SIERRA VIEW
MEDICAL CENTER

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

AGENDA
September 26, 2023

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9 (d)(2): Conference with Legal Counsel: significant exposure to litigation; privileged communication (1 Item).

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b); Cal. Civ. Code § 3426.1(d): Discussion Regarding Trade Secrets (1 Item) Estimated Date of Disclosure – February 2025

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b); Cal. Civ. Code § 3426.1(d): Discussion Regarding Trade Secrets (1 Item) Estimated Date of Disclosure – January 2025

F. Conference with Sierra View Local Health Care District Real Property Negotiator to give instructions regarding price and sale terms pursuant to Cal. Gov. Code § 54956.8. Property: 633, 663, and 643 N. Westwood Street, Porterville, CA 93257. Sierra View Local Health Care District Hospital Negotiator: Ron Wheaton. Prospective Purchaser: Chris Mano negotiating on behalf of the Burton School District or any other interested parties.

G. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

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

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

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

F. Conference with Legal Counsel Re: Real Property Negotiations
Recommended Action: Action to be taken at the discretion of the Board

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

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

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the

time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for th e Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

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

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

VIII. Approval of Minutes

A. **August 22, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove August 22, 2023 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **August 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

B. **Capital Budget – Quarter 4**
Recommended Action: Approve/Disapprove Report as Given

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
September 26, 2023

XI. Announcements:

A. Regular Board of Directors Meeting – October 24, 2023 at 5:00 p.m.

XII. Adjournment

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

Senior Leadership Team	9/26/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	9/26/2023

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
September 26, 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. Accessibility of the Medical Record	1	
2. Consent and HIV (HTLV III/LAV)Antibody Testing for Aids	2-4	
3. Delinquent Medical Records	5-6	

SUBJECT: **ACCESSIBILITY OF THE MEDICAL RECORD**	SECTION:

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

POLICY:

Sierra View Medical Center (SVMC) shall have all patient medical records accessible on a 24-hour per day basis.

PROCEDURE:

1. The electronic medical record is available to all SVMC staff members based on their access role 24/7.

2. From the hours of 5:00 PM through 7:00 AM, seven days per week, any appropriate individual requesting an old paper medical record must contact the Nursing Supervisor and provide the patient's name and medical record number, if the number is known.

    a. The Nursing Supervisor will unlock the Health Information Management (HIM) Department and obtain the requested medical record. The medical record will be logged out of the department by the Nursing Supervisor, listing the patient's name, medical record number, most recent discharge date (if multiple volumes in one [1] jacket) and destination of the medical record.

3. Should the record requested be located off campus, the Jack and Jeff Storage Company will be contacted and provided with the requested medical record number and patient name, if this is known. The Jack and Jeff Storage Company will courier the medical record to the HIM Department during normal business hours. They do not have 24 hour service.

REFERENCES:

- California Code of Regulations (2023). Title 22. § 70751,

  Retrieved from https://govt.westlaw.com/calregs/Document/IB47D04195B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1

- Code of Federal Regulations (2020). §482.24,

  Retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

SUBJECT:	SECTION:
CONSENT AND HIV (HTLV III/LAV) ANTIBODY TESTING FOR AIDS	***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 3**

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

PURPOSE:

To specify how consent procedures are related to testing for HIV at Sierra View Medical Center.

POLICY:

1. No person shall test a person's blood for antibodies to the HTLV III virus without written consent of the person being tested, unless the law expressly permits otherwise. The patient's consent must be obtained by the physician ordering the test before testing for the antibody.

2. In the event of incompetency, a health care provider may obtain written consent for testing from the patient's parents (if a minor), guardians, conservators, or other person lawfully authorized to make health care decisions for the patient.

    a. This consent is only appropriate when the test is necessary to aid in caring for the patient or in preventing the spread of the HIV virus.

    b. A person's agent appointed under a Durable Power of Attorney for Health Care may authorize a test.

3. The legal capacity of children twelve years of age or older to consent to diagnosis and treatment for certain infectious, contagious/communicable or sexually transmitted diseases shall be recognized in the case of HIV antibody testing. [Family Code Section 6926] However, the involvement of the child's parents or guardian is generally recommended unless the child expressly objects thereto.

    a. Under state law, children twelve years of age or older have the legal capacity to consent to HIV antibody testing. Given the implications of such testing, however, the involvement of the parents or legal guardian is generally recommended. The request of a child twelve years or older to have the HIV test without the knowledge or participation of parents or a guardian **shall** be respected unless there are serious doubts concerning the child's competence. (i.e. the child's capacity to appreciate the meaning of the test results and the implications of his/her decision.)

    b. Children twelve years of age or older have the right to refuse testing for the HIV antibody even if the child's parent or legal guardian is willing to consent to the testing. The patient must be informed of the consequences of this refusal.

    c. Other unique considerations involving minors including self-sufficient minors and emancipated minors should be based on applicable state laws. (See CAHHS Consent Manual)

4. Sierra View Medical Center retains the right to refuse to perform antibody testing for patients unwilling or unable to pay for such services.

5. Testing in Instances of Occupational Exposure

   a. California law provides a "narrow exposure notification and information mechanism" to permit heal care personnel and other "first responders" who have experienced a significant exposure to a patient's blood or other potentially infectious materials, to learn of the patient's HIV status *[Health and Safety Code Sections 121130-121140]*

   b. An "exposed individual" may have a "source patient's" blood, tissue or other material tested for HIV even though the patient refuses to be tested – provided the blood, tissue or other material was obtained prior to the exposure. The law does not permit a health care provider to draw blood or other bodily fluids except as otherwise permitted by law.

6. Deceased patients may be tested for the HIV antibody if:

   a. consent has been given to perform an autopsy or organ donation in accordance with the Uniform Anatomical Gift Act;

   b. the death falls under the jurisdiction of the Coroner's office and a medical examiner is involved;

   c. The relative authorized to control disposition of the remains has given consent. Relatives authorized to control disposition of remains are as follows in descending order of priority:

      - an "Attorney-in-Fact" appointed under Durable Power of Attorney for Health Care;
      - the spouse;
      - an adult son or daughter;
      - either parent;
      - an adult brother or sister;
      - a guardian or conservator of the decedent at the time of death;
      - any other person authorized or under obligation to dispose of the body.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL AREAS, LABORATORY, MEDICAL RECORD*

REFERENCES:

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

- CAHHS Consent Manual (2023)
- California Health & Safety Code

SUBJECT: **DELINQUENT MEDICAL RECORDS**	SECTION:

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

POLICY:

Medical record delinquency rates shall be measured every three (3) months.

The Health Information Management Department (HIM) shall notify a provider of suspension when he/she has delinquent medical records.

PROCEDURE:

- Notification of incomplete records are populated on the provider's workload within the Meditech system.
- Providers are sent a listing of incomplete medical records displayed on their system workload of deficiencies as a courtesy on the second Tuesday of each month.
- Providers identified as "on vacation" or "out of the office", must notify Medical Staff or HIM of the date range that they will be out. This is entered into the Meditech system to prevent incomplete days from counting against the provider.
- Should the medical record(s) remain incomplete on the 15th day after patient discharge, the HIM Department will notify the provider, via certified mail, that his/her admitting, consultative and surgical privileges have been suspended until his/her medical records have been completed.
- A copy of all suspension letters mailed are placed in the provider's peer review file housed in the Medical Staff Office.
- The nursing units, all clinical outpatient departments, medical staff, and Senior Leadership are notified by the HIM Department of the suspension. When the suspension of privileges has been lifted, a notice will be submitted and the admitting privileges will be restored in the electronic system.
- If a provider is on suspension for a total of 30 cumulative days in the fiscal year, his/her name shall be submitted to the Medical Executive Committee. The Committee shall then submit his/her name to the State Medical Board.
- The medical record delinquency rate shall be averaged from the last four (4) quarterly measurements and shall be 50% or less of the average monthly discharge (AMD) rate.
- Each individual quarterly measurement shall be no greater than 50% of the AMD rate.

REFERENCE:

- The Joint Commission (2023). Hospital accreditation standards. RC.01.03.01. Joint Commission Resources. Oak Brook, IL.
- California Code of Regulations (2023). Title 22. § 70751(g),

SUBJECT: **DELINQUENT MEDICAL RECORDS**	SECTION: **Page 2 of 2**

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MEDICAL EXECUTIVE COMMITTEE	09/06/2023
BOARD OF DIRECTORS APPROVAL	
	09/26/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
September 26, 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**
• Accessibility of the Medical Record	1	↓
• Administration of Varicella Vaccine to Adults	2-5	
• Admission Guidelines for the Ambulatory Surgery Department	6-7	
• Air Quality Control	8-11	
• Anesthesia Patient Classification	12-13	
• Arterial Puncture	14-19	
• Autoclave Qualifications Testing	20	
• Blood and Blood Components, Transfusion Reaction	21-23	
• Cardiac Arrest in OR/PACU	24-27	
• Code Blue at the Ambulatory Surgery Department	28	
• Crash Carts – Exchanging, Restocking, Security and Verification	29-37	
• Delinquent Medical Records	38-39	
• Discharge of Homeless Patients	40-42	
• Documentation in the PACU	43-44	
• Evacuation Procedure for the Ambulatory Surgery Services	45-46	
• Human Tissue Procurement and Storage	47-52	
• Implants, Premature Release from Quarantine	53-57	
• Infant Care Teaching Guidelines	58-61	
• Intra-Aortic Balloon Pump (IABP) Management	62-64	
• Obtaining Laboratory Services for Ambulatory Surgery Department Patients	65-66	
• Operating Room Cleaning	67-70	
• Oral Nutrition Supplement	71-73	
• Oxygen Protocol	74-79	
• Patient Food from Home – DPSNF	80-81	
• Patient Observations	82-83	
• Patient Safety – Ambulatory Surgery Department	84-85	
• Pediatric Blood Transfusions	86-90	
• Qualified Personnel: Arterial Puncture	91	
• Registered Nurse First Assistant (RNFA)	92-97	
• Scope and Complexity of Services at the Ambulatory Surgery Department	98-101	
• Sputum Induction	102-103	
• Universal Protocol	104-111	
• Unusual Occurrences in the Operating Room	112-113	
• Visitors in the Operating Room	114-115	

	• Wound Classification	116-120	
II.	**<u>Forms</u>:** • Code Blue Form	121-124	

SUBJECT: **ACCESSIBILITY OF THE MEDICAL RECORD**	SECTION: **Page 1 of 1**

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POLICY:

Sierra View Medical Center (SVMC) shall have all patient medical records accessible on a 24-hour per day basis.

PROCEDURE:

1. The electronic medical record is available to all SVMC staff members based on their access role 24/7.

2. From the hours of 5:00 PM through 7:00 AM, seven days per week, any appropriate individual requesting an old paper medical record must contact the Nursing Supervisor and provide the patient's name and medical record number, if the number is known.

    a. The Nursing Supervisor will unlock the Health Information Management (HIM) Department and obtain the requested medical record. The medical record will be logged out of the department by the Nursing Supervisor, listing the patient's name, medical record number, most recent discharge date (if multiple volumes in one [1] jacket) and destination of the medical record.

3. Should the record requested be located off campus, the Jack and Jeff Storage Company will be contacted and provided with the requested medical record number and patient name, if this is known. The Jack and Jeff Storage Company will courier the medical record to the HIM Department during normal business hours. They do not have 24 hour service.

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- California Code of Regulations (2023). Title 22. § 70751,

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- Code of Federal Regulations (2020). §482.24,

  Retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

SUBJECT:	SECTION:
ADMINISTRATION OF VARICELLA VACCINE TO ADULTS (Employees)	**Page 1 of 4**

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

INTRODUCTION

Varicella, commonly known as "chickenpox", is a vaccine-preventable infectious disease. Although usually mild, varicella can be a serious disease for high-risk populations such as infants, adolescents and pregnant people. In addition to the symptoms commonly associated with Varicella (itchy rash, fever, headache, etc.), it may lead to skin infection, generalized inflammation of the cardiovascular, musculoskeletal and central nervous system. Below is the policy on varicella vaccination for SVMC staff.

POLICY

SVMC will provide for the administration of varicella vaccine to any adult staff, who meet the criteria as established by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

PROCEDURE

1. **Eligible** nurses (see below, *Requirements For Administration: Education*) will identify adult staff in need of varicella vaccination using CDC ACIP criteria and if appropriate (see *Contraindications* for exceptions) vaccinate them, especially healthcare workers, non-U.S.-born persons, or any adult staff that lacks laboratory evidence of immunity or laboratory-confirmed disease.
2. **Screen** potential recipient for contraindications and precautions to varicella vaccination. Consider the following before moving forward with vaccination:
    a. **Contraindications**
        i. A history of serious reactions such as anaphylaxis after the administration of a previous dose of varicella vaccine or a known varicella vaccine components including, but not limited to (for a full list of excipients, see Vaccine Excipient Summary at https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf):

Vaccine Excipient Table

Vaccine (Trade Name)	Package Insert Date	Contains[a]
Varicella (Varivax) Frozen	01/2021[2b]	sucrose, hydrolyzed gelatin, sodium chloride, monosodium L-glutamate, sodium phosphate dibasic, potassium phosphate monobasic, potassium chloride, MRC-5 human diploid cells including DNA & protein, sodium phosphate monobasic, EDTA, neomycin, fetal bovine serum

ii. Currently **pregnant** or may become pregnant within 1 month. Pregnant women should be vaccinated upon completion or termination of pregnancy.

iii. **Immunodeficiency** – individuals with substantial suppression of cellular immunity due to disease or medical therapy. (See: Varivax Product Insert https://www.fda.gov/media/76008/download)

b. Precautions

i. Candidate is a recent **recipient of antibody-containing blood products** (within the past 11 months.) The specific wait time is dependent on the antibody-containing product – see product insert for each specific product.

ii. Acute moderate or severe illness with or without fever.

3. **Plan** – offer vaccination to all adult staff members who meet the criteria for varicella vaccination and enter in the appropriate record either receipt of vaccination or a statement of declination.

a. Treatment

i. Screen all adults (staff) for contraindications and precautions to varicella vaccine.

ii. Provide all adults with a copy of the most recent CDC Vaccine Information Statement (VIS). If necessary, provide non-English speakers with a copy of the VIS in their native language if available. The most recent VISs may be found at: https://www.cdc.gov/vaccines/hcp/vis/index.html, https://www.cdc.gov/vaccines/hcp/vis/current-vis.html or https://www.immunize.org/vis/).

iii. Administer 0.5 ml (23 – 25 mg) varicella vaccine subcutaneously using a 5/8" needle in the posterolateral fat of the upper arm.

iv. Administer the second dose 4 – 8 weeks after the first dose

4. Documentation

a. Employee File – record the date administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If the vaccine was not given, record the reason(s) for the refusal of the vaccine, for example, medical contraindication or refusal.

b. Personal immunization record card – record the date of vaccination, name/location of the clinic as well as the follow-up date, etc., as necessary.

5. Staff Authorized to Perform Vaccination Protocol

c. Licensed Vocational Nurses (LVNs) and Registered Nurses (RN)

d. Requirements for administration

i. Education – licensed staff only (LVN, RN, MD)

ii. Training as required by specific licensing board(s)

iii. Initial evaluation of recipient is conducted using CDC's immunization criteria and SVMC standardized procedures for immunizations

iv. Continuing evaluation every 2 years

DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE

1. An annual review schedule will be utilized to maintain a policy current with CDC guidelines.

2. The policy ownership and workflow

a. The policy is owned by the Infection Prevention Manager (IP Mgr). The IP Mgr will research the need to update the policy to reflect any changes or modification by the vaccine manufacturer, the FDA and/or the CDC.

b. The Power DMS workflow name for this policy is **QA IP Mgr IP Analyst CNE MEC BOD**:

   i. QA IP Mgr – Quality & Regulatory Affairs Infection Prevention Manager

   ii. IP Analyst – Infection Prevention Analyst

   iii. CNE – Chief Nursing Officer

   iv. MEC – Medical Executive Committee

REFERENCES

- **FDA Vaccines VARIVAX** (refrigerated and frozen formulations), Merck Sharp & Dohme Corp. **Date Viewed**: 2023-07-19. **Content Current** as of: 03/08/2023. **URL**: https://www.fda.gov/vaccines-blood-biologics/vaccines/varivax-refrigerated-and-frozen-formulations
  - VARIVAX Product Insert: https://www.fda.gov/media/76008/download
  - Highlights of Prescribing Information: https://www.fda.gov/media/76008/download
  - VARIVAX Patient Information: https://www.fda.gov/media/76904/download
  - Appendix B - Vaccine Excipient Summary: https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf
- **CDC** Adult Immunization Schedule by Age. **Date Viewed**: 2023-07-19. **Page last updated**: 2022-09-07. Appendix includes info on contraindications, precautions to commonly used vaccines, vaccines in the adult immunization schedule, and contact information. **URL**: https://tools.cdc.gov/medialibrary/index.aspx#/media/id/266012
- **CDC Chickenpox Vaccine Information Statement (VIS)**. Varicella (Chickenpox) Vaccine: What You Need to Know. **Date Viewed**: 2023-07-19. **Page Last Reviewed**: 2021-08-06. **URL**: https://www.cdc. gov/vaccines/hcp/vis/vis-statements/varicella.html
- Centers for Disease Control and Prevention. ***Epidemiology and Prevention of Vaccine-Preventable Diseases.*** Chapter 22: Varicella. Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. URL: https://www.cdc.gov/vaccines/pubs/pinkbook/index.html
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SUBJECT:	SECTION:
ADMISSION GUIDELINES FOR THE AMBULATORY SURGERY DEPARTMENT	**Page 1 of 2**

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

PURPOSE:

To provide guidelines for appropriate patient admissions to the Ambulatory Surgery Department.

POLICY:

1. Anesthesia Patient Classification Criteria will be used to identify appropriate patients for the Ambulatory Surgery Setting. (See Anesthesia Patient Classification Policy.)

2. Class I and Class II will be done without restriction. Class III cases can be performed with appropriate consultation between the physician/surgeon and the anesthesiologist. Class IV and Class V will not be done in the Ambulatory Surgery Department.

   Definitions:

   a. Class I-A normally healthy patient for an elective procedure. A Class I patient has no organic, physiological, biochemical or psychiatric disturbance. The pathologic process for which the operation is to be performed is localized and not conductive to systemic disturbance.

   b. Class II- A patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes. Examples would be the presence of mild diabetes which is treated by pill or diet, mild essential hypertension, moderate obesity and chronic bronchitis.

   c. Class III- A patient with severe systemic disease that limits activity but is not incapacitating. The Class III patient is one who has a rather severe systemic disturbance or pathology from whatever cause. Examples might be diabetes requiring insulin management, moderate to severe degrees of pulmonary insufficiency, severe hypertension that is difficult to manage, angina or recently healed myocardial infarction.

3. Children will be three years of age and above. Anesthesia will review charts of patients under 5 years of age prior to date of surgery.

4. Preoperative workup requirements will be given by the surgeon/anesthesiologist.

5. The anesthesiologist reserves the right to postpone any elective case that is medically unfit for surgery, including non NPO status.

6. Local Anesthesia with or without General Anesthesia Standby, Procedural Sedation, and General Anesthesia may be used in the provision of care at the Ambulatory Surgery Department.

7. Procedural Sedation may be administered by the Registered Nurse, under the direction and orders of the Surgeon. Guidelines have been established by the Medical Director. A second RN will perform circulating duties.

8. Surgical procedures scheduled should be those that are typically completed in less than 120 minutes and require less than 4 hours recovery time at the discretion of Anesthesia.

9. Patients who receive procedural sedation or any type of anesthesia should identify a responsible adult to drive them home after their procedure/surgery. It is recommended that an adult care for them, in the first 24 hours after discharge.

10. Patients with infections or communicable diseases requiring extensive isolation precautions, or history of difficult intubations, and patients with a BMI greater than 50, must have their procedure completed at the hospital in the main operating room with an anesthesia provider.

AFFECTED AREAS/PERSONNEL:

AMBULATORY SURGERY DEPARTMENT PERSONNEL AND MEDICAL STAFF

REFERENCES:

American Society of anesthesiologist (2023). *Recovery: what should you expect if you have general anesthesia.* Retrieved from: https://ASAHQ.ORG/MADEforthismoment.

CROSS REFERENCES:

- ANESTHESIA PATIENT CLASSIFICATION
- SCOPE AND COMPLEXITY OF SERVICES AT THE AMBULATORY SURGERY DEPARTMENT

SUBJECT: **AIR QUALITY CONTROL**	SECTION: **Page 1 of 4**

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

PURPOSE:

To define parameters of Relative Humidity (RH), Temperature and Airflow patterns within the perioperative environment, related to decreasing risks of fire hazards, microbial growth and particulates and increasing patient and personnel safety.

POLICY:

Relative Humidity in a restricted area shall be maintained within a range of 20% to 60%.
RH in a semi-restricted area is related to the function performed in that area:

- clean/sterile storage - maximum 60%
- soiled workroom/decontamination room – no recommendations
- sterilizer equipment access or corridors – no recommendations

RH in an unrestricted area is related to the function performed in that area:

- PACU – 20% to 60 %
- GI/Endoscopy suites/procedure rooms - 20% to 60 %

Temperature should be maintained within the limits recommended for each area (ie, unrestricted, semi-restricted, restricted) which are referenced in ASHE, the accepted professional guidelines for HVAC.

Temperature ranges for restricted areas should be 68˚F to 75˚F (20˚C to 24˚C) but the range may be adjusted for a limited time based on the individual (ie, pediatric, intentional hypothermia) needs of the patient.

Temperature ranges for semi-restricted areas depend on the use of the area.

- clean/sterile storage – 72˚F to 78˚F (22˚C to 26˚C)
- soiled workroom/decontamination room – 72˚F to 78˚F (22˚C to 26˚C)
- sterilizer equipment access or corridors – no recommendations

Temperature ranges for all unrestricted areas should be between 70˚F and 75˚F (21˚C and 24˚C)

Airflow direction should be maintained within the HVAC design parameters, per ANSI/ASHRAE/ASHE Standard 170-2008: Ventilation of Health Care Facilities. Section 7.4.1, and applicable others, such as California Mechanical Code.

- The restricted area should have a positive pressure relationship to the adjacent areas.

- The pressure relationship of the semi-restricted area should be based on the use of the area.
  - clean/sterile storage – positive
  - soiled workroom/decontamination room – negative
  - sterilizer equipment access or corridors – no recommendations

Free standing fans, dehumidifiers or other devices should not be used in restricted or sterile processing areas.

Doors should be kept closed except during entry and exit of patients and personnel. When doors are open, the HVAC system may be unable to maintain environmental controls such as pressurization or outside air exchanges.

- pre-planning may help reduce air turbulence from the number of door openings,
- keeping surgeons preference cards current,
- confirming all instruments and supplies are present before incision,
- posting signs to restrict traffic for procedures in progress,
- use means of communication that do not involve opening the door,
- analyze the stage of the procedure before breaks or lunches, provide education about the effects of opening doors

AFFECTED AREAS/ PERSONNEL:

MAIN OR, ASD, CENTRAL PROCESSING DEPARTMENT (CPD) STAFF, CARDIAC CATH LAB, ENDO

PROCEDURE:

1. Temperature and humidity will be monitored and recorded in the department log daily. Routinely, Orderlies will perform this task. Call-Back RN will be responsible making weekend and holiday entries when the department is normally closed. If no cases are done within a full 24 hour period, an entry of "closed" will be made in the log.

2. Variance (Out of Range) results will be documented and reported immediately by entering an electronic Engineering Service Request. The request may be made by any employee.

3. Engineering Department will make necessary adjustments to heating/air conditioning through facility control.

4. A re-check should be made within one hour of the correction, and new results documented in log.

5. After Re-check of variance, if required parameters are not met, Director of Surgery and Director of Engineering will be notified. Procedures scheduled in affected areas will be cancelled or re-scheduled to an area with proper air control.

QUALITY ASSURANCE:

Daily documentation of temperature and relative humidity results and actions will be monitored by on-going review of the department log, by Charge RN or Manager.

REFERENCES:

- ANSI/ASHRAE/ASHE. Standard ~~170-2018~~ 170-2021.Ventilation of Health Care Facilities. Atlanta, GA: ASHRAE; ~~2018.~~2021.
- NFPA 99 Health Care Facilities Code. Quincy, MA: National Fire Protection Association; ~~2018.~~ 2021.
- Joint Commission Online. CMS Adopts ASHRAE-Defined Range for Relative Humidity in Anesthetizing Locations. 2018. Temperature and Humidity Requirements – Guidance for Storage of Sterile Supplies. April ~~2019~~ 2021.

  https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/environment-of-care-ec/000001275/

- ~~Association of Surgical Technologists. AST Continuing Education Policies for the CST and CSFA. Guidelines for Best Practice for Humidity in the Operating Room. June 2017. https://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/ASTGuidelinesHumidityintheOR.pdf~~

- AORN Standards. Guideline for a Safe Environment of Care, ~~Part 2 DOI: 10.6015/psrp.15.01.265 http://www.aornstandards.org/content/1/SEC14.body Accessed 2019.~~ Guideline for design and maintenance of the surgical suite. In: Guidelines for Perioperative Practice. Denver, CO: AORN, Inc. June 2023. https://aornguidelines.org/guidelines/content?sectionid=173721980&view=book#194812984

SUBJECT: **ANESTHESIA PATIENT CLASSIFICATION**	SECTION:

PURPOSE:

To determine a patient's fitness for anesthesia according to standards set forth by the American Society of Anesthesiologists (ASA).

AFFECTED AREAS/ PERSONNEL:

OPERATING ROOM NURSES, AMBULATORY SURGERY DEPARTMENT NURSES, ENDOSCOPY NURSES AND OTHER NURSES MONITORING PATIENTS RECEIVING PROCEDURAL SEDATION.

DEFINITIONS of CLASSIFICATIONS:

ASA I	A normally healthy patient for elective operation.
ASA II	A patient with mild systemic disease. (Examples: chronic bronchitis, moderate obesity, diet-controlled diabetes mellitus, old myocardial infarction, and mild hypertension.
ASA III	A patient with severe systemic disease that limits activity but is not incapacitating. (Examples: coronary artery disease with angina, insulin-dependent diabetes mellitus, morbid obesity, moderate to severe pulmonary insufficiency).
ASA IV	A patient with incapacitating disease that is a constant threat to life. (Examples: organic heart disease with marked cardiac insufficiency, persisting angina, intractable arrhythmia, advanced pulmonary, renal, hepatic, or endocrine insufficiency).
ASA V	A patient who is not expected to survive 24 hours with or without an operation. (Example: ruptured abdominal aneurysm with profound shock)
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes.
"E"	Emergency: defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

REFERENCES:

- American Society of Anesthesiologists (2023) *ASA Physical Status Classification System.* Retrieved from https://www.asahq.org/.

SUBJECT: **ARTERIAL PUNCTURE #9014**	SECTION: **Page 1 of 6**

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

PURPOSE:

To instruct staff on the proper procedure for collecting a specimen by arterial puncture.

POLICY:

It is the policy of Respiratory Care Services to obtain accurate arterial blood samples so that pH, pCO_2, pO_2, $\%O_2$, HCO3 and BE values can be measured and calculated

AFFECTED AREAS/PERSONNEL: *ALL RESPIRATORY EMPLOYEES, PHYSICIANS*

Important Point:

If patient is less than 5 years old, notify the physician.

a. The physician may decide to attempt the arterial puncture him/herself
b. The physician may decide to cancel the order
c. The physician may decide to order a capillary blood gas
d. The physician may decide to order pulse oximetry instead

PROCEDURE:

1. Wash your hands. Put on fresh gloves.

2. Introduce yourself to the patient.

3. Verify the patient's identity using two identifiers by checking his/her ID bracelet.

4. Explain to the patient what you are about to do. Reassure the patient as necessary.

5. Perform the Allen's test to verify collateral circulation to the hand via the ulnar artery (see procedure for Allen's test).

   a. If the collateral circulation is adequate, continue with the procedure.

   b. If the collateral circulation is not adequate, test the patient's other hand. If collateral circulation to both hands is inadequate, notify the physician.

      - The physician may request that an alternate site be used for the puncture.
      - The physician may decide to attempt the radial arterial puncture himself/herself.
      - The physician may decide to cancel the order.
      - The physician may decide to order pulse oximetry instead.

6. Gather and prepare the blood gas kit.
   a) Pre-heparinized syringe with needle (20, 23, 25 gauge are acceptable)
   b) Syringe safety device if not equipped with one
   c) A sterile alcohol wipe to cleanse the site
   d) A 2x2 gauze and bandage to cover the site

7. Position yourself and the patient's arm so that both you and the patient are comfortable.

8. Carefully feel the pulse, taking as much time as necessary.

9. Cleanse the site thoroughly with the alcohol prep.

10. With the needle bevel pointing up and the pulse isolated, enter the patient's skin with a quick steady motion at a 45 degree angle.

11. Once the skin has been punctured, slowly insert the needle in a straight line until the artery is entered (blood will spurt into the needle hub and start to fill the syringe). Allow the blood to fill to appropriate level. DO NOT pull back on the syringe plunger. If the artery is missed, withdraw the needle until the tip is just beneath the skin. Adjust the needle angle and proceed as before until the sample is obtained.

12. Obtain at least 1cc of blood.

13. When the sample is obtained, using a quick steady motion, remove the needle from the patient's arm, putting pressure over the puncture site using a clean gauze pad. Hold pressure over the puncture site for a minimum of five minutes or longer if necessary.

14. Expel any air bubbles from sample.

15. Quickly seal the needle and syringe to maintain anaerobic conditions.

    a) If using the Radiometer brand safePICO sampler, holding the sampler in one hand slide the needle shield device over the needle until a click is heard. Remove the needle and discard into a sharps container. Holding onto the syringe barrel, firmly press down and twist the safeTIPCAP one-quarter turn onto the syringe luer tip. Hold the syringe vertically so the safeTIPCAP is at the top and gently flick the syringe barrel so that any air bubbles will rise to the top of the syringe. Press the plunger slowly to expel the air through the vented safeTIPCAP. A red band will form in the cap and there will be resistance in the plunger indicating that the air has been removed.

Mix the sample thoroughly to ensure a homogenous sample.

16. Transport the sample to the blood gas machine within 20 minutes.

17. Once bleeding has stopped, feel for a pulse distal to the puncture site to ensure that the patient's circulation has not been interrupted.

18. Place Band-Aid over site.

19. Wash your hands.

Indications:

- Dyspnea
- Tachypnea
- Impairment of lung function that has been documented
- Ventilatory support or being weaned from ventilatory support
- Pre-operative assessment of high risk patients receiving general anesthesia
- Suspicion of respiratory failure (patients with pneumonia, bronchospasm, acute heart failure, etc.)
- Smoke inhalation or suspicion of carbon monoxide poisoning

Contraindications:

Negative results of a modified Allen test (collateral Circulation test) are indicative of inadequate blood supply to the hand and suggest the need to select another extremity as the site for puncture.

Arterial puncture should not be performed through a lesion or through or distal to a surgical shunt (e.g., as in a dialysis patient). If there is evidence of infection or peripheral vascular disease involving the selected limb, an alternate site should be selected.

- Agreement is lacking regarding the puncture sites associated with a lesser likelihood of complications; however, because of the need for monitoring the femoral puncture site for an extended period, femoral punctures should not be performed without an order from a physician.
- A coagulopathy or medium dose anticoagulation therapy (e.g., heparin or coumadin, streptokinase, and tissue plasminogen activator, but not necessarily aspirin) may be a relative contraindication for arterial puncture.

Hazards & Complications:

Hematoma

- Arteriospasm
- Air or clotted blood emboli
- Anaphylaxis from local anesthetic

- Introduction of contagion at sampling site and consequent infection in patient;
- Introduction of contagion to sampler by inadvertent needle "stick"

Hemorrhage

Trauma to the vessel

Arterial occlusion

Vasovagal response

Pain Assessment of Need:

The following findings may assist the clinician in deciding whether arterial blood sampling is indicated:

- History and physical indicators (e.g., positive smoking history, and recent onset of difficulty in breathing independent of activity level, trauma).
- Presence of other abnormal diagnostic tests or indices (abnormal pulse oximetry reading, chest x-ray).
- Initiation of, administration of, or change in therapeutic modalities (e.g., initiation, of, changes in, or discontinuance of supplemental oxygen or initial of, changes in, or discontinuance of mechanical ventilation).
- Projected surgical interventions for patients at risk.
- Projected enrollment in a pulmonary rehabilitation program.

Equipment:

- Blood Gas Kit
- Gloves
- Label

Documentation:

- Enter all pertinent data into the label. (Time and location of draw, FiO2, SpO2 at time of draw, staff mnemonic)
- Blood gas report will automatically be generated when resulted and verified by the Clinical Lab Scientist in the Clinical Laboratory.

Infection Control:

- Wash your hands before and after this procedure.
- Wear gloves during this procedure.
- Use only sterile needles and syringes.
- Use a new sterile needle each time skin is punctured.
- Cleanse site thoroughly prior to the puncture.
- Any materials containing blood samples must be disposed of as infectious waste, according to hospital procedures.
- Environmental Services Department removes waste and replaces liners in trashcans.
- The container for infectious waste is clearly marked with an identifiable label.

Safety Precautions:

1. Only personnel approved by the Respiratory Care Services Medical Director are allowed to attempt this procedure.
2. Wear gloves during this procedure.
3. Exercise caution when handling needle to avoid injury to patient or yourself.
4. Choose puncture site in the following order:
   a. Radial
   b. Brachial
   c. Femoral (only when absolutely necessary and with a doctor's order) (Respiratory Care Practitioners only)

REFERENCES:

- National Library of Medicine. WHO Guidelines on Drawing Blood: Best practices in Phlebotomy. (2010). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK138661/
- Radiometer America Inc., Training Poster Arterial puncture for ABG using safePICO sampler.

- Radiometer America Inc. (2021). "How to perform an Arterial Puncture", Retrieved from www.radiometeramerica.com/en-us/knowledgecenter/guide-to-blood-gas-analysis.

SUBJECT: **AUTOCLAVE QUALIFICATION TESTING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To delineate the process for verification of an autoclave for routine use after any major repair, malfunction, positive biological or major interruption of utilities.

POLICY:

Any autoclave taken out of service for a major repair, malfunction, positive biological or major interruption of utilities, will be verified that it is operating within required parameters prior to putting the unit back into routine use.

AFFECTED AREAS/ PERSONNEL:

CPD, SURGERY, ASD/ CPD STAFF, SURGERY STAFF, ASD STAFF, SURGEONS.

PROCEDURE:

This qualification testing will be conducted in the health care facility by health care personnel in cooperation with the manufacturer.

1. PRE-VAC: Three cycles will be run with a process challenge device containing a biological indicator, one right after the other, in an otherwise empty chamber. All biological indicators must have negative outcome.

2. GRAVITY: Three cycles will be run with a process challenge device containing a biological indicator, one right after the other, in an otherwise empty chamber. All biological indicators must have negative outcome.

3. Three consecutive Bowie-Dick test cycles will then be run in an empty chamber, one right after the other, and the test sheets examined.

A total of nine cycles will be run and all test cycles must have favorable outcomes before autoclave is placed back into service.

When all cycles are complete and favorable test results are received, the autoclave may be placed back into routine service.

REFERENCE:

- AAMI ST79 2017. Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Retrieved: June 2023. https://www.hmark.com/wp-content/uploads/2020/08/ST79_White_Paper_2020-04-16.pdf

SUBJECT: **BLOOD & BLOOD COMPONENTS, TRANSFUSION REACTION**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 3**

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

PURPOSE:

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

POLICY:

All transfusion reactions shall be handled as an emergency and documented accordingly on the specified transfusion reaction form and submitted to the laboratory.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

EQUIPMENT:

- 0.9% Normal Saline Solution IV bag
- Primary IV tubing set

PROCEDURE:

1. If a transfusion reaction is suspected, immediately clamp off the blood unit.
2. Keep blood unit and tubing set intact, but disconnect from the IV port, protecting the tubing port connection.
3. Connect an IV bag of 0.9% Normal Saline with new primary tubing set to the injection port closest to the patient.
4. Regulate the IV to keep a vein open rate (25mL/hr).
5. Report symptoms to the physician and notify the blood bank.
   a. If the physician elects to stop the transfusion, notify the blood bank.
      - Enter and administer orders as given by the physician.
      - Complete the blood transfusion reaction form.
      - Call the lab to draw a blood sample.
      - Prepare the blood component bag and blood tubing and return to the blood bank.
      - Collect a urine sample, label it properly, and send to the lab.

   b. If the physician elects to continue the transfusion with symptomatic treatment:

- Notify the Blood Bank of the physician's decision.
- Obtain an order that physician elects to continue transfusion.
- Administer medications (if ordered).
- Observe the patient and continue to take and record the patient's vital signs.
- Update the physician with the patient's condition as needed.

DOCUMENTATION:

1. On the "Transfusion Administration Record"

   a. Note the reactions in the portion entitled "Patient Response to Transfusion"

   b. The most common symptoms are:

   - Fever (2 degree increase from baseline) with or without chills
   - Chest pain
   - Hypotension (30mmHg below baseline)
   - Nausea
   - Flushing
   - Dyspnea
   - Bleeding
   - Hemoglobinuria
   - Rapid onset of rales

   ***The above common symptoms often occur within the first 15 minutes.**

2. Documentation in medical record should include *(Please use "transfusion reaction" intervention):*

   a. Date and time of the reaction

   b. Description of objective and subjective symptoms of the patient

   c. Condition of the patient/ assessment

   d. Physician notified

   e. Vital signs every 15 minutes until stable or as ordered by the physician

   f. Persons contacted and time contacted

g. Samples drawn, e.g. urine/lab draws with times taken

h. Patient's response to the reaction and to interventions, if taken

REFERENCES:

- Nettina, S. (2019). Manual of Nursing Practice, (11th ed., pp. 781). Ambler, PA. Lippincott Williams and Wilkins.
- Kelly, William (2022). Health and Willness. Blood transfusion reactions: a comprehensive nursing guide. obtained from https://healthandwillness.org/blood-transfusion-reactions/

CROSS REFERENCES:

- *BLOOD & BLOOD COMPONENTS, ADMINISTRATION OF* - SVMC policies and procedures

SUBJECT: **CARDIAC ARREST IN OR/PACU**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide guidelines for the management of patients with cardiac arrest/life threatening emergencies in the Operating Room (OR)/Post Anesthesia Care Unit (PACU) areas.

POLICY:

- All anesthesia staff and OR/PACU/Flex Care staff shall respond, if able to do so without jeopardizing the welfare of the patients under their care, to all cardiac arrest or other emergencies in both the OR and PACU areas.
- All staff in the Surgical Services Department will maintain a current Basic Life Support (BLS) card.
- All OR registered nurses (RNs) will maintain Advanced Cardiovascular Life Support (ACLS) certification, Pediatric Advanced Life Support (PALS) strongly preferred.
- ALL PACU RNs will maintain ACLS and PALS certification.
- Each event will be evaluated at the time of its occurrence to determine if a hospital wide Code Blue will be announced.
- After regular hours or during an on-call situation, a hospital wide Code Blue will be called, so the appropriate personal can respond. Staff will dial 55.

AFFECTED AREAS/PERSONNEL: *MAIN OR/PACU/MCH/ALL STAFF*

PROCEDURE:

CODE LEADER

Anesthesia Providers

- The anesthesia provider will be the Code Leader for cases where they are administering the anesthesia.
- The Code Leader will call out the medications, dosages and route of administration as they are given.

Surgeon

- During local or procedural sedation cases, the surgeon will be the Code Leader. At any time, the surgeon may choose to request assistance from an anesthesia provider, if available, or call a hospital wide Code Blue and obtain assistance from the Emergency Department physician.
- The Code Leader will call out the medications, dosages and route of administration as they are given.

DIRECTOR/CLINICAL SUPERVISOR

- The responsibilities of the code will be accomplished through delegation.
- Will provide gate keeper to control traffic
- Assign professional and assistive support personnel to augment the team (e.g. extra circulator, personnel to obtain supplies, runner to laboratory with samples.)
- Notify the attending physician, if not present, and appropriate administrative personnel.
- Alert the Intensive Care Unit (ICU) of potential patient admission.
- Evaluate the arrest procedure and emergency equipment, and verify the documentation.
- Support the team as necessary.
- Keep the surgical suites running smoothly during the emergency.

CODE TEAM RECORDER

1. Designated by the Circulator.
2. Notes time Code Blue is called.
3. Is responsible for the completion of the Cardiopulmonary Resuscitation Report Form, kept on the top of the Crash Cart.
    a. Records all medications and IV solutions administered.
    b. Records assessment findings, changes in patient condition, interventions, and patient's response to treatment.
4. Communicate with Code Team Leader the time that the code began with time and dosages of medications given. Will prompt when times have elapsed for more medications needed.
5. Identify names and titles of personnel assisting with the arrest.

CIRCULATING NURSE

- Call to scheduling desk to report code and requesting help.

- Reposition the patient, as necessary, into the supine position for CPR. Lower bed and obtain backboard (placed under patient's chest) to facilitate cardiac compressions. Staff member will perform chest compressions until another resuscitator is available.
- Assign a licensed staff member to be the Code Recorder.
- Obtain the crash cart/defibrillator, would be delegated if other staff in room/ Apply Pads on Patient.
- Maintain the accuracy of sponge, needle and instrument count and sterility to the best of your ability if wound closure continues. All will be secondary to the resuscitation efforts.
- With successful resuscitation, if unable to maintain the accuracy of counts, follow Count Policy regarding incorrect count.

SCRUB TECHNICIAN

- Remove instruments from field.
- The surgical site is packed with moist laps and covered with towels. The wound is to be protected and covered at all times.
- Move sterile back tables away from the area while the code is in progress, to maintain sterility of the instruments.
- Maintain the accuracy of sponge, needle and instrument counts and sterility to the best of your ability, if wound closure continues. All will be secondary to the resuscitation efforts.
- Remain sterile, unless needed, and then break scrub to help.
- Following the code, re-establish a sterile field by placing new sterile drapes over the patient and remove wound coverings.
- With an unsuccessful outcome, the wound will need to be closed.
- If closure of the wound can be done rapidly, during resuscitation, a decision may be made by the surgeon to close the wound.

ANCILLARY STAFF

- During a code or emergent situation, respond to the area for instructions.

DOCUMENTATION

- Documentation will be the responsibility of the RN Circulator assigned to the procedure.

- The documentation will be provided in the Code Form, Operating Room Nurses Notes and Occurrence Report.
- Occurrence Report will be forwarded to the Risk Management Department.
- Documentation will be the same as for the hospital wide policy, refer to CARDIOPULMONARY EMERGENCIES.

PACU

- All Code Blue/Code White in the PACU will be announced house wide by dialing 55
- Primary PACU nurses will lead the code until an anesthesia provider or Emergency Room physician arrives.
- All code roles will be delegated by the primary PACU nurse.

OTHER EMERGENCIES

- The system for cardiac arrest may be used for other non-arrest emergencies, (e.g. intubation difficulties, upper airway obstruction, malignant hyperthermia), requiring crisis intervention.
- When calling for assistance, for non-arrest emergencies, call scheduling desk, announce "EMERGENCY IN," then announce the room number.

REFERENCES:

- Rothrock, Jane C., (~~2019~~) Aug 2022. Alexander's Care of the Patient in Surgery 17th Edition. St. Louis, MO.
- American Heart Association Advanced Cardiovascular Life Support ~~(2016)~~ 2023.

CROSS REFERENCES:

- Hospital Wide Policy: Code Blue/Code White

SUBJECT: **CODE BLUE AT THE AMBULATORY SURGERY 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 rapid emergency management of the patient in cardiac arrest or non-perfusing arrhythmias at the Ambulatory Surgery Department (ASD).

POLICY:

1. A Code Blue may be called by the anesthesiologist, surgeon or the first person to recognize the code situation. The Code Blue alarm will be activated from the operating room (OR) suites, Pre-op or PACU by announcing "Code Blue" and announcing location (i.e., OR suite).

2. All staff shall respond, if able to do so without jeopardizing the welfare of the patients under their care, to all cardiac arrest or other emergencies in the OR, Pre-op and PACU areas.

3. Emergency Medical Services (EMS) will be contacted by dialing 911. At the time of the call, they will be notified to use the staff entrance at the west side of the building.

4. The surgeon or anesthesiologist will direct the resuscitation efforts and transfer of the patient to Sierra View Medical Center via ambulance. ACLS protocol will be followed until arrival of EMS.

5. All treatments and medications will be recorded.

6. Support will be provided to family members.

7. All staff will assist with transfer of care to EMS personnel and expeditious transfer to Sierra View Medical Center's Emergency Department.

8. A copy of the Code Blue Form with medication received will accompany the patient and EMS personnel to the hospital. An incident report will be filled out and forwarded to SVMC Risk Management Department. Code Blue incidents will be reviewed by the Performance Improvement Committee and Medical Executive Committee.

AFFECTED AREAS/PERSONNEL: *ALL ASD CLINICAL STAFF*

CROSS REFERENCE:

- Code Blue/Code White Policy

SUBJECT:	SECTION:
CRASH CARTS --EXCHANGING, RESTOCKING, SECURITY AND VERIFICATION	***Medication Management (MM)*** **Page 1 of 9**

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

PURPOSE:

To ensure that a standardized and completely supplied crash cart for all patient care and surrounding areas, with no lapse of time between use, will be available at designated areas throughout the hospital.

POLICY:

Carts which can accommodate adult, pediatric and neonatal patients are maintained in accordance with current ACLS and PALS recommendations and are available for use in designated patient care areas. Once used, these carts are replaced with newly supplied and verified back-up carts located in the Central Processing Department (CPD).

Four (4) Adult Crash Carts, one (1) Pediatric Crash Cart exchangeable and two (2) Neonatal Crash Carts fully stocked and verified (sealed) are maintained in CPD and are available to exchange for used carts 24-hours per day.

Pediatric Resuscitation System – Broselow/Hinkle pediatric carts are located in areas where pediatric patients are potentially treated.

Additional medication trays and medical supplies are available 24-hours per day to accommodate additional needs. Procedures are outlined to address exchanging, restocking, security and verification (sealed) of the contents of Crash Carts.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF; PHARMACY; NURSING; RESPIRATORY THERAPY, CENTRAL STERILE PROCESSING*

PROCEDURE:

EXCHANGE PROCEDURE (Exchangeable Carts)

1.. A licensed Nurse from the department/unit/treatment area (where the Code Blue occurred) is "*responsible for delegating and ensuring*" that a fully stocked Crash Cart from CPD is obtained as soon as possible after the termination of the Code Blue situation. **The used cart shall NOT be removed from the area until a new cart is available** (see *"Exchange Procedure).*

Exchange Procedure When CPD is Open:

a. Upon cessation of the code, the medication nurse for the code will remove the blue lock provided in the medication tray of the crash cart and use it to lock the opened medication drawer back into the cart. Central Processing Department will then be notified that a replacement cart is required. The CPD Technician will bring a new crash cart to the code area and remove the secured crash cart to be processed.

b. Used carts will be retrieved by CPD and brought to the pharmacy to have the blue lock broken and the medication drawer removed by a licensed pharmacy staff member.

Pharmacy personnel will visually inspect the medication drawer of the cart for cleanliness and will wipe clean if necessary. A pharmacist, intern pharmacist or pharmacy technician will then load a new medication tray into the crash cart and secure the medication drawer with a red lock, with proper documentation. Intern pharmacists and pharmacy technicians performing these restocking duties must do so under the direct supervision and control of a registered pharmacist.

c. After the used medication drawer has been removed, replaced with a new sealed medication tray and locked into the cart with a red lock, CPD will then come to pharmacy to retrieve the newly stocked and locked carts to clean and process the cart for non-medication items.

Exchange Procedure When CPD is Closed:

a. Upon cessation of the code, the Med Nurse for the code will remove the blue lock provided in the medication tray of the crash cart and use it to lock the opened medication drawer back into the cart. The number of the lock will be recorded on the log in the binder with appropriate notations in the comment section.

b. The Night Administrative Supervisor will then obtain a newly supplied exchange cart from CPD and transport it to the patient care area where the code situation has terminated. **The used cart shall remain in the area until a new cart is available**

c. Once a newly supplied exchange cart has been delivered to the patient care area where the code has terminated, the Night Administrative Supervisor will transport the used cart to the decontamination area of the CPD and ensure it is behind locked doors. The cart is not to be left outside in the hallway.

d. When CPD staff arrive in the morning, they will transport the used cart to pharmacy for processing.

e. In the event that exchange cart supply is exhausted when CPD is closed, the Night Administrative Supervisor will call the on call CPD technician and the on call pharmacist for processing of a new exchange cart.

DEFIBRILLATORS AND EQUIPMENT LOCATED ON TOP OF THE CART:

1. Defibrillators and all equipment located on the top of the Crash Cart will remain in their assigned area to be transferred to the new exchange cart upon arrival.

2. Defibrillators will be checked daily throughout the hospital utilizing the "Crash Cart/Defibrillator Checklist." Defibrillators in the ASD, Imaging, Wound Healing Department, OR, and Cath Lab will be checked daily when the unit is open.

3. Defibrillators will be **UNPLUGGED** from the electrical outlet when tested in order to check the "Charge" status of the battery.

MEDICATION TRAYS AND SUPPLIES

1. The Adult, Neonatal and Pediatric Crash Carts will contain a Medication Tray that is prepared by Pharmacy, and contains a checklist that includes the name of the medication, strength, dispensing unit, and quantity. All medications contained within the Medication Tray will be consistent with medications used in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS).

2. The checklist will identify the "First Medication to Expire" and the "Expiration Date" of that item.

3. Medications placed in the tray will have at least 2 months dating prior to expiration (subject to market availability).

4. The trays will be verified by a Registered Pharmacist (see *"Emergency Medication Crash Cart List" form*).

5. Non-Pharmaceutical Crash Cart supplies will be replenished by CPD based upon the items and quantities listed on the Crash Cart Contents List, kept in CPD.

LOCATION OF ADULT CRASH CARTS:

- OB/OR Suite – 4th Floor
- Family Birthing Center – 4th Floor
- Pediatrics - 3rd Floor
- 3 South Medical/Surgical – 3rd Floor
- 3 West Medical/Surgical – 3rd Floor
- 3 East Medical/Surgical – 3rd Floor
- Intensive Care Unit (2 carts) – 2nd Floor
- Telemetry Unit – 2nd Floor
- Operating Room (2 carts) – 2nd Floor
- Post-Anesthesia Care Unit – 2nd Floor

- Flex Care Unit – 2nd Floor
- Emergency Department (3 carts) – 1st Floor
- Sub-Acute Unit – 1st Floor
- Radiology Department – Special Procedures
- Radiology Department – MRI Suite
- Radiology Department – CT Suite
- Central/Sterile Processing (4 carts) – 1st Floor
- Ambulatory Surgery Department (ASD)

LOCATION OF BROSELOW/HINKLE PEDIATRIC CRASH CART

- Emergency Room 2 carts
- 3 North Medical/Surgical
- Pediatrics
- PACU/Surgery
- Radiology –Interventional Radiology
- Radiology – General Procedures
- Ambulatory Surgery Department (ASD)
- Central/Sterile Processing – 1 cart
-

LOCATION OF NEONATAL CRASH CART

- NICU (2 carts)
- Central/Sterile Processing (2 carts) – 1st Floor

INSPECTION PROCEDURE:

Daily Inspection

1. The nurse will assure that:

   a. The defibrillator is plugged into the RED electrical outlet and charged.

   b. Test the defibrillator daily. UNPLUG before testing.

      Charge to the joules indicated on the machine.

   c. When charged, the energy is to be discharged and the delivered energy on the screen should match the set amount.

   d. If the delivered energy does not match the setting or there is any other problem in the operation, notify Plant Operations immediately and take the unit out of service.

   e. If the test is within limits, then the defibrillator is to be plugged back into the red emergency wall outlet.

   f. The initials of the staff nurse performing the check will document that this is completed.

2. Check the contents on top of the crash carts, assuring none of the supplies are compromised or expired.

3. Check the oxygen cylinder for adequate content (no less than 1500 psi) and performance of regulator. Notify Plant Operations of any problems or for a replacement if necessary. The initials of the staff nurse will be documented on the Crash Cart Integrity Check List.

4. If applicable, check the portable suction pump for proper operation.

5. Make sure that the top of the Crash Cart is clean and organized and ready for use.

6. Make sure the contents of the Crash Cart are secure by verifying tamper-evident seals are locked and that the lock number corresponds to the number recorded on the log. ***If the lock is broken, the cart is NOT to be used***. Exchange the Crash Cart in accordance with the "Exchange Procedure" of this policy.

7. Sign the Crash Cart Integrity Check List that is attached to the Crash Cart.

8. Only licensed personnel may complete and sign the Crash Cart Integrity Check List.

Monthly Inspection

1. A pharmacist, intern pharmacist or pharmacy technician will check the contents of the medication trays for dating during the Monthly Unit Area Inspections. Intern pharmacists and pharmacy

technicians performing the monthly checks must do so under the direct supervision and control of a registered pharmacist.

2. Any irregularities discovered in the monthly inspections must be reported to the Director of Pharmacy and the Chief Executive Officer (CEO) within 24 hours.

3. Trays with contents that outdate within the upcoming month will be removed and replaced with a tray with at least two (2) months dating. The pharmacist, intern pharmacist or pharmacy technician will re-certify the medication drawer according to procedure.

Quarterly Inspection

1. The Central Processing Department will check every non medication item on each Crash Cart throughout the hospital on a monthly basis. A log with expiration dates will be maintained by the CPD staff.

2. All carts will be restocked according to the Crash Cart Contents List, periodically reviewed and updated by the Code Blue Committee.

REFERENCES:

- California Code of Regulations. 22 CCR § 70263. March 2021.

CROSS REFERENCES:

- Crash Carts Tray Checklist Adult
- Crash Cart Tray Checklist Neonatal
- Crash Cart Tray Checklist Pediatric

ATTACHMENT A: CRASH CART TRAY CHECK LIST (ADULT)
REVISED 2-27-147/13/16

Sierra View Medical Center
Adult Emergency Medication "Crash Cart" List

Medication Name	Strength	Dispensing Unit	Quantity	Exp. Date
Adenosine	3 mg/ml	2 ml vial	5	
Amiodarone	50 mg/ml	3 ml Amp	4	
Atropine Sulfate	0.1 mg/ml	10 ml PFS	3	
Calcium chloride	100 mg/ml	10 ml PFS	1	
Calcium Gluconate	100 mg/ml	10 ml vial	3	
Dextrose 50%	0.5 gm/ml	50 ml PFS	2	
Dopamine drip in D5W	1.6 mg/ml	250 ml PMB	1	
Epinephrine	1 mg/ml (1:1,000)	1 ml Amp	2	
Epinephrine	0.1 mg/ml (1: 10,000)	10 ml PFS	10	
Flumazenil	0.1 mg/ml	10 ml vial	1	
Lidocaine	20 mg/ml	5 ml PFS	4	
Lidocaine drip in D5W	4 mg/ml	250 ml PMB	1	
Magnesium Sulfate	0.5 gm/ml	2 ml vial	2	
Metoprolol	1 mg/ml	5 ml Amp	3	
Naloxone	1 mg/ml	2 ml Amp	2	
Phenylephrine HCl	10 mg/ml	1 ml vial	2	
Procainamide	100 mg/ml	10 ml PFS	2	
Sodium Bicarbonate	1 mEq/ml	50 ml PFS	2	
Vasopressin	20 units/ml	1 ml vial	2	

First Medication to Expire:		**Expiration Date:**	

Tray Prepared by Technician (Initials):		**Date Prepared/Time:**	

Tray Checked by Pharmacist (Initials):	

ATTACHMENT A: (Continued)
Sierra View Medical Center
Pediatric Emergency Medication "Crash Cart" List

Medication Name	Strength	Dispensing Unit	Quantity	Exp. Date
Adenosine	3 mg/ml	2 ml vial	5	
Amiodarone	50 mg/ml	3 ml Amp	4	
Atropine Sulfate	0.1 mg/ml	10 ml PFS	3	
Calcium chloride	100 mg/ml	10 ml PFS	1	
Dextrose 10%	0.1 gm/ml	1000 ml	1	
Dextrose 25%- Pediatric	0.25 gm/ml	10 ml PFS	1	
Dextrose 50%	0.5 gm/ml	50 ml PFS	2	
Dobutamine drip in D5W	2000 mcg/ml	250 ml PMB	1	
Dopamine drip in D5W	1.6 mg/ml	250 ml PMB	1	
Epinephrine	1 mg/ml (1:1,000)	1 ml Amp	2	
Epinephrine	0.1 mg/ml (1: 10,000)	10 ml PFS	4	
Flumazenil	0.1 mg/ml	10 ml vial	1	
Lidocaine	20 mg/ml	5 ml PFS	4	
Lidocaine drip in D5W	4 mg/ml	500 ml PMB	1	
Magnesium Sulfate	40 mg/ml	50 ml PMB	2	
Naloxone	0.4 mg/ml	1 ml vial	2	
Naloxone	1 mg/ml	2 ml Amp	2	
Procainamide	100 mg/ml	10 ml PFS	2	
Sodium Bicarbonate	1 mEq/ml	50 ml PFS	2	
Sodium Bicarbonate- Pediatric	0.5 mEq/ml	10 ml PFS	1	

First Medication to Expire:		**Expiration Date:**	

Tray Prepared by Technician (Initials):		**Date Prepared/Time:**	

Tray Checked by Pharmacist (Initials):	

ATTACHMENT A: (Continued)
Sierra View Medical Center

Newborn Emergency Medication "Crash Cart" List

Medication Name	Strength	Dispensing Unit	Quantity	Exp. Date
Dextrose	10%	500 ml	1	
Epinephrine	0.1 mg/ml (1:10,000)	10 ml PFS	2	
Naloxone HCl	0.4 mg/ml	1 ml Amp	2	
Normal saline	0.9%	250 ml	2	
Normal saline (flush)	0.9%	10 ml	5	
Sodium bicarbonate	4.2%	10 ml PFS	2	
Sterile water for injection		50 ml	2	

First Medication to Expire:		**Expiration Date:**	

Tray Prepared By Technician (Initials):		**Date Prepared/Time:**	

Tray Checked By Pharmacist (Initials):	

SUBJECT: **DELINQUENT MEDICAL RECORDS**	SECTION:

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

POLICY:

Medical record delinquency rates shall be measured every three (3) months.

The Health Information Management Department (HIM) shall notify a provider of suspension when he/she has delinquent medical records.

PROCEDURE:

- Notification of incomplete records are populated on the provider's workload within the Meditech system.
- Providers are sent a listing of incomplete medical records displayed on their system workload of deficiencies as a courtesy on the second Tuesday of each month.
- Providers identified as "on vacation" or "out of the office", must notify Medical Staff or HIM of the date range that they will be out. This is entered into the Meditech system to prevent incomplete days from counting against the provider.
- Should the medical record(s) remain incomplete on the 15th day after patient discharge, the HIM Department will notify the provider, via certified mail, that his/her admitting, consultative and surgical privileges have been suspended until his/her medical records have been completed.
- A copy of all suspension letters mailed are placed in the provider's peer review file housed in the Medical Staff Office.
- The nursing units, all clinical outpatient departments, medical staff, and Senior Leadership are notified by the HIM Department of the suspension. When the suspension of privileges has been lifted, a notice will be submitted and the admitting privileges will be restored in the electronic system.
- If a provider is on suspension for a total of 30 cumulative days in the fiscal year, his/her name shall be submitted to the Medical Executive Committee. The Committee shall then submit his/her name to the State Medical Board.
- The medical record delinquency rate shall be averaged from the last four (4) quarterly measurements and shall be 50% or less of the average monthly discharge (AMD) rate.
- Each individual quarterly measurement shall be no greater than 50% of the AMD rate.

REFERENCE:

- The Joint Commission (2023). Hospital accreditation standards. RC.01.03.01. Joint Commission Resources. Oak Brook, IL.
- California Code of Regulations (2023). Title 22. § 70751(g),

Retrieved from
https://govt.westlaw.com/calregs/Document/IB47D04195B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1

SUBJECT: **DISCHARGE OF HOMELESS PATIENTS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To describe the steps taken to ensure that homeless patients are managed with the same care received by other patients.

DEFINITIONS:

Homeless: The United States Department of Housing and Urban Development defines homeless as:

1. An individual who lacks a fixed, regular, and adequate nighttime residence or
2. An individual who has a primary nighttime residence that is:
   a. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
   b. An institution that provides a temporary residence for individuals intended to be institutionalized; or
   c. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including but not limited to a street, Skid Row or other similar location (a "Street Location").

POLICY:

In recognition that homeless patients face particular barriers to ongoing medical care and have complex medical and social service needs, the discharge planning process will begin as soon as possible after hospital admission. All patients identified as homeless will receive a consultation and evaluation by a Care Integration staff, with the creation of a discharge plan that addresses the following:

A. Assistive Care Needs

B. Referrals to appropriate service providers and governmental agencies

C. Need for weather appropriate clothing at discharge

D. Shelter referrals

E. Transportation needs for follow-up medical care.

F. Transportation at time of discharge to patient discharge location up to 30 miles or 30 minutes travel.

G. A meal within two hours of discharge

H. Provide resources/transportation to obtain discharge medications

For shelter referrals, the discharge plan must include documentation that the patient meets the shelter's criteria for acceptance, is appropriate for the patient, and that the patient agrees to the referral. Whenever possible, community organizations will be contacted to explore alternatives to shelter referrals. No homeless patient will be discharged to a "street location" unless they have expressly indicated that this is their discharge preference; no appropriate resource is available; or the patient refuses to accept resources that are available; and the patient can safely be discharged to that location.

AFFECTED AREAS/PERSONNEL: *SOCIAL SERVICES, CASE MANAGEMENT, NURSING*

PROCEDURE:

1. A social service consult will be requested for every homeless patient admitted to the hospital and a complete assessment will be performed by a member of the social service department no later than the second day after referral, or prior to discharge, whichever comes first. The assessment will include evaluation of the patient's cognitive functioning.

2. It is the responsibility of the nurse caring for the patient at admission to place the order in Meditech for a Social Services / Case Management consult based on identifying the patient as homeless.

3. The Care Integration staff will initiate a plan for post hospital transition to the community with the participation and agreement of the patient or surrogate decision-maker. The discharge plan will include:

    a. Assistive care needs

    b. Arrangements for patient to obtain ongoing medical care

    c. Referrals to appropriate service providers and government agencies such as Adult Protective Services, Mental Health, Food Stamps, Medi-cal, County Health Department and similar programs

    d. Clothing needs for discharge

    e. If shelter referral is made, documentation will include contact of the shelter to confirm criteria, and patient's acceptance of the referral

4. Shelter referrals: If the patient requests or accepts a shelter referral, the social service staff will:

    a. Identify patient's preferred geographic residence

b. Identify local shelter criteria to determine if patient is a match for that shelter

c. Verify availability of a shelter bed

d. Thoroughly document placement and patient acceptance

5. Discharge to other than a shelter or residence:

a. If a patient requests to be discharged to a "street location", staff will document the patient's request in the electronic medical record, and indicate whether the patient requires follow-up care that would prevent a safe discharge to such location.

b. If a patient refuses to accept the proposed placement or services, and no longer requires acute medical care, the patient will be discharged to his/her own resources and this will be documented in the electronic medical record. The patient will be offered such basics as a sack lunch and a bus token. The patient will also be given written referrals for any recommended aftercare.

REFERENCES:

- Bill Information Text SB1152. (2018, October 1). Retrieved from California Legislative Information: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1152.

SUBJECT: **DOCUMENTATION IN THE PACU**	SECTION: **Page 1 of 2**

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

PURPOSE:

To outline proper method for completion of patient record in the PACU.

POLICY:

All charting for the PACU patient will be done in the EMR..

AFFECTED AREAS/ PERSONNEL: *PACU NURSES*

PROCEDURE:

1. Data pertaining to both the operative and immediate post-operative periods are included in the record.

2. All PACU charting will follow this outlined procedure:

   a. Vital signs will be taken every 5 minutes X3; then a minimum of every 10-15 minutes while in phase I, then every 30mins while in phase II..

   b. The Aldrete Post Anesthesia Scoring System will be used to document patient assessment concerning respiratory response, neuromuscular movement, and level of consciousness every 30 minutes, while in Phase I. In phase II if the patient is a 10 or meets baseline criteria only one aldrete needs to be documented

   c. Oxygen will be listed as to liter flow and type of delivery and pulse oximetry monitoring with O2 saturation levels >92%.

   d. Documentation of any type of airway assistance is done in the EMR under Post-Operative Assessment

   e. Documentation of respiratory assistance is charted in the EMR under Vital Sign Assessment.

   f. Parental fluids and blood will be charted in the intake section of the EMR in Phase I and Phase II record.

   g. All output of urinary catheters will be documented in the output section of the Phase I and Phase II record, as indicated. All intake of urinary irrigation will be documented in intake section of Phase I and phase II, as indicated. Assessment of urinary catheter should be documented in urinary cath/drain assessment in EMR or nurse can chart assessment in nursing notes.

h. All NG tubes, Hemovacs, and other drains will be charted in the output section of EMR in Phase I and Phase II as indicated

i. Cardiac monitoring will be documented in the EMR in the Post-Operative assessment, stating the rhythm displayed. A strip of the EKG will be placed in the physical chart.

j. In Phase I and Phase II notes section can be utilized for any other pertinent information, if patient specific assessment not found in EMR.

k. Dressing documentation will be done in the Post-operative assessment. Any additional noting of dressing will be done in the notes section of phase I or Phase II as indicted. The notes section should reflect whether the dressing required changing in the PACU.

l. The anesthesiologists' approval for discharge may be met by the presence of a note stating that the patient may leave the PACU, when the anesthesia criteria for discharge have been met. Patient may be discharged with an Aldrete score of 8, or within 2 points of baseline; anything less must be cleared with the anesthesiologist.

m. Discharge documentation in notes should include patient's condition, surgical site evaluation, and verification of verbal report to receiving nurse and presence of personal belongings.

n. The PACU nurse will be responsible for charting the name of the receiving nurse.

o. All entries will be timed stamped as indicated by the electric record giving reference to documenting nurse.

p. Documentation of a PAR score is required on all outpatient discharges. (Refer to Outpatient Discharge Criteria policy)

RESPONSIBILITY:

PACU personnel are responsible for correctly completing the PACU nurses' record, to include all pertinent information regarding the patient's condition and events that occurred in the PACU.

REFERENCES:

- American Society of Perianesthesia Nurses (2023). Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements; 2023-2024. Cherry Hill, NJ: ASPAN.

SUBJECT: **EVACUATION PROCEDURE FOR THE AMBULATORY SURGERY SERVICES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide a procedure to assist personnel in the recognition and performance of duties in the event of an Internal Disaster requiring evacuation.

POLICY:

A. To assist personnel in recognition and performance of duties in the event of an Internal Disaster requiring evacuation.

B. Internal Disasters which may require evacuation include the following:

1. Fire
2. Explosion
3. Hazardous Material Exposure
4. Bomb Threat
5. Earthquake
6. Radioactive Contamination/Spills
7. Flood

AFFECTED AREAS/PERSONNEL: *ALL AMBULATORY SURGERY DEPARTMENT STAFF*

PROCEDURE:

1. The Clinical Nurse Manager or designee is responsible for giving the order to evacuate, if such action is necessary prior to the arrival of the fire department or other hazardous materials authorities. In any evacuation, ambulatory patients and visitors should be dispatched first.

2. Patients and visitors shall be moved away from the danger area to an area of refuge. All fire doors should be closed and opened only for removal of patients. Be sure to account for everyone.

3. Follow the evacuation route indicated on the sign posted in your area.

4. If smoke or heat penetrates this area of refuge, then patients and visitors shall be moved to the next safe area.

5. As a last resort, and only if required by continued fire and smoke spread in the areas already vacated, patients shall be directed or carried to areas of refuge or to the outside if necessary.

6. Assist patients and handicapped as needed. Use proper procedures-ambulatory assist, wheelchair, basket carry or blanket carry.

BE FAMILIAR WITH EVACUATION AND FIRE EXIT ROUTES POSTED IN YOUR AREA AND WITH FIRE ALARM AND EXTINGUISHER LOCATIONS.

REFERENCE:

- California Code of Regulations (2019). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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

SUBJECT:	SECTION:
HUMAN TISSUE PROCUREMENT AND STORAGE	**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 the ordering and transplantation of Human Cells, Tissues, and Tissue-Based Products (HCT/Ps) specific to the needs of the surgical patient.
- To ensure safe preservation, storage and handling of HCT/Ps obtained from tissue banks.

POLICY:

1. The Director of Surgical Services, in coordination with Medical Staff participation, will have the accountability for directing the HCT/Ps program to include: acquisition, receipt, storage, issuance, tracing and adverse event reporting.

2. All HCT/Ps products obtained and stored at SVMC will be acquired by source facilities that are licensed by the state of California, and a registered tissue establishment of the FDA. Copies of licenses and certificates of the source facilities will be filed and readily available in the Tissue Log Book in the OR Scheduling Office. The Orthopedic Tech Team Leader will be responsible for keeping this data current.

3. All items received and implanted in patients will be recorded in a log to allow traceability if recall occurs. This information is retained for a minimum of ten years beyond the date of distribution, transplantation, disposition or expiration of the tissues (whichever is latest), or as required by state and/or federal law.

4. All stored and special ordered tissue which is reconstituted, re-hydrated or thawed must be time-monitored and prepared according to the guidelines and directions provided by the source facility.

5. Allograft transplants will be ordered according to the surgeon's request for a specific patient. All HCT/Ps to be kept in the Surgical Department will be stored according to the AATB (American Association of Tissue Banking) and source facility recommendations.

6. Source facility recommendations will be followed in the event that the HCT/P product needs to be returned.

7. Types of HCT/Ps obtained from outside facilities are:

    - Freeze dried cortical-cancellous bone stored at room temperature, unless otherwise specified by the manufacturer.
    - Demineralized Bone Matrix Putty, stored at room temperature, unless otherwise specified by the manufacturer.
    - Frozen bone, ligaments and tendons shipped and stored in the original container until use the same day.

- Corneal tissue (fresh) shipped and stored in the original container (on dry ice) until time to transfer to the sterile field the same day.

AFFECTED PERSONNEL/AREAS: *INTRA-OP, ASD/RN, LVN-ORT*

PROCEDURE:

TISSUE ORDERING AND RECEIPT:

1. The Surgery Lead Technician and/or designee will order the tissue from suppliers on an "as needed basis," based on the request of the surgeon or to replace inventory.

2. The Surgeon will specify the type and amount of tissue requested for the procedure.

3. When the tissue arrives at the receiving dock, it is to be delivered to the Surgery Department immediately if labeled as "Tissue".

4. Incoming tissues will be recorded in the Tissue Log Book by the Surgery Lead Technician or designee, including package integrity, unique identifiers of the graft (i.e., serial numbers), expiration date, the person accepting the tissue, date, time and receipt, and verification of the tissue ordered.

5. The packaging and transport conditions of the incoming grafts will be examined to verify:

   a. The integrity of the shipping container

   b. Integrity of the tissue package

   c. Transport temperature range, to ensure that it was controlled and acceptable (Check for damage to the container, breaks in the seal, tissue maintained on dry ice, and indicator check, if applicable.)

   d. Paperwork to assure appropriate tissue was sent

   e. Expiration date

   f. Product implantation records

6. In the event of a discrepancy, the source facility will be notified immediately.
   Because of potential violation of sterility, grafts will not be used under any of the following conditions if:

   a. the container seal is damaged or not intact

   b. the container has any physical damage

c. the container label is severely damaged, illegible or missing

d. the vacuum inside the freeze-dried container has been allowed to freeze or has otherwise been damaged by moisture or temperature

e. the expiration date on the package has passed

f. the package temperature/condition indicator appears out of range

g. the freeze-dried graft has been re-hydrated for more than recommended amount of time

7. If any of the above conditions exist or are suspected, the facility that distributed the tissue is to be notified and the graft is not to be used. The tissue in question will be disposed of in the biohazard trash.

8. Any non-conforming products will be quarantined in a biohazard bag and the manufacturer will be called immediately for recommended action for discard or return. Document actions, date and time and signature of the person who handled these non-conforming products in the Tissue Log Book.

9. Frozen tissue that arrives the day of surgery will remain in the container on dry ice until the surgeon requests it on the sterile field.

10. If graft is discarded, complete and return to source facility the tissue usage information card/form with reason for graft being discarded.

DOCUMENTATION:

1. When the tissue is needed for the case, the circulating nurse will obtain the tissue along with the accompanying paperwork. The source facility's tissue usage information card/form will be completed with the patient information and mailed to the source facility.

2. Circulating nurse will document in the patient's medical record:

a. The type of tissue and amount implanted

b. If there is a deviation from the manufacturer's instructions for reconstitution, a physician's order must be written.

c. Method, solutions and additives used for soaking the graft on the sterile field; i.e., graft is soaked in 200 ml NS with 1 gm Ancef for 30 minutes.

3. The nurse or designee will document in the Tissue Log Book:

a. Date and time that implant is removed from storage

b. Manufacturer/vendor, Lot #, serial #, expiration date

c. Recipient or other final disposition of each tissue

d. Lot # and expiration dates of reconstitution solution and any additives.

ADVERSE EVENTS REPORTING:

1. Adverse tissue reaction may be suspected if the patient presents with acute or chronic symptoms such as fever or hepatitis. Other examples of adverse reactions or complications could include, but are not limited to, infection (viral, bacterial or fungal), graft failure or immune response to the donor tissue.

2. It is the responsibility of the transplanting surgeon to discuss possible adverse reactions to allograft specimens with the patient. These reactions include:

   a. Transmission of infectious disease

   b. Immune rejection of transplanted tissue

   c. Wound infection

   d. Failure of graft

3. Adverse reactions will be identified through the following:

   a. Monitoring of tissue adverse reports or notification from Risk Management

   b. Monitoring of infection surveillance report at Infection Control Committee

   c. Monitoring of vendor notification of recall

   d. Return of patient to the Operating Room with infected graft.

4. Upon notification of adverse reaction, the Risk Manager will notify the implanting surgeon, the Director of Surgical Services and the Infection Prevention Manager of a potential adverse event. The surgeon will contact the patient with respect to the adverse event, and the Director will assist in completing any necessary investigation or interventions and documentations, along with Risk Management and the Infection Prevention Manager.

5. The donor graft vendor will also be immediately notified of the adverse reaction. The vendor is mandated to report the adverse reactions to MedWatch within 15 days of receipt of information.

6. Before tissue grafts are received from the licensed donor facilities, testing for HIV, HTLV-I/II, HBV and HCV, as well as other transmissible diseases, such as bacterial or fungal infections,

will have been performed. If the potential for adverse reactions are discovered by the donor source facility after distribution to SVMC, the donor source facility is required to immediately notify this facility's Surgical Services Department. Upon receipt of the notification, the operating physicians will then be notified so that they may in turn notify their recipient patients. A reasonable attempt to notify the recipient patient will be made for at least 12 weeks after receiving the notification. Documentation of the notification will be completed in the patient's hospital medical record. Other donor grafts received by SVMC under the same lot number will be sequestered or destroyed, according to donor source facility instructions.

QUALITY ASSURANCE:

1. Storage area room temperature [expected range to be 15° C to 30° C (59° to 86° F)] will be monitored 7 days a week, inclusive of holidays, per assigned OR and Central Sterile Processing (CPD) staff. This temperature monitoring log is entered in to the EVS log and is stored with the manuals on the counter next to the autoclave in Center Core.

2. Discrepancies outside the above range will be reported to the OR Manager, Risk Management and Engineering. Stored tissues will be discarded as per manufacturer or EPA recommendations.

3. Periodic monitoring of the tissue log will be conducted to review documentation of tissue graft handling and the preparation process, including time removed from storage to time of usage.

4. Infection Control Reports are sent to surgeons on a monthly basis; reports include patient's name, medical record number, surgery date, procedure performed and if tissue implanted. Reports will be returned within 30 days, noting yes or no to infection or adverse reactions. Non-adherence to response will be monitored and addressed by Infection Prevention Department.

ORIENTATION and ANNUAL COMPETENCY ASSESSMENT

1. Orientation of all new surgical employees on tissue and documentation process will be done upon hiring.

2. Competencies on tissue handling/storage/preparation will be performed annually with all staff involved in the process.

   a. Validation will be done by observation, verbal feedback and post-testing.

   b. Periodic education will be performed on an as needed basis.

REFERENCES:

- American Association of Tissue Banks Bulletin, AATB Guidance Document No. 9 *Qualification of Packaging and Validation of Shipping/Transport Procedures*. Version 1. October 23, 2017.

- AORN Perioperative Standards and Recommended Practices, Autologous Tissue Management Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173719950&view=book#173719950. December 9, 2019.

- U.S Food and Drug Administration. Tissue and Tissue Products. Retrieved from https://www.fda.gov/vaccines-blood-biologics/tissue-tissue-products. ~~07/11/2019~~. 2/6/2023

- Centers for Disease Control and Prevention. Transplant Safety. Investigating, Tracking, and Reporting Infections. Retrieved from https://www.cdc.gov/transplantsafety/protecting-patient/tracking-infections.html . ~~January 30, 2019~~. October 13, 2022

SUBJECT:	SECTION:
IMPLANTS, PREMATURE RELEASE FROM QUARANTINE	**Page 1 of 5**

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

PURPOSE:

To provide guidelines under which implantable devices or trays may be removed from quarantine and implanted prior to availability of biological indicator results.

POLICY:

All implantable items sterilized in the Central Processing Department (CPD), the Main OR or the Ambulatory Surgery Department (ASD) will be placed into quarantine until the rapid-action biological indicator result is negative prior to release to the end-user. It is only upon documentation of the medically-emergent need of the implantable items that the items will be released from quarantine before the results of the biological indicator are noted.

Documentation of early release from appropriate quarantine time is done on the "Exception Form for the Premature Release of Implant/Tray from Quarantine" (Addendum A). This form will be completed by the circulating nurse and signed by the surgeon. A copy of the completed form will be placed in the permanent patient record and a copy will be maintained by the Clinical Manager of the implanting department for Risk Management and Process Improvement follow-up.

AFFECTED AREAS/ PERSONNEL:

CENTRAL PROCESSING DEPARTMENT (CPD), SURGERY DEPARTMENT, AMBULATORY SURGERY DEPARTMENT (ASD)/ CPD TECHNICIANS, REGISTERED NURSES (RN), OPERATING ROOM (OR) TECHNICIANS

DEFINITIONS:

1. **Biological Indicator** – a sterilization process-monitoring device which is a small canister filled with a non-lethal bacteria that, in a properly loaded and functioning sterilizer, will be rendered inactive following sterilization and on incubation will not show biological growth.

2. **Emergent** – This is a situation in which the physician has determined that to delay the procedure will compromise the patient's health status.

3. **Implant Tracer** – This is an activity that allows the hospital to easily trace an implant's handling throughout our facility directly to the patient.

4. **Quarantine** – In CPD, this is the area identified for holding implant(s) for the required 1 hour biological indicator negative reading to be available prior to the release of the item(s)/tray to the end-user department. In the OR, this may be an established sterile field, not in direct contact with the primary sterile field, where the sterilized item(s) is held until the appropriate biological indicator negative reading is confirmed prior to release to the primary sterile field.

PROCEDURE:

1. Competent personnel clean and decontaminate items for IUSS in an area designed and equipped for decontamination using the manufacturer's instructions for use (IFU) to guide the process.

2. All implant loads processed in CPD are to be documented on the "Implantable Devices Load Record" (Addendum B) in CPD. This record is maintained to expedite the traceability of sterilized implants.

3. Implant loads be monitored with a PCD containing a biological indicator and a Type 5 integrating indicator.

4. Use IUSS for implantable devices only in cases of a defined emergency when no other option is available. Transport devices processed using IUSS in a manner that minimizes the risk of contamination and the risk of personal injury from handling hot, wet, or heavy trays.

5. Releasing implants before the biological indicator results are known is unacceptable. Steps will be taken to evaluate the occurrence of these emergent events. The OR/CPD Manager, the Surgical Services Director and Risk Management will work together to determine the cause of these high-risk events and propose solutions for their prevention.

6. In the event that unforeseen circumstances require that an implantable item is to be used before the appropriate quarantine time for release, the medical necessity will be documented on the "Exception Form for the Premature Release of Implant/Tray from Quarantine" (Addendum A). This form will be completed by nursing staff in the OR or ASD Department and will be signed by the surgeon.

7. Upon completion of this form, the circulator will place the original in the patient's chart and the yellow copy will remain with department paperwork.

8. In the event of a positive reading of the biological indicator (meaning that bacterial growth has occurred during incubation), the following communication must occur:

    a. The OR/CPD Manager is notified and an occurrence report is completed. In the absence of the OR/CPD Manager, the Surgical Services Director is to be notified.

    b. Risk Management, Infection Control, and the surgeon will be then be notified by Surgical Services management personnel.

REFERENCES:

- ANSI/AAMI ST79: 2017 and A1: & A2: (2017). Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Release criteria for implants, Arlington, VA. p. 92 and Annex L. February 2021.

AORN Perioperative Standards and Recommended Practices (2018). Recommended Practice: Sterilization. Retrieved from Policy and Procedures STERILIZATION—IMMEDIATE USE STEAM

STERILIZATION

- https://aornguidelines.org/guidelines/content?sectionid=173737535&view=book#229141933.
- The Joint Commission ~~(2020)~~ 2023. Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Central Service Technical Manual Eighth Edition (2017)

CROSS-REFERENCES:

- Sterilization of Implanted Devices

Addendum A – Exception Form for the Premature Release of Implant/Tray from Quarantine

Addendum B – Implantable Devices Load Record

Exception Form for **Premature Release** of Implantable Device/Tray

NOTE—In a documented emergency situation, implantable devices will be released from quarantine in Central Service without the biological monitor result. This form should accompany the implant to the Operating Room. Operating Room personnel should complete this form and return it to Central Service within 24 hours.

PLEASE COMPLETE ALL INFORMATION:

DATE: _____ SHIFT: _____ TIME: _____ AM PM

PERSON COMPLETING THIS REPORT IN CENTRAL SERVICE: _____

The following implantable devices/trays were prematurely released to the Operating Room:

_____

_____

_____

NAME OF OR PERSON REQUESTING PREMATURE RELEASE OF DEVICES:

_____

OPERATING ROOM REPORT:

PATIENT NAME: _____

SURGEON NAME: _____

TIME OF PROCEDURE: _____ AM PM DATE: _____

REASON PREMATURE RELEASE WAS NEEDED: _____

_____

_____

_____

WHAT COULD HAVE PREVENTED PREMATURE RELEASE OF THIS DEVICE/TRAY? _____

_____

_____

_____

NAME OF OR PERSON COMPLETING THIS REPORT: _____

DATE REPORT COMPLETED: _____ FORM RETURNED TO CENTRAL SERVICE ON: _____

Figure L.2—Exception form for premature release of implantable device/tray

Annex L
(Informative)

Example of documentation of premature release of implants

This Annex provides an Implantable Devices Load Record and an Exception Form for Premature Release of Implantable Device/Tray, as examples of the forms recommended in Section 10.6.3.

Implantable Devices Load Record

Date	Description of implants	Dept.	Time sterilized (specify AM/PM)	Sterilizer #	Load #	Date/time BI in incubator	Date/time and BI result	Early release?	Date/time released to OR	Released by (full name)

Figure L.1—Implantable devices load record

SUBJECT: **INFANT CARE TEACHING GUIDELINES**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish guidelines for infant care prior to discharge.

POLICY:

Mother will receive instruction and verbalize understanding of infant care prior to discharge.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/RNs & Lactation*

PROCEDURE:

GUIDELINES:

1. Breast Feeding, Breast Care (see policy and procedure, "Breastfeeding, Assisting the mother"):

   a. Frequency/Duration: Breastfeed on demand 8 or more times in a 24 hour period..

   b. Releasing infant from breast: If painful, release infant from breast by breaking suction by inserting clean finger on the corner of the infant's mouth.. Failure to do so may contribute to sore nipples.

   c. Supplements: Water, glucose or formula supplements are not necessary for healthy term infants who are nursing well.

   d. Nursing Positions: Varying nursing positions such as sitting, lying down, football hold or cradling may help to achieve a good latch and prevent sore nipples. Use pillows to support a comfortable position. infant.

2. Bottle Feeding (see policy and procedure, "Formula-Infant formula Preparation and Storage"):

   a. Demand feeding usually works best at home; usually every 3-4 hours, or 8 to 12 times per day.

   b. Sterilize bottles and nipples for first few months. Dishwasher that reaches 160 degrees F may be used later to wash bottles and nipples instead of sterilizing.

   c. Use sterile or bottled water to make concentrated or powdered formula, mixing for 5 minutes. Follow manufacturer's instructions.

   d. Do not reuse a partially fed bottle of formula for a subsequent feeding after more than 2-3 hours has passed.

   e. Burp after every ounce of formula for the first few days, then halfway through the feeding and when feeding completed.

3. Positioning:

   a. Position infant to allow for easy ventilation, paying careful attention to maintaining body alignment and facilitating hand-to-mouth positioning.

   b. Elevate head and trunk to decrease pressure on diaphragm from abdominal organs.

   c. Parents should be instructed to put baby back in the crib and **never** fall asleep with the infant in the bed to avoid the infant falling out of the bed with the parent and avoid possible suffocation of the infant.

4. Diapering, Elimination Pattern:

   a. Babies' first stools are sticky and green called meconium. By the second to fourth day the stools are yellow.

   b. Breast-fed babies usually have more frequent and looser stools. Frequency is variable. Wash baby's bottom well with clear water after each bowel movement and air dry.

   c. Should have 6 or more wet diapers per day, and at least 3 stools per day. Usually there are more.

   d. Disposable or cloth diapers can be used at home. Check for wetness frequently.

   e. Parents should be instructed to call their pediatrician if they see a "peach colored" stain with urine which is uric acid crystals. This is a typical sign of dehydration in first days.

5. Bathing:

   a. Sponge bathe until cord has detached. Wash and brush hair with bath.

   b. May use mild antibacterial soap for 2 weeks or any mild soap made for infants.

6. Skin Care:

   a. Dry Skin: Dry skin is normal for first few weeks. Lotions are unnecessary unless skin is cracked, may use a small amount of A & D Ointment, Vaseline, or baby oil (small amount of baby oil, just rubbed into palms) into mother's hands and then rubbed into skin.

   b. Diaper Rash Prevention:

      - Change baby as needed.
      - Rinse diaper area well.

- Expose diaper area to air daily.
-
- Never use powder on genital area.

c. Mild Rash:

- Expose diaper area to air, sun through window x 10-15 min/daily.
- May use A & D ointment, Desitin ointment or plain cornstarch applied by hand to buttocks only.
- Call pediatrician if rash is extensive or does not respond to above measures.

d. Cord Care:

- Apply alcohol to cord daily to aid drying.
- Cord usually detaches in 1-2 weeks.
- Signs of infection are redness or foul smelling discharge. Notify physician.
- See cord care handout.

7. Vaginal Care, Penis Care:

a. Female: Some girls have a pink or white mucous discharge during the first two weeks. Cheesy material between labia is also normal. May have small amount of blood in discharge due to mother's hormones in system.

b. Male:
Uncircumcised: Do not retract foreskin until about 2 years old. The pediatrician will tell caregiver when and how.

8. Temperature:

a. How to take axillary temperature:

- Place thermometer tip in armpit and hold arm down for three (3) minutes or until electronic temperature reads out.
- Normal infant temperature is 97.7° to 100.4° F (36. 5-37.3° C).

9. Auto Safety (see policy and procedure, "Car Seat Safety"):

a. Should be aware of California Buckle-Up and Helmet Law.

b. Should have car seat before discharge and know how to use it.

c. Place in the back seat facing back.

d. See additional car seat handouts.

10. When to Call the Physician:

a. Increased jaundice

b. Fever

c. Diarrhea

d. Vomiting

e. Lethargy

f. Any behavior you consider unusual.

DOCUMENTATION:

- Document that discharge teaching has been completed in Electronic Medical Record (EMR).
- Have mother sign teaching sheet and give her a copy.
- Document mother understands and demonstrates ability to feed the infant and assess infant well-being, provide skin and cord care, recognize signs of illness and provide emergency care.
- Document Discharge Packet given. Discharge packet will include Sudden Infant Death Syndrome (SIDS) handout and the Shaken Baby handout and a copy of the Release of Minor under 8 years of age or under 4'9" .

REFERENCES:

- TX, CC, PF, PE, RI, §70547 (b)(18)(19)(22)(28)

American Academy of Pediatrics & American College of Obstetrics and Gynecologist. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors. AWHONN Standards and Guidelines for Professional nursing practice in the care of women and newborns (2019) (8th Ed). Washington, D.C.; AWHONN.

SUBJECT:	SECTION:
INTRA-AORTIC BALLOON PUMP (IABP) MANAGEMENT	**[Enter Manual Section Here]**
	Page 1 of 3

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

PURPOSE:

This procedure provides guidelines for the safe and effective establishment of Intra-Aortic Balloon (IABP) Therapy. Only qualified physicians may insert or remove IABP catheter. The Radiologic Technologist will assist the physician in placement of the Intra-aortic Balloon Catheter (IABC). A Registered Nurse from CCL or ICU will assist in maintaining proper functioning of the pump until the patient is transferred to the ICU or transferred to an outside facility. Transferring a patient on an IABP to the ICU or an outside facility will be determined by the Attending Cardiologist. Each department's leadership (CCL & ICU) is responsible to ensure RN competencies are met in all aspects of IABP policy.

DEFINITIONS:

Intra-Aortic Balloon Therapy (IABP): A cardiac assist device consisting of an invasively placed balloon catheter (IAB) attached to a bedside pump console that controls balloon inflation and deflation. Inflation/deflation is timed to the cardiac cycle. The therapy is designed to increase coronary perfusion and decrease myocardial oxygen consumption.

POLICY:

Transferring a patient on an IABP from Cath Lab to the ICU:

A. Established by the Medical Directors of the ICU and CCL that it is permissible to admit IABP patients from the CCL to the ICU.
B. The decision to transfer a patient to the ICU will be determined by the Attending Cardiologist.
C. The CCL/IR Charge RN will contact the Bed Coordinator, as well as the Director or Manager, to communicate the decision to transfer patient to the ICU.
D. Maximum effort will be made to transfer patient to the ICU.
E. All patients being transported from the CCL to the ICU will be transported at the level of care consistent with the condition of the patient.
F. A CCL or ICU RN will be present during the transfer of the patient to the ICU.
G. An SBAR hand off will occur with the CCL RN and the ICU RN.

AFFECTED PERSONNEL/AREAS: *CARDIAC CATHETERIZATION LABORATORY (CCL) AND INTENSIVE CARE UNIT (ICU)*

EQUIPMENT:

- IABP, helium gas supply.
- ECG and arterial pressure monitoring supplies.
- IAB catheter insertion kit.
- IAB catheter.
- Antiseptic solution.
- Personal protection equipment.
- Sterile dressing supplies.
- O-silk suture on a cutting needle or a sutureless securement device.

- Scalpel, used for skin entry.
- 1% lidocaine without epinephrine, one 30ml vial.
- Stopcocks, one two-way and one three-way.
- One Luer-Lok plug
- 500ml of normal saline flush solution (add heparin if prescribed by physician).
- Single-Pressure transducer system.
- Emergency equipment available for immediate use.
- Crash cart.

PROCEDURE:

A. **Indications but not limited to the following:**

1. Refractory unstable angina.
2. Impending myocardial infarction (MI).
3. Acute MI with mechanical impairment as a result of mitral regurgitation, ventricular septal defect, papillary muscle dysfunction or rupture.
4. Intractable ventricular tachycardia as a result of myocardial ischemia.
5. Refractory ventricular arrhythmias.
6. Cardiogenic shock.
7. Support for diagnostic percutaneous revascularization and interventional procedures.
8. Prophylactic support in preparation for cardiac surgery.
9. Emergency support following PTCA or high-risk percutaneous coronary interventions.

B. **Contraindications but not limited to the following:**

1. Severe Aortic Insufficiency.
2. Thoracic and abdominal aortic aneurysms.
3. Severe calcific aorta-iliac disease or peripheral vascular disease.
4. Prosthetic graft in thoracic aorta.

C. **Patient Assessment and Preparation:**

1. See AACN Procedure guidelines for step by step assessment and preparation of patient.

D. **Assisting with IAB Catheter Insertion:**

1. See AACN Procedure guidelines for step by step assisting with IAB Catheter insertion.

E. **Establishing IAB Therapy:**

1. Physician will give order to begin counterpulsation
2. Start IABP counterpulsation immediately after insertion, as directed: review manufacturer's manual for IABP equipment in use.(See Lippincott Manual of Nursing Practice guidelines for step by step).
3. Troubleshooting references:

- IABP console Help Screen.
- IABP manufacturer's 24 hour Emergency Helpline.
- IABP manufacturer's Operator Manual.

F. **Patient Monitoring and Care while on IAB Therapy:**

1. Prepare for transfer to higher level of care facility. CCL or Intensive Care Unit (ICU) registered nurse (RN) will accompany patient during transport.
2. Refer to Lippincott's Nursing Procedures and Skills Manual for additional nursing responsibilities.

REFERENCES:

- Maquet Getinge Group. (2015, December). Mechanisms of Counterpulsation Clinical Support Manual. Wayne, New Jersey, United States of America: Datascop Corp.
- Nettina, S. M. (2019). Lippincott Manual of Nursing Practice 11th edition. Philadelphia: Wolters Kluwer.
- Wiegand, D. L. (2017). AACN Procedure Manual for High Acuity, Progressive, and Critical Care 7th edition. St. Louis: Elsevier.

SUBJECT: **OBTAINING LABORATORY SERVICES FOR AMBULATORY SURGERY DEPARTMENT PATIENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To arrange for routine laboratory services when needed.

POLICY:

Laboratory services will be provided by Sierra View Medical Center (SVMC) according to the same standards, regulations and policies in effect on the Main Campus.

AFFECTED AREAS/PERSONNEL: *AMBULATORY SURGERY PERSONNEL AND MEDICAL STAFF*

PROCEDURE:

A. Preoperative Lab Work

1. Preoperative lab studies requested by the physician may be performed at the MOB or at the Main Lab of SVMC during regular operating hours up to 72 hours prior to the scheduled procedure.

2. Lab values will be sent via Meditech to the Ambulatory Surgery Department (ASD) as soon as processing is complete.

3. Abnormal lab values will be reported to the ordering physician and anesthesiologist for preoperative evaluation.

4. Normal lab values will be placed on the patient's chart in preparation for the procedure.

B. Emergency or STAT lab studies may be necessary after the patient arrives at the ASD.

1. Obtain the blood specimen in the appropriate collection tube.

2. After checking the armband, place the patient label on the collection tube. Include on the label the initials of the person collecting the sample, along with the date and time of the draw.

3. Place the labeled tube in a biohazard bag for transport to the SVMC Laboratory.

4. Notify the SVMC Laboratory at 784-7852. Request the specimen to be processed on an URGENT basis and for results to be called or faxed to the ASD. (STAT results should be called within 20 minutes of receipt.)

5. Enter order in Meditech or complete lab request form

6. If possible, the ASD Unit Clerk or designee will take the specimen to the SVMC Laboratory.

7. Note the order for lab work by the surgeon or anesthesiologist.

SUBJECT: **OPERATING ROOM CLEANING**	SECTION: **Page 1 of 4**

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

PURPOSE:

This document provides guidance on cleaning procedures, personnel education, competency verification, and monitoring cleanliness through performance improvement processes. All perioperative team members have a responsibility to provide a **clean** and safe environment for patients. Perioperative and environmental services leaders can cultivate an environment in which perioperative and environmental services personnel work collaboratively to accomplish cleanliness in a culture of safety and mutual support.

POLICY:

All employees will follow consistent cleaning, according to established routine.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), MATERNAL CHILD HEALTH (MCH) OR, AMBULATORY SURGERY DEPARTMENT (ASD), CATH LAB, INTERVENTIONAL RADIOLOGY OR / ALL SCRUB PERSONNEL, CARDIAC CATH LAB PERSONNEL*

PROCEDURE:

1. Patients will be provided with a safe, clean environment, free from dust and organic debris.
   a. Performing terminal cleaning or closing the OR after a contaminated or dirty/infected procedure
   b. Furniture, surgical lights and equipment will be damp-dusted before the first scheduled procedure of the day. Damp dusting will be done with a clean, lint free material moistened with a hospital grade chemical germicide.
   c. Preparation of the surgical suites will include a visual inspection of the room for cleanliness before the case carts, supplies, and instrument sets are brought into the room.
   d. Operating and procedure rooms must be cleaned and disinfected after each patient procedure.

2. During the surgical procedure, activities will be directed to confine and contain contamination.
   a. Have an interdisciplinary team determine cleaning procedures and frequencies based on the type of surfaces and tasks to be performed
   b. Identify high-touch objects and surfaces to be cleaned and disinfected
   c. Determine the frequency and extent of cleaning required when areas are not occupied (eg, unused rooms, weekends
   d. Assign responsibility for cleaning perioperative areas and equipment to competent personne

e. Areas outside the sterile field, contaminated by organic debris, will be cleaned as contamination occurs.

f. Contaminated disposable items will be discarded into leak proof containers.

g. Items contaminated with potentially infectious waste will be handled using protective barriers.

h. All blood, body fluids and tissue specimens will be placed in a clean, leak proof container for transport.

i. All items that come in contact with the patient and/or sterile field during a procedure will be considered contaminated.

j. Disposable items will be disposed of according to policy and procedure of medical waste disposal.

k. Reusable items will be processed according to the established policy and procedure.

l. Disposable items contaminated with blood and body fluids are placed in closable, leak proof containers or red biohazard bags.

m. Gowns and gloves will be removed (inside out) and placed into the appropriate receptacle before leaving the surgical suite.

n. Contaminated linen will be handled as little as possible and with minimal agitation.

o. All disposable sharps will be placed in puncture resistant containers.

p. Contaminated instruments, basins, trays and other items shall be handled only by personnel wearing personal protective equipment/attire, until the items are decontaminated.

q. Disposable suction tubing and containers will be used.

r. After each surgical procedure, equipment and furniture used during the surgical procedure will be cleaned with tuberculocidal, hospital-grade chemical germicide.

s. Mechanical friction will be used while cleaning.

t. Patient transport vehicles will be cleaned with a hospital-grade disinfectant/detergent.

u. Floors will be cleaned using hospital-grade disinfectant/detergent.

3. At the conclusion of the day's schedule, operating rooms, scrub/utility areas, corridors, furnishings and equipment shall be terminally cleaned with mechanical friction and a hospital-grade disinfectant/detergent which will include:

a. Surgical lights and tracks

b. Fixed ceiling-mounted equipment

c. All furniture, including wheels and casters

d. Face plates of vents

e. Horizontal surfaces (e.g., tops of counters, autoclaves, fixed shelving)

f. Entire floor

g. Scrub sinks

4. All of the following areas and equipment in the surgical area shall be cleaned on a routine scheduled basis:

a. Air conditioning grills and/or filters

b. Cabinets

c. Shelves

d. Walls

e. Ceiling

f. Offices

g. Lounges

h. Locker Rooms

i. Flash sterilizer shall be cleaned by Central Processing Department personnel on a routinely scheduled basis.

5. Cleaning equipment shall be disassembled, cleaned with a hospital-grade disinfectant/detergent and dried before storage.

REFERENCE:

- ~~California Code of Regulations (2020). Title 22. §70015. *Cleaning*. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.~~

- AORN Standards and Recommended Practices (Jan 2020). Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173715702&view=book#236401528

- The Joint Commission ~~(2020)~~ 2023. Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- Surgery Between Case Cleaning
- Surgery End of Day Terminal Cleaning

SUBJECT: **ORAL NUTRITION SUPPLEMENT**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish protocol for oral nutrition supplement (ONS).

DEFINITIONS:

ONS includes high calorie protein drinks and protein powders/liquids that are considered by the manufacturer to be medical foods.

POLICY:

ONS and oral modular supplements are available to patients as ordered by the physician and/or registered dietitian (RD).

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

PROCEDURE:

A. The RD may order or discontinue any ONS for patients on a modified diet using the ONS and Diet Type chart. The RD may modify the frequency, delivery time, and flavor of the existing ONS orders entered by the physician. RDs may only discontinue ONS ordered by other RDs. *See attached addendum.*

B. The RD may add protein modular (amino acid powders/protein powders/liquids).

C. The RD may adjust the diet downwards for calories, protein and textures.

REFERENCES:

- California Code, Business and Professions Code - BPC § 2585. (n.d.). Retrieved from https://codes.findlaw.com/ca/business-and-professions-code/bpc-sect-2585.html.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). 482.2 8(b) Tag-0629 482.28(b)(1). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2023). Hospital accreditation standards. PC.02.02.03, EP 7

ADDENDUM

Food and Nutrition Services Dept. Diet Manual
Diet Types & Oral Nutrition Supplements (ONS)

Oral Nutrition Supplements by Diet

A crosswalk illustrating the ONS that fits the macronutrient composition and pattern of the diets listed. These may be selected by the Clinical Dietitian or Nurse, to be offered to patients based on assessed need. Only a physician may order alternate supplements.

Diet in Electronic Medical Record	Allowed Oral Nutrition Supplements
• **High Iron** • **Regular** • **Vegetarian** • **Kosher** • **High Calorie/High Protein Pregnancy/Lactation** • **Low Microbial/Neutropenic** • **Full Liquid** • **Low Fiber/Low Residue** • **Dysphagia I,II, III** • **Blenderized Puree** • **Cardiac** • **Low Sodium2 gm No Added Salt (4 gm)** • **Low Fat/** • **Gluten Free** • **PUD/GERD** • **6 Small Meals** • **Hyperemesis Gravidarum**	• Boost Plus • Ensure Clear • Ensure Plus High Protein • Ensure Plant Based Protein • Ensure Max Protein • Glucerna Therapeutic Nutrition Shake • TwoCal HN • Nepro • SF Mighty Shake, regular Mighty Shake • Suplena • Pediasure • Propass Powder • SF Prostat • Banatrol Plus • Juven
• **Thickened liquids**	All ONS thickened to appropriate consistency
• **Clear Liquid w/Supplement** • **Clear Liquid** • **Diabetic Full Liquid** • **Diabetic Clear Liquid**	• Ensure Clear (Not on Diabetic Clear/Diabetic Full Liquid) • Juven • SF ProStat • Diabetic FL: Glucerna, SF Mighty Shake, Ensure Max Protein, Banatrol Plus, Ensure Plant Based

SUBJECT: **ORAL NUTRITION SUPPLEMENT**	SECTION: **Page 3 of 3**

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• **Consistent Carbohydrate** • **Consistent Carbohydrate Low** • **Gestational DM**	• Glucerna Therapeutic Nutrition Shake • Ensure Plant Based • Ensure Max Protein • Banatrol Plus • Nepro • Suplena • Propass powder • SF Prostat • SF Mighty Shake
• **Renal -** • **Renal – High Protein**	• Nepro, Glucerna (dialysis) • Suplena (Low Protein Diet, no dialysis) • Ensure Clear • Propass Powder, SF ProStat • Juven
• **Calorie Restriction: 1200,1500,1800,2000,2400**	• All ONS • Propass • SF Prostat • Consult RD if needed
• **Hepatic 2gm Na+, 50gm protein** • **Low protein (50gm)** • **Renal Low Protein (60g)**	• Suplena, consult RD if needed
Combination Diets • **Consistent Carb/Renal** • **Consistent Carb Cardiac** • **Cardiac Low Potassium**	• Glucerna, no chocolate • Nepro • Suplena • Propass Powder • SF Prostat
• **Toddler 1-2** • **Pediatric 2-12**	• PediaSure • Ensure Enlive
• **Gastro Pediatric** • **BRAT**	No supplement
• **NPO Except Supplements**	Any liquid oral supplement (No TRAY)

SUBJECT: **OXYGEN PROTOCOL**	SECTION: **Page 1 of 6**

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

PURPOSE:

To define a process to ensure that supplemental oxygen is administered appropriately according to the patient's condition and status.

POLICY:

A. The oxygen therapy protocol will be instituted by a physician written/electronic order, which indicates:

1. Initial flow rate
2. Type of delivery appliance
3. Target Sp02 of 92% or target Pa02 of 60 mmhg

AFFECTED PERSONNEL/AREAS: *ALL PATIENT AREAS*

ACRONYMS:

- SpO2 = Peripheral capillary oxygen saturation
- Pa02 = Oxygen content in arterial blood
- I&O = Intake and output
- COPD = Chronic Obstructive Pulmonary Disease
- CO2 = Carbon dioxide
- SOB = Shortness of breath

PROCEDURE:

1. Oxygen therapy will be titrated and weaned as appropriate for patients that meet the following condition:

   a. Cardiopulmonary stability including vital signs and respiratory pattern

   b. Adequate tissue perfusion based upon clinical assessment which includes but is not limited to:

   - Level of consciousness or neurological changes
   - Adequate cardiac function: Blood pressure, heart rate, distal pulses, extremity temperature (capillary refill of < 2 seconds for infants and children)
   - Stable I & O

2. For COPD patients with documented C02 retention, oxygen will be titrated to maintain an SP02 between 88-92% unless the physician specifies a different target SP02.

3. For all other patients, oxygen will be titrated to maintain an SP02 > 92% [Pa02 =>60 mmhg] unless the physician specifies a different target SP02 or Pa02.

4. The physician will be notified immediately for any patient who cannot maintain an adequate $SP0_2$ or $Pa0_2$ based upon this protocol.

5. Patients who use oxygen therapy at home will not be discontinued without a physician's order.

6. Oxygen will be titrated and weaned when the patient meets the conditions of the protocol:

   a. Sp02 >92% or physician specified target [Pa02 > 60 mmhg]

   b. Stable vital signs

   c. Does not de-saturate with minimal exertion

   d. Adequate tissue perfusion

   e. Stable fluid status

   f. Absences of dyspnea or c/o SOB

7. Oxygen will be continued when:

   a. Room air $Sp0_2$ < 92% or physician specified target $Sp0_2$, and/or

   b. Room air Pa02 < 60 mmhg or physician specified target Pa02

8. Oxygen will be discontinued when:

   a. The room air $Sp0_2$ > 92% or the physician specified target Sp02, and/or

   b. The room air $Pa0_2$ > 60 mmhg or the physician targeted Pa02

9. All patients scheduled for transport (internally or externally) will be evaluated by Respiratory Therapy for the following:

   a. Stable vital signs

   b. Type of delivery appliance

c. Initial flow rate

d. adequate oxygen source for transport

10. Any patient requiring more than 5 l/m nasal cannula for transport will be assisted in transport by Respiratory Therapy.

11. The results of all assessments performed in conjunction with the oxygen therapy protocol as well as the results [titrating/weaning, continuing or discontinuing] is to be documented in the Interventions: Oxygen and continuous pulse oximeter for each 12 hr. shift.

12. High flow Nasal Cannula (HFNC) in pediatric patients less than 2 years of age:

a. A respiratory assessment score (RAS) will be documented every 4 hours by the RCP.

b. The RAS will be used to manage oxygen therapy and the need for HFNC.

c. See appendix B for pediatric in-patient oxygen management.

d. See Appendix C for pediatric HFNC management.

Note: Physician may drive practice by order rather than flow chart

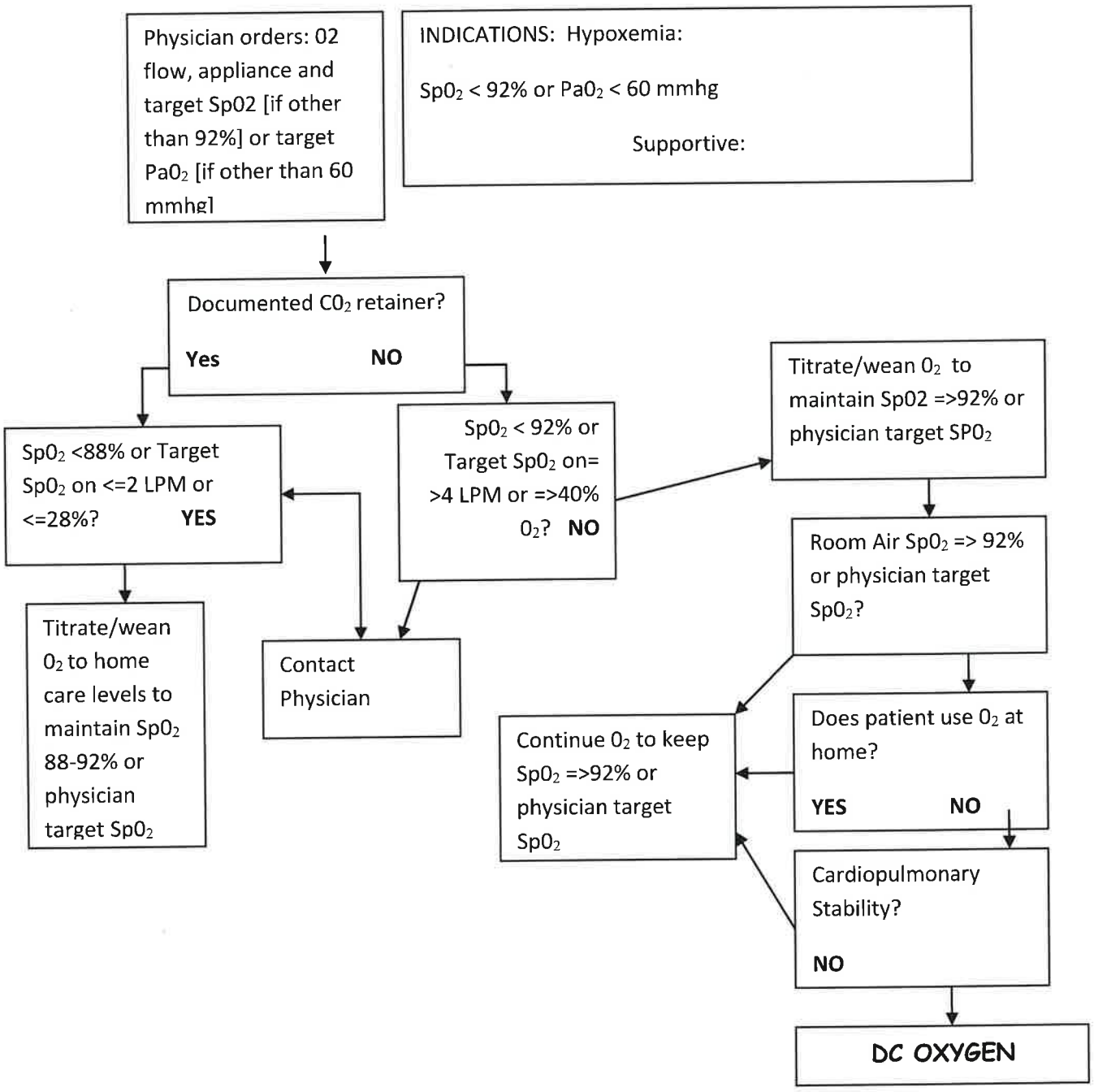
REFERENCES:

- Clinical Practice Guidelines. (n.d.). Retrieved from https://www.aarc.org/resources/clinical-resources/clinical-practice-guidelines/
- Seattle Children's Hospital. (2023, June). *Bronchiolitis Pathway v14.2*. Retrieved from https://www.seattlechildrens.org/pdf/bronchiolitis-pathway.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=fovdelivery&utm_term=

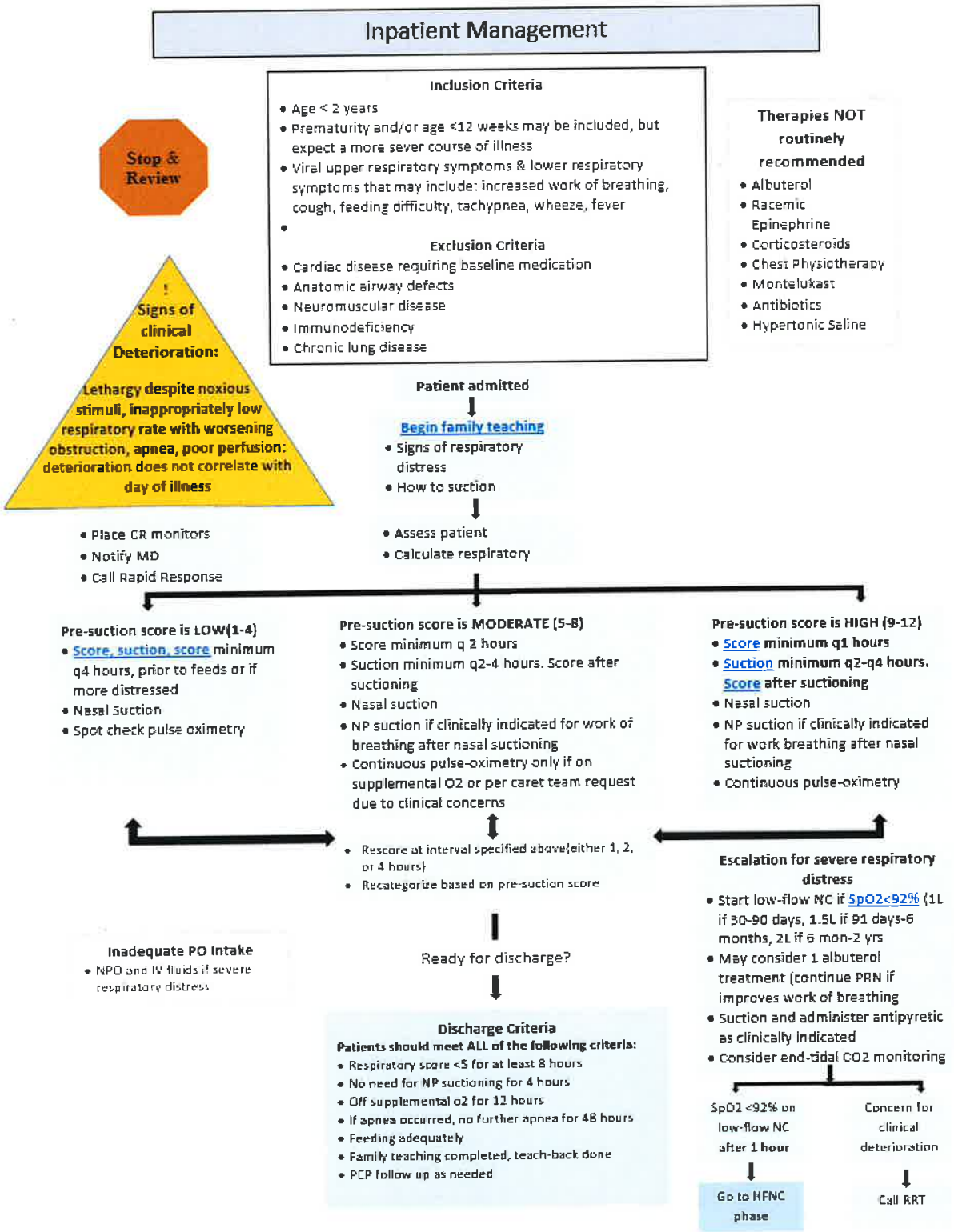
CROSS REFERENCES:

- *Pulse Oximetry* – SVMC Policies and Procedures

Appendix A- Adult protocol
Oxygen Therapy Protocol Flow Chart



Appendix B- Pediatric Inpatient Management
Oxygen Therapy Protocol Flow Chart



Appendix C- Pediatric HFNC Management

HFNC Protocol Flow Chart

HFNC Management

Stop & Review

HFNC Inclusion Criteria

- Primary diagnosis of bronchiolitis
- Age 44 weeks PMA to <2 years
- Severe respiratory distress PLUS persistent SpO2 <92% on maximum low-flow settings NC (1 L if 30-90 days, 1.5L if 91 days – 6 months, 2 L if 6 months- 2 years

HFN Exclusion Criteria

- Concern for impending respiratory failure (lethargy, poor perfusion, apnea)
- Primary diagnosis of pneumonia, asthma, or croup
- Born prematurely <34 weeks (if <6months)
- History of intubation for respiratory failure
- Cardia disease requiring baseline medication
- Anatomic airway defects
- Neuromuscular disease
- Immunodeficiency
- Chronic lung disease

Huddle Pre-HFNC Initiation

- ED: no huddle necessary
- Acute Care: Include RN, RT, general medicine MD

↓

Initiate HFNC at 1.5L/min/kg*
(max 25L/min), FiO2 21%

- Titrate FiO2 to keep SpO2≥ 90%
- Vital signs q30 min x 3

↓

Huddle 60 Minutes Post HFNC Initiation

- ED: Include ED (RN, RT, MD) and accepting acute care MD
- Acute Care: Include RN, RT, general medicine MD

↓

Hypoxia or Respiratory Distress Not Improved

- ED: Notify Physician
- Acute Care: Call RRT

Hypoxia or Respiratory Distress Improved

ED: transfer to acute care

- Suction + vitals q2hr until transfer

Acute Care:

- Wean flow rates and FiO2 as tolerated (see below)
- Vitals q2 hours x 12 hours, then q4 hours

Minimum flow	Maximum flow
0.5L/min/kg	1.5L/min/kg (max 25 L/min)

Weaning HFNC in Improving Patients

- Daily weaning trial and as often as q4 hours as tolerated
- On 21% FiO2: trial off HFNC at least daily
- On >21% FiO2: trial to 0.5L/min/kg at least daily, then off HFNC
- Avoid gradual weans using other flows

SUBJECT: **PATIENT FOOD FROM HOME - DPSNF**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a policy regarding use and storage of foods brought to Sierra View Medical Center Distinct Part Skilled Nursing Facility (DP/SNF) residents by family and other visitors to ensure safe and sanitary storage, handling and consumption.

POLICY:

It is the policy of the Food & Nutrition Services (FNS) Department to prepare and deliver food safely to our residents, families and staff. This policy will ensure proper handling, serving and storage of any food items brought in for our residents from all outside sources.

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

PROCEDURE:

1. It is a resident's right to obtain foods from outside sources such as ordering takeout and to receive foods brought in by the resident's family and friends. The FNS Department and the unit's nursing staff will make every effort to advise the residents of foods that are permitted within their diet restriction. However, the resident has the right to make food choices that may not follow their diet restriction.

2. All food or beverages brought into the unit for resident consumption will be checked by a staff member before being accepted for storage. Any suspicious or obviously contaminated food or beverage will be discarded immediately.

3. Foods and beverages brought in from the outside will be labeled with the resident's name, room number and dated by the receiving staff with the current date that the item(s) are brought into the facility for storage.

4. Residents with dietary restrictions, texture modifications and adaptive equipment needs will be advised and assisted as necessary to ensure the resident's diet/devices are being followed/provided.

5. Food or beverage items may be stored in the designated patient refrigerator, freezer or pantry. Items may be stored in the resident's room or their personal room refrigerator.

    a. Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by staff.

    b. All cooked or prepared food brought in from outside will be dated by the receiving staff member, when accepted for storage, and discarded after three (3) days. No home-prepared foods that are home canned or preserved will be permitted.

6. In support of our residents, families and visitors, and in understanding of safe food handling practices, a copy of the food handling safety guidelines will be included in our admission packets and reviewed annually with resident and/or family during the interdisciplinary team meeting.

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). §483.60(i)(3). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2023). Hospital accreditation standards. PC.02.02.03. Joint Commission Resources. Oak Brook, IL.
- Med Pass, Inc. (Updated Feb 6, 2015) Facility guide to OBRA Regulations, 483.10.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of regulations 72343, 72335 (6), San Francisco, California. Title 22.
- Food From Home handout, Tips for Family Members 2022. https://www.cahf.org/Portals/29/Clinical-Quality/Food%20From%20Home%20Handout.pdf?ver=2022-03-29-180723-740

SUBJECT:	SECTION:
PATIENT OBSERVATIONS	***Security Management***

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

PURPOSE:

To provide guidelines for the implementation of patient observations by assigned patient sitters.

POLICY:

Patient observations are implemented by security personnel or assigned patient sitters, when requested by Nursing Services. Patient observations are implemented when a patient is awaiting mental health evaluation, intoxicated, requires additional observation for safety, or has become a disruption to the nursing care environment. The observation is intended to maintain a safe and secure environment from and for patients who may be a danger to themselves, others, gravely disabled or a disruption to the care environment.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

- Assigned sitters will position themselves inside the patient's room and maintain a direct, unobstructed view of the patient at all times on a suicidal observation, at the request of a physician, to prevent the patient from causing harm to themselves, others or disruptive behavior to the nursing environment.
- Assigned sitters will maintain continuous observation of the patient while on suicide precautions. This includes bathing and toileting. In the event that the assigned sitter is the opposite sex of the patient, a same sex employee will be engaged to observe bathing and toileting.
- Assigned sitters will not use cell phones or other personal electronic devices while posted on a suicidal observation.
- The security officer will post directly outside of the room if the patient is being observed due to aggressive behavior and not on a suicidal observation.
- Assigned sitters will only leave the room to take breaks when relieved by another staff member.
- Patients awaiting mental health evaluations who express wanting to leave prior to being evaluated and cleared by CRISIS, shall result in the assigned RN being immediately notified.
- Unless the patient is an immediate threat to self or others or is incapable of understanding the risks and benefits associated with leaving, patients shall not be physically restrained from leaving.
- In the event that a patient does leave, initiate Code Green policy.

- Assigned sitters shall uphold the organization's Standards of Performance at all times while on duty and shall make every attempt to maintain the patient's privacy and dignity during observation situations.

- The least restrictive force necessary must be used when performing patient observations. If a patient who has been placed on a security observation becomes violent, staff will immediately initiate a "Code Gray" in order to restore the safety and security of the care environment.

- All sitters (security and otherwise) will be trained in ligature risks and patient observation, via e-learning module.

- All security officers will be trained in a Nonviolent Crisis Intervention (CPI) training program and will also pass e-learning modules on Ligature Risks and Patient Observations.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL. NPSG 15.01.01.

CROSS REFERENCES:

- CODE GRAY-VISITOR OR PATIENT OUT OF CONTROL
- 1799 HOLDS IN THE EMERGENCY DEPARTMENT
- CODE GREEN- MISSING PATIENT OR RESIDENT
- SUICIDAL PATIENT ASSESSMENT & MANAGEMENT

SUBJECT: **PATIENT SAFETY – AMBULATORY SURGERY DEPARTMENT**	SECTION:

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

PURPOSE:

To ensure patient safety in the Ambulatory Surgery Department (ASD), Interventional Radiology, and Cardiac Catheterization Lab, guidelines are established and followed.

POLICY:

National Patient Safety Goals and standards of perioperative nursing care, as defined by the Association of Perioperative Registered Nurses (AORN), will be followed to assure patient safety in the ASD, OR, Interventional Radiology and Cardiac Catheterization Lab.

AFFECTED AREAS/PERSONNEL: *AMBULATORY SURGERY PERSONNEL, INTERVENTIONAL RADIOLOGY STAFF, CARDIAC CATH LAB STAFF, AND MEDICAL STAFF*

PROCEDURE:

1. All patients will be accompanied by the perioperative nurse from the pre-op area into the OR.
2. The perioperative nurse will assist the patient, with assistance as needed, onto the operating table, making sure the patient is properly positioned with feet uncrossed and safety strap secured.
3. Positioning aides (pillows, axillary rolls, etc.) will be used to protect bony prominences and avoid pressure areas.
4. Special attention will be given to patients in unusual or extreme positions during the operative procedure.
5. When the OR table is adjusted to new positions, the perioperative nurse is responsible for checking the patient's position.
6. The patient shall at no time be left alone in the OR.
7. All patients will be transported to the Post Anesthesia Care Unit (PACU) via gurney with rails up, accompanied by the perioperative nurse and anesthesiologist, if provided. Patients who receive deep sedation (monitored anesthesia care) and are awake in the OR at the end of the procedure may be transported to PACU via recliner by a perioperative nurse and anesthesiologist. Those who receive straight local anesthesia may be transported to PACU via wheel chair or ambulation, accompanied by a perioperative nurse.
8. All equipment to be used for procedures will be checked for proper functioning before the procedure begins and removed from service if malfunctioning is noted.

REFERENCES:

- AORN Guideline for Safe Patient Handling and Movement. Guidelines for Perioperative Practice. Denver. CO. (2023). AORN, Inc.
- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PEDIATRIC BLOOD TRANSFUSION**	SECTION: **Page 1 of 5**

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

PURPOSE:

To assist in maintaining equilibrium in the hemodynamically stable child.

POLICY:

1. To obtain, safely administer, and document blood/blood products.
2. Proper identification of the patient and blood unit.
3. Check for informed consent.
4. A consent for the transfusion must be signed by the child's parent or guardian before the infusion.
5. Do not add IV additives or medication to blood/blood products. Flush the line 3 to 5 ml of normal saline to give medication, if necessary. Do not interrupt infusion for more than 1 hour.
6. Flush the IV line with normal saline before and after administering blood products.
7. 1:1 monitoring of the patient during the transfusion process.
8. If a reaction occurs, stop the blood transfusion immediately and notify the physician.

AFFECTED PERSONNEL/AREAS: *CDU RNs*

EQUIPMENT:

- Nonsterile gloves
- Y-tubing with blood filter
- Blood/blood product
- Normal saline
- Thermometer
- Blood pressure equipment
- Stethoscope
- IV infusion pump/syringe pump
- Oximetry monitoring

PROCEDURE:

1. Prepare the child and family.
   a. Obtain Type & Cross as ordered.
   b. Check for informed consent.
   c. Determine if the child has received a previous transfusion and has had a transfusion reaction.
   d. Consult the physician if the child has had a previous reaction.
   e. Administer premedication per physician's order if child has had a previous reaction during administration.
2. Assemble the equipment.
3. Obtain the blood/blood product.
   a. Obtain blood from Lab Technician.
   b. With Technologist, check unit number, group and Rh type, expiration date, patient's name and medical record number, BBK number and sign blood bank slips.
   c. First, verification of accuracy is confirmed by the Lab Technician and employee picking up blood at the time that the blood is obtained. Both signatures are required on designated space on blood bank slips.
   d. ** There must be exact correspondence of the information before the unit leaves the blood bank. Only licensed nursing staff may go to the blood bank to pick up the unit(s) of blood.
4. Verify that the blood/blood product is correct.
   a. Check the blood product, amount to be infused, and rate against the physician's order.
   b. Verify appropriate volume/rate for patient weight and clinical condition, correlate with maintenance fluid requirement. Dose and rate is physician ordered; suggested doses and rates may be: (see attached table).
   c. The blood product will be verified by the transfusionist and scanned as the second verification. Scanning should include all indicators: Patient name, date of birth (DOB), patient account number, BBK number, blood unit number, donor blood group and Rh

type in order to qualify as the second verification. If unable to scan, the blood product can be verified with two (2) qualified licensed staff against the "Transfusion Administration Record" at the bedside. The one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the patient. At least two unique identifiers are used in the verification process and will be conducted after the blood or blood component matches the order has been issued or dispensed. If two licensed staff are verifying, a **signature is required of the nurse who administers blood and signature of licensed witness should appear next to RN.**

d. Hand hygiene needs to be performed.

e. Using the Y-tubing, connect the 250 ml bag of normal saline to one port and flush the line. Connect IV tubing to the child's venous access.

f. Inspect catheter insertion site for signs of infiltration or infection prior to starting the blood transfusion. A 23 gauge needle is the smallest size to be used for transfusion.

g. Put on gloves and prime the appropriate blood administration set with the blood/blood product.

h. Take baseline vital signs (temperature, pulse, respiration, blood pressure and oxygen saturation).

i. Using an infusion pump/syringe pump to regulate flow, stop the normal saline and: Begin infusion with 0.5ml/kg/hr over the first 15 minutes, and then advance to the ordered rate after the 15 minute vitals if no adverse reactions are seen.

5. Identify possible transfusion reactions promptly and intervene immediately.

a. Watch for increased, shallow, or labored respirations; stridor or wheezing; tachycardia; decreased blood pressure.

b. Remain with child at bedside during entire transfusion.

c. Rate changes in skin color or mentation.

d. Auscultate lungs for rales, rhonchi or muffled breath sounds.

e. Fever—Temperature rise from baseline vitals >2 degrees C (3.5 degrees F) for blood components

f. Itching

g. Chills

h. Rash

i. Flank pain

j. Hematuria

k. Urticaria

2. Take vital signs at start of infusion, 15 minutes after start, 30 minutes after start and post transfusion. Document in the electronic medical record and on the blood transfusion form.

3. Discontinue blood if untoward effects occur and call physician.

a. Notify lab of reaction. Lab will draw blood specimens as required.

b. Complete upper part of Transfusion Reaction form in duplicate.

c. Obtain urine and remaining blood in bag/syringe, blood tubing and saline to Lab.

4. Discontinue when blood absorbed or as ordered.

5. Resume primary IV fluid as ordered.

6. Attach chart copy of Blood Transfusion Slip to Laboratory Record Sheet in the patient's chart when completed.

7. Care of Equipment Return of empty transfusion bag to lab.

d. Remove patient information/identification from bag/syringe.

e. Place transfusion empty pack in red bag.

f. Discard in red bag bin.

8. Documentation

g. Document pertinent observations in the electronic medical record.

h. Document in I & Os

i. Transfusion Administration Record

REFERENCES:

- Bowden, V.R., Smith Greenberg, C. (2016). Pediatric Nursing Procedures. Fourth Edition. Lippincott Williams & Wilkins.

- Nettina, S. (2019). Manual of Nursing Practice, 11 Edition. Ambler, PA. Lippincott Williams and Wilkins.

CROSS REFERENCES:

- Blood and Blood Components, Administration of
- Blood and Blood Components, Transfusion Reaction

SUBJECT: **QUALIFIED PERSONNEL: ARTERIAL PUNCTURE #9013**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the personnel qualified to collect arterial blood samples.

POLICY:

The Respiratory Care Department at Sierra View Medical Center (SVMC) is available to collect arterial blood samples 24 hours per day, 7 days per week. Outpatients at the Medical Office Building (MOB) will be directed to the main hospital for procedure.

AFFECTED AREAS/PERSONNEL:

RESPIRATORY CARE PRACTITIONER (RCP), REGISTERED NURSE (RN).

PERSONNEL QUALIFICATIONS:

1. To perform an arterial puncture, the individual must have competency assessed by the Respiratory Care Services Medical Director or Department Director. This competency will be reviewed on an annual basis.

2. To analyze a blood sample through the blood gas analyzers and/or co-oximeter, all personnel must be at least one of the following:

    a. A Respiratory Care Practitioner

    b. Registered Nurse in the Critical Care (ICU and ED) Department or in the Cardiac Cath Lab

    c. Clinical Lab Scientist

    d. Phlebotomist/Lab Aide

CERTIFICATION:

Persons authorized to perform arterial punctures will have one of the following: Respiratory Care Practitioner license (CRT or RRT) or Registered Nurse license (RN).

REFERENCES:

- Respiratory Care Board of California, Scope of Practice, https://www.rcb.ca.gov/licensees/forms/scope_of_practice.pdf, 2020.

SUBJECT: **REGISTERED NURSE FIRST ASSISTANT (RNFA)**	SECTION: **Page 1 of 6**

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

POLICY:

Function: The Registered Nurse First Assistant (RNFA) renders direct patient care as part of the perioperative role in compliance with the California State Board of Registered Nursing and the official statements of the American College of Surgeons (September 1980) and the Association of Perioperative Registered Nurses (AORN). The RNFA is responsible for the delivery of safe, effective, and quality patient-family centered care in the OR and other areas of perioperative services for all patient populations. They function as an RN first assistant during operative and other invasive procedures and throughout the perioperative continuum in accordance with scope of practice credentials, privileges, experience, education, and competency verification.

Primary Responsibilities:

1. Promote the mission, vision, and values of the organization.

2. Assess patients at intervals in accordance with facility or health care organization policies and procedures.

3. Participate in preoperative assessment and planning for surgical patients specific to RNFA activities (e.g., anatomical exposure, wound closure) in collaboration with perioperative team members.

4. Develop an individualized perioperative patient plan of care.

5. Implement the plan of care by

    - Protecting the patient from injury caused by extraneous objects and chemical, electrical, laser, mechanical, and thermal sources;
    - Participating in accounting procedures to protect the patient from unintended retained surgical items;
    - Performing interventions necessary to ensure that the patient's procedure is performed on the correct site, side, and level;
    - Assisting with management of the patient's specimens as necessary;
    - Communicating the patient's current status to relevant parties throughout the continuum of care;
    - Administering medications safely and correctly;
    - Performing interventions to maintain the patient's wound and tissue perfusion at or above baseline levels;
    - Performing interventions to maintain the status of the patient's genitourinary, gastrointestinal, musculoskeletal, endocrine, respiratory, cardiovascular, and neurological systems and fluid, electrolyte, and acid-base balances at or above baseline levels;
    - Performing interventions to ensure the patient is at or returned to normothermia at the conclusion of the immediate postoperative period;
    - Performing interventions to protect the patient from surgical site infection;
    - Assessing the knowledge level of the patient or designated support person;

- Providing education regarding the expected psychosocial response, nutritional management, medication management, pain management, wound management, and expected responses to the operative or invasive procedure;
- Involving the patient or designated support person actively in decisions affecting his or her perioperative care and the rehabilitation process;
- Protecting the patients' rights, dignity, and privacy;
- Providing age-specific, culturally competent, ethical care within legal standards of practice; and
- Providing consistent and comparable care regardless of the setting.

6. Function as an RN first assistant during operative and other invasive procedures by

   - Providing exposure through correct use of instruments, retractors, suction, and sponging techniques;
   - Handling and dissecting tissues in collaboration with the surgeon;
   - Clamping blood vessels, coagulating bleeding points, and ligating vessels in collaboration with the surgeon;
   - Placing drains as directed by the surgeon; and
   - Suturing muscle, fascia, subcutaneous, and skin in collaboration with the surgeon.

7. Follow selected surgical patients postoperatively specific to RNFA activities (e.g., postoperative rounding, dressing changes) in collaboration with the interdisciplinary team.

8. Evaluate the patient's progress toward attaining outcomes.

9. Transfer care as applicable.

10. Delegate tasks according to the state Nurse Practice Act and job descriptions.

11. Document nursing care accurately, completely, and legibly.

12. Collaborate effectively with other disciplines as applicable.

13. Participate in quality review and performance improvement projects.

14. Participate in the performance appraisal process.

15. Use problem-solving and conflict resolution skills to foster effective work relationships with team members.

16. Serve as an educator, mentor, consultant, and resource to peers, colleagues, and others in relation to RNFA activities.

17. Maintain regulatory, credentialing, and privileging requirements required for practice as an RNFA.

18. Participate in ongoing educational and competency verification activities applicable to RN and RNFA activities.

19. Act as a patient advocate and maintain privacy and confidentiality of individuals and health information.

A. **Circumstance:**

1. **Setting:** Main Operating Room, ASD, OB or other procedural areas

2. **Supervision:** The RNFA practices in the role of first assistant under the direct supervision of the surgeon during surgical interventions (including C-Sections) that do not require a surgeon as first assistant.

   In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the responsibility of the RNFA is to:

   a. Maintain hemostasis, according to approved standardized procedure

   b. Keep the surgical site moistened, as necessary, according to the type of surgery

   c. Maintain integrity of the sterile field

   d. Remain scrubbed in appropriate attire

   e. Remain at the field while a replacement surgeon is being located

   The RN circulator will initiate the procedure for obtaining a surgeon in an emergency.

3. **Patient Condition/Contraindications:** Based on the RNFA's scope of practice, type of surgical procedure and potential complications, the RNFA must recognize and communicate his/her limitations. The RNFA must perform only as a first assistant and not concurrently as a scrub nurse.

PROCEDURE:

A. **Definition:** The RNFA is a perioperative nurse with the necessary training, education and competence to function as a surgical first assistant. He/she is accountable for carrying out acts as directed by the surgeon. These actions include: controlling bleeding, providing wound exposure, suturing and other surgical tasks; i.e., mobilization of tissue and patient positioning. The RNFA is not the same as an individual designated to perform scrub functions.

B. **Data Base:**

1. **Subjective:** The presence of RNFAs on surgical/C-Section procedures are at the request of the surgeons at the time of scheduling.

2. **Objective:** A list of those currently validated to perform the RNFA duties will be kept in Human Resources. A log will be kept of all surgical procedures with names and roles of surgical team participants, including RNFAs.

C. **Diagnosis:** The RNFA practices in this first assistant role under the guidance of this Standardized Procedure

D. **Plan:**

1. **Intervention:**

a. **Privileging:**

- RNFAs are hired by Human Resources.
- Proof of malpractice insurance must be provided.

b. **Initial Evaluation of Competence:**

- Six (6) cases to be proctored.
- The six cases are to be proctored utilizing the Proctor/Competency Form.
- It is the responsibility of the RNFA to have the proctor forms completed by the supervising surgeons and delivered to the Manager or Director of Surgical Services. A copy will also be kept in the employee's departmental blue file.

c. **Annual Physician Review and Competency Evaluation:**

- It is the responsibility of the RNFA to obtain annual competency evaluations from 3 different surgeons (3 specialties). The forms will be delivered to the Manager or Director of Surgical Services to be forwarded to AHPC and a copy to be kept in the departmental blue file, along with the employee performance evaluation.
- Proof of continued malpractice insurance must be provided.

2. **Consultation Required:** Supervising Surgeon

3. **Patient Education**: As a perioperative nurse, the RNFA will participate in patient education as needed.

4. **Documentation**: The name of the RNFA who is first assisting on procedures will be recorded on the intraoperative nursing record as the "RNFA."

REQUIREMENTS FOR REGISTERED NURSE FIRST ASSISTANTS:

RNFA Qualifications:

- Licensed as an RN in California
- Proficient in perioperative nursing practice in the scrub and circulating role for at least 3 years.
- Completion of an accredited course in RN First Assisting which meets AORN recommended education standards for RNFA programs. Uses the AORN core curriculum as a foundation.
- Current Certified Nurse Operating Room (CNOR) status (National certification in operating room nursing)
- Demonstrates knowledge and skill in applying principles of asepsis and infection control.
- Demonstrates knowledge of surgical anatomy, physiology and operative procedures wherein the RNFA assists.
- Demonstrates ability to function effectively and harmoniously as a team member.
- Basic and Advanced Cardiopulmonary Life Support (BLS & ACLS) required.
- Proof of malpractice insurance.

DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

A. **Method:** Human Resources

B. **Review Schedule:** Yearly

REFERENCES:

- Association of Perioperative Registered Nurses. Jeb Description Registered Nurse Fist Assistant. (n.d.) Retrieved ~~October 30, 2017~~ June 28th 2023 f ~~http://www.aorn.org/~~ https://aornguidelines.org/tool/content?gbosid=394132
- Association of Perioperative Nurses. Essential Elements of RNFA Practice. Retrieved June 28th 2023. https://aornguidelines.org/books/content?sectionid=179179185#179179185

- ~~Association of Perioperative Registered Nurses (AORN) standards for RN first assistant education programs. In: Perioperative Standards and Recommended Practices. Denver, CO: AORN, Inc.; 2012:749-751.~~

- ~~Association of Perioperative Registered Nurses (AORN) (2020). Retrieved from https://aornguidelines.org/.~~ **Job**

SUBJECT:	SECTION:
SCOPE AND COMPLEXITY OF SERVICES AT THE AMBULATORY SURGERY 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 to our patients by performing high quality surgical procedures with the appropriate staff, space, and equipment needed.

POLICY:

The Ambulatory Surgery Department (ASD) will provide quality, competent and cost-effective care with respect for life and dignity.

AFFECTED PERSONNEL/AREAS: *AMBULATORY SURGERY PERSONNEL; MEDICAL STAFF*

SCOPE OF SERVICE AND COMPLEXITY OF CARE:

1. Department Goals:

   a. To provide the highest standard of care to our patients/families regardless of sex, race, creed, color, national origin or economic status.

   b. To provide quality care in identifying and meeting the psychological, physiological and sociological needs of each patient.

   c. To provide knowledgeable customer-centered care in a safe environment to promote quality outcomes in a cost-effective manner.

2. Type of Patients:

   a. The Sierra View Medical Center (SVMC) ASD provides care for patients undergoing outpatient surgical and invasive procedures who meet criteria for American Society of Anesthesiologists (ASA) classifications 1, 2 and at the discretion of anesthesia services, Class 3. Patients with ASA classifications of 4 and 5 are NOT candidates for procedures at the ASD.

3. Age of Patients:

   a. The patient population age range includes adolescent to the geriatric patient.

4. Services and Procedures:

   a. The services provided are Endoscopy, Urology, and Ophthalmology procedures. Surgical procedures scheduled should be those that are typically completed in less than 120 minutes and require less than 4 hours recovery time at the discretion of Anesthesia.

   b. The list of appropriate procedures to be performed is delineated and approved by the SVMC Medical Staff.

5. Anesthesia Types:

   a. Regional

   b. Monitored Anesthesia Care (Deep Sedation)

   c. Procedural Sedation

   d. Local with or without procedural sedation

   e. General Anesthesia

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 $C0_2$ respiratory rate alarms
   d. Cardiac defibrillator
   e. Appropriate supplies and drugs for emergency use (crash cart and Pyxis)
   f. Clinical educator will be responsible for training and maintaining records of all staff

7. Hours of Operation:

   a. The ASD has staff available from 0630 to 1530 Monday through Friday. The Department is staffed to operate at least one suite, five days per week.

8. Staffing Plan:

   a. The ASD includes preoperative, intraoperative and post-operative care areas under the direction of the Director of Surgical Services. Upon admission to the preoperative area, the patient is assessed by a registered Nurse. Intraoperatively and postoperatively, the patient is continually reassessed by a Registered Nurse. Modifications to the plan of care are based on reassessment of the patient. In the immediate postoperative phase, the patient is under the direct supervision of a Registered Nurse or the anesthesiologist/anesthetist (if applicable), who maintains responsibility for the needs of the patient until the patient has completed the recovery phase. The patient's disposition is a collaborative decision between the anesthesiologist (if applicable) and surgeon with information related to clinical data provided by the Post Anesthesia Care Unit (PACU) Registered Nurse.

b. The surgical team for a procedure is composed of a registered nurse circulator and a surgical technician and sedation nurse if applicable. Assistive personnel are registration clerks/schedulers and Environmental Services (EVS)/ Central Processing Department (CPD) technicians.

c. Staffing is based on the number of scheduled cases and complexity of the cases.

d. The Disaster Manual call-in roster will be used to augment staff in the event of a disaster.

8. Qualifications of Staff:

a. Registered Nurse with experience in and demonstrated competencies in Surgical Services nursing e.g. Flex Care/PACU, Operating Room, Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and procedural sedation.

b. Operating Room Technician or Endoscopy technician with experience in and demonstrated competencies in surgical procedures – BLS.

c. Unlicensed assistive personnel that demonstrate competencies in providing support for surgical services – BLS.

3.

a. The perioperative clinical educator and the hospital education department will maintain an ongoing program of insurance, education and clinical skill competency evaluation for all staff.

9. Standards of Practice:

a. The Association of Operating Room Nurses (AORN 2023), the American Society of Peri-Anesthesia Nurses (ASPAN) 2023-2024, the Association for the Advancement of Medical Instrumentation (AAMI), the Centers for Disease Control (CDC) and the California Department of Public Health (CDPH), Title 22, are references used in the formulation and review of policies, procedures and standards of practice used in the operating room area.

REFERENCES:

- Association of Perioperative Registered Nurses (AORN). *Guidelines for Perioperative Practice.* (2023). Retrieved from http://www.aornstandards.org.
- American Society of PeriAnesthesia Nurses. (2023). Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements. Cherry Hill, NJ: American Society of PeriAnesthesia Nurses.
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- California Code of Regulations (2020). 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:

- Scope of Services of the Surgical Services Department (main operating rooms department)

SUBJECT: **SPUTUM INDUCTION**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define a process that ensures safe, timely and accurate induction and collection of sputum specimens

POLICY:

Respiratory Care Services will obtain sputum samples for culture and sensitivity utilizing sterile techniques and the least invasive technique possible, starting with a voluntary cough to produce sputum, followed by nebulization of a 10% solution of NaCl and including mechanical airway clearance (suctioning) as necessary.

AFFECTED AREAS/PERSONNEL: *RESPIRATORY CARE PRACTITIONERS*

PROCEDURE:

1. Verify physician's written/electronic order for Sputum Induction.
2. Ensure that order for 10% NaCl has been ordered through pharmacy.
3. Ensure that an order for a bronchodilator has been ordered for risk of bronchospasm.
4. Bring a sterile conical tube for collection with a patient label.
5. Wash hands upon entering the patient's room.
6. Identify the patient utilizing at least two forms of identification.
7. Identify yourself and explain the purpose of your visit.
8. Instruct patient to cough and expectorate into specimen container. Educate patient on the importance of receiving sputum versus saliva and the minimum amount of sputum required (5ml).
9. Immediately replace the cover on the specimen container and fill out patient label; send to the laboratory.
10. If the patient is unable to expectorate, administer a SVN with 3-5 mls of 10% NaCl solution.
11. Upon completion of treatment, have patient cough and expectorate into specimen cup, label and send to the laboratory.
12. Document Sputum Induction under Interventions: RCP Pre/Post Treatment.
13. Document a Note in the patients' medical record indicating the status of the collection attempt.

14. For sputum inductions related to TB patients, 3 sputum samples are required. A sample is to be collected every 8 hours. Notify the RN and MD if the induction attempts are not successful.

PRECAUTIONS:

Hypertonic saline may precipitate bronchial spasms, wheezing and increased secretions. If these symptoms appear, immediately stop the treatment and administer 0.5 ml of albuterol and notify MD.

REFERENCES:

- Instructions for Hospitalized/Institutionalized Tuberculosis Patients: Public Health Hold, Reporting, Discharge Treatment Plan, and Conditions of Discharge. (2023, February 10). Tulare County Health & Human Services Agency. Retrieved from http://hhsawebdocs.tchhsa.org/File.ashx?id=6058

- Procedures for Collection of Induced Sputum Specimens From Children | Clinical Infectious Diseases | Oxford Academic. (2012, April 01). Retrieved April 19, 2018, from https://academic.oup.com/cid/article/54/suppl_2/S140/376549/Procedures-for-Collection-of-Induced-Sputum

CROSS REFERENCES:

- Respiratory Policy & Procedure: SMALL VOLUME NEBULIZER (SVN)

SUBJECT: UNIVERSAL PROTOCOL	SECTION: Page 1 of 8

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

PURPOSE:

- To provide guidelines for a standardized verification process, utilizing a safety checklist, for all patients undergoing a surgical/non-surgical invasive procedure requiring an informed consent.
- To assure that the correct procedure is performed on the correct patient and body site/side
- To define the process by which hospital staff and licensed practitioners (e.g. physicians, nurse practitioners) participating in a surgical or non-surgical invasive procedure will actively participate in the three-part Safe Surgery Checklist, including Sign-In, Time-Out, and Sign-Out, as described in this policy.

POLICY:

- The Universal Protocol, which includes a three-stage checklist modeled after the World Health Organization (WHO) Surgical Safety Checklist, must be conducted whenever an inpatient or outpatient undergoes a surgical or non-surgical invasive procedure requiring an informed consent, . This protocol applies to all operative and non-operative areas.

DEFINITIONS:

- Invasive Procedure: For the purposes of this policy, an invasive procedure is any intervention that involves penetration or manipulation of the body's natural barriers to the external environment.
- Procedure Room: Any site within the facility where a surgical or non-surgical invasive procedure may occur inclusive of the patient's bedside.
- Site Marking: A process by which a skin marker, which will produce a mark with sufficient permanence, is used to clearly denote the intended procedure site.
- Safe Surgery Checklist: A three-stage checklist modeled after the WHO Surgical Safety Checklist performed by the surgical/procedural team: 1) prior to sedation or anesthesia intervention (i.e., nerve block), 2) after anesthesia induction and prior to incision or start of procedure, and 3) at end of the procedure before leaving the OR/procedural area.

AFFECTED PERSONNEL/AREAS:

ALL PATIENT CARE AREAS; ALL PATIENT CARE PROVIDERS

PROCEDURE:

1. When a patient is prepped for a surgical or non-surgical invasive procedure in an area other than the actual procedure location, then a pre-procedure verification must occur prior to transfer or at the patient's bedside if this is the location of the procedure. Missing items or discrepancies must be addressed prior to the start of the procedure.

a. **Pre-Procedure** Verification process includes:

- Correct patient
- Correct procedure(s)
- Consent form(s) accurately completed and signed
- Labs, radiological images labeled and available
- Correct site/side marked with appropriate providers' initials or implementation of alternative site/side marking (blue band) if necessary
- Blood products, implants, devices/equipment available
- Antibiotics per physician order, if applicable
- Beta Blocker medication given, if applicable
- Venous Thromboembolism prophylaxis ordered, if applicable
- Normothermia measures implemented
- H&P, assessments and other pertinent documents available

2. Site Marked and Verified (the patient should be involved in site marking if possible). The site must be marked and verified for procedures involving right/left distinction, multiple structures (e.g., fingers, toes) or multiple levels (as in spinal procedures). The site must be marked with the appropriate provider's initials so that the mark will be visible after the patient has been prepped and draped.

a. A provider who is credentialed to perform the procedure AND who will be present during the procedure is responsible for marking the site. In limited circumstances, the Licensed Independent Practitioner (LIP) may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the LIP (e.g. the APRN, PA). It is to be noted that the LIP who delegates this responsibility is the practitioner ultimately responsible for the procedure.

b. Site will be marked with the provider's initials with the patient awake and aware if possible, (if not possible then the family/caregiver or legal guardian) using a marker that is sufficiently permanent to remain visible after completion of skin prep and draping. Do not mark the non-operative site(s) unless necessary for some other aspect of care. (*Note:*

It is never appropriate to mark a procedure site with an "X" or the words "Yes" or "No".)

c. EXCEPTIONS to marking the site:

- Procedures done through or immediately adjacent to a natural body orifice (e.g. upper GI/lower GI endoscopy, tonsillectomy, hemorrhoidectomy, procedures involving perineum), where laterality is not a concern.
- Teeth – however, indicate operative tooth names(s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram.
- Endoscopies without laterality
- Midline or single organ cases (e.g. gallbladder, appendix)
- Procedures for which the incision/insertion site is not predetermined (e.g. epidural/spinal, cardiac catheterization, pacemaker).
- Procedures that include needle marker localization (The patient has needle left in place to mark breast or tumor.)
- Premature infants for whom the mark may cause a permanent tattoo.
- Cases in which the individual performing the procedure is in continuous attendance with the patient. Continuous attendance is defined as from time of decision to perform the procedure and informed consent is obtained of the patient or family as to performance of the procedure.
- Procedures involving bilateral structures (e.g. bilateral tubal ligation, bilateral myringotomy with tubes)
- "Possible" procedures involving laterality will not be marked in order to avoid confusion (e.g. "Right myringotomy, possible left myringotomy". The right side will be marked but NOT the left.)
- (e.g. "Right ureteral stent placement, possible left ureteral stent placement". The "right ureter" will be hand-written on the white area of the blue band, indicating site, but not the left.)
- Wounds or lesions that are obvious (e.g. left heel decubitis debridement)

  (NOTE: If there are numerous wounds and lesions and the site is not obvious, site marking is necessary).

d. Where laterality, surface, level, digit or lesion is important and marking is not possible, a designated blue extremity band will be used. The facility defined alternative for site marking of the skin will be applied, using the designated blue band on the wrist, for purposes of designating the correct operative SIDE. The specifics as to the surgical site/procedural site are to be hand written on the white area of the blue band. This information is to be recorded with the patient and/or family/caregiver or legal guardian present and participating, if possible. The blue bands are stored in the forms storage room in Flex Care.

NOTE: If a patient is consented for a "Cystoscopy and Right Ureteral Stent Insertion", "right ureter" is to be handwritten on the white portion of the blue band which is then placed on the patient's right wrist to indicate the correct side.

NOTE: The blue band may be removed at the conclusion of the case when its presence is no longer required.

e. For the patient refusing site marking, the nursing staff will re-confirm and re-educate the patient and/or family/caregiver or legal guardian the reason and safety precautions in completing the site marking. This education process is to be documented in the intra-operative nursing record.

- If the patient and/or family/caregiver or legal guardian continues to refuse the site marking, even after additional education, the patient's physician will be contacted advising of the patient's wishes.
- The alternative to site marking designated in # d. above will serve to mark the site in terms of laterality.

3. Procedural Area Verification – Three (3)-Stage Safe Surgery Checklist

a. Sign-In before induction of anesthesia. After introduction of the procedural team in the room, the RN and anesthesia care provider confirm with the patient, if possible, that:

- his/her identity is confirmed
- the procedure and site are correct, and the site is marked by the surgeon
- consent for surgery has been obtained and the form is signed
- pulse oximeter is on the patient and functioning
- review of allergies, airway difficulty and potential blood loss is reviewed
- blood is available if applicable
- the Anesthesia Safety Checklist is completed

b. Time Out before incision: The "Time Out" is a deliberate pause in activity involving clear communication (that includes active listening and verbal confirmation of the patient, procedure, site and side) among all members of the procedural team. It is initiated by the circulating nurse (or technician if the presence of a nurse is not required for the procedure.) The procedure is not started until any questions or concerns are resolved. The "Time Out" occurs only when all procedural team members are present and attentive.

- When two or more procedures are being performed on the same patient, and the person performing the procedure changes, a "Time Out" must be performed before each procedure is initiated.
- A "Time Out" must be performed by the anesthesia provider and the RN before performance of an anesthetic block; i.e., spinal or regional block
- Additional "Time Outs" must be performed after bed rotation of 180 degrees before patient is prepped and draped.
- The "Time Out" includes, at a minimum:
  - Correct patient identity
  - Correct site
  - Drug allergies
  - Site marking is visible after prepping and draping or is verified with blue band or with available radiographs
  - Antibiotic(s) as ordered by physician (if applicable)
  - Beta Blocker medication given, if applicable
  - Venous Thromboembolism prophylaxis ordered, if applicable
  - Procedure team agrees as to procedure(s) to be performed
  - Prep site is dry
  - Fire Risk Assessment (See Attachment 1: Fire Risk Assessment Tool)
- The following items may be included in the "Time Out" if relevant to the patient and procedure.
  - Safety precautions are in place based on patient history, allergies and medication use

- Patient positioning is correct
- Labs and Relevant radiological images and results are properly labeled and appropriately displayed
- Required blood products, implants, devices and/or necessary equipment available
- Antibiotic fluids prepped for irrigation, as applicable

c. Sign-Out before the patient leaves the OR or procedural area. The Circulating Nurse confirms with the team that:

- Name of procedure
- The sponge/instrument/sharps count is correct
- Specimens are identified and labeled
- Any equipment problems are addressed
- Any concerns for recovery or management of the patient

4. Documentation of performance of the stages of the Universal Protocol, from Pre-Procedural Verification to Sign-Out after the procedure, will be done in the electronic nursing record in the Pre-Procedure Assessment and Intraoperative sections of the PCS or ORM systems, or on the Procedural Sedation Nursing Record.

REFERENCES:

- CAMH Manual. **Educating Patients about Surgical Site Infections: Complying with NPSG.07.05.01.** Joint commission On-Line – ~~September 17, 2012,~~ July 2023 http://www.jointcommission.org/standards
- World Health Organization. World Alliance For Patient Safety: Implementation Manual WHO Surgical Safety Checklist (First Edition)/Safe Surgery Saves Lives. http://www.who.int.patientsafety/en/ ~~(accessed September 25, 2012~~). July 2023
- AORN Perioperative Standards and Recommended Practices, ~~2012~~ 2023 Edition; Transfer of Patient Care Information.

ATTACHMENTS: **Safe Surgery Checklist and Fire Risk Assessment Tool**

ATTACHMENT A: Safe Surgery Checklist

SIGN-IN		
• Introduction of Team, if applicable • Identity confirmed • Procedure & Site (Marked if applicable) • Consent obtained and signed • Pulse oximeter on & functioning • Review of allergies • Review of airway • Blood products needed / available • Anesthesia Checklist completed 9/04/12	• Pause by team • Identity confirmed • Procedure & site confirmed • Site marked and visible, or verified with blue band • Review of allergies • Meds labeled • Antibiotic infused • Beta Blocker given • VTE prophylaxis ordered • Prep site dry • Fire Risk Assessment done • If applicable – * Blood available * X-ray images displayed * Antibiotic fluids prepped for irrigation	• Name of procedure • Completion of sponge, sharps, instrument count • Specimens identified & labeled • Any equipment problems? • Key concerns for Hand-Off to Recovery

ATTACHMENT B

Fire Risk Assessment Tool

A. Is an alcohol-based prep agent or other volatile chemical being used preoperatively?
- ☐ Yes
- ☐ No

B. Is the surgical procedure being performed above the xiphoid process?
- ☐ Yes
- ☐ No

C. Is open oxygen or nitrous oxide being administered?
- ☐ Yes
- ☐ No

D. Is an ESU, laser, or fiber-optic light cord being used?
- ☐ Yes
- ☐ No

E. Are there other possible contributors (e.g. defibrillator, drills, saws, burrs)?
- ☐ Yes
- ☐ No

SUBJECT:	SECTION:
UNUSUAL OCCURRENCES IN THE OPERATING ROOM	**Page 1 of 2**

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

PURPOSE:

To outline the process to be followed when an unusual occurrence takes place so that timely reporting is assured.

POLICY:

Surgical Services Personnel shall adhere to the guidelines set forth regarding unusual occurrences in the operating room.

In an unusual occurrence of any nature (i.e., death or fire in the OR, fire, wrong site surgery, patient burn, significant medical error), patient safety is the primary focus. After patient safety is assured and the patient is stabilized, timely reporting must occur.

AFFECTED AREAS/PERSONNEL: *MAIN OR/ASD/PACU, MCH OR/ALL PERSONNEL*

PROCEDURE:

1. **Death in the operating room or PACU.**

   a. The Coroner will be notified regarding all deaths occurring in the Operating Room, immediately after the patient has been pronounced.

   b. The Coroner will be notified regarding all deaths where a patient has not fully recovered from anesthesia immediately after the patient has been pronounced

2. **Fire in the operating room**

   a. The most important step is prevention. All electrical equipment is checked by the Engineering or Biomedical Department prior to being placed into service.

   b. If a fire should occur, it will be extinguished as quickly as possible. A Code Red will be called immediately following the established hospital procedure.

   c. If the fire is easily extinguished, the case will be completed and the patient moved to the area designated for the recovery period.

   d. The Porterville City Fire Department will be contacted immediately following the case to investigate the situation.

   e. The Operating Room where the fire occurred will be left intact. The drapes, grounding pad, and all electrical equipment will be left in the room in the manner in which it was used. The staff will remain in attendance to maintain the scene and assist the Fire Department personnel.

f. The Engineering Department will be informed immediately of the occurrence so they are able to run equipment checks and gather data for the medical device report to the manufacturer and/or the Food and Drug Administration.

3. **Reporting**

a. The Clinical Manager will be contacted if any unusual occurrence occurs during normal working hours and the Nursing Supervisor will be contacted during off hours. The Director of the Department, the Vice President of Patient Care Services and Hospital Administration (Administrator On Call) will be contacted, as soon as possible.

b. All deaths, fires or any other unusual occurrences are documented and communicated according to the house-wide policy titled "Patient Safety Event."

REFERENCES:

- ~~California Code of Regulations (2020). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1~~.

- The Joint Commission: Only You Can Prevent Surgical Fires. ~~10/12/2017 By Gerard M. Castro, PhD, MPH, Project Director, Patient Safety Initiatives~~. Laura Gayton. 8/30/21. https://www.jointcommission.org/resources/news-and-multimedia/blogs/ambulatory-buzz/2021/08/only-you-can-prevent-asc-fires/#:~:text=Joint%20Commission%20Requirement&text=periodically%20evaluate%20potential%20fire%20hazards,of%20flammable%20germicides%20or%20antiseptics

CROSS REFERENCES:

- Patient Safety Event
- Disaster Manual, Life Safety Management Plan
- Disaster Manual, Medical Equipment Management Plan

SUBJECT: **VISITORS IN THE OPERATING ROOM**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define guidelines for visitors in the Operating Room (OR) and Post Anesthesia Care Unit (PACU).

POLICY:

All visitors to the Surgical Services areas will follow the guidelines set forth, thereby promoting a safe environment for the patient as well as patient privacy and infection control.

AFFECTED AREAS/PERSONNEL:

MAIN OPERATING ROOM (OR); OB-OR; POST ANASTHESIA CARE UNIT (PACU); ENDOSCOPY SUITE; ALL VISITORS

PROCEDURE:

1. The Director and/or Clinical Manager will be notified of any planned visit to the department in advance.

2. Visitors will be expected to follow established standards within the department. Examples include but are not limited to dress code, traffic patterns, and aseptic technique. Only visitors in proper surgical attire will be allowed into the department past the red floor line marking.

3. Conversation in the OR suite will be limited to business and will be conducted in a quiet tone of voice.

4. Medical and paramedical personnel whose purpose is education may observe procedures with the permission of the patient, Surgeon, Anesthesiologist, and Clinical Manager or designee. To protect the patient's right to privacy, an Observer Consent, signed by the patient, observer and physician must be obtained before the observer is allowed into the procedural room.

5. Visiting physicians may observe a procedure following the approval of all individuals listed in #4 above. If he/she wishes to assist in a procedure, and is not a privileged medical staff member, temporary privileges must be obtained through the process established by the SVMC Medical Staff.

6. Representatives of equipment manufacturers and suppliers may be authorized to be present for the following circumstances:

    a. When new equipment/supplies or techniques are being introduced.

    b. To provide technical advice.

    c. Representatives do not require patient consent.

7. Since manufacturer's representatives are temporarily part of the surgical team, an Observer Consent is not required.

8. Non-medical personnel may be allowed to observe surgical procedures under certain circumstances. The patient must be informed and written consent obtained using the Observer Consent.

9. Under no circumstances will non-medical personnel be allowed to scrub in.

10. Visitors may be requested to leave the OR at any time during the procedure and must do so immediately.

11. Family members are not permitted to observe the surgical procedure unless specifically requested by the patient and surgeon and approved by the anesthesiologist. The Observer Consent must be signed by the patient, surgeon and observer.

REFERENCE:

AORN Perioperative Standards and Recommended Practices, ~~2019 .~~ *Should a visitor wear personal protective equipment when visiting a patient who is under transmission-based precautions*. **retrieved June 2023.**

- ~~AORN Guideline for Transmission-Based Precautions. In: Guidelines for Perioperative Practice. Denver, CO: AORN, Inc. Munoz-Price LS, Banach DB, Bearman G, et al. Isolation precautions for visitors. Infect Control Hosp Epidemiol. 2015;36(7):747-758. Updated December 1, 2018.~~

CROSS REFERENCE:

- Medical Staff, Temporary Privileges
- Cesarean Section: Criteria for Admission of Support Person to Main OR policy
- "Vendor Representatives, Hospital Visits By " policy

SUBJECT: **WOUND CLASSIFICATION**	SECTION: **Page 1 of 5**

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

PURPOSE:

To identify for nursing staff the guideline for classifying surgical wounds.

POLICY:

Surgical wounds will be classified and recorded at the time of surgery according to the likelihood and degree of wound contamination as determined by the American College of Surgeons.

AFFECTED AREAS/ PERSONNEL: *SURGICAL SERVICES,MCH OR CATH LAB/CIRCULATING RN*

PROCEDURE:

1. Classification of all surgical wounds will be documented by the Circulating RN on the electronic medical record. The information will be entered for each case in the computer data bank for the surgery log.

2. If at least two procedures with different classifications are done on the same patient, the wound will be classified according to the higher class.

3. Factors that will increase the wound class of the operative wound are major breaks in technique, significantly acute nonpurulent inflammation, presence of pus, delayed treatment of traumatic wounds/lacerations/fractures.

4. Statistics will be coordinated between surgical services and infection control to track wound infections by wound classifications and will be surgeon specific. These statistics will be evaluated and forwarded to appropriate chief of service or medical staff committees.

WOUND CLASSIFICATIONS

A. CLASS I (CLEAN WOUNDS)

   1. Respiratory, alimentary, genital or urinary tracts are **not** entered.

   2. No inflammation, cellulitis, or infection in the operative field or in other body areas.

   3. All clean wounds are closed primarily, and selected ones can have a closed drainage system.

   4. Wounds that follow non penetrating blunt trauma can be listed as a clean wound if all of the other criteria are met.

   5. Operating Room-No break in aseptic technique.

6. Narrative: Clean wounds are those in which the operation does not enter a contaminated or potentially contaminated viscus or area. There is no local or distant infection, inflammation, or cellulitis. Aseptic technique is adhered to without any possibility of contamination of instruments or the operative field. All clean wounds are closed primarily, and selected ones can have a closed drainage system. Wounds that follow penetrating (blunt) trauma can be listed as a clean wound if all the other criteria are met. Almost all clean wounds occur in elective cases, but not all elective cases have a clean wound.

EXAMPLES:

Abdominal Aortic Aneurysmectomy
Adrenalectomy
Aorto-bifemoral Bypass
Aorto-coronary Bypass
Amputation (unless infected)
AV Fistula
Arthroplasty
Cataract Surgery
Carotid Surgery
Carotid Endarterectomy
Embolectomy
Exploratory Laparotomy
Eye Surgery (elective)
Femoral-popliteal Bypass
Heart Valve Repair/Replacement
Hip Nailing (plus other reconstructive surgeries/joint prosthesis)
Hydrocelectomy
Vein Stripping
Mastectomy (including radical)
Neurosurgery (craniotomy, spinal infusion, laminectomy, ventricular shunts)
Orchiectomy
Orchiopexy
Ovarian Cystectomy
Pacemaker Placement
Parotidectomy
Portacaval Shunt
Radical Neck (outside incision)
Salpingo-oophorectomy
Skin Graft
Splenectomy
Sympathectomy
Thyroidectomy
Parathyroidectomy
Total Joint Replacement
Tubal Ligation

B. CLASS II (CLEAN-CONTAMINATED)

1. The respiratory, alimentary, genital, and urinary tracts are entered under very controlled circumstances without any significant contamination of the operative field or surrounding area.

2. Specifically, operations involving the biliary (in absence of infected bile), oropharynx, appendix, and vagina are included in this category.

   a. Although some evidence of minimal inflammation may be present, there is no cellulitis or infection in the operative field or in other organs or sites.

   b. Operating Room-Minor break in aseptic technique occurs but no major break or contamination.

Narrative: Clean-contaminated wounds are generally those in which the operation enters a viscus which may have minimal inflammation, ***WITH NO INFECTION.*** Included but not limited surgical procedures including the biliary tract, appendix, vagina, and oropharynx, provided no evidence of infection is encountered and no major break in sterile technique occurs. Most clean-contaminated wounds can be closed primarily; however, many of them will have some form of mechanical drainage.

EXAMPLES:

Abdominal Hysterectomy
Abdominal Perineal Resection (prepped)
Appendectomy
Bowel Resection
Cesarean Section
Cholecystectomy (negative cultures)
Biliary Tree Procedures
Colostomy Closure
Cystoscopy (negative culture)
Esophagectomy
Gastrectomy (vagotomy, antrectomy)
Intranasal Surgery (no inflammation)
Laceration <8 hours old
Laparoscopy
Laryngectomy
Nephrectomy (if urine is sterile)
Tympanoplasty
Oscopies-cysto, sigmoid procto, broncho, laryngo, esophago, etc.
Oral/dental Surgery
Open Fractures<10 hours old
Paranasal Sinus Surgery
Pilonidal cyst/sinus surgery
Pneumonectomy/Lobectomy
Polypectomy
Radical Neck
Rectal/Vaginal Surgery
uterine cervix, D & C, Vaginal Hysterectomy Hemorrhoidectomy)
Small Bowel Surgery
Stapedectomy
Tracheostomy
Prostatecomy (not TURP)
Ureterolithotomy (other ureter, bladder surgeries)

C. CLASS III (CONTAMINATED)

1. The respiratory, alimentary, genital and urinary tracts are not only inflamed, but also infected.

2. The infection is generally contained and not throughout the entire area.

3. There is gross inflammation, active infection, or cellulitis in the operative field.

4. There can be infection or inflammation in another organ or site.

5. Operating Room-There is a major break in technique.

6. Fresh, traumatic wounds less than four (4) hours old.

Narrative: Contaminated wounds are those in which the operation enters an infected viscus or area. There is local or distant infection. A major break in aseptic technique occurs such as

contamination such as a large tear in the glove or contaminated foreign body falling into the operative field. Gross spillage of visceral contents, even if not infected, is generally considered contamination of the area and placed in Class III. Most contaminated wounds are not closed or may be partially closed with external drainage of wound.

EXAMPLES:

Appendectomy (with perforation/peritonitis)
Bowel Resection (with perforation/peritonitis)
Burns (debridement)
Cholecystectomy (positive culture)
Diverticulectomy
Fistulectomy
Traumatic Wounds>10hours
Intranasal Surgery
Lacerations >8 hours
Myringotomy
Nephrectomy (bacteriuria)
Open fractures >10 hours\
Tonsillectomy & Adenoidectomy
TURP

D. CLASS IV (DIRTY/INFECTED)

1. There is gross contamination in the abdomen with infected material or spillage from a viscus in an inflamed or infected area.

2. There is active infection such as an abscess, devitalized tissue with infection or a foreign body with infection.

3. This definition suggests that the organisms causing post-operative infection were present in the operative field before the operation.

4. Operating Room-There is major break in aseptic technique with a grossly infected foreign body.

Narrative: Dirty wounds are those in which the operation drains an abscess or significantly infected area. There is local or systemic infection. The break in aseptic technique involves contamination of the operative field from an infected source. This factor rarely occurs and an example would be placement of non-sterilized prosthesis. No dirty wounds are closed primarily.

REFERENCES:

- ~~The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.~~
- ~~American College of Surgeons~~
- ~~Center for Disease Control and Prevention 2019.~~ CDC. *Surgical Site Infection (SSI) Event*. https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf Updated January 2019. Accessed August 16, 2019.

- ~~Association Of Operating Room Nurses Standards Of Practice 2019~~
- Association of Operating Room Nurses. 2012-2018. Surgical Wound Classification Tree. https://aornguidelines.org/searchresults?page=1&q=surgical%20wound%20classification%20tree

SIERRA VIEW MEDICAL CENTER

CODE BLUE FORM

DATE:	LOCATIONS: ☐ FIELD ☐ ED ☐ ICU ☐ M/S ☐ OTHER:_____	FAMILY NOTIFIED ☐ YES ☐ NO	NAMES: Pharmacist:_____ Nurse:_____ Nurse:_____ Nurse:_____ RT:_____ Other:_____ Other:_____
Time Initiated:	ARREST TYPE: ☐ RESPIRATORY ☐ CARDIAC	WITNESSED: ☐ YES ☐ NO	☐ N/A ☐ PRESENT Name of Family:

AIRWAY/ VENTILATION

Initial: ☐ Spontaneous ☐ Apnea ☐ Agonal ☐ Assisted

Type: ☐ ETT ☐ BVM Intubation Time _____ Size _____

Confirmation: ☐ Auscultation ☐ End Tidal CO2 ☐ CXR

Placement: _____ cm @ Teeth/Gum Lip

Placement By: _____

RESP LEGEND:

B: Bagged

S: Spontaneous

V: Ventilated

PMD NOTIFIED:
Name: _____
Time: _____ NA

SIGNATURES:
Recorder:_____
Physician:_____

Blood Glucose

Type			
Value			

Time	VITALS/ RHYTHM					INTERVENTIONS				MEDICATIONS										Interventions					
										Bolus / IVP					Infusions				IVF	Type	Time	Initials	Peripheral IV's		
	BP	Rhythm	Heart Rate/Pulse	Respiratory Rate/Method	SpO2	Bagging (BVM)	Compressions	Defib/Cardio Jules	External Pacing Rate/Amplitude	Amiodarone mg	Atropine mg	Epinephrine mg	Lidocaine mg	Sodium Bicarb mEq	Amiodarone (mcg/min)	Dopamine (mcg/min)	Epinephrine (mcg/min)	Norepinephrine(mcg/min)	☐ NS ☐ LR	CVC					
																				A-Line					
																				NG/OG					

COMMENTS

Additional Meds, Interventions, etc.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

CODE BLUE FORM

Form # 009194 REV 4/23

White - Chart Medical Record Canary - Pharmacy Copy

PATIENT LABEL

Time Ended
Patient Outcome
☐ Deceased
☐ Survived

Disposition
☐ Remain in Room
☐ Transferred to: _____

Copies
White – Chart
Yellow - Pharmacy
Pink - Manager

121

CODE BLUE/CODE WHITE EVALUATION REVIEW FORM

For Quality Purposes Only • * Confidential, protected by California evidence code section 1157

QUALITY OF RESPIRATORY AND CARDIOPULMONARY RESUSCITATION

CPR Quality:

• Was continuous end tidal C02 monitoring (Capnography) used to monitor quality of CPR?	☐Yes ☐No / Not Documented
If yes, was an end tidal C02 value of >10 mmHg achieved?	☐Yes ☐No / Not Documented
• ROSC (Return of Spontaneous Circulation) If achieved, time documented?	☐Yes ☐No / Not Documented
• Was a feedback *device or technology used to monitor quality of compressions? (* e.g, an electronic sensor which connects to a monitoring device to measure= Zoll R series One Step CPR. Complete for compression rate, depth and full chest recoil and hands off timer)	☐Yes ☐No / Not Documented
If Yes, Was a compression rate 100-120/minute provided during CPR (target 110.min)?	☐Yes ☐No / Not Documented
If Yes, Was a compression depth of 2-2.4 inches provided during CPR?	☐Yes ☐No / Not Documented
• Were compressions interrupted (hands off period) for > 10 seconds at any time during CPR?	☐Yes ☐No / Not Documented
• Was CCF % (chest compression fraction) monitored and 60-80% (GOAL >80%)?	☐Yes ☐No / Not Documented
• Was a CPR Coach assigned to monitor the Quality of CPR (Compressions and Ventilation)?	☐Yes ☐No / Not Documented

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

Chest Compression:
☐ Delay ☐ No board ☐ Other (specify in comments section)

Defibrillation(s):
☐ Given, not indicated ☐ Indicated, not given ☐ Equipment malfunction
☐ Energy level lower / higher than recommended ☐ Initial delay, personnel not available to operate defibrillator
☐ Initial delay, issue with defibrillator access to patient ☐ Initial delay, issue with pad or paddle placement
☐ Other (specify in comments section)

Universal Precautions:
☐ Not Followed By All Team Members (specify in comments section)

Documentation:
☐ Signature of code team leader not on code sheet
☐ Incomplete Record ☐ Other (specify in comments section)

Alerting Hospital - Wide Resuscitation Response:
☐ Delay ☐ Pager issue(s) ☐ Other (specify in comments section)

Airway:
☐ Aspiration related to provision of airway ☐ Delay
☐ Intubation attempted, not achieve ☐ Delayed recognition of airway misplacement/displacement
☐ Multiple intubation attempts (# attempts _____) ☐ Other (specify in comments section)

Vascular Access:
☐ Delay ☐ Inadvertent arterial cannulation
☐ Infiltration/Disconnection ☐ Other (specify in comments section)

Leadership/Team Dynamics:
☐ Delay in identifying leader
☐ Knowledge of roles/responsibilities
☐ Knowledge of medications / protocols
☐ Knowledge of equipment
☐ Effective communication
☐ Other (specify in comments section)

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

Protocol Deviation:
☐ BLS ☐ ACLS / PALS ☐ NRP ☐ Other (specify in comments section)

Equipment:
☐ Availability ☐ Function ☐ Other (specify in comments section)

Comments:

_____
_____
_____
_____
_____

☐ RRT trigger(s) present but team not immediately activated
RRT Response Delay
☐ RRT criteria / process not known or misunderstood by those calling RRT.
☐ RRT communication system not working (e.g. phone, operator, pager)
☐ Incomplete or accurate information communicated
☐ Other (specify in comments)
☐ Essential patient data not available
☐ Medication delay
Equipment Issue:
☐ Specify equipment _____
☐ Availability
☐ Function
☐ Issues between RRT team and other caregivers / departments

Comments:

_____
_____
_____
_____
_____

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

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 **August 22, 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 5:06 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, PANDYA, KASHYAP**

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Tracy, VP of Human Resources, Dickson, Doug, Chief Financial Officer, Donna, President/Chief Executive Officer, Franer, Julie, Admin Director of Revenue Cycle, Gomez, Cindy, Director of Compliance, Hakimi, Ahmad, Vice Chief of Staff, Hudson, Jeffery, VPPCS/CNO/DIO, Lambag, Deven, Darden Architects, Mandujano-Roberts, Silvia, Manager of Care Integration for Social Services and Case Management, Mitchell, Melissa, VP Quality and Regulatory Affairs, Nelson, Michael, Darden Architects, Pryor-DeShazo, Kimberley, Director of Marketing, Reed-Krase, Alex, Legal Counsel, Wallace, Marcella, Director of Communications, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

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

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:01 p.m. to discuss the following items:

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

Director LOMELI presented at 5:12 p.m.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

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

Closed Session Items C, E, and 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 5:41 p.m., reconvening in Open Session at 5:42 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 Vice Chief of Staff Hakimi. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

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

REDDY	Abstain
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

Following review and discussion, it was moved by Director LOMELI, seconded by Director PANDYA, 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

D. Discussion Regarding Trade Secret

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IV. Public Comments

None.

V. Consent Agenda

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director LOMELI and seconded by Director KASHYAP to approve the July 25, 2023 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes

LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. CEO Report

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

In the District:

- Sierra View Medical Center has applied for $17.35M Distressed Hospital Loan to strengthen healthcare services for our local community. Our commitment to healthcare access and enhancing patient services drives this application. If approved, the interest-free loan will assist our comprehensive turnaround plan by strengthening operations, enhancing staff development, and supporting our GME Internal Medicine Residency Program, reinforcing our commitment to healthcare education.

- Join the Sierra View Foundation on October 14th, 2023 to Rock N Roll for a Cause! Enjoy a night of great company and fun entertainment as Run for Cover shows us what it means to Rock N Roll for a good cause!

- Join the Porterville Breakfast Rotary Club's 20th Annual Cancer Run/Walk at Granite Hills High School on September 9, 2023.

VIII. Business Items

A. July 2023 Financials

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

Total Operating Revenue was $12, 311,416. Supplemental Funds were $1,401,152. Total Operating Expenses were $13,170,047. Loss from operations of $858,631.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IX. Closed Session: Board adjourned Open Session at 6:12 p.m. and went into Closed Session at 6:12 p.m. to discuss the following items:

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item) Estimated Date of Disclosure – February 2030

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 – October 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 8:42 p.m. and went into Open Session at 8:42 p.m. to discuss the following items:

C. Discussion Regarding Trade Secret

Following review and discussion, it was moved by Director PANDYA, seconded by Director LOMELI and carried to approve the Seismic Plan as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

Following review and discussion, it was moved by Director PANDYA, seconded by Director LOMELI and carried to approve initiation of process for Public Bid for Capital Improvement Project as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

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

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

XII. Announcements:

A. Regular Board of Directors Meeting – September 26, 2023 at 5:00 p.m.

The meeting was adjourned 8:45 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww

FINANCIAL PACKAGE
August 2023

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE