIONS:

The California False Claims Act, Ca. Govt. Code 12651 provides a civil remedy for the submission of false and fraudulent claims to state health care programs, primarily Medi-Cal. Like the federal FCA, the California False Claims Act includes whistleblower provisions that allow enforcement through *qui tam* actions, and protect whistleblowers from retaliation. Key provisions of the California False Claims Act as it relates to the healthcare industry are as follows:

A. **Application**

1. Any person who commits any of the following acts shall be liable for three times the amount of damages sustained due to the act of that person. A person who commits any of the following acts shall also be liable for the costs of a civil action brought to recover any of those penalties or damages, and may be liable for a civil penalty of not less than five thousand five hundred ($5,500) and not more than eleven thousand dollars ($11,000) for each false claim (there is currently no floor in the state of CA for civil penalties):

    a. Knowingly presents or causes to be presented to an officer, employee or intermediary of the government, a false claim for payment or approval.

    b. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false claim paid or approved.

    c. Conspires to defraud the government by getting a false claim allowed or paid.

    d. Is a beneficiary of an inadvertent submission of a false claim to the government, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the government within a reasonable time after discovery of the false claim.

2. If false claims are found to have been submitted, the court may assess *minimal* civil monetary penalties if the following criteria are met:

    a. The person committing the violation furnished officials of the government responsible for investigating false claims violations with all information known to that person about the violation within 30 days after the date on which the person first obtained the information.

    b. The person fully cooperated with any investigation by the government of the violation.

c. At the time the person furnished the government with information about the violation, no criminal prosecution, civil action, or administrative action had commenced with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

3. Liability under this section shall be joint and several for any act committed by two or more persons in an organized conspiracy.

4. This section does not apply to any controversy involving an amount of less than five hundred dollars ($500) in value. For purposes of this subdivision, "controversy" means any one or more false claims submitted by the same person in violation of this article.

FEDERAL PROVISIONS

A. Enforcement: The Federal False Claims Act is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years after a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed.

B. Penalties assessed after 1/20/2023. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than $13,508 and not more than $27,018, plus up to three times the amount of damages sustained by the federal government.

EMPLOYEE PROTECTION – *QUI TAM ACTION* "WHISTLEBLOWER PROTECTION"

1. SVMC shall not make, adopt, or enforce any rule, regulation, or policy preventing an employee from disclosing information to a government or law enforcement agency or from acting in furtherance of a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under Section 12652 (State of California).

2. SVMC shall not discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against, an employee in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in, an action filed or to be filed under Section 12652.

3. If SVMC were to violate subdivision 2 (above), SVMC would be liable for all relief necessary to make the employee whole, including reinstatement with the same seniority status that the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a

result of the discrimination, and, where appropriate, punitive damages. In addition, SVMC would be required to pay litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate superior court of the state for the relief provided in this subdivision.

4. An employee who is discharged, demoted, suspended, harassed, denied promotion, or in any other manner discriminated against in the terms and conditions of employment by SVMC because of participation in conduct which directly or indirectly resulted in a false claim being submitted to the government shall be entitled to the remedies under subdivision 3 (above) if, and only if, both of the following occur:

   a. The employee voluntarily disclosed information to a government or law enforcement agency or acted in furtherance of a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed.

   b. The employee had been harassed, threatened with termination or demotion, or otherwise coerced by SVMC management into engaging in the fraudulent activity in the first place.

DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Detailed information with regards to detection, prevention and resolution of false claims is provided in specific SVMC policies such as (1) Auditing and Monitoring, (2) Compliance Issue Reporting, (3) Correction of Errors Related to Government Reimbursement, (4) Code of Conduct, and (5) Non Retaliation – Compliance Issue Reporting. Additionally, SVMC staff members receive compliance training during their annual orientation, which emphasizes false claims prevention and whistleblower protection.

SVMC RESPONSE TO FALSE CLAIMS VIOLATIONS

This policy has thus far focused on government response to false claims allegations. The response of SVMC in the event of false claims violations by a SVMC employee, contractor, or agent shall be as follows.

1. Any officer, employee, contractor or agent of SVMC who believes another officer, employee, contractor or agent of SVMC has committed a False Claims violation should immediately report it to his or her supervisor or the Compliance Officer (CO). Supervisors receiving such reports should immediately forward all information to the CO.

2. The CO will conduct a thorough and confidential investigation into the allegations.

3. As noted in the Employee Handbook, SVMC has a progressive discipline policy under which sanctions become more severe for repeated infractions. At the discretion of management, SVMC may terminate an employee for the first breach of any False Claim related policies and/or

standards if the seriousness of the offense warrants such action, and may also be obligated to report the offense to law enforcement agencies, depending on the severity. An employee could expect to be terminated for willful or grossly negligent False Claims violations. For less serious violations (such as innocent mistakes or indications of small-scale negligence), management may impose a lesser sanction, depending on the circumstances, such as training, verbal or written warning, verbal or written reprimand, suspension without pay, or demotion.

4. SVMC will seek to include such violations by contractors as grounds for termination of the contract and/or imposition of contract penalties.

5. Significant False Claims violations (grossly negligent, intentional, and/or numerous) will likely constitute a criminal offense, in which case SVMC will provide information concerning the violation to appropriate law enforcement agencies and will cooperate with any law enforcement investigation or prosecution.

REFERENCES:

- Code of Federal Regulations Civil Monetary Penalties Inflation Adjustment https://www.ecfr.gov/current/title-28/chapter-I/part-85
- Deficit Reduction Act of 2005: https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf
- California False Claims Act: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=12650&lawCode=GOV
- Federal False Claims Act: https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title31-section3729&num=0&edition=prelim\

CROSS REFERENCES:

- COMPLIANCE AUDITING AND MONITORING
- COMPLIANCE ISSUE REPORTING
- CORRECTION OF ERRORS RELATED TO GOVERNMENT REIMBURSEMENT
- CODE OF CONDUCT
- NON RETALIATION- COMPLIANCE ISSUE REPORTING

MEDICAL EXECUTIVE COMMITTEE	05/03/2023
BOARD OF DIRECTORS APPROVAL	
	05/23/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
May 23, 2023 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Admission/Treatment Criteria for PDC Clients Receiving Services at Sierra View Medical Center	1-2	↓
• Discharge Planning - Assessment and Reassessment	3-6	
• Exposure Control Plan - Bloodborne Pathogen Standard	7-33	
• Outpatient/Observation Status	34-36	
• Patient Positioning	37-42	
• Procedural Sedation	43-64	
• Protection of Patient Privacy	65-77	
• Respiratory Protection Plan	78-98	
• Scope of Services of the Surgical Services Department	99-102	
• Staffing for the Ambulatory Surgery Services Department	103	

SUBJECT:	SECTION:
ADMISSION/TREATMENT CRITERIA FOR PDC CLIENTS RECEIVING SERVICES AT SIERRA VIEW MEDICAL CENTER	***Ethics, Rights and Responsibilities (RI)***

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

PURPOSE:

To define the guidelines to be followed when a Porterville Developmental Center (PDC) client is admitted or treated at Sierra View Medical Center (SVMC).

POLICY:

It will be the responsibility of Nursing to ensure that all communication between PDC and SVMC regarding PDC clients be coordinated through the coordinator of Nursing Services office by the ACNS/NOD on duty at 782-2356 (office) or 782-2222. ***Note***: If residence staff is contacted directly by SVMC, they will notify the ACNS office.

AFFECTED AREAS/ PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

1. PDC staff will accompany the client and give all necessary paperwork and report to the admitting staff in the outpatient area.
   a. SVMC will accept our Consent for Surgery, Form 5683, signed by the Medical Director/Designee in the absence of client's parents (under 18) or conservator.
   b. Off hours admissions may be made without Medicare/Medical cards or stickers. These need to be taken to SVMC the next normal working day.
2. PDC staff may leave client after completing admission process and reporting to the outpatient admitting staff, if there are no behavioral issues.
3. PDC staff will stay with client until client goes into surgery or after receiving pre-sedation, if the client exhibits any of the following:
   a. Severe acting out behavior (hitting, biting, screaming, etc.)
   b. Safety is compromised by attempting to roll off gurney, injure self, etc.
4. PDC staff may be required to accompany client during Endoscopy procedures performed under conscious sedation. Operating Room (OR) Coordinator/Manager will make the determination.
5. On occasion, it may be necessary for the Psychiatric Technician to accompany the client into the surgical suite until the patient is anesthetized. The necessity of the Psychiatric Technician accompaniment is determined by the Anesthesiologist/Surgeon and the Circulating Registered Nurse (RN).

SUBJECT:	SECTION:
ADMISSION/TREATMENT CRITERIA FOR PDC CLIENTS RECEIVING SERVICES AT SIERRA VIEW MEDICAL CENTER	***Ethics, Rights and Responsibilities (RI)*** **Page 2 of 2**

STAFF ASSISTANCE

Staff from SVMC may request assistance from PDC staff when any of the below listed criteria are present. (Prior to calling PDC for assistance, SVMC staff should notify the Shift Manager to ensure criteria for 1:1 are met or to explore alternative solutions).

CRITERIA FOR 1:1 CLIENT SUPERVISION

1. Unable to prevent client from pulling out IVs, surgical tubes, sutures or removing dressings, etc., even though restraints are in place.

2. Restraints are contraindicated due to the surgical site and the behavior of the client endangers his/her own life (refer to #1).

3. Restraints are not feasible, as it only intensified the client's uncooperative behavior, which predisposes the client to harm.

4. Client requests that PDC staff stay with him/her.

COMPROMISE SOLUTION

In the event of a request for 1:1 when the client has no known behavior problems and/or criteria in Section 3 are not met, PDC may send a staff person from the Coordinator of Nursing Services Office to evaluate the client's behavior and meet with SVMC Nursing Manager to reach a workable solution.

SUBJECT:	SECTION:
DISCHARGE PLANNING-- ASSESSMENT AND REASSESSMENT	**Page 1 of 4**

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

PURPOSE:

To describe the process of discharge planning, assessment and reassessment of the patient by the interdisciplinary healthcare team during their hospital stay. It is the responsibility of each discipline assessing discharge planning needs to document associated assessment findings within the medical record and make appropriate referrals to discharge planning.

POLICY:

A. Continuity of care requires thoughtful preparation by the entire healthcare team. Each patient's needs for continuing care are assessed in an ongoing fashion by all members of the healthcare team, as dictated by their presenting condition(s). This assessment may begin prior to admission, but in no event later than at the time of the Nursing Admission Assessment. Appropriate disciplines are involved in the assessment, referral and planning for after discharge healthcare needs of the patient and/or family -may include ~~including~~, but are not limited to:

1. Members of the medical staff
2. Nursing staff members
3. Rehabilitation services professionals
4. Social workers
5. Respiratory care practitioners
6. Pharmacists
7. Discharge Planners
8. Dieticians

B. The Registered Nurse caring for the patient is ultimately responsible/accountable for the discharge planning needs of the patient.

C. The discharge planning function focuses on meeting the patient's continuing healthcare needs after discharge. These needs may have necessitated the admission to the facility or may occur as an expected outcome to medical or surgical intervention, such as cast care following open reduction of a fracture. The purpose of discharge planning is to identify a patient's unique needs for continuing physical, emotional, safety, transportation, social and other needs and to arrange services to meet those needs. Needed discharge services may include:

1. Long-term care
2. Home health services

3. Palliative services

~~3.~~4. Hospice services

~~4.~~5. Ambulatory care services

6. Rehabilitation services

~~5.~~7. Durable Medical Equipment

~~6.~~8. Support groups

~~7.~~9. Community agency services

~~8.~~10. Community mental health

~~9.~~11. Adult foster care

D. Patient education is a major focus of discharge planning activities for all patients. Many patients' after care needs are met through education provided by ~~each~~ members of the healthcare team.

E. A list of available post-hospital extended services identified in the discharge plan will be provided to the patient or designated caregiver and documented in the patient's medical chart. If the patient or designated caregiver does not have a preference, referral will be given to any available agency that can provide the requested service.

~~D. As a result, documentation for patients with less complex discharge planning needs is often found within documentation associated with patient education.~~

AFFECTED AREAS/PERSONNEL:

UTILIZATION MANAGEMENT / SOCIAL SERVICES / NURSING STAFF/CASE MANAGEMENT

PROCEDURE:

A. The initial screening assessment for discharge planning needs is conducted during the Nursing Admission Assessment using "high risk screening criteria" that triggers a referral to the Social Services department for discharge planning. ~~Discharge planning referrals are computer generated reports identifying additional high risk patients in need of a discharge plan~~.

B. In addition, ~~each~~ disciplines involved in the care of the patient, assesses needs for aftercare as part of their ongoing assessment and reassessment processes. It is the responsibility of each discipline assessing discharge planning needs to document associated assessment findings within the

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medical record and make appropriate referrals to discharge planning. For Social Services, specifically, an initial discharge screening assessment is to be completed after admission to identify needs early in the admission, then a re-evaluation is to be done every 33 business days after to assess for any ongoing needs or changes in the original plan of care. In addition, each patient will be provided the opportunity to identify one family caregiver, who may assist in post-hospital care, and record the designated caregiver's information in the patient's medical record. Additionally, each patient is also offered the opportunity to name a support person, who would be in charge of determining who may or may not visit the patient if the patient is no longer able to decide that for themselves. If the patient or legal guardian declines to designate a caregiver or support person, the hospital must document the declination in the patient's medical record. In the event that the patient is unconscious or otherwise incapacitated upon admittance, the hospital must provide the patient with the opportunity to identify the caregiver and support person after the patient recovers consciousness or capacity. If patient permits, this person identified as the family caregiver is to be notified of discharge or transfer as soon as possible, but no later than at the time a discharge order is written by the physician. The family caregiver, if named, will also receive information pertaining to the continuing health care needs after discharge and providing the caregiver an opportunity to engage in and ask questions during the discharge planning process. This should include providing information and instruction on a patient's post hospital care needs, and when applicable, include education and counseling about the patient's medications, including proper dosing and proper use of medication delivery devices. Additionally, information and instruction must be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver. If the named family caregiver is not available, the inability to provide this information will not delay the discharge, but attempts must be noted in the chart.

C. Patients in the following high-risk category receive initial assessment by social services staff within two (2) business days of referral. The Patient/Family/Guardian will be given the opportunity to be involved in formulating the discharge plan, upon patient consent to do so.

D. High-risk patients include:

1. 70 or older, living alone or with a non-capable caregiver
2. Admissions from nursing homes or residential care homes
3. Re-admissions within 30 days
4. No identification, i.e. John/Jane Doe
5. Multiple trauma
6. Substance Abuse issues or presenting mental health issues
7. Patients with cognitive deficiencies

8. Patients requiring transportation needs

9. Requires assistance with ADL's (Activities of Daily Living)

E. Reassessment of patients is an ongoing process and will be documented on a minimum of every three (3) business days, in the Discharge Planning/Social Service progress notes. Physician Orders for follow up care will be incorporated into the plan.

REFERENCE:

- The Joint Commission (2023~~18~~). Oakbrook Terrace, IL. Provision of Care chapter.
- Centers for Medicare & Medicaid Services Conditions of Participation. Subpart C. Discharge Planning. §482.43

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

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

PURPOSE:

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

POLICY:

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

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

   a. Determining exposure risks of personnel

   b. Providing protection against exposure risks

   c. Implementing a blood borne pathogen program

   d. Providing Hepatitis B vaccinations at no cost to personnel

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

   f. Being available to answer all employee questions

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

2. The goals of the Exposure Control Plan are:

   a. To inform personnel of the contents of the OSHA standards as it applies to Hepatitis and Acquired Immune Deficiency Syndrome (AIDS) transmission.

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

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

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

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

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

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

   c. New or revised employee positions with occupational exposure.

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

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

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

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

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

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

   a. Made available at no cost to the employee

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

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

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

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

GENERAL FACTS ABOUT AIDS AND HEPATITIS

1. Hepatitis Transmission

a. Hepatitis B (HBV)

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

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

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

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

b. Hepatitis C

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

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

HCV symptoms resemble the symptoms associated with HBV.

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

2. Hepatitis Protection

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

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

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

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

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

b. Using disinfectants to reduce pathogens in the environment.

c. Taking thorough patient medical histories.

d. Washing hands between patient treatment contacts.

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

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

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

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

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

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

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

4. HIV / AIDS Transmission

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

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

STANDARD PRECAUTIONS

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

B. Standard Precautions amplifies Universal Precautions in that it also incorporates infection prevention procedures that protect the patient as well as the employee from disease-causing pathogens.

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

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

E. STANDARD PRECAUTIONS applies to:

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

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

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

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

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

DEFINITIONS OF INFECTIOUS CONDITIONS

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

1. A sufficiently large dose to constitute a dangerous quantity

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

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

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

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

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

PERSONAL PROTECTIVE EQUIPMENT

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

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

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

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

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

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

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

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

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

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

Disposal of Personal Protective Equipment

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

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

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

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

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

Gloves

1. Types

   Three basic glove types are provided by SVMC:

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

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

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

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

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

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

   c. Discard gloves after each patient.

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

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

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

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

   h. Wash hands after glove disposal.

Masks, Protective Eyewear / Goggles, and Face Shields

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

Gowns / Aprons or Other Protective Body Clothing

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

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

   Resuscitation Equipment:

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

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

HANDWASHING

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

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

10. After hands have touched a potentially contaminated surface

11. Before leaving the work area and upon return

12. Upon completing work shift

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

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

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

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

C. Alcohol-based Hand Sanitizers/ Wipes

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

EXPOSURE INCIDENT OCCURRENCE

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

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

B. Report the incident to the Supervisor immediately.

C. Complete all necessary forms to document the facts.

D. Fill out an Electronic Incident Report.

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

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

EXPOSURE INCIDENT FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

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

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

F. Information provided to Healthcare Professionals:

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

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

   a. A copy of this regulation

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

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

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

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

G. Healthcare Professional's Written Opinion

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

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

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

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

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

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

H. Medical Recordkeeping

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

SHARPS INJURY LOG

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

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

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

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

EXPOSURE RESPONSE, PREVENTION AND CONTROL

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

SVMC

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

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

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

   a. Safety training in blood borne pathogens

   b. the protective clothing required by OSHA against pathogen exposure

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

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

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

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

6. Provides for documenting patient safety determinations.

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

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

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

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

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

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

A. Methods of Compliance

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

2. Engineering and Work Practice Controls – General Requirements:

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

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

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

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

3. Engineering and Work Practice Controls – Specific Requirements:

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

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

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

- Withdrawal of body fluids
- Accessing a vein or artery

- Administration of medications or fluids

  EXCEPTIONS:

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

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

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

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

4. Prohibited Practice

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

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

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

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

d Disposable sharps shall be used.

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

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

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

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

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

B. Requirements for Handling Contaminated Sharps

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

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

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

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

2. Maintained upright throughout use, where feasible.

3. Replaced as necessary to avoid overfilling.

C. Sharps Containers for Contaminated Sharps:

1. All sharps containers for contaminated sharps shall be:

a. Rigid

b. Puncture resistant

c. Leak proof on the sides and bottom

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

e. Labeled appropriately with the universal biohazard symbol

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

D. Regulated Waste.

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

1. General

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

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

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

2. Disposal of Sharps Containers

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

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

- Closeable

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

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

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

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

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

E. Handling Specimens of Blood or Other Infectious Material

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

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

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

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

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

F. Servicing or Shipping Contaminated Equipment

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

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

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

G. Cleaning and Decontamination of the Worksite / Housekeeping

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

1. General Requirements

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

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

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

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

2. Specific Requirements

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

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

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

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

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

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

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

H. Hygiene

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

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

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

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

I. Laundry

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

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

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

INDIVIDUALS COVERED BY THE PLAN

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

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

TRAINING DOCUMENTATION

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

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

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

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

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

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

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

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

RISK EXPOSURE CATEGORIES

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

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

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

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

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

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

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

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

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

NOTE: HOUSE-WIDE POLICY:

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

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

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

REFERENCES:

- California Code of Regulations, Title 22 – Social Security, Division 5 – Licensing and Certification of Health Facilities. Chapter 1 General Acute Care Hospitals, Article 7. ***Cal. Code Regs. Tit. 22, § 70739 - Infection Control Program***. Accessed 2023, https://www.law.cornell.edu/regulations/california/22-CCR-70739

- *Occupational Safety and Health Administration (OSHA). Code of Federal Regulations, 29 CFR 1910.1030 – Bloodborne Pathogens. Accessed 2023. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030*

- Occupational Safety and Health Administration (OSHA). Federal Registers Hazard Communication Standard Publication. Accessed 2023. https://www.osha.gov/hazcom

- California Code of Regulations, Title 8, Section 5193 - Industrial Relations, Records on Training and Transfer of Training Records. Subchapter 7 General Industry Safety Orders. *Title 8, CCR § 5193 Handling of Blood.* Accessed 2023, https://www.dir.ca.gov/title8/5193.html

CROSS REFERENCES:

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

SUBJECT: **OUTPATIENT/OBSERVATION STATUS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish guidelines on how to accommodate patients requiring diagnosis and/or treatment of short term, non-acute problems that may not require hospitalization as an inpatient.

POLICY:

There are occasions when a patient will need to remain in the hospital for outpatient/observation for up to forty-eight (48) hours. This may include but is not limited to those patients following Outpatient Surgery, Emergency Department visit, direct admission from the physician's office and Maternity patients undergoing screening for false labor or fetal monitoring.

UM-Utilization Management will review these patients for medical necessity based on InterQual and/or MCG-Milliman Care Guidelines Standards.

AFFECTED AREAS/DEPARTMENTS: *ALL PATIENT CARE AREAS/UTILIZATION REVIEW*

PROCEDURE:

1. Patient Registration will inform the patient that they will be an "Outpatient/Observation Patient" and will be considered an outpatient until a decision is made by the physician to be admitted as an inpatient to the hospital or discharged.

2. Patient Registration will issue the outpatient/observation information brochure to the patient.

3. Physician coverage will be provided by the attending physician.

    a. All patients must be under the medical supervision of the attending physician. The decision to place or discharge from outpatient/observation is the responsibility of the attending physician.

    b. The patient must be seen by the attending physician during the outpatient/observation stay.

    c. The attending physician is responsible for calling consulting physicians. The decision to admit the patient may be made following the consult. When a consultant is called to see an outpatient/observation patient, every effort should be made to see the patient as soon as possible.

4. Documentation for Outpatient/Observation patients will include:

    a. An order stating "Place in Outpatient/Observation Services".

b. A note stating clinical rationale for Outpatient/Observation, history and physical and final progress notes.

5. To place a patient in Outpatient/Observation:
   a. For patient's in physician offices, the physicians must call the direct admit phone number (559)791-4752 just as they do for a direct inpatient admission.

   b. The Emergency Department and Surgical Services will contact the Nursing Staffing Coordinator and/or the Nursing House Supervisor to inform them of the patient's need for placement in outpatient/observation status and obtain a room assignment.

   c. The patient will be placed in the appropriate ~~Clinical Decision Unit (CDU) or on a~~ nursing unit. The unit will be determined by the admitting physician and the patient's diagnosis and bed availability.

   d. If the patient's status is changed to inpatient, Meditech System will print an order to patient registration where they will change the patient status in the Meditech system. ~~census~~.

6. How to find an outpatient/observation patient:

   a. Even though observation patients are outpatients, they can be found on the inpatient census.

   b. Outpatient/Observation patients are also found on the individual floor census.

7. Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy, blood transfusion). In situations where such a procedure interrupts observation services, Sierra View Medical Center (SVMC) will deduct the average length of time of the interrupting procedure from the total duration of time that the patient receives observation services.

8. Each morning UR nurses will review the current list of Observation patients, they will then review each chart to determine the correct status for the patient is ordered. If the Observation patient is now meeting inpatient status a "change" order will be requested from the attending physician to make the appropriate change in status. If the patient is to remain in the Observation status the physician will be contacted to discuss timeliness of discharge orders.

9. There may be times when a patient is admitted as an inpatient initially and is found to be Observation appropriate. In those instances a "change" order will be entered. A member of registration will then give the appropriate notice to the patient to notify of the change from inpatient to outpatient/observation status (i.e. Medicare Outpatient Observation Notice or Non Medicare Outpatient Observation Notice).

10. If a Primary Medicare patient is in an inpatient status incorrectly and must be changed to Observation status a "change" order will be entered into the patients chart with a CC44-Condition Code 44 information added to the order. CMS requires the following criteria to be met:
    1. Order must be entered before the patient discharges from the facility
    2. An inpatient claim must not have been sent.
    3. The following must be documented in the chart; concurrence of the attending physician with a physician member of the UR Committee and a UR Committee member. Compliance by SVMC will be indicated by; a chart overview with the Utilization Management (UM) Director and UR Committee physician with the mutual decision of the need for a CC44. The "change" order will then be entered by the RN-UM Director, accompanied by a note in the CC44 field identifying the concurrence of the UR Committee physician. The order will then be signed by the attending physician to indicate their concurrence. All of the criteria will have then been met for Patient Finance to proceed with processing the CC44.

REFERENCES:

- Centers for Medicare & Medicaid Services, Utilization Control, Subchapter C, §456.50-456.145
- The Joint Commission (2023). CAMH-Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Medicare Claims Processing Manual, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS). 290.2.2 – Reporting Hours of Observation.

SUBJECT: **PATIENT POSITIONING**	SECTION: **Page 1 of 6**

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

PURPOSE:

To establish guidelines for positioning the surgical patient and to facilitate and maintain a safe and efficient surgical procedure.

POLICY:

The Surgical Team will follow the positioning guidelines set forth to provide optimum exposure and access to the operative site, shall sustain circulatory and respiratory function, shall not compromise neuromuscular structures and shall afford as much comfort to the patient as possible.

AFFECTED AREAS/ PERSONNEL:

OPERATING ROOM NURSES, SURGICAL TECHNICIANS, ANESTHESIOLOGISTS, SURGEONS, MCH, CATHETERIZATION LAB, AMBULATORY SURGERY DEPARTMETN (ASD), SURGICAL SERVICES

EQUIPMENT NEEDED:

- Positioning devices
- Pillows
- Safety Straps
- Towels, padding

PROCEDURE:

1. The patient shall be assessed prior to the procedure for the following:
   a. Age
   b. Height
   c. Weight

      Underweight patients experience greater than normal pressure on bony surfaces. Adipose tissue is not well perfused. Positioning devices used need to be of an appropriate size to prevent patient injury.

   d. Skin condition

      Previously damaged tissue and tissue receiving decreased circulation have increased risk for pressure ulcers. Hypothermia, Hypotension, and prolonged procedures without position change are conditions that can lead to decreased tissue perfusion.

e. Nutrition

f. Physical limitations

If the patient is unable to assist, an adequate number of personnel and/or devices to safely transfer the patient will be used.

g. Neuropathies

h. Pre-existing disease and conditions

i. Type of procedure

2. Following a repositioning or any movement of the patient, operative bed, or devices that attach to the operative bed, the patient will be reassessed for body alignment and tissue integrity.

3. Proper positioning for a number of different procedures is outlined.

4. **Supine position** -This is the most common position used. Patients are usually anesthetized in this position and modifications are made after the induction of anesthesia.

a. The position of the head shall place the cervical, thoracic, and lumbar vertebrae in a straight, horizontal line.

b. A pillow may be placed under the knees to prevent strain on the patient's back muscles and ligaments.

c. A small pad or pillow placed under the head allows the muscles to relax and prevent neck strain.

d. Hips shall be parallel.

e. Legs are placed parallel and uncrossed to prevent compromised circulation and nerve damage. The legs shall be slightly separated so that skin surfaces are not in contact.

f. The safety strap is placed across the thighs so that the patient is secured, but superficial venous return is not impaired.

g. The heels may need to be padded with foam protectors, if the procedure will be extended or the patient's condition warrants it.

h. Arms are usually placed on arm boards, at less than a 90-degree angle to the body. The palms shall be turned upwards to diminish the pressure on the brachial and ulnar nerve. Foam protectors may be used to pad the elbows if necessary. Table pads and arm board pads must be of the same height.

i. When the head is turned to one side, the bony prominences of the skull and the ears must be padded, to prevent pressure on nerves or blood vessels.

j. The patient's eyes must be protected from pressure and corneal drying or abrasions. The anesthesiologist, when present, cares for the patient's eyes; i.e., taping the eyes.

k. Variations of the supine position include Trendelenburg, Reverse Trendelenburg, and Fowler's positions. In all the variations, the principles remain the same. Bony prominences must be well padded and circulation must not be impeded.

5. **Lithotomy Position**

a. With the patient in the supine position, the legs are raised simultaneously and abducted to expose the perineal area. Each leg is raised by grasping the sole of the foot in one hand and supporting the leg near the knee in the other hand. The leg is raised and the knee flexed slowly.

b. The foot is secured in the holder with disposable straps. One loop of the disposable strap is placed around the sole at the metatarsals and the other loop placed around the ankle. The lower part of the leg shall be free of pressure against the leg holders. Foam padding may be needed to protect areas of the leg or foot from excess pressure.

c. The leg stirrups must be level and the height adjusted to the length of the patient's legs. By placing the patient's anterior iliac spine on a line with the leg holder and the buttocks level and on a line with the edge of the table pad, a good position can be achieved with a minimum of effort.

d. The patient's position must be symmetrical. The perineum is in line with the longitudinal axis of the table: The pelvis is level and the head and trunk are in a straight line.

e. The arms are placed on arm boards, using the previously described precautions.

f. The patient is released from lithotomy position slowly to allow gradual adjustment to the change. The legs are brought down simultaneously to prevent strain on the lumbosacral muscles.

6. **Prone Position** - Patient is lying with abdomen on the surface of the operating table.

In preparation for placing patient in prone position, place two bolsters lengthwise on the operating table. One or two pillows must be available for placement under the patient's feet. The patient is placed supine on a gurney.

For Females: Assess the breast
For Males: Assess genital area

a. Four (4) people are required to safely place a patient in prone position. The anesthesiologist supports the head and neck. One person stands at the side of the stretcher, with hands at the patient's shoulders and buttocks, to initiate the roll of the patient. A second person stands opposite, at the side of the operating table, with arms extended to support the chest and lower abdomen on outstretched arms, as the patient is rolled forward and over. The third person stands at the foot of the stretcher to support and turn the legs. At the completion of the turn, the stretcher is removed.

b. All movements must be coordinated by the anesthesiologist to ensure maintenance of the airway.

c. An arm board is provided on each side of the table and the patient's arms are brought down and forward to rest with elbows flexed and hands pronated at either side of the head. Arm pads may be used for ulnar and brachial nerve protection. Extra rolled towels may be used for shoulder, if necessary

d. The head is positioned on a foam pillow or doughnut, keeping the neck in alignment with the spinal column. The eyes are protected from the pillow and the drapes.

e. Chest rolls should extend from the acromioclavicular joint to the iliac crests to allow movement of the chest for respiration.

f. One or two pillows are placed under the ankles, to prevent pressure on the toes and feet.

g. The restraint is placed across the thighs to secure the patient and allow unimpaired venous return.

h. While a patient is in prone position, a firm stretcher must be readily available outside of the room in event of an emergency.

i. The patient is returned to the supine position by reversing the four-man roll described above.

7. **Lateral Position** -The patient is lying on the unaffected side with the operative site (chest, kidney exposed.)

a. The patient is induced in supine position. A bean bag positioning device, peg board, three-inch cloth adhesive tape, pillow (2 or 3), a supply of blankets, 1 or 2 towels and an arm board must all be available for use prior to placing the patient in a lateral position.

b. Four (4) people are required to safely place a patient in the lateral position. The anesthesiologist supports the head and neck. One person stands at the shoulders of the operative side facing the patient's head; this person's arm and hand nearer the patient, cross the chest and grasp the patient's shoulder, the other hand is placed under the nearer shoulder. The second person stands at the hips of the operative side, facing the patient's head; this person's arm and hand nearer the patient, cross the hips and grasp the patient's

opposite buttock; the other hand is placed under the nearer buttock. The third person stands at the foot of the table to turn and support the legs.

c. At a signal from the anesthesiologist, the first and second persons lift and bring the patient to his/her side at their edge of the operating table; the patient is then placed in the center of the table. A pillow is placed under the patient's head to maintain good alignment of the vertebrae.

d. One assistant remains at the patient's back to steady and support the torso during the remainder of the positioning.

e. The upper arm is flexed slightly at the elbow and placed parallel to the lower arm. Several towels or blankets are used to pad the lower arm and arm board and the patient's upper arm is placed on the padding.

f. The lower shoulder is brought slightly forward to prevent pressure on the brachial plexus and the arm is flexed at the elbow. A rolled towel is placed under the axilla to reduce pressure and improve respiratory efforts.

g. The patient may be maintained in proper position with sandbags or adhesive tape. The patient's legs may also be positioned in one of the following manners:

- Both legs may be flexed at 90-degree angles at the hips and knees, with a pillow placed between the legs. Ankles should also be padded with foam pads
- The lower leg may be extended straight on the table, the upper hip and knee flexed at 90-degree angles with one or two pillows between the legs.

h. The operating room bed is flexed to bring the patient's chest and legs down and flex the patient's flank.

8. Fracture Table:

a. The Fracture bed allows the patient to be positioned for hip nailing and other orthopedic procedures, requiring C-arm or fluoroscopy.

b. The surgeon will be in the operating room during the positioning of the patient for the fracture table.

c. Operative side will be on traction and non-operative leg will be extended, but not on traction.

9. Documentation

   a. Documentation of the procedure is done on the Intraoperative Nurses' Notes by the Circulating RN. Documentation must include: position and devices uses, safety and security measures, and patient monitoring

   b. Any skin issues prior to surgery must be documented pre-op and if any skin issues occur intra-op, it shall be documented as well

REFERENCE:

- Association of Perioperative Registered Nurses (AORN) Standards and Recommended Practices, ~~2019~~ 2023. Positioning the Patient . Retrieved from ~~https://www.aorn.org/guidelines/about-aorn-guidelines~~. https://aornguidelines.org/guidelines/content?sectionid=173734066

SUBJECT:	SECTION:
PROCEDURAL SEDATION	***Provision of Care, Treatment and Services (PC)*** **Page 1 of 22**

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

PURPOSE:

To establish appropriate standards for administering and monitoring patients receiving procedural sedation.

POLICY:

All patients at Sierra View Medical Center receiving procedural sedation, IV/PO/IM, for short term diagnostic, therapeutic or invasive procedures will be cared for as stated in this policy.

Exceptions:

This policy applies to the use of analgesia and/or sedation in all hospital departments and areas except as stated below:

1. Those patients in the Intensive Care or Post Anesthesia Care Unit under a 1:2 nurse to patient ratio who are mechanically ventilated or whose cardiovascular and respiratory status are continuously monitored by the same monitoring devised as specified in this policy. These patients are excluded because their care always includes continuous monitoring of vital signs and are documented according to ICU and/or PACU protocol based on patient acuity.

2. Single dose drugs used as pain control and anxiolysis (where the patient retains a normal response to verbal stimulation and airway ventilation is unaffected) with a local infiltration analgesia to perform minimal procedures, e.g. episiotomies, simple lacerations, closed reductions, lumbar puncture, dressing change, bone marrow aspiration.

3. Medications given for procedure-related anxiolysis or deep sedation.

4. Those patients requiring emergency tracheal intubation.

5. An adult patient receiving strictly a one time pre-diagnostic PO sedative will be exempt from the documentation and monitoring of this policy if in the judgment of the prescribing physician, the dosage and drug given would not result in impairment of protective or airway reflexes. The provider assumes responsibility of ensuring the patient is accompanied by an escort, instructions are given regarding when the patient may resume normal activities, and counseling regarding possible side effects is given. This exception does NOT apply to children. It also does not apply if any additional PO, IM or IV sedation/analgesia is given.

6. Pre-operative medications, pre-procedural management of anxiety or pain management medications.

7. Deep sedation under by IV Ketamine ~~or Propofol~~ administered by physicians or IM Ketamine.

DEFINITIONS:

Levels of Sedation:

Sedation occurs in a dose related continuum, is variable, and depends on each patient's response to various drugs. The definitions below progress on a continuum from a high state of consciousness to unconsciousness.

Table 1. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia (2014)

	Minimal Sedation (Anxiolysis)	**Moderate Sedation/ analgesia (Conscious Sedation)**	**Deep Sedation/ Analgesia**	**General anesthesia**
Responsiveness	Normal response to verbal stimulation	Purposeful* response to verbal or tactile stimulation	Purposeful* response following repeated or painful stimulation	Unarousable, even with painful stimulation
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

*Reflex withdrawal from a painful stimulus in NOT considered a purposeful response.
American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia, 2014.

NOTE: Anesthesiologists, CRNA's or physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment or physician assistant in the ED may provide sedation for patient's assessed as being ASA Class 4 or 5 and any patient requiring deep sedation. ***EXCEPT in emergent situations with an ER physician present.***

AFFECTED AREAS/PERSONNEL: *MAIN OPERATING ROOM (OR); OBSTETRICS (OB)OR; ENDOSCOPY SUITE; EMERGENCY DEPARTMENT; INTENSIVE CARE UNIT (ICU); INTERVENTIONAL RADIOLOGY; POST ANESTESIA CARE UNIT (PACU), AMBULATORY SURGERY DEPARTMENT (ASD), CARDIAC CATHETERIZATION LAB*

MEDICATIONS APPROVED FOR PROCEDURAL SEDATION:
(See Addendum A for Procedural Sedation Dosing Guidelines)

1. Minimal or Light Sedation

a. Ativan

b. Diazepam (Valium)

2. Moderate Procedural Sedation

a. Midazolam (Versed)

b. Fentanyl (Sublimaze)

c. Meperidine (Demerol)

d. Morphine Sulfate

3. Reversal Agents

a. Benzopdiazepines – Flumazenil (Romazicon)

b. Opiods – Naloxone (Narcan)

Only anesthesiologists, anesthesia providers (i.e. Certified Registered Nurse Anesthetists), physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment may administer the following (deep sedation) anesthetics:

- Ketamine
- Sodium Thiopental
- Propofol
- Etomidate
- Nitrous Oxide

PATIENT ASSESSMENT AND CRITERIA FOR SELECTION:

1. Registered Nurses who have successfully completed the Moderate Procedural Sedation competency may provide care to the following types of patients:

a. Patients who are to have minimal or moderate sedation.

b. Patients who are assessed as ASA 1, ASA 2, or ASA 3 as designated by the American Society of Anesthesiologist (ASA) Classifications. (Note: ASA 3 patients may be appropriate, but need to be evaluated on an individual basis.):

- *ASA 1: A normal healthy patient.*
- *ASA 2: A patient with mild systemic disease.*
- *ASA 3: A patient with severe systemic disease.*
- *ASA 4: A patient with severe systemic disease that is a constant threat to his/her life.*
- *ASA 5: A moribund patient who is not expected to survive 24-hours with/without an operation.*

2. Anesthesiologists, CRNAs or physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment are required to provide care to the following types of patients:

   a. Patients who are to have deep sedation or analgesia

   b. Patients who are assessed as ASA 4 or ASA 5

3. It is the responsibility of the physician to select only those patients who can safely undergo the required procedure with the use of moderate sedation.

4. An anesthesiologist or anesthetist should be consulted for the following patients:

   a. Significantly compromised patients; e.g., severe obstructive pulmonary disease, coronary artery disease, congestive heart failure
   b. Morbid obesity

   c. Significant risk of aspiration

   d. Pregnancy

   e. Difficult airway

   f. If it appears likely that sedation to the point of unresponsiveness or general anesthesia will be necessary to perform the procedure

   g. History of symptoms of obstructive sleep apnea (OSA), or diagnosed OSA.

5. Patients must be screened for potential risk factors of receiving any pharmalogical agents selected. The decision as to which agent and dosage to use, will be based on the goals of sedation, the type of procedure being performed, and the age and physiologic condition of the patient.

6. NPO Guidelines:

a. Clear liquids(not to include alcohol) > 2 hours is advisable

b. Solids > 6 hours is advisable

Fasting recommendation to reduce the risk of pulmonary aspiration:

- Clear liquids(not to include alcohol) 2 hours
- Breast milk 4 hours
- Infant formula 6 hours
- Non human milk 6 hours
- Light meal 6 hours
- Regular meal 8 hours

NOTE: NPO status exempt in emergency situations.

PROCEDURE:

PRE-PROCEDURE PREPARATION:

1. Physician's responsibility

a. Prior to the procedure, it is the physician's responsibility to complete and record the following in the patient's medical record

- Focused physical examination (performed within 30 days and 24 hour update), including pertinent medical history, auscultation of the heart and lungs, and evaluation of the airway.
- ~~Indicated diagnostic test(s), including pregnancy test if female age 12-50 years unless sterilized.~~
- Indicated diagnostic test(s), including pregnancy test for female patients between the onset of menses and post-menopause, typically between the ages of 10-55 years, unless sterilized
-
- Informed consent of sedation risks, benefits and options as discussed with the patient and/or family prior to administration.

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- Pre-procedure diagnosis
- Pre-sedation assessment and ASA category;
- Order for sedation medications
- Procedure/sedation plan.
- Sedation goal using the Ramsay Sedation Scale below;
  - Anxious and/or restless
  - Cooperative, oriented, tranquil
  - Responds to commands
  - Brisk response to stimulus
  - Sluggish response to stimulus
- Determination of patient's appropriateness for the planned sedation, and
- Time-Out with RN and team prior to sedation to confirm patient identity, procedure and site, plus agreement on patient status, planned sedation level and recommended dosages of medications.

2. RN Responsibilities:

~~2.~~a. Two perioperative RNs will be assigned to care for the patient receiving procedural sedation. One RN will administer the sedation medication and monitor the patient and the other RN will perform the circulator role.

~~a.~~b. During Cardiac Cath Lab procedures requiring moderate sedation, in addition to the Cardiologist, one RN is continuously present to monitor the patient and assist with minor, interruptible tasks that do not interfere with the ability to monitor the patient. In addition, immediately available is another RN readily available to go into procedure.

~~b.~~c. Validate the following:

- Physician orders for sedation medications
- Presence of the current H&P, updated if not done on day of procedure
- Signed Informed Consent for procedure and moderate sedation

~~c.~~d. Provide pre-procedural patient education, including the following:

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- To anticipate drowsiness/sleep lasting a short time
- That conscious awareness of activity will be limited
- That ability to hear will remain; nurse will communicate throughout procedure
- That BP cuff and pulse oximeter will remain on during the procedure
- To advise the nurse if pain, itching, or difficulty breathing occurs
- To advise nurse if pain is not tolerated
- That recovery period will remain relatively short
- Addressing any questions the patient may have at that time

d.e. Confirm patent IV access

e.f. Validate presence of emergency equipment:

- Oxygen set-up with tubing and face mask/nasal cannula
- Suctioning equipment
- Pulse oximetry
- Cardiac monitor
- Non-invasive, automatic blood pressure cuff/machine
- Code cart immediately accessible
- Sedative and analgesic antagonists

3. All team members participate in pre-procedure Time Out (following Universal Protocol) to confirm patient identity, procedure and site, plus agreement on patient status, planned sedation level and recommended dosages of medications.

IMMEDIATELY PRIOR TO DRUG ADMINISTRATION

1. RN conducts and documents a baseline assessment to include the following:

   a. Respiratory rate;

   b. Oxygen saturation via pulse oximetry;

c. Blood Pressure;

d. Heart rate;

e. Pain assessment

f. Level of consciousness

2. Physician delivers or directs the RN to deliver the initial and subsequential doses of moderate sedation medications.

3. Immediately prior to start of procedure, the RN verbally confirms drug and dosage with physician, repeating sedation medication orders prior to administration.

THROUGHOUT THE ADMINISTRATION OF THE AGENT(S) AND DURING THE PROCEDURE

1. During the procedure with sedation the physician must be present and continuous monitoring will begin at the time the sedation medication is administered. Every 5 minutes throughout the procedure and for at least 15 minutes after the last dose of medication, the patient will be monitored , and the following will be documented:

a. Oxygen saturation (pulse oximetry);

b. End Tidal CO2;

c. Blood pressure;

d. Rate and quality of respirations;

e. Level of consciousness;

f. Response to verbal commands;

g. ECG Monitoring;

h. Vital signs.

2. Verbally confirm drug and dosage with physician, repeating sedation medication orders prior to administration.

3. Notify physician if patient-specific maximum dosage of sedative or analgesic has been administered. (Note: Administration of procedural sedation medication above the recommended dosages for the patient's age, status and desired level of sedation (as outlined by the Procedural Sedation Dosing Guidelines, Appendix A) will be done at the physician's discretion and documented as such.

4. During the procedure and during post-procedure observation, the RN will verbally notify the physician of any signs or symptoms of adverse reaction or physiologic compromise. These include, but are not limited to:

   a. Variation of 20% in blood pressure or heart rate

   b. Oxygen saturation drops more than 2% from baseline.

   c. Dyspnea, apnea or hypoventilation

   d. Chest pain or cardiac arrhythmia

   e. Diaphoresis

   f. Inability to arouse the patient

   g. The need to maintain the patient's airway mechanically

   h. Any other untoward or unexpected patient responses.

5. The RN must have no other responsibilities that would leave the patient unattended or would compromise continuous monitoring until the patient recovers.

IMMEDIATELY POST PROCEDURE:

1. The physician and team do a "Sign-Out", reviewing the name of the procedure, specimens are identified and labeled, equipment problems are addressed, and any concerns for the continued management of the patient to be communicated to the next care-providers

2. The physician will remain available (within hearing distance) and the pulse oximeter and ECG monitor will remain in place until the patient recovers protective airway reflexes, responds to verbal stimulation and moves extremities appropriately.

3. The physician will complete the Post Procedure Assessment Note including: procedure performed, post-operative diagnosis, findings, EBL, specimens removed and if there was an assistant.

4. One set of vital signs will be recorded in the procedural area before transfer to the PACU or immediate post-procedure area for continued recovery from procedural sedation if the patient remains in the procedural area longer than 15 minutes.

5. Patient status will then be monitored for a minimum of 30 minutes after the last dose of medication by a qualified RN until the patient has reached baseline status or acceptable level according to the Aldrete scoring system in the following parameters:

a. Level of consciousness;

b. Oxygen saturation;

c. Movement of extremities;

d. Vital signs stable for 30 minutes;

e. Maintenance of airway; and

f. Pain assessment.

6. The Aldrete score is to be recorded in the immediate post-procedure recovery period, repeated every 15 minutes until criteria is met. (see below)

ALDRETE SCORE

SCORE	ADD 2	ADD 1	ADD 0
Activity	Moves 4 extremities voluntarily or upon command.	Moves 2 extremities voluntarily or upon command.	Moves 0 extremities voluntarily or upon command.
Respiration	Deep breathe or cough on command.	Limited or difficult respiration.	Apnea.
Circulation	BP +/- 20 mm Hg of pre-anesthetic level	BP +/- 20-50 mm Hg of pre-anesthetic level.	BP +/- 50 mm Hg or more of pre-anesthetic level.
Consciousness	Fully awake.	Responsive to voice stimuli.	Not responsive.
Oxygenation	Maintain SaO2 > 92%.	Maintain SaO2 > 90%	Sa02 < 90% even with O^2

7. IV access will be maintained throughout the post-procedure recovery until the LOC returns to the baseline, unless otherwise ordered by the MD.

8. A physician will be available to discharge the patient in accordance with hospital policy.

9. Patients may be recovered in the following areas only:

a. PACU

b. ICU/CCU

c. ER

d. Radiology

e. Endoscopy

f. ASD

g. Cardiac Catheterization Lab

10. The patient must be accompanied by an RN if transported prior to the return to baseline status with O2 available. Transportation mode is determined based upon patient status and need.

11. Patients may be discharged from the recovery phase after the hospital-approved discharge criteria is met.

Inpatients:

a. It has been at least 30 minutes since the last dose of sedation (or *1 hour if a reversal agent was used.*)

b. The patient has an Aldrete score within 2 points of pre-procedure baseline level.

EXCEPTION: Patient admitted to or currently in ICU.

c. Vomiting is absent or controlled with ordered medications.

d. Pain is managed via ordered medications after alternative methods are attempted; i.e., repositioning.

Outpatients

a. Discharge criteria (Post-Anesthesia Recovery or PAR), including level of consciousness, should be met for a 30 minute period before discharge. (See Outpatient Discharge Criteria Standardized Procedure.)

b. It has been at least 30 minutes~~1 hour~~ since last dose of sedation medication and 2 hours after a reversal agent was used.

c. The patient has an Aldrete score within 2 points of pre-procedure level.

d. Pain and nausea are controlled.

e. The patient is able to ambulate with assistance consistent with age and procedure.

f. The patient will be accompanied by a responsible adult who will be able to report any post-procedure complications.

g. Discharge instructions are given, including resources to contact if any problems arise.

h. Patient and/or responsible adult verbalize understanding of discharge instructions.

DOCUMENTATION:

1. The Procedural Sedation Flow Sheet and the electronic medical record will be utilized for documentation before, during and after the procedure.

2. Documentation will include, but will not be limited to:

a. The patient's status before, during and after the procedure;

b. Dosage and route of all drugs and agents used;

c. Type and amount of intravenous fluids administered;

d. All assessment data;

e. Unusual events during the procedure.

COMPETENCY REQUIREMENTS

NURSING STAFF

1. All RNs administering medications to produce moderate procedural sedation are required to demonstrate competency in management of the patient. At the end of the initial training program, the nurse will be able to:

a. State the pharmacological agents used for local analgesia and procedural sedation, their dosages, route, desired effects and adverse reactions.

b. Identify the pharmacologic agents used as antagonists to opioids and benzodiazepines and their dosages.

c. Describe the procedure for procedural sedation including benefits and potential complications.

d. Demonstrate appropriate assessment parameters prior to, during and after the procedure.

e. Identify basic dysrhythmias

f. Demonstrate ability to recognize and treat an obstructed airway

g. Describe reportable conditions and appropriate nursing interventions.

2. Both cognitive and psychomotor skills, including airway management, will be validated initially and annually through the E-Learning Module and annual nursing competency fair.

3. All RNs who do procedural sedation monitoring must have valid and current BLS and ACLS certifications. Emergency Department RNs must also have PALS -certification.

PHYSICIAN TRAINING AND COMPETENCY

1. Minimum formal training requirements are delineated on Procedural Sedation Privilege Request form.

2. Current ACLS is required for non-anesthesiologists who are not Board Certified in Emergency Medicine, Pulmonology or Cardiology. Physicians who have completed a residence training in Emergency Medicine and are not Board Certified, will be exempt from the ACLS or ATLS requirements if they have had 10+ years current consecutive practice in an emergency department environment.

3. Completion of the tutorial on Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, Airway Management Tutorial, and is passing the exam by no less than 80%.

4. Competency re-exam is waived for the reappointment applicant that has documented satisfactory performance of 10 cases within the last twenty-four months.

5. The privilege to perform moderate procedural sedation will be granted upon recommendation by the Department of Anesthesiology and approved by the Credentials Committee, the Medical Executive Committee and the Governing Board.

6. Only those practitioners who have been granted appropriate clinical privileges by the Governing Board are permitted to order and/or supervise the administration of moderate procedural sedation.

QUALITY ASSURANCE and RISK MANAGEMENT

1. Outcomes for patients undergoing sedation are collected and analyzed in the aggregate to identify opportunities to improve care.

2. The following events are reported through the QM/RM module and are evaluated for Risk Management and Performance Improvement Services. A summary of the findings are reported to the Anesthesia Services quarterly, including cases appropriate for peer review.

a. Cardiac or respiratory arrest

b. Use of reversal agents

c. Need for assisted ventilation (ambu)

d. Sedatives or analgesic dosing outside of the dosing guidelines

e. Transfer to a higher level of care after sedation

REFERENCES:

- Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018: **A Report by the American Society of Anesthesiologists Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology**. *Anesthesiology* 2018; 128:437–479 doi: https://doi.org/10.1097/ALN.0000000000002043~~American Society of Anesthesiologist – The Joint Commission Model Policy~~
- ~~Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. An Updated Report by the American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists: 2002~~
- American Society of Post Anesthetic Nurses. 2021-2022 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. Pg 73 ~~*The Role of the Registered Nurse in management of Patients Receiving II' Procedural Sedation for Short-Term Therapeutic Diagnostic or Surgical Procedures:*~~
- Association of perioperative Registered Nurses (AORN) Standards and Recommended Practices, 2021~~2~~
- Association of PeriOperative Registered Nurses: Guidelines for Perioperative Practice. Guideline for managing the patient receiving moderate sedation/analgesia. Denver, CO: AORN; 2021. https://aornguidelines.org/guidelines/content?sectionid=245927163&view=book#245927269. Retrieved March 2023
- ~~Anesthesiology, Volume 96: pg. 1004 – 1016, April 2002: *Practice Guidelines for Sedation and Analgesia by Non-anesthesiologist*~~
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- ~~Emergency Medicine Report, Vol 23, No. 21 – October 7, 2002~~
- ~~Emergency Medicine Report, Vol 23, No. 22 – October 21, 2002~~

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- American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia, 201004
- The Joint Commission. (202217). ~~Hospital accreditation standards. Oakbrook Terrace, Illinois~~Sedation and Anesthesia-Understanding the Assessment Requirements.
- ~~King, C. (2010) *Moderate Sedation /Analgesia: Competency Assessment Module. Competency and Credentialing Institute.*~~
- ~~Lexi-Comp Online, accessed July 2012.~~
- ~~"Model Sedation Protocol for Moderate Sedation and Analgesic Performed by Non-Anesthesia Practitioners." California Society of Anesthesiologists, May 2010.~~
- ~~Orlewicz, Marc MD. Procedural Sedation. Emedicine.medscape.com, updated 11/8/11. Accessed July 2012.~~

CROSS REFERENCES:

- Assessment of Patients for Surgical/Invasive Procedures Policy – SVMC
- Intrafacility Transfers Policy - SVMC
- ~~lity Transfers Policy – SVMC~~

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APPENDIX A: Procedural Sedation & Analgesia Guidelines (Adult & Pediatric)

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	MEDICATION	PEDIATRICS < 12 years	ADULTS PEDS ≥12 years	GERIATRIC > 60 years	ONSET	DURATION	COMMENTS
Moderate (Conscious) Sedation	FENTANYL (Sublimaze®)	1 mcg/kg/dose IM or slow IV push, if needed, may repeat by 1 mcg/kg increments; not to exceed a cumulative dose of 4mcg/kg	1-2 mcg/kg slow IV push (over 1-2 min); may repeat dose after 30 min	Same as adult dosing unless renal impairment	1 – 2 min	30 – 60 min	• **Reversal with Naloxone if respiratory depression occurs** • IV push slowly • Risk of skeletal and thoracic muscle rigidity with rapid injection. Risk of respiratory depression • ***(If patient is pre-medicated with opiate or other CNS depressant, reduce dose by 50%.)*** • **Use lowest possible dose in patients with renal impairment. Modify dose based on clinical response and degree of renal impairment**
	HYDROMORPHONE (Dilaudid®)	**Not recommended**	Incremental doses of 0.5 mg – 1 mg; **not to exceed 6 mg maximum**	Incremental doses of 0.5 mg – 1 mg; **not to exceed 6 mg maximum**	3 – 5 min	1 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Risk of respiratory depression • Monitor for 45

							minutes after last dose. Watch for delayed respiratory depression • **Use lowest possible dose in patients with renal impairment. Modify dose based on clinical response and degree of renal impairment**
	LORAZEPAM (Ativan®)	**For infants and children:** 0.05 mg/kg PO, IM, or IV (range: 0.02-.09 mg/kg) one hour prior to procedure. **Not to exceed 2 – 4 mg/dose.** Alternatively, for slow titration to effect, 0.01—0.03 mg/kg IV initially, may repeat every 20 minutes to titrate to desired effect within the hour before procedure.	0.044 mg/kg IV 15-20 min before procedure. **Max dose of 2 mg IV.** Alternative: 0.05 mg/kg IM 2 hours before procedure. **Max IM dose of 4 mg.**	Refer to adult dosing. Increased sensitivity to lorazepam in this age group.	5 – 20 min	6 – 8 hours	• **Reversal with Flumazenil if respiratory depression occurs** • Use of this in infants and children is an off-label indication and safety and efficacy has not been established • **Dosage should be modified depending on clinical response and degree of renal impairment, but no quantitative recommendations are available**

	DIAZEPAM (Valium®)	0.2 – 0.4 mg/kg PO. **Not to exceed a total dose of 0.4 mg/kg. (Max dose is 20 mg PO)** or Incremental dose of 0.05 – 0.1 mg/kg IV. **Not to exceed a total dose of 0.25 mg/kg**	5-15 mg IV 5-10 min before cardioversion or titrated up to 20 mg IV for endoscopy. Alternative: 10 mg PO 45-60 minutes before procedure.)	Refer to adult dosing. Increased sensitivity to diazepam in this age group.	IV: 1 – 5 min Oral: rapid	IV: 20 – 30 min Oral: variable	• **Reversal with Flumazenil if respiratory depression occurs** • **Dosage should be modified depending on clinical response and degree of renal impairment and/or hepatic impairment but no quantitative recommendations are available**
	MEPERIDINE (Demerol®)	Pre-op sedation induction: SC/IM: 1.0 - 2.2 mg/kg 30-90 min. before beginning of anesthesia. **Not to exceed max adult dose (100mg)**	Pre-op sedation induction: 50—100 mg SC/IM 30—90 minutes before the beginning of anesthesia. **Not to exceed 100mg**	Pre-op sedation induction: 50 mg SC/IM 30—90 minutes before the beginning of anesthesia. **Not to exceed 50mg.**	SC: 10 – 15 min IV: 5 min	2 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Note: Naloxone does not reverse, and may even worsen, neurotoxicity (anxiety, tremors, seizures) • Avoid use in the elderly if possible • **Avoid use in renal impairment** • **Use caution in hepatic impairment**

	MIDAZOLAM (Versed®)	**Infants under 6 mos:** DO NOT GIVE 6 mos. – 5 years: Initial dose of 0.05-0.1 mg/kg IV, up to 0.6 mg/kg may be necessary. **Max dose = 6 mg** **6 – 12 years**: Initial dose of 0.025 – 0.05 mg/kg IV, up to 0.4 mg/kg may be necessary. **Max dose = 10 mg.** **12 – 16 years**: Dose as adults **Max dose = 10 mg**	Initial: Incremental doses of 0.5 – 2 mg slow IV over at least 2 minutes. Slowly titrate to effect by repeating doses every 2 – 3 min if needed. Usual total dose needed is 2.5 – 5 mg. Maintenance: 25% of the dose needed to reach sedative effect	Initial: 0.5 mg slow IV; give no more than 1.5 mg in a 2 minute period. If additional titration is needed, give no more than 1 mg over 2 min, waiting another 2 min or more to evaluate sedative effect. A total dose of > 3.5 mg is rarely needed	3 – 5 min	< 2 hours	• **Reversal with Flumazenil if respiratory depression occurs** • IV push slowly • Wait ≥ 2 min to assess sedative effect prior to administering additional doses • NOTE: Children < 6 years old may require higher doses and closer monitoring than older children. • **If patient is pre-medicated with opiate or other CNS depressant, reduce dose by 50%**
	MORPHINE Dilute to 1 mg/mL	Infants, children & adolescents: 0.1 - 0.2 mg/kg IV with onset of action 2 - 5 mins. Neonates: 0.05 - 0.2	**Off label** dosing for sedation induction: 2 mg IV *Reduce dose if patient is pre-medicated with benzodiazepin	Increased risk of respiratory depression in elderly. Use with caution.	5 – 10 min	2 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Use fluids and trendelenburg position if hypotension occurs • IV push slowly over 4 to 5

		mg/kg IV. Onset of action 5 mins. Use lower end of range for opiod-naïve neonates. Use preservative free formulation.	e				minutes • Monitor for 45 minutes after last dose. Watch for delayed respiratory depression • **If patient is pre-medicated with benzodiazepine reduce dose by 50%.** • **Prolonged half-life and/or accumulation in hepatic and renal impairment & pre-term neonates. Use with caution.**
	KETAMINE	6 – 10 mg/kg PO for one dose. (mixed in Cola or another beverage). Given 30 min. before procedure. 0.5 – 1.0 mg/kg/dose IV (given slowly over 60 seconds). **Not to exceed 0.5 mg/kg/min.**	Off label use: IM: 2 – 4 mg/kg IV: 0.2 – 0.75 mg/kg Titrate dose to effect	Refer to adult dosing	IV: 30 sec IM: 3 – 4 min PO: 15 – 20 min	IV: 5 – 10 min IM: 12 – 25 min	• In children, drink oral dose immediately after mixing with cola or other beverage. • Can cause emergence psychosis. Pre-treatment with a benzodiazepine can decrease psychosis by > 50% • **No renal adjustment appears to be necessary.**
	NALOXONE (Narcan®)	**Post-operative opiate agonist induced**	0.1 – 0.2 mg IV push every 2-3 min. until desired response	Refer to adult dosing.	2 min	20-60 min	• Reversal agent for opioids o Fentanyl o Hydromorph one

	respiratory depression: Initially, 0.005 – 0.01 mg/kg IV at 2 – 3 min intervals until desired response obtained.	obtained.				o Meperidine o Morphine • Administer over 30 seconds • Use in caution in patients with CVD and liver impairment • Additional doses may be necessary at 1–2 hour intervals depending on patient response as well as dosage/duration of action of the opiate agonist. • **It appears that no renal adjustment is necessary.**
FLUMAZENIL (Romazicon®)	For Adolescents and Children: Dosage has not been definitively established. Initial dose of 0.01 mg/kg (max = 0.2 mg), followed by 0.005 – 0.01 mg/kg (max = 0.2 mg) every minute. **Not to exceed a total cumulative dose of 1 mg.**	0.2 mg IV initial, then repeat dose after 45 seconds, then every 1 minute until desired level of consciousness achieved. **Max Total Cumulative Dose: 1 mg over 5 min** If resedation occurs, repeat the regimen at 20 minute intervals, up	Refer to adult dosing, however, increased sensitivity may occur in some elderly patients	1 – 3 min	~ 1 hour	• Reversal agent for benzodiazepines o Midazolam o Lorazepam o Diazepam • Administer over 15 seconds • May induce seizure • CAUTION: the effects of flumazenil may subside prior to those of the Benzodiazepine and therefore, the patient may require additional ventilator support. DO NOT USE in

			to a maximum of 3 mg/hour.				patients requiring benzodiazepine for control of a potentially life-threatening condition or in patients with serious concurrent cyclic antidepressant overdose. • Safety and efficacy has not been established in children less than 1 year old • **It appears that no renal adjustment is necessary.** • **In hepatic impairment, no adjustment to the initial dose but subsequent doses should be reduced in size or frequency**

SUBJECT: **PROTECTION OF PATIENT PRIVACY**	SECTION: **Page 1 of 13**

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

PURPOSE:

To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy and Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act of 2009 (ARRA), and all other Federal and State regulations and interpretative guidelines.

This policy sets forth guidelines for protecting and maintaining the confidentiality of individually identifiable patient health information (referred to hereafter as "Protected Health Information" or "PHI").

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to protect each patient's right to privacy and confidentiality by following applicable state and federal laws. SVMC recognizes that employees have access to private and confidential information about patients. As such, it is incumbent upon the organization to inform and educate staff about their moral, ethical and legal responsibility to ensure the confidentiality of such information.

No officers, employees, volunteers, students, instructors, vendors, contractors, or physicians (individuals) shall use, disclose or access the medical information of any Sierra View Medical Center (SVMC) patient (including themselves or family members) unless they are directly involved in the treatment, payment or healthcare operations regarding that patient, or as otherwise permitted by Patient Privacy policies. SVMC's Patient Privacy policies provide that the amount of PHI that shall be used, accessed or disclosed on any patient shall consist only of the minimum necessary to complete the assigned duties, except for purposes of treatment. Any individual who engages in behaviors inconsistent with these standards violates this policy, and such violations constitute grounds for disciplinary action up to and including termination, professional discipline, and civil or criminal prosecution. All individuals are expected to comply and cooperate with the facility's administration of this policy and other Patient Privacy Policies.

DEFINITIONS:

Protected Health Information (PHI) – Any individually identifiable health information, in any format, including verbal communications. "Individually identifiable" means that the health or medical information includes or contains an element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity. PHI includes patient billing and health information and applies to a patient's past, current or future physical or mental health or treatment.

Electronic Protected Health Information or ePHI – PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet or stored on a computer, a CD, a disk, magnetic tape or other media

Personal Information (PI) – an individual's first name or first initial and last name combined with any one of the following:

Social security number,

Driver's license number or California identification card number,

Account number, credit, or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account,

Medical information, or

Health insurance information.

Medical information – means any information, in either electronic or physical form, regarding an individual's medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional and which may be in the possession of or derived from a health care provider, health care service plan, pharmaceutical company or contractor.

Health insurance information – means an individual's health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the individual, or any information in an individual's application and claims history, including any appeals records.

Restricted information – describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or transit. This includes Personal Information, PHI, and ePHI as defined in this section but could also include other types of information such as research data.

Disclosure – is the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Health care operations – covers a broad range of activities such as quality assessment, patient education, and training, student training, contracting for health care services, medical review, legal services, auditing functions, compliance, business planning and development, licensing and accreditation, business management and general administrative activities.

Payment – can be defined as activities related to being paid for services rendered. These include eligibility determinations, billing, claims management, utilization review, etc. It also includes using debt collection and location agencies.

Treatment – under the Privacy Rule is defined to include all the preventive, diagnostic, therapeutic, rehabilitation, maintenance and palliative care provided to an individual as well as the provision,

coordination, and management of health care and related services by one or more health care providers, including the coordination of management of health care provider with a third party, consultation between health care providers relating to patient, or the referral of a patient for health care from one provider to another.

Use – means the sharing, employment, application, utilization, examination, or analysis of information within an entity that maintains such information.

Workforce – means employees, volunteers, and other persons who conduct, in the performance of their work for SVMC, are under the direct control of SVMC whether or not SVMC pays them. The workforce includes employees, medical staff, and other health care professionals, agency, temporary and registry personnel, and trainees, house staff, students and interns, regardless of whether they are SVMC trainees or rotating through SVMC locations from another institution.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES, AGENTS, AND PROFESSIONALS OF SVMC*

PROCEDURE:

I. Protection of Individually Identifiable Health Information (PHI)

Members of the SVMC workforce may not disclose, share, or otherwise use any individually identifiable health information except for Treatment, Payment, and Health Care Operations (referred to as "TPO") unless expressly authorized by the patient or otherwise permitted by law.

II. Classification of PHI information

All information contained within patient medical and billing records is confidential regardless of format (i.e. print medium, audio recording, electronic display or storage). These confidentiality protections extend not only to the patient's medical record but also to information from the record. Thus, abstracts of charts, medical record numbers, diagnoses, case histories, or descriptions of medical procedures that include or refer to the patient's name, social security number, or identifying information, as well as information orally communicated about a particular patient, must be maintained as confidential PHI.

Also, special laws govern mental health, substance abuse and HIV test results information. Questions regarding the release of sensitive medical information should be referred to the Health Information Management department.

III. Notice of Privacy Practices

The Privacy Rule requires that providers give patients detailed information about their privacy practices. The "Notice of Privacy Practices" shall be given to all SVMC patients upon admission or, in the case of outpatients, at the time of service, as further described in SVMC policy "Notice of Privacy Practices."

IV. Authorization to use PHI

The Privacy Rule requires providers to obtain a written authorization from an individual before using or disclosing a patient's PHI for purposes other than TPO.

V. Patient Access to PHI

The Privacy Rule gives an individual (or that person's representative) the right to access to inspect and obtain a copy of the individual's own PHI. Providers may deny an individual access to his or her information under certain circumstances only if specified procedures are followed.

All requests from patients for information from medical records should be referred to or coordinated with the Health Information Management Department.

VI. Restrictions on the Use of PHI

The Privacy Rule and California law generally allow a provider to use or disclose PHI to carry out TPO. An individual, however, has the right to request that providers restrict their use or disclosure of PHI to carry out TPO – that is, a patient may request that the provider voluntarily agree not to use or disclose PHI in a way that the law would otherwise allow. The Privacy Rule also gives individuals the right to request restrictions on the information that may be released to family or friends.

VII. SVMC Workforce (Employee) Responsibilities to Maintain Confidentiality of PHI

All members of the SVMC Workforce are responsible for maintaining the security and confidentiality of PHI on behalf of SVMC patients. This responsibility includes both the physical (electronic or paper) record and all information contained in or derived from the medical record, including information disclosed or transmitted orally.

A. Minimum Necessary

When using or disclosing PHI, or when requesting PHI from another entity, a Workforce member must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. This requirement does not apply to:

a. Disclosure to, or requests by, a health care provider for treatment;

b. Uses or disclosures made to the individual, as permitted or required.

c. Uses or disclosures made under an authorization;

d. Disclosures made to the Secretary of the Department of Health and Human Services under an investigation or compliance review; or

e. Other use or disclosures that are required by law and are compliant with the requirements of the law.

Note: If the request for PHI constitutes the use of information (for example the sharing of information between two SVMC physicians), the minimum necessary provision still applies.

B. Workforce Access to PHI

All members of the SVMC Workforce should only access and use PHI as necessary for their job functions. Repeating or any way disseminating patient information, either by oral communication or in writing except as permitted herein or required by law, is considered an unauthorized release of medical information and is a serious offense, which may have personal civil and/or criminal liability. Violation of this policy constitutes grounds for disciplinary action up to and including termination.

VIII. Release of PHI to Third Parties

A. Requests for PHI by Outside Entities

SVMC receives numerous requests for copies of medical records daily from outside entities such as health plans, law enforcement agencies, licensing and regulatory agencies, attorneys, etc. Because of the specific accounting and disclosure requirements imposed by HIPAA, all copies of medical records for release to third parties or agencies must be completed or coordinated by the Health Information Management Department.

For example, when releasing PHI to third parties, except for purposes of TPO and those other instances in which the accounting requirements do not apply (i.e. disclosures under patient written authorization) as stated in the HIPAA Privacy Rule, SVMC is required to document all of the following:

i. The date of the disclosure;

ii. The name of the entity or person who received the PHI and the address of such entity or person (if known);

iii. A brief description of the PHI disclosed;

iv. The name of the individual and/or dependent who completed the disclosure; and

v. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or a copy of the patient's authorization for such disclosure.

Also, PHI records shall be screened before their release to ensure that: (1) only the minimum necessary information is released; and (2) no privileged information (e.g. attorney-client, peer-review information) is released except as permitted or required by law.

IX. Mandatory Reporting Requirements

Although a patient has the right to refuse to disclose and to prevent others, including physicians, from disclosing confidential communications between the patient and his/her physicians, there are certain laws, which require or permit a provider to disclose patient records without the patient's written authorization. These circumstances, which are outlined in the Notice of Privacy Practices (See the Notice of Privacy Practices policy), include, but are not limited to:

i. Public health activities that involve safety or communicable disease;

ii. Reporting victims of abuse, neglect, or domestic violence;

iii. Judicial and administrative proceedings;

iv. Law enforcement purposes;

v. Organ and tissue donations;

vi. National security and intelligence activities;

vii. Workers' compensation; or

viii. Requests related to decedents.

X. Mental health, Substances Abuse, and HIV Test Result information

Special laws govern mental health, substance abuse, and HIV test result information. Questions regarding the release of sensitive medical information should be referred to the Health Information Management Department.

XI. Psychotherapy Notes

Psychotherapy notes receive stricter treatment under the Privacy Rule than other types of PHI. A health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session that is separated from

the rest of the individual's medical record, but excludes certain records, narrowly defines psychotherapy notes under the Privacy Rule to include notes. Before releasing any psychotherapy notes without patient authorization, an employee should first consult with the Health Information Management Department.

XII. Privacy Requirements Relating to Research

Research is not considered a part of TPO under the Privacy Rule, except for certain studies related to health care operations, such as quality assurance and utilization management activities. Consequently, the use or disclosure of PHI for research purposes requires either:

i. Written authorization from the individual about whom the information is collected;

ii. A waiver of authorization from SVMC Compliance Committee;

iii. The satisfaction of another research exception under the Privacy Rule.

XIII. De-Identified Information

According to the Privacy Rule, health information that does not identify an individual (referred to as "de-identified information") is generally not considered PHI and may be disclosed without the patient's authorization. To de-identify PHI, SVMC must remove all eighteen of the HIPAA identifiers specified in the Privacy Rule. Also, before using any such de-identified information for research purposes, there must be no means to re-identify the data by the recipient of the de-identified data set.

XIV. Limited Data Sets

The Privacy Rule permits the use and disclosure of a limited data set of information for research purposes without patient authorization provided certain requirements be met, including entering into a Data Use Agreement with the recipient of the information.

XV. Disclosure to Business Associates

The Privacy Rule requires providers to enter into a written agreement with certain third parties (individuals or entities) that provide services and functions on behalf of SVMC, which involves using, accessing, disclosing, or maintaining PHI.

XVI. Marketing

In general, PHI may not be disclosed for marketing purposes without the patient's authorization. If the marketing involves direct or indirect payment to SVMC from a third party, the

authorization form that the individual signs must include a statement that SVMC received payment for using and/or disclosing PHI for marketing purposes.

XVII. Fundraising

SVMC may use or disclose limited PHI to a Business Associate (see Section XIII, above) or to an institutionally related foundation to raise funds for its benefit, provided the PHI used or disclosed must be limited to demographic information and the dates of health care provided to the individual. Demographic information includes the individual's name, age, gender, insurance status, address, and other contact information. SVMC must obtain the individual's prior written authorization to use or disclose any other information (such as the treating or referring physician, the department or practice area, illness or treatment) for fundraising purposes. Since only the individual's demographic information may be used, reports cannot be generated for fundraising purposes from an information system using non-demographic information fields, such as a physician, medical condition or clinical department.

Also, all fundraising materials sent to an individual must describe, in a conspicuous place, how the individual can opt-out of receiving further fundraising communications.

XVIII. Media Inquiries

Both California law and the Privacy Rule restrict the amount of information that may be provided to the media without the patient's authorization. In general, if the patient has not requested that information be withheld, SVMC may release the condition and location of the inpatient, outpatient or emergency patient, but only if the inquiry specifically contains the patient's name. No information can be given if a request does not include the patient's name or if the patient has requested that information be withheld.

A patient's condition may only be described in general terms that do not communicate specific medical information about the individual. For example, "undetermined", " good", "fair", "serious", "critical", or "deceased". All inquiries from the media should be referred to the SVMC Marketing Department.

XIX. Safeguards to Protect PHI

In addition to protecting the privacy of a patient's health information by complying with regulations regarding the use and disclosure of PHI, Workforce members are responsible to protect PHI with reasonable physical, electronic and administrative safeguards. It is the responsibility of all Workforce members to secure PHI that they have access to or are using to complete assigned responsibilities.

Reasonable safeguards are to be used at all times to ensure that confidential information is not disclosed to individuals who are not authorized to receive the information and to minimize incidental disclosure of PHI.

XX. Physical Safeguards

Each Workforce member is responsible to protect the physical security of the PHI he/she is using, accessing or maintaining in his/her work area, including but not limited to:

i. Ensuring that PHI is not readily visible to visitors or the public;

ii. Maintaining charts in designated secure areas and not leaving charts unattended in areas to which the public has access;

iii. Locking areas in which there are medical and billing records at the end of the day or when no staff are in the area.

iv. Never taking paper PHI records of any kind offsite (i.e. home) unless the individual's supervisor, Privacy Officer and/or Health Information Management Director through a documented and auditable process, approves doing so.

v. Checking that all PHI is removed upon leaving conference rooms and other meeting locations and the unwanted materials are properly disposed (i.e. shredded); Taking reasonable measures (i.e. lower voices, draw curtains) to provide auditory privacy to individuals in areas where interviews or other conversations including PHI are being conducted and have the potential to be overheard. Examples of such situations include:

-Conversations among caregivers that involve patients;

-Discussion of a patient's condition or lab tests with the patient, either in person or over the phone; and/or

-Discussing a patient's condition during teaching rounds with SVMC;

-Positioning computer screens so that the information is not visible to passersby;

-Leaving minimal information for patients on answering machines and voice mail;

-Locating printers and fax machines in secure areas;

-Retrieving and distributing faxed PHI promptly; and

-Using professional judgment when calling out patient names in the waiting room areas.

-At times, minimally necessary information may be displayed and incidentally available within patient treatment areas in the following circumstances:

-Information related to the patient's treatment and condition supports patient safety;

-Information to display within patient treatment areas to support staff safety; and/or

-Workforce members continue to use physical safeguards to protect all PHI.

XXI. Electronic Safeguards

Workforce members are responsible for ensuring compliance with safeguards to protect electronic information including but not limited to:

i. Not sharing passwords for computer systems;

ii. Not maintaining passwords in locations where they can be obtained and used by others (i.e. post-it notes on computer monitors, stored in a Rolodex, placed under computer keyboards); and

iii. Using time out functions or locked screen savers to auto-logout of computer functions when not in use.

XXII. Administrative Safeguards

i. Departmental managers are responsible for orientating Workforce members under their direction with requirements to secure PHI in their specific areas or units.

ii. Workforce members who are responsible for maintaining both PHI and non-PHI must assure that if the data is co-mingled, it is all maintained consistent with HIPAA standards or the data must be maintained in separate formats.

XXIII. Workforce (Employee) Training and Education

The Privacy Rule requires that covered entities such as SVMC train their Workforce on privacy policies and procedures at a level appropriate for the Workforce members to carry out their roles and responsibilities. All members at SVMC Workforce will be provided with training on the HIPAA Privacy and Security Rules consistent with their job responsibilities.

XXIV. Patient Privacy Violations

A patient privacy violation is unauthorized access, disclosure, or use of medical information or PHI. Any individual, who believes another individual has breached the facility's Patient Privacy policies, or otherwise breached the integrity or confidentiality of PHI, should immediately report such breach to his/her supervisor, the PO, the CO, the ISO, or Risk Management. Supervisors receiving such reports should immediately forward all information to the PO, the CO, the ISO, or Risk Management. Such violations may include, but are not limited to:

i. An individual reviewing their medical information, or that of a family member, without filling out the appropriate Release of Information form with the Health Information Management (HIM) Department;

ii. Open discussions of PHI within public areas such as the Café, hallways, or elevators;

iii. Reviewing medical records of patients to obtain personal demographic information or for other purposes not authorized by Patient Privacy Policies;

iv. Discussing PHI with other hospital personnel who are not involved in the care of the patient or otherwise authorized to receive such information by Patient Privacy Policies; or

v. Reviewing patient information because of personal interest.

SVMC will conduct a thorough and confidential investigation into any reported violation of Patient Privacy Policies. The facility will inform the complainant of the results of the investigation (an exception being if the complaint was received anonymously, then no follow up will be attempted). SVMC will not retaliate against or permit reprisals against a complainant who has filed a complaint in good faith. SVMC will provide information concerning the violation to appropriate law enforcement personnel and will cooperate with any law enforcement investigation or prosecution.

XXV. Unauthorized Access to Patent Information

It is important to understand that, for purposes of this policy, "unauthorized" does not mean "without a patient's written or verbal authorization." Instead, "unauthorized" means, in essence, the inappropriate accessing of medical information without a direct need for that information for lawful use and as permitted by Patient Privacy Policies. An example of a reportable "unauthorized access" is a situation in which an individual peeks at a patient's medical record merely to satisfy his or her curiosity, or an individual is seeking information about neighbors, fellow employees, church members, etc.

Complaints of breaches will be thoroughly investigated by the appropriate personnel. Any confirmed breaches of this nature will be reported to the CDPH within 15 business days of notification. No proof of patient harm is required for the breach to be reportable, or for CDPH to fine the facility. The patient, whose record was involved in the breach, will also be notified.

All individuals need to realize that the California Department of Health (CDPH) may forward any reports from the hospital of breaches by individuals to California Office of Health Information Integrity (CalOHII). CalOHII may investigate individuals involved in the breach (in addition to the investigation that will be conducted by SVMC). CalOHII may assess its fines against the individual including recommendations of disciplinary actions to that individual's licensing board if the individual is licensed. Fines levied by the CalOHII range from $2,500.00 up to $250,000.00 per violation. Determination of the fine will be made by CalOHII and will be based on an individual's intent, time of the violation, and the individual's assets, liability and net worth.

Breaches affecting less than 500 patients will be reported to the Office of Civil Rights of the U.S. Department of Health and Human Services annually.

Breaches affecting 500 or more patients will be reported to the Office of Civil Rights of the U.S. Department of Health and Human Service at the time the incident is confirmed.

XXVI. Disciplinary Procedure

Employees/Officers: If an investigation of any reported or suspected violation of Patient Privacy Policies substantiates the violation by any individual, appropriate disciplinary action will be taken, which could include termination upon the first offense.

Medical Staff Members/Physicians: If a medical staff member or physician is determined to have violated Patient Privacy policies, the matter will be referred to the Medical Staff Office for appropriate action. Confirmed breaches will be reported to the applicable state agencies as mandated by law without deference to any pending disciplinary actions against the accused medical staff member or physician.

Contractors/Vendors: SVMC will seek to include such violations by contractors or vendors as grounds for termination of the contract and/or imposition of contract penalties.

Students/Instructors/Volunteers: Violations by students, instructors, or volunteers will be subject to having their access to the hospital systems terminated. Additionally, their continued association with any educational or volunteer program at SVMC will be reviewed and could be discontinued upon first offense.

Violation of SVMC Patient Privacy policies and/or standards by any individual may constitute a civil or criminal offense under HIPAA and/or other federal or state laws. Any individual who

violates such laws may expect that SVMC will provide information concerning the violation to appropriate law enforcement personnel and will cooperate with any law enforcement investigation or prosecution.

REFERENCES:

- Health Insurance Portability and Accountability Act, 45 CFR 160-164
- Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act of 2009 (ARRA)
- California Medical Information Act, California Civil Code Section 56 et seq.
- Information Practices Act of 1977, California Civil Code Sections 1798.29 and 1798.82
- California Health and Safety Code Sections 1280.15 and 130203
- California Lanterman-Petris Short Act ("LPS Act")

CROSS-REFERENCES:

- Release of Patient Information Policy
- Marketing under the HIPAA Privacy Standards/HITECH
- Minimum Necessary
- Patient Privacy – Program Requirements

SUBJECT: **RESPIRATORY PROTECTION PLAN**	SECTION: **Page 1 of 21**

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

PURPOSE:

To ensure that all employees required to wear respiratory protection as a condition of their employment are protected from respiratory hazards through the proper use of respirators. To meet the Occupational Safety and Health Administration (OSHA) Respiratory Protection Standard, 29 CFR 1910.134.

DEFINITIONS:

1. **Aerosol-generating procedures**— Procedures that may increase potential exposure to aerosol transmissible disease pathogens due to the reasonably anticipated aerosolization of pathogens. Aerosol-generating procedures may also be known as high hazard or cough inducing procedures.

2. **Airborne infection isolation room (AIIR)** - A single-occupancy patient-care room designed to isolate persons with suspected or confirmed airborne infectious diseases. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that can be spread from person-to-person by the airborne route. AIIRs should maintain negative pressure relative to adjacent rooms and halls (so that air flows under the door gap into the room), an air flow rate of 6–12 air changes per hour, and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter.

3. **Airborne Precautions** - A category of Transmission-Based Precautions that Centers for Disease Control and Prevention (CDC) and Healthcare Infection Control Practices Advisory Committee (HICPAC) may recommend when Standard Precautions alone are not sufficient to prevent the transmission of disease. When Airborne Precautions are required, patients should be placed in airborne infection isolation rooms and healthcare personnel sharing patients' airspaces should wear respirators.

4. **Air-purifying respirator (APR) -** A respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through an air-purifying element.

5. **Aerosol transmissible disease (ATD) or aerosol transmissible disease pathogen** - Any disease or pathogen requiring Airborne Precautions and/ or Droplet Precautions.

6. **Droplet Precautions** - A category of Transmission-Based Precautions that CDC and HICPAC may recommend when Standard Precautions alone are not sufficient to prevent the transmission of disease. When Droplet Precautions are required, patients should be spatially separated, preferably in separate rooms with closed doors. Healthcare personnel should wear surgical masks for close contact and, if substantial spraying of body fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles). Patients should be masked during transport.

7. **Employee Exposure** - Exposure to a concentration of an airborne contaminant that would occur if the employee were not using respiratory protection.

8. **Facemask** - A loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Facemasks may be labeled as surgical, laser, isolation, dental, or medical procedure masks and are cleared by the FDA for marketing. They may come with or without a face shield. Facemasks do not seal tightly

to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection.

9. **Filter-** A component used in respirators to remove solid or liquid aerosols from the inspired air.

10. **Fit Test** - A protocol to quantitatively or qualitatively evaluate the fit of a tightfitting respirator on an individual.

11. **Food and Drug Administration (FDA)** - An agency within the U.S. Department of Health and Human Services. The FDA is responsible for, among other things, protecting the public health by assuring drugs, vaccines, and other biological products and medical devices intended for human use are safe and effective.

12. **Healthcare Infection Control Practices Advisory Committee (HICPAC) -** A federal advisory committee assembled to provide advice and guidance to the CDC and the U.S. Department of Health and Human Services regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections and antimicrobial resistance in United States healthcare settings. CDC and HICPAC authored the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, which describes Standard and Transmission-Based Precautions used for infection control.

13. **Healthcare personnel (HCP) -** Paid and unpaid persons who provide patient care in a healthcare setting or support the delivery of healthcare by providing clerical, dietary, housekeeping, engineering, security, or maintenance services.

14. **High-efficiency particulate air (HEPA) filter** - The NIOSH classification for a filter that is at least 99.97% efficient in removing particles and is used in powered air-purifying respirators (PAPRs). When high-efficiency filters are required for non-powered respirators, N100, R100, or P100 filters may be used.

15. **N95 respirator** - A generally used term for a half mask air-purifying respirator with NIOSH approved N95 particulate filters or filter material (i.e., includes N95 filtering facepiece respirator or equivalent protection).

16. **Personal protective equipment (PPE) -** Specialized clothing or equipment worn by an employee to protect the respiratory tract, mucous membranes, skin, and clothing from infectious agents or other hazards. Examples of PPE include gloves, respirators, goggles, facemasks, surgical masks, face shields, footwear, and gowns.

17. **Powered air-purifying respirator (PAPR)** - An air-purifying respirator (APR) that uses a blower to force air through filters or cartridges and into the breathing zone of the wearer. This creates a positive pressure inside the facepiece or hood, providing more protection than a non-powered or negative-pressure half mask APR.

18. **Respirator program administrator (RPA)** - Individual designated to oversee a facility's respiratory protection program (RPP).

19. **Respiratory protection program (RPP)** - Program required by OSHA under the Respiratory Protection standard that includes development and implementation of detailed policies and worksite-specific procedures for respirator use for control of respiratory hazards.

20. **Surgical mask -** A loose-fitting, disposable type of facemask that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Surgical masks are fluid resistant and provide protection from splashes, sprays, and splatter. Surgical masks do not seal tightly to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection.

POLICY:

Sierra View Medical Center (SVMC) Respiratory Protection Program (RPP) is designed to minimize or eliminate occupational exposure of heath care workers to infectious airborne transmissible diseases (ATDs) through the provision and use of appropriate respiratory protective devices. This program was developed in accordance with the Centers for Disease Control and Prevention (CDC) and California OSHA ATD control enforcement guidelines. The RPP program includes:

1. A plan for annual risk assessment.
2. The methods by which employees are educated concerning the risks associated with airborne transmissible diseases in the healthcare setting.
3. The high-risk procedures for ATD transmission
4. Engineering, work practice controls, and personal protective equipment, to minimize employee exposures to ATDs.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES WHO COULD POTENTIALLY BE EXPOSED TO AIRBORNE RESPIRATORY ILLNESSES DURING NORMAL WORK OPERATIONS, AND DURING NON-ROUTINE OR EMERGENCY SITUATIONS*

**COVID-19 Addendum Note: For the duration of the Public Health Emergency (PHE) related to COVID-19, all staff, contingent staff, and volunteers at SVMC are considered applicable to ATD and will engage in current CDC/local public health recommendations regarding universal source control, exposure tracing, and testing.*

EQUIPMENT:

- Powered Air-Purifying Respirator (PAPR)
- N-95
- N95 fit testing equipment

PROCEDURE:

I. Respiratory Protection Program responsibilities:

A. PROGRAM ADMINISTRATORS: The Infection Prevention Department and Employee Health are responsible for administering the Plan:

1. Infection Prevention Department will provide the knowledge of infection control principles and practices and oversight of Employee Health as they apply to SVMC, and be responsible for:

    a. Conducting an annual evaluation of the respiratory protection program. Any new hazards or changes in policy that would require respirator use are presented to and acted upon by the Infection Control and Prevention Committee.
    b. Responding to any Aerosol Transmissible Disease (ATD) Alerts sent by public health departments and/or the Center for Disease Control (CDC).

2. Employee Health (EHS) will have oversight of implementing the RPP with employees and providing employee education; due to knowledge of healthcare worker exposure protocols, testing, and the potential need for employee follow-up. EHS will be responsible for:

    a. Identifying work areas, processes, or tasks that require respiratory protection
    b. Monitoring OSHA policy and standards for changes and making changes to SVMC's policy
    c. Coordinating selection of respirator protection products, in conjunction with the Infection Prevention and Control Coordinator, Respiratory Therapy and Materials Management
    d. Monitoring respirator use to ensure that respirators are used in accordance with their certification
    e. Distributing and evaluating medical questionnaire
    f. Arranging for and/or conducting training and fit testing in conjunction with Respiratory Therapy
    g. Ensuring proper storage and maintenance of respirator protection equipment in conjunction with Respiratory Therapy
    h. Providing data regarding any suspected or known employee exposure to ATDs
    i. Conducting any necessary testing to confirm exposure to ATDs
    j. Conducting any necessary follow-up with any employee with confirmed ATD exposure.

B. PURCHASING AGENT – Materials Management Supervisor is responsible for the RPP equipment storage and inventory:

1. Purchasing respiratory protection equipment

2. Assuring that all respiratory protection equipment purchased has been approved by the National Institute of Occupational Safety and Health (NIOSH)

C. STORAGE AND MAINTENANCE OF CAPRs/PAPRs – The manager of the Emergency Department, ED, and the Intensive Care Unit, ICU, where the carts are kept, will be responsible for:

1. Maintaining Carts - ED Cart and ICU Cart

   a. Clean/free of clutter
   b. Stocked
   c. Locked when not monitored

2. Daily inspection of helmets and reusable equipment CAPR Sets (ED-1through ED-6 helmets and ICU-1 through ICU-6 helmets, battery, and charger). If any set is signed out, inspect set when logged back in:

   a. No tear or breaks of helmets and accessories
   b. No contamination from blood or other bodily fluids
   c. No damage or distortion of filter
   d. No physical damage or tampering of Lithium Ion Batteries (LIB)
   e. No compromise between the filter and filter cover seal
   f. LED light working properly (if yellow or red light on, see manual instruction for further instruction or contact IP)

3. Storing of PAPRs in designated cart

4. Checking and maintaining supplies:

   a. Check on par levels of disposable items daily
   b. Perform the LIB Check Procedure every 3-6 months (see Monthly Inspection Log)

5. Checking battery charge status daily

6. Monitoring expiration date of equipment daily

7. Logging of the sign-in/sign-out sheet for the PAPRs daily

8. Documentation of ***Sign In/Sign Out Log, Daily Inspection Log, and Monthly Log*** will be kept in binder on or near the designated carts

D. DIRECTORS and MANAGERS are responsible for:

1. Knowing which hazards within their areas require respiratory protection
2. Knowing the types of respirators that need to be used

3. Enforcing the use of respiratory protection in areas where it is required
4. Ensuring that employees are knowledgeable about the respiratory equipment for the areas in which they work.

E. EMPLOYEES are responsible for:

1. Participating in all training
2. Wearing respirator when indicated
3. Maintaining equipment:
   a. Logging PAPR in and out with witness initials in Log Binder
   b. Cleaning of helmet and reusable accessories after each use and prior to returning PAPR to designated cart
      i. Inspect the system and perform any assembly/dis-assembly instructions necessary for disposable items and for all components that have become worn or damaged
      ii. Apply a suitable wipe with a decontamination agent over all outside reachable surfaces, and then over all inside surfaces
      iii. Let air dry and re-assemble or place in storage
   c. Properly dispose of all disposable items
4. Reporting equipment malfunctions or concerns.

II. Respiratory Protection Program Elements

A. Medical evaluations for respirator users

1. A medical evaluation will be conducted to determine each individual's fitness to wear a respirator (see Appendix C). These evaluations consist of administering a medical questionnaire and/or providing a physical examination that elicits the same information as the questionnaire.

2. All new hires and current employees involved in patient care shall be required to complete a Medical Evaluation form. Each employee involved in patient care shall receive a medical clearance by a licensed HCP stating they are able to wear a PAPR prior to performing any of the designated activities that require respiratory protection.

3. Follow-up medical examinations will be provided to employees as required by Employee Health:

   a. If an individual gives a positive response to any question among questions 1-8 in Section 2, Part A of Appendix C of the OSHA Respiratory Standard (20 CFR 1910.134) (attached to policy) (NOT DONE ON MD)
   b. If the initial medical examination demonstrates the need for a follow-up medical examination.

c. These follow-up exams must include any medical tests, consultations, or diagnostic procedures that Employee Health deems necessary to make a final decision.

4. All employees will be granted the opportunity to speak with Employee Health about their medical evaluation, if they so request.

5. After an employee has received clearance and has begun to wear a respirator, a medical re-evaluation will occur under the following circumstances:

   a. Employee reports physical symptoms that are related to the ability to use a respirator (e.g. wheezing, dizziness, shortness of breath, chest pain).
   b. It is identified that an employee is having a medical problem during respirator use.
   c. Employee Health or the employee's Supervisor/Director determines that the employee needs to be reevaluated and the frequency of the evaluation.
   d. If a change occurs in workplace conditions (e.g. physical work effort, protective clothing, and temperature) that may result in substantial increase in physiological burden placed upon respirator users.

B. Documentation and Record Keeping

1. All examinations, evaluation and questionnaires are to remain confidential between the employee and Employee Health.
2. All employee medical records will be maintained by Employee Health. Relevant medical information will be maintained for the duration of the employment of the individual plus thirty years.
3. E-Learning will keep a record of HCWs completing the Annual Competency module on *"PAPR Use"*.
4. Department Leaders will keep a record of all staff within their department completing PAPR training.

C. Respirator Training

1. Employees will be trained prior to the use of a respirator and thereafter when deemed necessary by knowledgeable department designee.

2. Training will include:

   a. Identification of hazards, potential exposure to these hazards and health effects after exposure to hazards.
   b. Respirator fit, improper fit, usage, limitations and capabilities for maintenance, usage, cleaning and storage.
   c. Emergency use, if applicable.
   d. Inspecting, donning, doffing (removal), seal check and trouble shooting.

e. Explaining the respirator program policies and procedures.
f. The following will be done annually:
   1. Departments required to wear a PAPR will take the E-Learning module on *PAPR Use*.
   2. Departments required to use the PAPR will perform the donning and doffing steps in **Departmental Competencies** and add to initial department checklist.

D. Respirator Use

1. No employee shall wear any type of respirator until they have been trained and medically cleared to wear the respirator.
2. Employees will use their respirators under conditions specified by this program and accordance with the training they receive on the use of each particular model. In addition, the respirator shall not be used in a manner for which it was not certified by NIOSH or by its manufacturer.
3. Employees who detect problems, with, or experience failure of, the respirator shall leave the hazardous environment immediately and notify their supervisor.
4. No employee shall be assigned to tasks requiring the use of a respirator if Employee Health determines that the individual will be unable to function normally while wearing a respirator.
5. EHS will provide documentation of individuals unable to wear a PAPR by notifying the employee's manager.

E. Emergency Fit Testing – The Infection Prevention and Control Committee will activate emergency fit testing for use of an N95 Mask.

1. N95 fit testing will be required for a core group of employees who are anticipated to have direct patient care contact with a known ATD.

2. A PAPR may be available to be used by employees unable to be fitted with a N95 respirator.

3. Fit testing will be conducted prior to an employee being allowed to wear an N95 respirator.

4. Employee Health will conduct fit tests following the protocol found in Appendix B of the 29 CFR 1910.134 OSHA Respiratory Protection Standard.

F. Cleaning and Disinfecting Respirators

1. PAPRs should be cleaned according to manufacturer's recommendations, after every use by HCW:

   a. All outer and inner surfaces of the assembled system may be wiped down with approved cleaning solution/wipes between uses and between different users wearing the system.

b. Replace the front headband comfort strip.
c. The rear closed cell foam comfort strip may be cleaned for reuse by cleaning with approved cleaning solution/wipes.
d. Allow hood to air dry before placing in new storage bag.

G. Inspecting, Maintenance and Repairs of the PAPR is to be done by HCW before and after every use:

1. Examine the helmet for physical damage; if parts are damaged, contact BioMed.

2. Check for airflow prior to use.

3. Follow manufacturer's recommendations on maintenance, including battery recharging.

4. The battery will hold a charge for one year. As with all rechargeable batteries, the amount of charge will decline slowly when not in use or during storage. The Manager of the unit where the carts are kept will check charge status every 6 months or more often if needed.

III. Risks for Occupational Exposure to ATDs (e.g. Mycobacterium tuberculosis, Severe Acute Respiratory Syndrome (SARS), measles, smallpox, and/or COVID-19)

A. All employee job classifications that include direct patient care are at risk of exposure to ATDs.

B. Risk from exposure to high-hazard medical procedures in patients with an ATD include, but are not limited to:

1. Respiratory care procedures such as tracheotomy, endotracheal tube care or sputum induction.

2. Diagnostic medical procedures such as fiberoptic endoscopic evaluation of swallow (FEES), laryngoscopy, bronchoscopy and pulmonary function testing.

3. Any medical procedure performed on a "suspect" or "confirmed" infectious TB case which can aerosolize body fluids or tissue likely to be infected with TB bacteria.

4. Resuscitative procedures performed by any personnel.

5. Invasive procedures such as tracheotomy, thoracentesis, insertion of chest tube, or lung biopsy.

C. All employees entering the room or assisting with a high hazard procedure on a patient with an ATD will use respiratory protection in accordance with OSHA regulations, such

as a PAPR as designated by OSHA and CDC, and follow contact precautions to use Personal Protective Equipment (PPE) - gloves and gown.

D. Employees attending a patient who has been determined to have or may have an ATD are at risk of exposure to ATDs and are required to use Personal Protective Equipment (PPE) and respiratory protection.

IV. Control Measures and Early Detection of ATD

A. Engineering controls: Patients with potential ATD will be transferred to a medical facility with a negative air pressure room.

B. Work Practice Controls: To prevent or minimize employee exposure to airborne, droplet, and contact transmission of aerosol transmissible pathogens (ATP), precautions are in accordance with the CDC Guidelines.

1. Hand hygiene
2. Gloving, gowning, mask, face shield/goggles
3. Cleaning and disinfecting contaminated surfaces, articles and linens.

C. Available personal protective equipment (PPE) includes, but is not limited to:

1. A NIOSH-approved PAPR or NIOSH-approved N-95 respirator
2. Eye Protection
3. Gown
4. Gloves

D. Source Control Measures

1. At the first point of contact with a potentially infected person, standard precautions are implemented, which include respiratory hygiene and cough etiquette.

2. Persons identified to have or are suspected of having an airborne transmissible disease will be masked with a surgical mask for source control.

3. Visual alerts to instruct patients and visitors to practice respiratory hygiene and cough etiquette will be posted until the infected person is transferred.

4. Employees and visitors are made aware of placement of disposable tissues and hand hygiene dispensers.

5. Infected persons are placed in an area where contact with others not wearing respiratory protection is eliminated or minimized until transfer to another facility with an airborne isolation room.

6. Respiratory hygiene and cough etiquette measures include:

   a. Cover nose and mouth when coughing or sneezing.
   b. Use tissues to contain respiratory secretions and dispose of them immediately after use in the nearest waste receptacle.
   c. Wash hands with soap and water or alcohol-based hand rub after contact with respiratory secretions, contaminated objects or materials.

7. Health care workers will wear a PAPR or approved N-95 when examining a patient with symptoms of respiratory infection, especially if fever is present.

ATTACHMENTS:

- Appendix A: Respiratory Assignments by Task or Location
- Appendix B: Information for Voluntary Users
- Appendix C: OSHA Respirator Medical Evaluation Questionnaire
- Appendix D: Max Air CAPR Sign In and Out Log
- Appendix E: Max Air CAPR Respirator Monthly Inspection Log
- Appendix F: PAPR Cart Daily Log
- Appendix G: Competency Assessment Tool

REFERENCES:

- *Healthcare Respiratory Protection Resources: Written Program with Policies and Procedures*. (2020, May 5, last review Feb. 2021, accessed Mar. 2023). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/niosh/npptl/hospresptoolkit/policies.html
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RPP Appendix A: Respirator Assignments by Task or Location

Task or Location	Potential Exposure	Respiratory Protection	Employees Included
Performing aerosol-generating procedures on patients suspected or confirmed with a disease requiring Airborne Precautions or present when such procedures are performed **[see HICPAC 2007 or other public health guidance for lists of diseases], including**: • Sputum induction • Bronchoscopy • Aerosolized administration of medications • Pulmonary function testing • Manual Ventilation • Open suctioning of air ways • Endotracheal Intubation and Extubation • Cardiopulmonary resuscitation • Non-invasive ventilation (BiPAP, CPAP)	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR) ***[Note: PAPR use for aerosol-generating procedures on patients with a disease requiring Airborne Precautions is High Priority]***	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Performing aerosol-generating procedures on patients suspected or confirmed with influenza cases or present during such procedures.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Entry into airborne infection isolation room or other area occupied by patients suspected or confirmed with a disease requiring Airborne Precautions.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Performing, or present during, routine patient care and support operations on a patient suspected or confirmed with a disease requiring Airborne Precautions	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Cleaning/decontaminating an area occupied by a patient suspected or confirmed with a disease requiring Airborne Precautions, or cleaning/decontaminating such an area after a patient has left but before the space has been adequately ventilated.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• EVS • RT • Lab techs • IR techs • OR techs • Radiology techs
Laboratory operations involving aerosol transmissible disease pathogens **[see HICPAC, CDC, OSHA]** for which requires respiratory protection	Infectious aerosols	As specified in biosafety plan	• Lab techs • Lab personnel

NOTE ** Priority PAPR use for staff who **failed** the N-95 *"Fit Test"* and staff providing AGPs **

RPP Appendix B: Information for Voluntary Users

Information Taken From OSHA Appendix D to Sec. 1910.134: (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1) Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations.

2) Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.

3) Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors or very small solid particles of fumes or smoke.

4) Keep track of your respirator so that you do not mistakenly use someone else's respirator.

APPENDIX C: OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

SIERRA VIEW MEDICAL CENTER

OSHA Respirator Medical Evaluation Questionnaire

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: _____ Your age (to nearest year):_____

Your name:_____ Dept: _____

Job title:_____ Sex : Male/Female

Height: _____ft. _____ in. Your weight: _____ lbs.

Type of respirator you will use: NIOSH approved, disposable, R- rated filter mask, non- cartridge type.

Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

If you answer "YES" to any of the following questions, you will be contacted by a Licensed Health Care Professional for further clarification. You may call EHS at the hospital to obtain the name and contact information of the health professional who will be reviewing the questionnaires.

Please provide a phone number where you can be reached by the health care professional who will review this questionnaire (include the Area Code): _____

The best time to phone you at this number: _____

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month:

( ) Yes ( ) No

2. Have you ever had:	YES	NO
Seizures		
Diabetes		
Allergic reaction that interferes with breathing		
Claustrophobia(fear of closed places)		
Trouble smelling odors		
3. Have you ever had any of the following pulmonary or lung problems:	**YES**	**NO**
Asbestosis		
Asthma		
Chronic Bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax		
Lung Cancer		
Broken Ribs		
Any chest injury or surgery		
Any other lung problem you have been told about		
4. Do you currently have any of the following symptoms of pulmonary or lung illness?	**YES**	**NO**
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:		
Shortness of breath when walking with other people at an ordinary pace on level ground:		
Have to stop for breath when walking at your own pace on level ground:		
Shortness of breath when washing or dressing yourself		

ehs → EHS FORMS → Current EHS forms Revised 2009 → New Hire forms → NEW – Initial Fit to test medical evaluation

4. Continued		
Shortness of breath that interferes with your job		
Coughing that produces phlegm (thick sputum):		
Coughing that wakes you early in the morning		
Coughing that occurs mostly when you are lying down:		
Shortness of breath		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
5. Any other symptoms that you think may be related to lung problems	**YES**	**NO**
Heart Attack		
Stroke		
Angina		
Heart Failure		
Swelling in your legs or feet (not caused by walking):		
Heart arrhythmia (heart beating irregularly)		
High Blood Pressure		
Any other heart problem that you've been told about		
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical activity		
Pain or tightness in your chest that interferes with your job:		
In the past two years, have you noticed your heart skipping or missing a beat		
Heartburn or indigestion that is not related to eating:		
Any other symptoms that you think may be related to heart or circulation problems: _____ _____		
6. Do you currently take medication for any of the following problems:	**YES**	**NO**
Heart Trouble		
Blood Pressure		
Seizures		
Breathing or lung problems		
7. If you've every used a respirator, check yes or no after the following and go to **question 8:**	**YES**	**NO**
Eye Irritation		
Skin Allergies or rashes		
Anxiety		
General Weakness		
Any other problem that interferes with your use of a respirator:		

8. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: ( ) Yes ( ) No

Do not write below this line

Date: Physician/Licensed Healthcare Professional Signature:

Fit to test? YES NO

If no, why?

ADDENDUM (A)

Employee Name:_____ Dept:_____

The following questions below must be answered by every employee who has been selected to use either a full-face piece respiratory or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

1. Have you ever lost vision in either eye (temporarily or permanently): ☐ Yes ☐ No
2. Do you currently have any of the following vision problems:
   a. Wear contact lenses: ( ) Yes ☐ No
   b. Wear glasses: ( ) Yes ( ) No
   c. Color blind: ( ) Yes ☐ No
   d. Any other eye or vision problems: ( ) Yes ☐ No

		YES	NO
1.	Have you ever had an injury to your ears, including a broken ear drum		
	Do you currently have any of the following hearing problems?		
	a. Difficulty hearing ( ) Yes ☐ No		
	b. Wear a hearing aid ☐ Yes ☐ No		
	c. Any other hearing or ear problems ( ) Yes ☐ No		
2.	Have you ever had a back injury:	YES	NO
3.	Do you currently have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet: ( ) Yes ☐ No		
	b. Back pain ( ) Yes ☐ No		
	c. Difficulty fully moving your arms and legs: ☐ Yes ( ) No		
	d. Pain & stiffness when you lean forward or backward at the waist: ☐ Yes ( ) No		
	e. Difficulty fully moving your head up or down: ☐ Yes ( ) No		
	f. Difficulty fully moving your head side to side: ( ) Yes ☐ No		
	g. Difficulty bending at your knees: ☐ Yes ( ) No		
	h. Difficulty squatting to the ground: ☐ Yes ( ) No		
	i. Climbing a flight of stairs or a ladder carrying more Than 25 lbs: ( ) Yes ☐ No		
	j. Any other muscle or skeletal problem that interferes With using a respiratory: ( ) Yes ☐ No		

Do not write below this line

Date: Physician/Licensed Healthcare Professional Signature:

Fit to test? YES NO

If no, why?

ehs → EHS FORMS → Current EHS forms Revised 2009 → New Hire forms → NEW – Initial Fit to test medical evaluation

APPENDIX D: MAX AIR CAPR SIGN IN AND OUT LOG

Max Air: CAPR RESPIRATOR DAILY SIGN IN/OUT LOG

Prior to each use, if any of the following issues are discovered for any system component(s), replace the particular item(s) by following the assembly/dis-assembly procedures for the particular item(s).

CAPR SET: **ED** **ICU**
(Please circle)

_____/_____
Month Year

Employee name	CAPR SET	Date	Print corresponding number: • Helmet (1) • Battery (2) • Charger (3) • Belt (4)	No contamination	No damage to filter cartridge, batteries or threat to proper function	No yellow or red indicator lights	No compromise between the filter cartridge and helmet seal	Return Date and Time	User initials	Witness Initials	Comments

APPENDIX E: MAX AIR CAPR RESPIRATOR MONTHLY INSPECTION LOG

SIERRA VIEW MEDICAL CENTER
Infection Prevention

Max Air: CAPR RESPIRATOR MONTHLY INSPECTION LOG												
Log begin date: **Log end date:**	**CART: ED 1-6 (sets) ICU 1-6 (sets)** Circle appropriate Cart											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Monthly respirator cleaning record	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X
Helmet: Intact, clean, without breaks or visible damage												
Helmet Power Cord: Intact, clean, and securely connected to helmet												
Filter: Clean, without tears or breaks; proper seal between Filter and helmet (Visual Inspection **ONLY**; Do **NOT** remove Filter Cover)												
Filter Cover (FC): FC is secured and helmet mounting is stable; no tears or breaks												
Battery: • Lithium Ion Battery (LIB) connected to charger. If charger LED light is green, disconnect LID from charger • LIB is free from visible damage • Perform the LIB Check Procedure every 3-6 months (See back of page)												
Daily Log: Daily Log is up-to-date												
Note: If any boxes above are marked X address item and/or contact IP: Ext: 3795 or 3781												
IP contact on date:												
Supervisor monthly review (initial):												

Notes: Which item needs to be addressed (e.g., ER-1 helmet; ICU-3 Battery), discrepancy, and any needed descriptive information need to clarify the issue:

_____

_____

_____

Y:\Administrative Assistant\Policy & Procedure Committee\8-19-2020 Max Air Monthly Check List.docx

SIERRA VIEW MEDICAL CENTER
Infection Prevention

LIB Check Procedure - MAXAIR LIB Test for Diminishing Battery Capacity

CAUTION: If the LIB performs in one of the "Suspect LIB" categories below, discontinue using it and replace that LIB as soon as possible.

Case 1: The LIB has been connected to a charger and the charger green LED is on.

- **Procedure:** Unplug the LIB from the charger and plug the helmet power cord to the LIB. Allow the helmet to settle for about 10 seconds.
  - A. **Good LIB:** The helmet runs with 3 or 2 green indicator lights on.
  - B. **Suspect LIB**: The helmet runs with only 1 green indicator light on.
  - C. **Suspect LIB:** The helmet runs with the red indicator light on.
  - D. **Suspect LIB:** The helmet doesn't run.

Case 2: The LIB has been in storage.

- **Procedure:** Plug the helmet power cord to the LIB to be tested. Allow the helmet to settle for about 10 seconds.
  - A. **Good LIB:** The helmet runs with 3, 2 or 1 green indicator light on.
  - B. **Suspect LIB:** The helmet runs with the red indicator light on.
  - C. **Suspect LIB:** The helmet doesn't run.

Case 3: The LIB is connected to the MAXAIR Charger.

- A. **Good LIB:** the LIB is felt to be about room temperature.
- B. **Suspect LIB:** the LIB is warm or hot to touch.

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APPENDIX F: PAPR CART DAILY LOG

SIERRA VIEW MEDICAL CENTER
Infection Prevention

Month: _____ **Year**_____

PAPR Cart Daily Log							
DATE:	PAPRS	Batteries	Chargers	Belts	Cart stock with DLC and Helmet Liner	Signature	Comments
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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31							

C:\Users\bermm10\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Y2W2ARK3\8-25-20 PAPR Cart Daily Log v2.docx

APPENDIX G: COMPETENCY ASSESSMENT TOOL

SIERRA VIEW MEDICAL CENTER
Infection Prevention

MAX AIR: CAPR SYSTEM
Competency Assessment Tool

Name: _____ Unit: _____

Skills Validation Method of Evaluation: DO-Direct Observation VR- Verbal Response WE-Written Exam OT-Other				
	MAX AIR: CAPR SYSTEM	**Method of Evaluation**	**Initials**	**Comments**
	Assemble the Cuff to the Helmet			
1	Attach Lens to Helmet			
2	Remove Lens Protective Cover from Lens			
	Donning			
1	Connect Power Cord to Battery			
2	Loosen Headband Ratchet Knob prior to Donning helmet			
3	Don Helmet per Manufacture Instructions			
	Doffing the Helmet			
1	Reverse Donning steps			
2	Connect Battery to Charger, leaving Cord attached to helmet			
4	Wipe down all reusable item surfaces with approved cleaning solution			
5	Dispose of Lens at end of patient care (shift)			

Name of Person Validating the Skills:_____

Signature of Skills Validator:_____ Date:_____

Employee Signature:_____ Date:_____

References

Max Air Systems User's Instructions. (n.d.). Retrieved from Max Air Systems: http://maxair-systems.net/ManualsUIMIFU/78SP_Rev_F.pdf

SUBJECT:	SECTION:
SCOPE OF SERVICES OF THE SURGICAL SERVICES DEPARTMENT	**Page 1 of 4**

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

PURPOSE:

To provide a safe and comfortable environment for both patients and personnel in order to provide optimum assistance to the surgeons in meeting the emergency, preventive and restorative health needs of the patients. To perform high quality surgical procedures with the appropriate staff, space, equipment and supplies.

POLICY:

The Surgical Services Staff will provide their patient quality-conscious, competent and cost-effective care.

SCOPE OF SERVICE AND COMPEXITY OF CARE:

1. Type of Patients -
   Surgical Services provides care for patients undergoing inpatient or outpatient surgical and invasive procedures.

2. Age of Patients -
   The patient population served by the Surgical Services Department consists of the pediatric patient (1 year-12 years), adolescent patient (12 years-18 years), adult patient (18 years-65 years) and geriatric patient (65 years and older).

3. Services and Procedures -

   a. Operating Room – The surgery and procedural services provided are Ear, Nose & Throat (ENT), General, Obstetrics-Gynecology (Ob-Gyn), Ophthalmology, Orthopedics, Podiatry, Urology and Vascular. The list of procedures for each service performed are delineated and approved by the Medical Staff.

   b. Post Anesthesia Care Unit (PACU)/Flex Care – Service provides ambulatory surgery procedures, pre-operative teaching and preparation, post anesthesia/recovery care and procedural care, examples being:

      - Transfusions blood/iron
        Antibiotic infusions
        Bladder instillations
        Bone Marrow Biopsies

   c. Endoscopy – This Gastroenterology service provides diagnostic and therapeutic procedures.

4. Hours of Operation -

   The Surgical Services Department provides services for operative and other invasive procedures and immediate postoperative care twenty-four hours a day, seven days a week. The Department

has staff available to operate four operating room (OR) suites, two endoscopy suites from 7:30 a.m. to 3:15 p.m. each day. One OR suite is open until 5:00pm. PACU/Flex Care is staffed from 5:30 a.m. to 6:30p.m. An "on-call" staff is available to cover the additional hours from 3:15 p.m. until 6:45 a.m. Weekend and holiday services are covered by the on-call staff or additional staff may be arranged if needed.

5. Staffing Plan -

The Surgical Services Department is under the direction of the Director of Surgical Services. The Operating Room and Flex Care/Post Anesthesia Care Unit have Registered Nurse Clinical Managers to facilitate provision of quality patient care. The Surgical Liaison nurse communicates with the patient/family before the scheduled procedure in order to obtain the nursing assessment, provide information for the patient/family and answer their questions. Upon admission to the pre-op area, the patient is assessed by a Registered Nurse. Intraoperatively and postoperatively, the patient is continually reassessed. Modifications to that plan of care are based on reassessment of the patient. In the immediate postoperative phase, the patient is under the direct supervision of the anesthesiologist/anesthetist, who maintains responsibility for the needs of the patient until the patient has been appropriately discharged from the PACU. Disposition of the patient from the PACU is based on the complexity of the patient's care needs. This decision is made collaboratively between the anesthesiologist and surgeon, with information related to clinical data provided by the PACU staff.

The Flex Care and PACU registered nurses provide pre and postoperative care. The surgical team for a procedure is composed of a Registered Nurse Circulator, a Surgical Technician or RN scrub nurse and, if needed for the procedure, a Registered Nurse First Assistant (RNFA). Unlicensed Assistive Personnel are Scheduling Secretaries, Unit Clerks and EVS/Orderlies. For procedural sedation procedures, an additional RN must be present to monitor the patient.

Staffing is based on the number of scheduled cases and complexity of the cases. In the event that adequate staffing is unavailable, or if during regular hours of operation an emergency or disaster occurs, cases will be prioritized based on the following criteria:

a. acuity of the patient needs

b. special circumstances, i.e., bowel prep needed for procedure, needle marker inserted pre-procedure, age of patient

c. special equipment needs

d. vendor availability

e. surgeon's schedule

The Director of Anesthesia will be the resource person to assist in a satisfactory resolution to the issue, minimizing the need for case cancellations.
The Disaster manual call-in roster will be used to augment staff in the event of an emergency.

6. Equipment and Supplies

There shall be adequate and appropriate equipment and supplies related to the needs and services offered, including but not limited to:

a. Cardiac monitor with pulse oximeter
b. Electrocardiographic monitor
c. Oxygen and CO_2 respiratory rate alarms
d. D. C. defibrillator
e. Appropriate supplies and drugs for emergency use (crash cart, Pyxis, and pharmacy)
f. Clinical educator will be responsible for training and maintaining records of all staff

7. Qualifications of Staff

a. Registered Nurse with experience in and demonstrated competencies in Surgical Services nursing (Flex Care/PACU, Operating Room) require BLS, ACLS, and PALS (PALS not required for operating room nurses). CNOR (Certified Nurse in the Operating Room) and CPAN (Certified Peri-Anesthesia Nurse) are strongly encouraged.

b. Registered Nurse First Assistant (RNFA) – BLS, ACLS, CNOR, attendance at an AORN approved RNFA program, CRNFA encouraged.

c. Licensed Vocational Nurse (LVN) experience in and demonstrated competencies in the care of the surgical patient (pre-op, surgical scrub, endoscopy procedures) - BLS

d. Operating Room (Surgical) Technician with experience in and demonstrated competencies in surgical procedures. Newly hired surgical technicians must have graduated from an accredited school of surgical technology. – BLS

e. Unlicensed assistive personnel that demonstrate competencies in providing support for surgical services – BLS

An ongoing program of assurance, education and clinical skill competency evaluation for all staff will be maintained by the Perioperative Clinical Educator and the Hospital Education Department.

REFERENCES:

- Association of Perioperative Registered Nurses (AORN) ~~(2019)~~ (2023). Guidelines for Perioperative Practice. AORN, Inc.
- American Society of Perianesthesia Nurses. Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements (~~2019-2020~~) (2023-2024).

- ~~California Code of Regulations (2019). Title 22. §70221, 70223, 70225, 70227. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.~~

CROSS-REFERENCE:

- Emergency Operations Plan policy
- Staffing Patterns PACU policy

SUBJECT: **STAFFING FOR THE AMBULATORY SURGERY SERVICES DEPARTMENT**	SECTION: **Page 1 of 1**

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

PURPOSE:

To provide adequate numbers of qualified clinical personnel to deliver safe, comprehensive outpatient care to our patients and families during the preoperative, intraoperative and postoperative phases of care at the Ambulatory Surgery Department (ASD).

POLICY:

Clinical staffing is based on the numbers and types of scheduled procedures.

Preoperative staff will include a minimum of one registered nurse (R.N.) as long as patients are present. Additional preoperative staff will be determined based on number of patients, average time involved in patient preparation, patient acuity and procedures performed. Preoperative assessment will be done by the R.N.

Intraoperative: One R.N. and one Surgical/Endoscopy/~~En~~Technician will be present for each surgical procedure in progress. For ~~local or~~ procedural sedation procedures, an additional competent RN will be present to monitor the patient. That RN's responsibility is only to monitor the patient; not to circulate.

Postoperative: According to ASPAN Standards, there will be a minimum of 2 RNs in the same unit as the patient receiving Phase I level of care at all times, one being competent in Phase I postanesthesia care nursing. During Phase II and III, 2 competent personnel, one of whom is an RN competent in Phase II postanesthesia nursing, are in the same unit.

~~All clinical personnel will be qualified by training and/or experience in caring for surgical patients.~~

In the absence of the Clinical Director or Nurse Manager, a delegated R.N. will be responsible for maintaining appropriate staffing patterns.

There will be a minimum of two staff members in the Ambulatory Surgery Department at all times when patients are present. At least one of the staff members will be an RN with ACLS training.

AFFECTED AREAS/PERSONNEL:

R.N., SURGICAL/ENDOSCOPY TECHNICIAN, ANCILLARY AMBULATORY SURGERY SERVICES STAFF

EVIDENCE-BASED REFERENCE:

- American Society of Perianesthesia Nursing (ASPAN) Standards of Practice (2021~~19~~-2022~~20~~)

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

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **April 25, 2023 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:04 p.m.

Directors Present: REDDY, LOMELI, MARTINEZ, PANDYA, KASHYAP

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Gomez, Cindy, Director of Compliance, Dickson, Doug, Chief Financial Officer, Espinoza, Alexis, Porterville Recorder, Hefner, Donna, President/Chief Executive Officer, Hirte, Todd, Contracts Administration, Hudson, Jeffery, VP Patient Care Services, CNO and DIO, Franer, Julie, Admin Director Revenue Cycle, Johnson, Dianne, Porterville Academy of Health Sciences, Pryor-DeShazo, Kimberley, Director of Marketing and Public Relations, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Sousa, Kelvin, Community Member, Stringham, Zaelin, Director Food and Nutrition, Suorsa, Tim, OD, Wallace, Marcy, Director Patient Access and Communication, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:05 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

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

Director KASHYAP presented at 5:18 p.m.

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

III. Open Session: Chairman REDDY adjourned Closed Session at 5:26 p.m., reconvening in Open Session at 5:26 p.m.

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

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Discussion Regarding Trade Secret

Information only; no action taken.

IV. Public Comments

None.

V. Consent Agenda

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director PANDYA and seconded by Director MARTINEZ to approve the March 28, 2023 with changes to page 3 to correct the voting to reflect the motion was moved by Director PANDYA, not LOMELI. The motioned carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. Business Action Items

A. Porterville Academy of Health Sciences Health Careers Scholarship

Presented by Dianne Johnson

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve a donation of $10,000 to the PAHS Health Careers Scholarship Fund. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

B. March 2023 Financials

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

Total Operating Revenue was $13,655,009. Supplemental Funds were $1,712,802. Total Operating Expenses were $14,558,581. Loss from operations were $903,572.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Formation of Operational Efficiency Ad Hoc Advisory Committee

Per SVLHCD Bylaws 6.3, Special committees may be appointed by the Chairman for special tasks as circumstances warrant, and upon completion of the task for which appointed, such special committee shall stand discharged.

Chairman REDDY requested the formation of the Operational Efficiency Ad Hoc Advisory Committee for the task of; investigating operations to create more efficiencies. The work of the committee is to be completed by December 2023.

Chairman REDDY appointed Vice Chairman LOMELI and Director KASHYAP to the special committee.

VIII. CEO Report

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

In the District:

- Wound Healing receives Healogics Award for 2022

- Baby Friendly Award recipient for Breast Feeding initiatives

- Honored by First 5 Tulare County, Cora Blancio was awarded the Exceptional Volunteer Award for 2023

- SVMC's Volunteer League voted to dissolve the Volunteer League. This is an opportunity to restructure how the volunteers operate and the services provided

- Congratulations to Sergio Reyes, our newest Clinical Laboratory Scientist (CLS) Training Program Graduate!

- The full 3-year Bachelor of Science in Nursing (BSN) Unitek application window is now open for the cohort starting September 18, 2023

- SVMC was awarded the funds for Worker Retention Bonus payments. Payroll will prepare for an issuance of this one time retention payment for distribution to eligible workers as determined by the State of California on May 5th, 2023

IX. Closed Session: Board adjourned Open Session at 6:38 p.m. and went into Closed Session at 6:38 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54956.9(d)(2): Conference with Legal Counsel, Anticipated Litigation

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

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

X. Open Session: Board adjourned Closed Session at 7:46 p.m. and went into Open Session at 7:46 p.m. to discuss the following items:

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

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

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

XII. Announcements:

A. Regular Board of Directors Meeting – May 23, 2023 at 5:00 p.m.

The meeting was adjourned 7:46 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww

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Table of Contents

1. POLICY STATEMENT

Sierra View Local Health Care District ("District") is a California Health Care District formed by resolution of the Tulare County Board of Supervisors. The District was created pursuant to the California Health and Safety Code §32000 to address health care needs in the southeast portion of Tulare County. It is governed by an elected five-member board of directors.
All funds of the District shall be invested in accordance with principles of sound treasury management and in accordance with the provisions of the California Government Code §53600 et seq., (the Municipal Code), which sets forth the investment parameters for local agencies (including districts) in California, and guidelines established by the California Municipal Treasurer's Association, and this Investment Policy ("Policy").

2. INVESTMENT POLICY OBJECTIVES

A. Overall Risk Profile

The objectives of the District's Investment Program are, in order of priority:

1. Safety of principal of invested funds;
2. Maintenance of Sufficient Liquidity to Meet Cash Flow Needs; and
3. Attainment of the Maximum Yield Possible Consistent With the First Two Objectives.

To achieve these objectives, The District shall consider the following when making an investment:

1. Safety of Principal of Invested Funds

The District shall mitigate the risk to the principal of invested funds by limiting credit and interest rate risks. Credit Risk is the risk of loss due to the failure of a security's issuer or backer. Interest Rate Risk is the risk that the market value of the District's portfolio will fall due to an increase in general interest rates.

a) Credit risk will be mitigated by:

(i) Limiting investments to only the most creditworthy types of securities defined as "investment grade" by a Nationally Recognized Statistical Rating Organization (NRSRO) including (a). Standard and Poor's Rating Service, (b). Moody's Investors Service and (c). Fitch Ratings.
(ii) By pre-qualifying the financial institutions with which it will do business; and

(iii) By diversifying the investment portfolio so that the potential failure of any one issue or issuer will not place an undue financial burden on the District.

b) Interest rate risk will be mitigated by:

(i) Structuring the District's portfolio so that securities mature to meet the District's cash requirements for ongoing obligations, thereby avoiding the possible need to sell securities on the open market at a loss prior to their maturity to meet those requirements; and

(ii) Investing primarily in shorter term securities.

2. Liquidity

The District's investment portfolio shall be structured in a manner which emphasizes that securities mature at the same time the cash is needed to meet anticipated demands (Static Liquidity). Additionally, since all possible cash demands cannot be anticipated, the portfolio should consist of securities with active secondary markets (Dynamic Liquidity). The maximum percentage of different investment instruments and maturities is described in Appendix A of this Policy.

3. Yield

Yield on the District's investment portfolio is of secondary importance compared to the safety and liquidity objectives described above. Investments are limited to relatively low risk securities in anticipation of earning a fair return relative to the risk being assumed. While it may occasionally be necessary or strategically prudent for the District to sell a security prior to maturity to either meet unanticipated cash needs or to restructure the portfolio, this policy specifically prohibits trading securities for the sole purpose of speculating on the future direction of interest rates.

B. Basic Investment Strategy

The District shall pursue a "passive" strategy of investment under which investments shall be of "laddered" maturities, facilitating a "buy and hold" process where financial instruments are held until maturity rather than actively bought and sold at various times. An "active" strategy of market timing, sector rotation, indexing to a benchmark and similar strategies are considered inappropriate for the size of the District's portfolio. It is understood that it may be appropriate to sell a particular security prior to maturity to meet unanticipated cash needs. Any such transaction will be reported to the Board of Directors at its next regularly scheduled meeting.

The District's investment portfolio shall be structured to provide that sufficient funds from investments are available each month to meet the District's anticipated cash needs. Subject to the objectives stated above, the choice in investment instruments and maturities shall be based upon an

analysis of future anticipated cash needs, existing and anticipated revenues, interest rate trends and specific market opportunities. No investment may have a maturity of more than five (5) years from its date of purchase without receiving prior Board of Directors approval. After approval by the Board, reserve funds associated with bond issues may have a maturity of more than five (5) years, up to the earliest date the bonds may be redeemed or mature.

3. INVESTMENTS

This section of the Investment Policy identifies the types of investments in which the District will invest its idle or surplus funds.

A. Standard of Prudence

The District operates its investment portfolio under the Prudent Investor Standard (California Government Code §53600.3) which states, in essence, that "when investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the District, that a prudent person in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the District".

This standard shall be applied in the context of managing the overall portfolio. Investment officers, acting in accordance with written procedures and this investment policy and exercising the above standard of diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control adverse developments.

B. Allowable Investments

Investment of District funds is governed by California Government Code §53600 et seq. See Appendix A for a listing of Allowable Investments.

The District may choose to restrict its permitted investments to a smaller list of securities that more closely fits the District's cash flow needs and requirements for liquidity. If a type of investment is added to California Government Code §53600, it will not be added to the District's listing of Allowable Investments until this policy is amended and approved by the Board of Directors. If a type of investment permitted by the District should be removed from California Government Code §53600, it will be deemed concurrently removed from the District's listing of Allowable Investments, but existing holdings may be held until they mature.

A thorough investigation of any pool or fund is required prior to investing and on a continual basis. The investigation will, at a minimum, obtain the following information:

- A description of eligible investment securities, and a written statement of investment policies and objectives.
- A description of interest calculations and how it is distributed, and how gains and losses are distributed.
- A description of how securities are safeguarded (including the settlement process) and how often the securities are marked to market and how often an audit is conducted.
- A description of who may invest in the program, how often, what size deposits and withdrawals are permitted.
- A schedule for receiving statements and portfolio listings.
- Does the pool/fund maintain a reserve or retain earnings or is all income after expenses distributed to participants?
- A fee schedule which also discloses when and how fees are assessed.
- Is the pool or fund eligible for bond proceeds and/or will it accept such proceeds?

The purpose of this investigation is to determine the suitability of a pool or fund and evaluate the risk of placing funds with that pool or fund.

The District will generally avoid "Brokered CD's" pools in which brokers arrange for deposits (usually $250,000 each to obtain federal deposit insurance). Such brokered CD's are frequently issued by failing or marginal institutions whose safety is derived almost exclusively by the existence of federal insurance rather than by the strength of the issuing institution.

One of the purposes of this Investment Policy is to define what investments are permitted. If a type of security is not specifically authorized by this policy, it is not a permitted investment.

C. Qualification of Brokers, Dealers and Financial Institutions

The District's Chief Financial Officer (CFO) or designee will (1) establish and maintain a list of the financial institutions and broker/dealers authorized to provide investment and depository services to the District, (2) perform an annual review of the financial condition and registrations of the qualified bidders, and (3) require annual audited financial statements to be on file for each approved company. The District shall annually send a copy of its current Investment Policy to all financial institutions and broker/dealers approved to do business with the District. Receipt of the Policy and Enabling Resolution, including confirmation that it has been received and reviewed by the person(s) handling the District's account, shall be acknowledged in writing within thirty (30) days.

All broker-dealers and financial institutions that desire to become qualified bidders for investment transactions must submit a "Broker-Dealer Application" and related documents relative to eligibility. This includes a current audited financial statement, proof of state registration, proof of NASD registration and a certification they have received and reviewed the District's Investment Policy and agree to comply with the provisions outlined in the Investment Policy. The District's CFO or designee may establish any additional criteria deemed appropriate to evaluate and approve any financial services provider. The selection process for broker- dealers shall be open to both "primary dealers" and "secondary/regional dealers" that qualify under Securities and Exchange Commission Rule 15c3-1 (Uniform Net Capital Rule). The provider must have an office in California and the provider's representative must be experienced in institutional trading practices and familiar with the California Government Code as it relates to investments by a Special District. The current form of the Broker Dealer Questionnaire appears as Appendix B of this policy.

D. Collateralization Requirements

Uninsured Time Deposits with banks and savings and loans shall be collateralized in the manner prescribed by state law for depositories accepting municipal investment funds.

E. Diversification

The District will diversify its investments by security type and investment. The District's CFO or designee will adopt a strategy that combines current market conditions with the District's cash needs to maintain the maximum degree of safety of principal and liquidity throughout market and budgetary cycles. This strategy will include diversification by investment type and maturity allocations and will be included in the regular quarterly reports to the Board. This strategy will be reviewed quarterly and can be changed accordingly.

F. Confirmations

Receipts for confirmation of purchases or sales of authorized securities shall include at a minimum the following information: trade date, settlement date, description of the security, par value, interest rate, price, yield to maturity, District's name, net amount due and third party custodial information.

4. SAFEKEEPING OF SECURITIES

The District shall contract with a bank or banks for the safekeeping of securities that are owned by the District as a part of its investment portfolio.

All securities owned by the District shall be held in safekeeping by a third party bank trust department acting as agent for the District under the terms of a custody agreement executed by the