SIERRA VIEW
MEDICAL CENTER

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

AGENDA
June 27, 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 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets; Pertaining to Service (1 Item) Estimated Date of Disclosure – November 2024

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

E. 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)

F. Pursuant to Gov. Code Section 54956.9: Conference with Legal Counsel Regarding Anticipated Litigation

G. 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 – February 2026

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

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

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

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

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

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

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
June 27, 2023

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. 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. **May 23, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove May 23, 2023 Minutes of the Regular Meeting of the Board of Directors

B. **June 5, 2023 Minutes of the Special Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove June 5, 2023 Minutes of the Special Meeting of the Board of Directors

IX. Business Items

A. **SVLHCD Fiscal Year 2024 Operating Budget**
Recommended Action: Approve/Disapprove

B. **Capital Budget Quarter 3**
Recommended Action: Approve/Disapprove

C. **May 2023 Financials**
Recommended Action: Approve/Disapprove

D. **Guidelines for Public Comment**
Recommended Action: Approve/Disapprove

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – July 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.

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MEDICAL EXECUTIVE COMMITTEE	06/07/2023
BOARD OF DIRECTORS APPROVAL	
	06/27/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
June 27, 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** ↓
• 340B Drug Pricing Program Compliance	1-10	
• Admission Guidelines for the Ambulatory Surgery Department	11-12	
• Capnography	13-15	
• Crash Cart in the Ambulatory Surgery Department	16	
• Extravasation Management of Sympathomimmetic Vasoconstrictors (Pressors)	17-19	
• High-Alert Medications and Look Alike Sound Alike Medications	20-32	
• Pandemic COVID-19 Management Plan	33-49	
• Pharmacy Organization	50-51	
• Pyxis Access	52-54	
• Pyxis Medication Overrides and Discrepancy	55-62	
• Radiation Protection and Safety	63-64	
• Routine Patient Care in the Post-Anesthesia Care Unit (PACU)	65-67	
• Scope of Service – Cardiac Cath Lab	68-70	
• Standard Maintenance of Water Treatment System	71-72	
• Tracheostomy Care – DP/SNF	73-75	
• Transfer of Patient to Higher Level of Care from Cardiac Cath Lab	76-77	

SUBJECT: **340B DRUG PRICING PROGRAM COMPLIANCE**	SECTION: *Pharmacy* **Page 1 of 10**

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

PURPOSE:

To define the policy and outline the procedures to ensure compliance with all state and federal requirements related to Sierra View Medical Center's (SVMC) participation in the 340B Program, including but not limited to registration with the Health Resources and Administration's (HRSA) Office of Pharmacy Affairs ("OPA"), medication procurement, billing, inventory management, and prevention of diversion of 340B Drugs.

POLICY:

The Pharmacy Department shall purchase, manage the inventory, and dispense 340B drugs to eligible patients treated in eligible hospital areas (Covered Sites), in accordance with procedures described below.

The Director of Pharmacy Services, in coordination with the Compliance Department, shall be responsible for overseeing compliance with this policy and ensuring that appropriate policies and procedures are in place to ensure such compliance. 340B Program compliance and oversight is the responsibility of SVMC Management, and the Director of Pharmacy Services shall provide regular reports to the Compliance Committee.

DEFINITIONS:

- Authorized Official: The individual registered as the authorized official of SVMC on OPA's 340B Program database, and who is eligible to make changes to the database listing.
- 340B Drugs: Means prescription drugs purchased pursuant to the 340B Program for dispensing or administration to Eligible Patients in the outpatient care setting of a Covered Site.
- 340B Program: Means the 340B Program established by the Veterans Health Care Act of 1992, and is codified as Section 340B of the Public Health Service Act (42 U.S.C. 256b). The 340B Program limits the cost of covered outpatient drugs to certain federally recognized covered entities. The program enables these covered entities to stretch federal resources, reach more eligible patients and provide more comprehensive services.
- Contact Official: The individual registered on the OPA's 340B program database to receive and respond to communication from OPA on behalf of the entity. The contact official may make changes to the OPA database but these changes must be approved by the authorizing official.
- Covered Outpatient Drug: The category of drugs for which manufacturers must pay rebates to State Medicaid agencies under the Medicaid rebate program and give discounts to covered entities under the 340B Program. The 340B Program statute defines "covered outpatient drug" by referencing the definition found in Section 1927(k) (2) of the Social Security Act.+42++742
- Covered Site: Means those: (i) outpatient departments or mixed-use settings of SVMC located within the four walls of the hospital, and (ii) off-site locations of SVMC that appear as a reimbursable hospital-based facility on a filed SVMC Medicare cost report, and are registered with HRSA as part of the hospital.

- Eligible Patient: Means an individual who meets all of the following criteria and only during periods when such criteria are met:

  - A patient with whom a Covered Site has established a relationship such that SVMC maintains records of such patient's treatment and care; and; the patient receives health care services from an Eligible Provider.

  An individual will not be considered an Eligible Patient if the only care he or she receives from SVMC or a Covered Site is the dispensing of a drug or drugs for subsequent self-administration in the home setting.

- Eligible Provider: Means a health care professional who is either: (a) employed by Sierra View Medical Center, or (b) provides health care under a contract or other arrangement (e.g., referral for consultation) with SVMC such that responsibility for the care provided to individuals pursuant to such contract or arrangement remains with SVMC, but only with respect to those services.

- OPA: Means the Office of Pharmacy Affairs, which oversees the 340B Program, within the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

- Material Breach: Sierra View Medical Center defines a material breach of compliance as a violation(s) that exceeds 5% of total 340B purchases in a calendar year.

- Group Purchasing Organization (GPO): An organization that represents and organizes a group of hospitals to evaluate and select pharmaceutical products. Using the purchasing power of the entire group, the GPO negotiates contracts that are more favorable than a single organization.

PROCEDURES:

1. Program Eligibility

   Eligibility to participate in the 340B Program is based on meeting the following requirements, applicable to Disproportionate Share Hospitals (DSH):

   a. Meet one of the following: (1) be owned or operated by a unit of state or local government; (2) be a public or private non-profit corporation which has been formally granted governmental powers by a unit of state or local government, or (3) be a private non-profit hospital with a contract with a state or local government to provide health care services to low-income individuals who are not entitled to benefits under Medicare or Medicaid;

   b. Have a Medicare DSH percentage greater than 11.75 percent for the most recent cost reporting period; and

   c. The Authorizing Official shall complete written verification that outpatient drugs will not be obtained through a Group Purchasing Organization (GPO).

The Authorizing Official will notify OPA in the event of any change(s) in eligibility, location, operating status, and authorizing official/primary contact information.

2. **Service Site Eligibility**

a. SVMC recognizes that OPA relies on the most recently filed Medicare cost report to determine which facilities are an "integral part" of SVMC for purposes of the 340B Program. The Director of Pharmacy, with assistance from Finance, shall review and confirm that each Covered Site is listed as a reimbursable center on SVMC's most recently filed cost report.

b. The Authorizing Official will take all steps necessary to register Covered Sites that are not located within the four walls of the hospital in OPA's 340B Covered Entity Database as child sites of SVMC, or to de-register Covered Sites that are no longer operated by SVMC or no longer listed as a reimbursable centers on the most recently filed cost report. OPA does not currently require sites located within the four walls of the hospital to be separately registered as a Covered Site.

c. 340B Drugs will not be dispensed by or shipped to service sites that are not Covered Sites.

d. On no less than an annual basis, an independent auditor as well as the contact official and the authorizing official will review the Office of Pharmacy Affairs Information System (OPAIS) database to ensure that SVMC's parent and all child sites are registered and that the information is correct, accurate and complete including:

- Physical address of all registered locations
- NPI and Medicaid Billing numbers for all locations

If there are any changes in the parent or child site registration information then SVMC will update the OPAIS database in a reasonable and timely manner.

3. **Covered Outpatient Drugs**

A covered outpatient drug is defined in the Medicaid rebate statute and represents the category of drugs for which manufacturers must pay rebates to state Medicaid agencies under the Medicaid rebate program.

a. Exceptions to a listed covered outpatient drug (as defined in the Medicaid rebate statute) can be made if the drug is part of a bundled charge or incident to another service. Outpatient purchases may be made on a group purchasing organization (GPO) account for drugs that do not meet the definition of a covered outpatient drug.

b. A drug is not considered a covered outpatient drug if all of the following tests are met:

i. The drug is "part of" or "incident to" a service

ii. The drug is given in the same setting as the service
iii. The drug is paid as part of the service

c. Any drug that is given to or administered to an ambulatory patient that is billed separately with the intention of getting paid, shall be considered a covered outpatient drug.

d. Contrast Media, IV solutions, and anesthesia gases are considered "part of" or "incident to" a service and billed without the intention of getting paid above and beyond the service. These drugs and IV solutions shall be considered an exception, and not a covered outpatient drug.

e. These drugs shall be flagged in the accumulators for the mixed use hospital sites, allowing for ambulance and inpatient purchases to be made on the sites' GPO account.

4. **Recertification**

a. The Authorizing Official shall recertify/decertify the hospital's child sites on an annual basis.

b. The Authorizing Official, or the primary contact individual listed on the 340B Database, shall receive advance notification from HRSA/OPA prior to the start of the recertification period. Only the Authorizing Official will receive the username and password to complete the process.

c. Prior to submitting a recertification, the Authorizing Official shall consult with the Director of Pharmacy Services to review compliance with all 340B Program rules and requirements.

5. **Inventory Management**

- SVMC maintains both a virtual and physical inventory.

Virtual inventory accumulation process:

- All dispensations that occur within the hospital are accumulated via split billing software.
- An electronic data feed is transferred to the split billing software vendor on a daily basis.
- Order is developed through SVMC's wholesaler, originating in the WAC account.
- Order is then uploaded into split billing software where the system determines which account number each product needs to go to.

- Order is automatically (via EDI) transmitted back to wholesaler and order is sent to be filled.
- Invoices are processed daily in the split billing software.
- Temporary products are merged to CDMs accordingly.

Physical inventory accumulation process:

- A physical inventory is maintained for the outpatient departments of the Cancer Treatment Center (CTC), Ambulatory Surgery Center (ASD), Wound Healing, Urology Clinic, , Medical Office Building, and Women's Imaging.
- All patients of these departments are eligible outpatients; therefore all drugs are purchased off the 340B Program account.
- Separate purchase orders (POs) are placed off the hospital's 340B Program account with the PO including the name of the site for which the purchase was made.
- These orders shall be directly transferred to the respective departments or shall be stored in the designated areas(s) of the hospital inpatient pharmacy.

  Utilization of this stock is restricted to usage for the designated areas.

- Borrowing of the 340B Drugs in emergency situations
  - Notify the pharmacy buyer and pharmacy director.
  - Staff shall fill out "Borrowing/Replacing of 340B Drugs" form.
  - Pharmacy buyer shall replace the drug on the 340B Program account.
  - The "Borrowing/Replacing of 340B Drugs" form will be completed and a copy of the invoice will be attached.
  - Forms will be maintained in a binder in the pharmacy, per regulatory requirements.

6. GPO Prohibition Compliance

- As a DSH covered entity, SVMC shall not purchase covered outpatient drugs through a GPO or other group purchasing arrangement for any of its clinics or departments within the four walls of the hospital. SVMC shall only purchase outpatient drugs through a GPO or other group purchasing arrangement for outpatient facilities outside the four walls of the hospital if the facility meets all the following criteria:

- Is located at a different physical address from SVMC,
- Is not registered on the 340B Covered Entity Database as a child site of SVMC, the drugs are purchased through a separate pharmacy wholesaler account than used by SVMC DSH facility,
- SVMC maintains records demonstrating that any outpatient drugs purchased through the GPO at those sites are not utilized or otherwise transferred to SVMC or any of the hospital's registered child sites. SVMC shall purchase covered outpatient drugs for its clinics or departments within the four walls of the hospital using a non-GPO account and shall only replenish with 340B Drugs once 340B patient eligibility is confirmed and can be documented through auditable records.
- When using the split billing software, if the exceptional circumstance arises where an unmatched 11 digit NDC occurs, then the split billing software will default to a WAC (Non-GPO, Non-340B) purchase. To ensure compliance with the GPO prohibition in this circumstance invoices will be checked by the pharmacy buyer upon delivery of the drug to the pharmacy. In the event of a purchase not on a WAC account, the contact official will be immediately notified.

  In addition, weekly quality reports, (i.e., transaction reports) will be run that will identify crosswalk mismatches. These mismatches will then be validated for proper accumulation. Any discrepancies in any of these procedures will be immediately reported to the contact official.

6. **Anti-Diversion Program**

a. SVMC is committed to safeguarding against the diversion of 340B Drugs to: individuals who are not Eligible Patients, to entities other than a Covered Site or Contract Pharmacy, or to hospital inpatients; toward these ends, SVMC shall have in place the following components of an Anti-Diversion Program, and shall revise such components as necessary to reflect new or revised 340B Program guidance:

i. SVMC shall ensure that those sites that receive or dispense 340B Drugs are a Covered Site or, in-house pharmacy.

ii. SVMC shall ensure that where 340B Drugs are used in a mixed care setting (e.g., an emergency room or perioperative care settings), adequate procedures are in place to ensure that the 340B Drugs are administered only to those Eligible Patients who are receiving outpatient care in such a setting.

iii. SVMC shall permit and cooperate with HRSA and/or the manufacturer of 340B drugs (with respect to those drugs it manufactures) to audit the records that pertain to compliance with 340B Program requirements, provided that any such audit undertaken by a manufacturer is in accordance with those

procedures established by HRSA relating to the number, duration and scope of any such audits.

7. **Billing and Reimbursement**

a. SVMC is committed to ensuring that the Medi-Cal program (California's Medicaid program) does not claim rebates from manufacturers with respect to 340B Drugs purchased by SVMC.

b. For each Covered Site that will use 340B Drugs for Eligible Patients enrolled in the Medi-Cal Program, SVMC shall undertake the following:

- Follow the appropriate procedures for notifying the HRSA Office of Pharmacy Affairs that the site will use Program Drugs for Eligible Patients who have Medicaid coverage for outpatient drugs, including, but not limited to, reporting the Covered Site's Medi-Cal and/or NPI billing numbers to the HRSA Office of Pharmacy Affairs.

- Submit claims to the Medi-Cal program consistent with Medi-Cal's billing requirements for 340B Drugs: 340B actual acquisition cost plus single administration fee for professional services for injections if applicable and UD modifier.

- On a regular basis, not less than annually, confirm that the Medi–Cal and NPI billing numbers for each Covered Site location using 340B Drugs for Medicaid patients are listed in the Office of Pharmacy Affairs' Medicaid exclusion file and that such Program Drugs are being properly billed to the Medi-Cal program consistent with the Medi-Cal approved billing methodology for Program Drugs;

- On not less than an annual basis, audit the accuracy and effectiveness (see Program Compliance Monitoring and Auditing section) of the foregoing system and safeguards.

8. **Program Compliance Monitoring and Auditing**

SVMC has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B Program requirements.

a. On a monthly basis, SVMC shall select a sample of claims from the following areas:

- 15 hospital claims
- 5 Cancer Treatment Center claims
- 5 Ambulatory Surgery Center
- 5 Urology Clinic
- 5 Wound Healing
- 5 Women's Imaging
- As needed for Medical Office Building

SVMC shall review the hospital claims for the following criteria:

i. The patient was an outpatient at the time the drug was administered. Patient status, either inpatient or outpatient, will be determined by the patient's recorded disposition in the electronic medical record

ii. The drug accumulated on the correct account (i.e., 340B, GPO, WAC). Furthermore, accumulation will be checked on all sample claims in each of the areas monitored monthly. In addition, at least quarterly a split billing software report will be run to survey for accumulation inaccuracies. Any found discrepancy will be immediately reported to the contact official. Reconciliation will be made immediately in the software so that correct accumulations are maintained.

iii. The patient was an eligible patient, the medical records are owned and maintained by SVMC.

b. SVMC shall review the claims selected pursuant to subdivision (a) to confirm whether Medi-Cal or a Medi-Cal Managed Care Organization (MCO) was the payer. If none of the claims selected pursuant to subdivision (a) were submitted to Medi-Cal or a MCO, SVMC shall continue to select claims until 5 claims that were submitted to Medi-Cal and/ or a MCO have been selected.

- For each of these claims submitted to Medi-Cal or a MCO, SVMC shall review them to confirm the following criteria:

i. That it was billed at the 340B Program actual acquisition cost (AAC) and single administration fee for professional services for injections if applicable , and

ii. That the UD modifier was attached to the claim submitted to Medi-Cal

c. The audit activity, frequency, and method are designed to serve as a tool for the purpose of monitoring program activities and standard operating procedures for ongoing compliance. The auditing tool activities, frequency, and method may be adjusted accordingly by those parties responsible for SVMC's 340B Program oversight and integrity in order to validate that all systems are properly working.

d. Medi-Cal Managed Care claims will be billed according to California State Laws so that duplicate discounts will be prevented from occurring. On no less than an annual basis, the SVMC 340B committee will confirm compliance with California State billing requirements for MCOs.

e. SVMC shall retain auditable records related to 340B purchasing, dispensing, and screening in accordance with established hospital policies and procedures and for as long

as required by Federal and State laws. Auditable records shall include but may not be limited to: electronic health record from any system used at SVMC, drug purchasing and return records, automated dispensing cabinet records, or any other medium used to record patient information or drug disposition records.

f. Monitoring and auditing shall be completed in accordance with established hospital policies and procedures. Such audits may be performed by an independent third party.

g. The Director of Compliance shall work with the Director of Pharmacy and other appropriate individuals to resolve material issues raised during audits or otherwise, to ensure ongoing compliance with all 340B Program rules. Such actions may include, without limitation, the education of staff, resolution or remedying of inappropriate billing or purchases, or de-registration of child sites, and recommendation of disciplinary actions against workforce members that have breached this policy.

h. Should the Director of Pharmacy or any other SVMC employee reasonably suspect or determine that there has been a material breach of 340B Program requirements (e.g., diversion of 340B Drugs or a Medicaid duplicate discount); he or she shall report this suspicion or determination immediately to the Director of Compliance and CEO. Under the Director of Compliance and CEO's direction, SVMC shall take immediate action, including consultation with SVMC counsel, to investigate and remedy the specific occurrence or the factors that permitted the occurrence in order to ensure future compliance. As required by law or HRSA guidance, and as approved by the Director of Compliance and CEO, SVMC shall also notify the OPA regarding such material non-compliance and include in such notice the actions taken to remedy the non-compliance.

REFERENCES:

- Apexus Answers Prime Vendor. (n.d.). Retrieved November 21, 2019, from https://www.340bpvp.com/about/apexus-answers/.
- 340B Health (n.d.). Retrieved November 21, 2019, from https://www.340bhealth.org/.

Attachment A

340B Monitoring and Oversight Activity

		Area of Focus			
Activity	Frequency	**Program Eligibility**	**Diversion**	**Duplicate Discount**	**GPO Prohibition**
Review all OPA database information for SVMC, Medicare Cost Report (Worksheet E, Part A and Worksheet A), prior to recertification	Annual	√			
Review 340B Self-Audit Reports (mixed-use, outpatient)	Monthly		√	√	√
3rd Party Vendor External Audit of Entity	Annual	√	√	√	√
Split-Billing software maintenance/auditing (CDM-NDC mapping, updates, etc.)	As required		√		√

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~~IV Regional~~, 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 ~~a general~~ anesthesia should identify a responsible adult to care for them in the first 24 hours after discharge.

10. Patients with infections or communicable diseases requiring extensive isolation precautions. ~~morbid obesity~~, ~~history~~and or history of difficult intubations, ~~or latex allergies will be eligible for admission to the Ambulatory Surgery Department at the discretion of Anesthesia~~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.

~~10. 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.

CROSS REFERENCES:

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

~~California Code of Regulations (2019). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90ID4BB11DE8879F881C8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1~~

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SUBJECT: **CAPNOGRAPHY**	SECTION: *[Enter manual section here]* **Page 1 of 3**

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PURPOSE:

The purpose of monitoring end-tidal CO2 (etCO2) is to provide a non-invasive measure of the patients ventilation, circulation and metabolism. Because it indirectly measures cardiac output, it is also useful in assessing the efficiency of cardiopulmonary resuscitation. Capnography is also required for patients using PCAs, with the exception of Palliative Care patients not receiving treatment.

DEFINITIONS:

PCA (Patient Controlled Analgesia)
ABG (Arterial Blood Gas)
CO2 (Carbon Dioxide)
ETT (Endotracheal Tube)
ROSC (Return of spontaneous circulation)
COPD (Chronic Obstructive Pulmonary Disease)
CHF (Congestive Heart Failure)

POLICY:

Capnography will be performed as routine monitoring on all patients using invasive mechanical ventilation and patients receiving procedural sedation in the emergency department. Non-invasive capnography monitoring is indicated for patients that are experiencing, or at risk of developing, respiratory failure and also for patients weaning from mechanical ventilation and during cardiopulmonary resuscitation. Capnography may be initiated and monitored by a Registered Nurse or Respiratory Therapist that has documented competency in the procedure. Arterial blood gas lab tests (ABG) will be drawn and the arterial CO2 will be correlated to the etCO2 reading for purposes of trending ventilated patients.

AFFECTED PERSONNEL/AREAS: RESPIRATORY THERAPIST, REGISTERED NURSE

INDICATIONS FOR THE USE OF CAPNOGRAPHY:

Airway & Emergency Management
- Detects airway obstruction, ventilation problems, endotracheal tube placement & verification.
- Provides continuous feedback on airway, breathing and ventilatory status for the non-intubated and intubated patients.

Critical Care Unit
- Detects apnea immediately, regardless of supplemental oxygen administration, and provides an earlier warning than pulse oximetry.
- Helps clinicians make decisions on weaning patients from mechanical ventilation and titrating pressure support.
- Provides a continuum of care of ventilation monitoring from intubated patients during mechanical ventilation to monitoring the weaning of the patient from the

ventilator.

Medical/Surgical Units
- Monitoring patients who are receiving PCA or epidural opioid medications; detecting respiratory depression.
- Aids in decision making for clinical staff.

Procedural Sedation
- Effectively monitors the patient's airway providing the earliest indication of airway compromise.

For the intubated patient etCO2 can be used:
- To verify ETT placement
- To provide feedback regarding ventilations –too fast or too slow
- As an indicator for ROSC (return of spontaneous circulation)
- Rescuer fatigue during compressions
- Prediction of survivability

For the non-intubated patient etCO2 can be used:
- Indicator of bronchospasm in patients with asthma, COPD exacerbation or anaphylaxis
- Indicate hypoventilation caused by CHF, drug intoxication, respiratory muscle fatigue or circulatory compromise.

PROCEDURE:

1. Wash hands and observe Standard Precautions.

2. Enter room, introduce self, check patient ID using two (2) identifiers and explain procedure to patient, when appropriate.

3. Gather necessary supplies:

   - Microstream Capnography Monitor (stored in Respiratory Care Department)
   - Smart Capnoline O2 Plus - used for EtCO2 sampling and oxygen administration on the non-intubated patient.
   - Smart Capnoline Plus – used for EtCO2 sampling for patients on noninvasive ventilation.
   - FilterLine H Set w/Airway Adaptor – used for EtCO2 sampling for patients on mechanical ventilation.

4. Turn monitor on and attach appropriate sampling line(s); allow monitor to complete self-test.

For noninvasive ventilation, best results are obtained by placing Smart Capnoline Plus under full-face mask.

5. Verify function through waveform and numerical read out.

6. Wash hands upon completion when exiting patient room.

7. Capnography values will be obtained as part of the patient-ventilator system checks for patients on noninvasive or mechanical ventilation, when applicable.

8. The time and value obtained will be documented on the Ventilator Flow Sheet in the shift summary section for patients on noninvasive or mechanical ventilation; for the non-intubated patient the time and value obtained will be documented on the Patient Therapy Record in the comment section.

9. Return Microstream Capnography Monitor to Respiratory Care Department.

INFECTION CONTROL:

- Universal precautions
- Any equipment that touches the patient is single patient use.

REFERENCES:

- Capnography Monitoring Policy and Procedure Development. (2015, October). Retrieved from https://www.medtronic.com/covidien/en-us/support/capnography-policy-and-procedure.html.
- Krauss, B., Falk, J.L., and Ladde, J.G. Carbon dioxide monitoring (capnography). (2019, November). Retrieved from https://www.uptodate.com/contents/carbon-dioxide-monitoring-capnography?search=carbon-dioxide-monitoring-capnography.&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1.

SUBJECT: **CRASH CART IN 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 assure that a standardized, completely supplied crash cart will be available at all times at the Ambulatory Surgery Department (ASD).

POLICY:

The crash cart defibrillator and supplies are checked and kept stocked by a joint effort of ASD nurses, Pharmacy and Central Processing Department (CPD) personnel.

AFFECTED AREAS/PERSONNEL: *ALL AMBULATORY SURGERY STAFF*

PROCEDURE:

1. Defibrillator checks, oxygen tank checks, medication outdate tag and security checks will be done daily by the ASD staff and recorded.

2. Non-pharmaceutical supplies will be checked monthly and replenished as needed by Central Processing based upon the items and quantities listed on the Crash Cart Contents List.

3. Medication trays will be replaced and certified by a Registered Pharmacist.

4. Pharmacy and Central Processing will be notified immediately in the event that the Crash Cart is opened.

REFERENCE:

- California Code of Regulations (2019). Title 22. §70227. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
EXTRAVASATION MANAGEMENT OF SYMPATHOMIMMETIC VASOCONSTRICTORS (PRESSORS)	***Drug Protocols***

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

PURPOSE: To provide guidance on the management of extravasation of sympathomimetic vasoconstrictors (pressors)

DEFINITIONS:

1. "Pressors"- refers to medications including but not limited to the following:
    - Norepinephrine
    - Epinephrine
    - Phenylephrine
    - Dopamine
    - Dobutamine
    - Vasopressin

POLICY: Extravasation management of sympathomimetic vasoconstrictors

AFFECTED PERSONNEL/AREAS: *PHARMACY; EMERGENCY DEPARTMENT; INTENSIVE CARE*

GENERAL CARE:

A. **Initial Measures**

- Stop the infusion immediately. Do not flush the line, & avoid additional pressure on site
- Disconnect but leave cannula/needle in place.
- Gently aspirate extravasated solution (do NOT flush the line).
- Remove needle/cannula & elevate the extremity.
- Consider antidote's for further management.
- Report extravasation event & management post therapeutic intervention.

FIRST-LINE AGENT (Consider Nitroglycerin as first line for Vasopressin):

PHENTOLAMINE (REGITENE)

A. **Extravasation of norepinephrine, management (manufacturer's labeling):** SubQ

- Local infiltration: Inject 5mg (diluted in 10 mL 0.9% sodium chloride) into extravasation area (as soon as extravasation is noted but within 12 hours of extravasation)

- Apply dry warm compresses

B. Extravasation of sympathomimetic vasopressors (besides norepinephrine), management (off-label use): SubQ

- Infiltrate extravasation site with 5mg diluted in 10mL 0.9% sodium chloride as soon as possible after extravasation (Peberdy, 2010).
- Apply dry warm compresses
- May readminister if patient remains symptomatic

ADMINISTRATION:
5mg of phentolamine in 10 ml NS should be infiltrated liberally, multiple 1 mL (0.5mg) injections, throughout the affected area which is identified by coldness, hardness and a pallid appearance.

CONTRAINDICATIONS/PRECAUTIONS
Hypersensitivity to phentolamine, any component of the formulation

ADVERSE EFFECTS:
Local: Pain at injection site

ALTERNATIVE AGENTS:

TERBUTALINE

A. **Extravasation management, sympathomimetic vasoconstrictors (off-label use; based on limited case reports):** SubQ:

- Large extravasations: Infiltrate extravasation area using a solution of 1 mg diluted in 9 mL (total volume: 10 mL) of 0.9% sodium chloride; volume of terbutaline solution administered varied from 3 to 10 mL (Stier 1999).
- Small/distal extravasations: Infiltrate extravasation area using a solution of 1 mg diluted in 1 mL (total volume: 2 mL) of 0.9% sodium chloride; volume of terbutaline solution administered varied from 0.5 to 1 mL (Stier 1999).

ADMINISTRATION:
Stop vesicant infusion immediately and disconnect IV line (leave needle/cannula in place); gently aspirate extravasated solution from the IV line (do NOT flush the line); remove needle/cannula; elevate extremity. Infiltrate extravasation area with terbutaline solution 1 mg diluted with 9 mL (large extravasation site) or 1 mg diluted with 1 mL (small/distal extravasation site) of 0.9% sodium chloride into extravasation site (Stier 1999).

CONTRAINDICATIONS/PRECAUTIONS:
Hypersensitivity to terbutaline, sympathomimetic amines, or any component of the formulation

ADVERSE EFFECTS:
Hypersensitivity reactions: Immediate hypersensitivity reactions (urticaria, angioedema, rash, bronchospasm) have been reported

NITROGLYCERIN TOPICAL 2% OINTMENT (First line for Vasopressin)

A. **Extravasation management, sympathomimetic vasoconstrictors (off-label use; based on limited case reports): Topical:**

- Apply a 1-inch strip to the site of ischemia; may repeat every 8 hours as necessary

CONTRAINDICATIONS/PRECAUTIONS:
Hypersensitivity to nitroglycerin, other nitrates or nitrites, or any component of the formulation (includes adhesives for transdermal product); concurrent use with phosphodiesterase-5 (PDE-5) inhibitors (avanafil, sildenafil, tadalafil, or vardenafil); concurrent use with soluble guanylate cyclase (sGC) stimulator.

ADVERSE EFFECTS:
Hypersensitivity reactions: Immediate hypersensitivity reactions (urticaria, angioedema, rash, bronchospasm) have been reported, headache, hypotension.

REFERENCES:

- Nitroglycerin (Lexi-Drugs). (2023, March 4th). Retrieved March 17th, 2023 from http://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7377?cesid=0wjb3VykNgF&searchUrl=/lco/action/search?q=NITROGLYCERIN&t=name&va=NITROGLYCERIN#adr
- Phentolamine (Lexi-Drugs). (2023, February 15th). Retrieved March 17th, 2023. From https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7482?cesid=8yNIzlNVnCJ&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dphentolamine%26t%3Dname%26acs%3Dtrue%26acq%3Dphento
- Terbutaline sulfate injection [package insert]. Bedford, OH: Bedford Laboratories; April 2011.
- Terbutaline (Lexi-Drugs). (2023, March 17th). Retrieved March 17th, 2023, from http://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7737?cesid=a3avA9zcdI5&searchUrl=/lco/action/search?q=terbutaline&t=name&va=terbutaline

PURPOSE:

To establish a process for the identification of high-alert or high risk medications and provide methods to be utilized to promote the safe administration of these medications and help prevent adverse drug events.

POLICY:

1. It is the policy of Sierra View Medical Center (SVMC) to administer medications in a safe manner by placing safeguards into the entire medication delivery system. These safeguards are especially crucial when considering the administration of high-alert or high-risk medications including look-alike, sound-alike drugs.

2. The medications listed on Addendum A are considered high-alert or high-risk medications at Sierra View Medical Center. Also, refer to Addendum A for a listing of the risk reduction measures taken to prevent adverse drug events for those identified medications.

3. Addendum C details the list of hazardous drugs that may or may not be handled, prepared, or administered at Sierra View Medical Center. A significant number of medications are limited to the Cancer Treatment Center, such as those classified as high-risk. However, some hazardous drugs may be addressed at SVMC provided that all elements of the assessments of risk are followed.

AFFECTED PERSONNEL/AREAS: *PHARMACY; NURSING*

PROCEDURE:

1. The medications listed on Addendum A are considered high-alert or high-risk medications at Sierra View Medical Center. Also, refer to Addendum A for a listing of the risk reduction measures taken to prevent adverse drug events for those identified medications.

2. Through the oversight of Pharmacy and Therapeutics (P&T) Committee, the pharmacy has comprised the Look-Alike, Sound-Alike (LASA) list that warrant extra safety precautions to prevent medication errors. Also refer to Addendum B for a list of risk reduction measures taken for the identified drug pairs.

3. At minimum, one who deals with a hazardous drug (Addendum C) will check ancillary information in the electronic health record, the assessments of risk, or with Pharmacy prior to administration.

4. The lists in Addendums A, B, and C will be updated no less than annually at P&T Committee. New issues, new concerns, or newly identified trends in medication errors made at Sierra View will be considered by the P&T Committee when reviewing, modifying, and approving these lists.

5. These lists will be posted in medication rooms and/or near Pyxis Med Stations for easy review by nursing personnel that administer medications.

SUBJECT:	SECTION:
HIGH-ALERT MEDICATIONS AND LOOK ALIKE SOUND ALIKE MEDICATIONS	**Page 2 of 13**

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ADDENDUM A

2023 HIGH ALERT MEDICATIONS AND RISK REDUCTION MEASURES

Medication	Standard Dosage Form	Pyxis Alert	Nursing double check, double document	Pharmacist-double check and or nurse	Warning Label on container	Stocked only in pharmacy, separate from regular inventory	Only dilute form available on in patient care area	Access with pharmacist approval (thru pyxis profile)
IV Beta Blockers		X						
Chemotherapeutic Medications			X	X				
Concentrated potassium	X					X	X	
Concentrated magnesium	X					X	X	
Concentrated sodium chloride						X	X	
Heparin	X	X	X	X				
Insulin		X	X					
Neuromuscular blocking agents		X			X			
Oral anticoagulants		X						X
IV Opioid/Anxiolytic Drips	X	X	X					X

ADDENDUM B

2023 LOOK ALIKE SOUND ALIKE AND RISK REDUCTION MEASURES

Medications	Tall-Man Lettering in CPOE	Separation on Shelving in Pharmacy	Separation in Pyxis	Clinical Screen in Pyxis
Alprazolam lorazepam	X		X	X
Amitriptyline Azathioprine		X		
Buproprion Buspirone	X			X
Captopril Carvedilol	X	X	X	X
Carboplatin Cisplatin	X	X		X
Clonazepam Lorazepam	X			X
Dexamethasone Diphenhydramine		X		
Dobutamine Dopamine	X	X	X	X
Duloxetine Fluoxetine	X	X	X	X
Fluoxetine Paroxetine	X	X	X	X
Glipizide Glyburide	X	X	X	X
Infliximab Rituximab	X	X		
Lamotrigine Levetiracetam	X			X
Levofloxacin Linezolid		X		
Nicardipine Nifedipine	X			X
Midazolam (Versed) Vecuronium*		X	X	X
Rifampin Rifamixin	X		X	X
Tramadol Trazodone	X		X	X

- Repackaged in Pyxis and auxiliary label on package "Caution Neuromuscular Blocker"

ADDENDUM C

Sierra View Medical Center Pharmacy – NIOSH Hazardous Drug List			
Generic Name	**Dosage Form/ Packaging**	**Type of HD**	**Risk of Exposure**
ADO-TRASTUZUMAB EMT INJ	VIAL	Antineoplastic	High Risk
ZIV-AFLIBERCEPT INJ	VIAL	Antineoplastic	High Risk
ALDESLEUKIN INJ	VIAL	Antineoplastic	High Risk
PEMETREXED INJ	VIAL	Antineoplastic	High Risk
ARSENIC TRIOXIDE INJ	VIAL	Antineoplastic	High Risk
ASPARAGINASE INJ	ML	Antineoplastic	High Risk
ATEZOLIZUMAB INJ	VIAL	Antineoplastic	High Risk
AZACITIDINE INJ	VIAL	Antineoplastic	High Risk
BACILLUS CALMETTE GUERIN (BCG)	VIAL	Vaccine	High Risk
BENDAMUSTINE HCL INJ	VIAL	Antineoplastic	High Risk
BEVACIZUMAB INJ	VIAL	Antineoplastic	High Risk
BEVACIZUMAB INJ	SYRINGE	Antineoplastic	High Risk
BLEOMYCIN SULFATE INJ	VIAL	Antineoplastic	High Risk
BORTEZOMIB INJ	VIAL	Antineoplastic	High Risk
CABAZITAXEL INJ	VIAL	Antineoplastic	High Risk
CARBOPLATIN INJ	VIAL	Antineoplastic	High Risk
CARFILZOMIB INJ	VIAL	Antineoplastic	High Risk
CARMUSTINE INJ	VIAL	Antineoplastic	High Risk
CETUXIMAB INJ	VIAL	Antineoplastic	High Risk
CISPLATIN INJ	VIAL	Antineoplastic	High Risk
CLADRIBINE INJ	VIAL	Antineoplastic	High Risk
CYCLOPHOSPHAMIDE INJ	VIAL	Antineoplastic	High Risk
CYTARABINE INJ	VIAL	Antineoplastic	High Risk
DECARBAZINE INJ	VIAL	Antineoplastic	High Risk
DECITABINE INJ	VIAL	Antineoplastic	High Risk
DACTINOMYCIN INJ	VIAL	Antineoplastic	High Risk
DAUNORUBICIN INJ	VIAL	Antineoplastic	High Risk
DEGARELIX ACET INJ	KIT/ INJ	Antineoplastic	High Risk
DOCETAXEL INJ	VIAL	Antineoplastic	High Risk
DOXORUBICIN INJ	VIAL	Antineoplastic	High Risk
DOXORUBICIN LIPOSOMAL INJ	VIAL	Antineoplastic	High Risk
EPIRUBICIN INJ	VIAL	Antineoplastic	High Risk
ERIBULIN MESYLATE INJ	VIAL	Antineoplastic	High Risk
ETOPOSIDE INJ	VIAL	Antineoplastic	High Risk

FAM-TRASTUZUMAB DERUXTECAN INJ	VIAL	Antineoplastic	High Risk
FLUDARABINE PHOS INJ	VIAL	Antineoplastic	High Risk
FLUOROURACIL INJ	VIAL	Antineoplastic	High Risk
GEMCITABINE INJ	VIAL	Antineoplastic	High Risk
IDARUBICIN INJ	VIAL	Antineoplastic	High Risk
IFOSFAMIDE INJ	VIAL	Antineoplastic	High Risk
IPILIMUMAB	VIAL	Antineoplastic	High Risk
IRONOTECAN INJ	VIAL	Antineoplastic	High Risk
ISATUXIMAB INJ	VIAL	Antineoplastic	High Risk
IXABEPILONE INJ	VIAL	Antineoplastic	High Risk
LEUPROLIDE ACET INJ	KIT	Antineoplastic	High Risk
MECHLORETHAMINE INJ	VIAL	Antineoplastic	High Risk
METHOTREXATE SOD INJ	ML	Antineoplastic	High Risk
MITOMYCIN INJ	VIAL	Antineoplastic	High Risk
MITOMYCIN	VIAL	Antineoplastic	High Risk
MITOMYCIN INJ (ASD)	VIAL	Antineoplastic	High Risk
NIVOLUMAB INJ	VIAL	Antineoplastic	High Risk
MITOXANTRONE INJ	ML	Antineoplastic	High Risk
OXALIPLATIN INJ	VIAL	Antineoplastic	High Risk
PACLITAXEL, PROTEIN-BOUND INJ	VIAL	Antineoplastic	High Risk
PACLITAXEL, SEMI-SYNTHETIC INJ	VIAL	Antineoplastic	High Risk
PANITUMUMAB INJ	VIAL	Antineoplastic	High Risk
PEMBROLIZUMAB INJ	VIAL	Antineoplastic	High Risk
PENDOSTATIN INJ	VIAL	Antineoplastic	High Risk
PERTUZUMAB INJ	VIAL	Antineoplastic	High Risk
SILTUXIMAB INJ	VIAL	Antineoplastic	High Risk
STREPTOZOCIN INJ	VIAL	Antineoplastic	High Risk
TEMSIROLIMUS INJ	VIAL	Antineoplastic	High Risk
THIOTEPA INJ	VIAL	Antineoplastic	High Risk
TOPOTECAN INJ	VIAL	Antineoplastic	High Risk
TRASTUZUMAB INJ	VIAL	Antineoplastic	High Risk
VINBLASTINE INJ	VIAL	Antineoplastic	High Risk
VINCRISTINE INJ	VIAL	Antineoplastic	High Risk
VINORELBINE INJ	ML	Antineoplastic	High Risk

Generic Name	Dosage Form/ Packaging	Type of HD	Risk of Exposure
ANASTRAZOLE	TABLET	Reproductive	Low Risk
AZATHIOPRINE	TABLET	Carcinogen, Reproductive	Low Risk
CAPECITABINE	TABLET	Reproductive	Low Risk
CARBAMAZEPINE	CHEW	Reproductive	Low Risk
CARBAMAZEPINE	TABLET	Reproductive	Low Risk
CARBAMAZEPINE	TABCR	Reproductive	Low Risk
CARBAMAZEPINE	UDC	Reproductive	Low Risk
CARBAMAZEPINE	ML	Reproductive	Low Risk
CHLORAMBUCIL	TABLET	Carcinogen, Reproductive	Low Risk
CLONAZEPAM	TABLET	Reproductive	Low Risk
COLCHICINE	TABLET	Reproductive	Low Risk
CYCLOPHOSPHAMIDE	TABLET	Carcinogen, Reproductive	Low Risk
CYCLOSPORINE	CAPSULE	Carcinogen, Reproductive	Low Risk
DINOPROSTONE	VAG.SUPP		Low Risk
DIVALPROEX SOD	SPRINKLE	Carcinogen, Reproductive	Low Risk
DIVALPROEX SOD DR	TABDR...ER	Carcinogen, Reproductive	Low Risk
DIVALPROEX SOD EC	TABEC	Carcinogen, Reproductive	Low Risk
DIVALPROEX SOD ER	TABER	Carcinogen, Reproductive	Low Risk
DRONEDARONE HCL	TABLET	Reproductive	Low Risk
DUTASTERIDE	CAPSULE	Reproductive	Low Risk
ESTRADIOL	PATCH.TDWK	Carcinogen, Reproductive	Low Risk
ESTRADIOL	PATCH.TDWK	Carcinogen, Reproductive	Low Risk
ESTROGENS, CONJ	TABLET	Carcinogen, Reproductive	Low Risk
ESTROGENS, CONJ INJ	TABLET	Carcinogen, Reproductive	Low Risk
ESTROGENS, CONJ VAG CR	TUBE	Carcinogen, Reproductive	Moderate Risk
ETOPOSIDE	CAPSULE	Antineoplastic	Low Risk
FINASTERIDE	TABLET	Reproductive	Low Risk
FLUCONAZOLE	TABLET	Reproductive	Low Risk
FLUCONAZOLE	ML	Reproductive	Low Risk
FLUCONAZOLE IN NS	BAG	Reproductive	Low Risk
FLUTAMIDE	CAPSULE	Reproductive	Low Risk
FOSPHENYTOIN SOD INJ	VIAL	Reproductive	Low Risk
FULVESTRANT INJ	SYRINGE	Reproductive	Low Risk
GANCICLOVIR INJ	VIAL	Reproductive	Low Risk
GOSERELIN ACET INJ	SYRINGE	Reproductive	Low Risk
HYDROXYUREA	CAPSULE	Reproductive	Low Risk
IMATINIB MESYLATE	CAPSULE	Reproductive	Low Risk
LETROZOLE	TABLET	Reproductive	Low Risk
LEUPROLIDE ACET INJ	KIT	Reproductive	Low Risk
LR WITH PITOCIN 20 UNITS	BAG	Reproductive	Low Risk
LUSPATERCEPT INJ	VIAL	Reproductive	Low Risk
MEDROXYPROGESTERONE ACET	TABLET	Reproductive	Low Risk
MEDROXYPROGESTERONE ACET INJ	SYRINGE	Reproductive	Low Risk
MEGESTROL ACET	TABLET	Reproductive	Low Risk

MEGESTROL ACET	UDC	Reproductive	Low Risk
MELPHALAN	TABLET	Carcinogen, Reproductive	Low Risk
METHIMAZOLE	TABLET	Reproductive	Low Risk
METHOTREXATE	TABLET	Reproductive	Low Risk
MISOPROSTOL	TABLET	Reproductive	Low Risk
MYCOPHENOLATE	CAPSULE	Reproductive	Low Risk
OXCARBAZEPINE	TABLET	Carcinogen, Reproductive	Low Risk
PAMIDRONATE INJ	VIAL	Reproductive	Low Risk
PAROXETINE HCL	TABLET	Reproductive	Low Risk
PHENYTOIN	CAPSR	Reproductive	Low Risk
PHENYTOIN	UDC	Reproductive	Low Risk
PHENYTOIN INJ	VIAL	Reproductive	Low Risk
PROGESTERONE IM	VIAL	Carcinogen, Reproductive	Low Risk
PROPYLTHIOURACIL	TABLET	Reproductive	Low Risk
RALOXIFENE	TABLET	Reproductive	Low Risk
RISPERIDONE	TABLET	Reproductive	Low Risk
SPIRONOLACTONE	TABLET	Reproductive	Low Risk
TACROLIMUS	CAPSULE	Carcinogen, Reproductive	Low Risk
TAMOXIFEN CITRATE	TABLET	Carcinogen, Reproductive	Low Risk
TEMAZEPAM	CAPSULE	Reproductive	Low Risk
THIOGUANINE	TABLET	Reproductive	Low Risk
TOPIRAMATE	TABLET	Reproductive	Low Risk
TRETINOIN	CAPSULE	Reproductive	Low Risk
VALPROATE SOD INJ	VIAL	Reproductive	Low Risk
VALPROIC ACID SYRUP	UDC	Reproductive	Low Risk
VORICONAZOLE	TABLET	Reproductive	Low Risk
VORICONAZOLE INJ	VIAL	Reproductive	Low Risk
WARFARIN SODIUM	TABLET	Reproductive	Low Risk
ZIDOVUDINE	CAPSULE	Reproductive	Low Risk
ZIDOVUDINE	ML	Reproductive	Low Risk
ZIPRASIDONE	CAPSULE	Reproductive	Low Risk
ZIPRASIDONE INJ	VIAL	Reproductive	Low Risk
ZOLEDRONIC ACID INJ	VIAL	Reproductive	Low Risk
ZONISAMIDE	CAPSULE	Reproductive	Low Risk

Personal Protective equipment and engineering controls for working with hazardous drugs in healthcare settings.

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
All types of hazardous drugs	**Receiving, unpacking, and placing in storage**	**no (single glove can be used, unless spills occur)**	**yes, when spills and leaks occur**	**no**	**yes, when spills and leaks occur**	**no**
Intact tablet or capsule	Administration from unit-dose package	no (single glove can be used)	no	no	no	N/A
Tablets or capsules	**Cutting, crushing, or manipulating tablets or capsules; handling uncoated tablets**	**yes**	**yes**	**no**	**yes, if not done in a control device**	**yes†**
	Administration	no (single glove can be used)	no	yes, if vomit or potential to spit up†	no	N/A

†It is recommended that these activities be carried out in a control device, but it is recognized that under some circumstances, it is not possible

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
Solution for irrigation	**Compounding**	**yes**	**yes**	**yes, if not done in a control device**	**yes, if not done in a control device**	**yes, BSC or CACI; use of CSTD recommended**
	Administration (bladder, HIPEC, limb perfusion, etc.)	yes	yes	yes	yes	N/A
Powder/solution for inhalation/ aerosol treatment	**Compounding**	**yes**	**yes**	**yes, if not done in a control device**	**yes, if not done in a control device**	**yes, BSC or CACI**
	Aerosol administration	yes	yes	yes	yes	yes, when applicable
	Administration	**yes**	**yes**	**yes, if liquid that could splash†**	**yes, if inhalation potential**	**N/A**
Drugs and metabolites in body fluids	Disposal and cleaning	yes	yes	yes, if liquid that could splash	yes, if inhalation potential	N/A
Drug-contaminated waste	**Disposal and cleaning**	**yes**	**yes**	**yes, if liquid that could splash**	**yes, if inhalation potential**	**N/A**
Spills	Cleaning	yes	yes	yes	yes	N/A

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
Oral liquid drug or feeding tube	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes[†]
	Administration	yes	yes	yes, if vomit or potential to spit up[‡]	no	N/A
Topical drug	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes[†], BSC or CACI (Note: carmustine and mustargen are volatile)
	Administration	yes	yes	yes, if liquid that could splash[=]	yes, if inhalation potential	N/A
Subcutaneous/ intra-muscular injection from a vial	Preparation (withdrawing from vial)	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI
	Administration from prepared syringe	yes	yes	yes, if liquid that could splash[=]	no	N/A
Withdrawing and/or mixing intravenous or intramuscular solution from a vial or ampoule	Compounding	yes[§]	yes	no	no	yes, BSC or CACI; use of CSTD recommended
	Administration of prepared solution[¶]	yes	yes	yes; if liquid that could splash[=]	no	N/A; CSTD required per USP 800 if the dosage form allows

Sierra View Medical Center - Hazardous Drugs – Assessments of Risk (last revised 10/21/22)

Generic	Trade	NIOSH Group	AHFS Classification	Supplemental Information	FDA Pregnancy Category	Risk of Exposure	Alternative Containment Strategies and/or Work Practice	Justification
Leuprolide (Intramuscular kit, as acetate)	Lupron Depot	1	10:00 antineoplastic agents	Contraindication: patients with undiagnosed uterine bleeding	X	_X_ Skin contact _X_ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **Preparation:** prefilled syringe **IM administration:** Chemo-certified RN (call CTC and coordinate in advance), double chemo gloves, protective gown, N95 mask, face shield	No compounding is involved. Rx is in final dosage form. No further manipulation required. Reconstitution performed in a closed system prepared by the kit.
Fosphenytoin Inj	Cerebyx	2	28:12.12 hydantoins	Metabolized to phenytoin	D	_X_ Skin contact __ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	Exposure is relevant if injected. Cancer studies in experimental animals focused on ingestion. Inadequate cancer studies in humans. Inhalation issues not reported.
Ganciclovir Inj	Cytovene	2	8:18:32 nucleosides and nucleotides	**Black box warning:** animal and limited human data show that it may cause temporary or permanent inhibition of spermatogenesis in males or suppression of fertility in females. Animal data shows potential birth defects and cancers in humans.	C	__ Skin contact __ Ingestion __ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI **IV administration:** double gloves, protective gown	Exposure is relevant if injected.

Medroxyprogesterone (prefilled syringe)	Depo-Provera	2	68:32 progestins	IARC Group 2B	X	__ Skin contact __ Ingestion __ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IM administration:** double gloves, protective gown	Exposure is relevant if injected.
Phenytoin Inj	Dilantin	2	28:12.12 hydantoins	IARC Group 2B; NTP	D	_X_ Skin contact __ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	Exposure is relevant if injected. Cancer studies in experimental animals focused on ingestion. Inadequate cancer studies in humans. Inhalation issues not reported.
Fluconazole Oral Solution	Diflucan	3	8:14.08 azoles	Case reports describe congenital anomalies in infants exposed in utero to maternal fluconazole (400-800 mg/day) during most or all of the first trimester, similar to those seen in animal studies	C	_X_ Skin contact _X_ Ingestion _X_ Inhalation __ Injection	**Receiving:** single pair of gloves **PO administration:** double gloves, protective gown, eye protection (potential vomit), signed acknowledgement forms for prospective child-bearing workers	Exposure is relevant if ingested and focuses on patients that intentionally received doses of Fluconazole.
Misoprostol Oral Tablet	Cytotec	3	56:28.28	FDA Pregnancy Category X	X	_X_ Skin contact _X_ Ingestion _X_ Inhalation __ Injection	**Receiving:** single pair of gloves **PO Preparation:** Double chemo-therapy gloves, protective gown N95 mask **PO administration:** double gloves, protective gown, eye protection (potential vomit). signed acknowledgement forms for prospective child-bearing workers	Exposure is relevant if ingested.

Oxytocin Inj	Pitocin	3	76:00 oxytocics	Hazardous only for women in 3rd trimester	C	__ Skin contact __ Ingestion __ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	As NIOSH states, "hazardous only for women in 3rd trimester." Exposure is relevant if injected.
Pamidronate Inj	Aredia	3	92:24 bone resorption inhibitors	Embryo-fetal toxicities at doses below the recommended human dose	D	_X_ Skin contact __ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	Exposure is relevant if injected.
Valproic Acid Inj	Depakote	3	28:12:92 anticonvulsants	Black Box warning for teratogenicity; congenital malformations, including neural tube defects; teratogenic in multiple species	D	__ Skin contact _X_ Ingestion __ Inhalation _X_ Injection	**Receiving:** single pair of gloves **PO administration:** double gloves, protective gown, eye protection (potential vomit), signed acknowledgement forms for prospective child-bearing workers **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	Exposure is relevant if ingested or injected.

Voriconazole Inj	Vfend	3	8:14.08 azoles		D	_X_ Skin contact __ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	Exposure is relevant if injected.
Ziprasidone Inj	Geodon	3	28:16:08:04 atypical antipsychotics	Developmental toxicity, including possible teratogenic effects at doses similar to human therapeutic doses; an increase in the number of pups born dead and a decrease in postnatal survival at less than MRHD	C	__ Skin contact __ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IM preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IM administration:** double gloves, protective gown	Exposure is relevant if injected.
Zoledronic Acid Inj	Zometa	3	92:24 bone resorption inhibitors	Number of stillbirths increased and survival of neonates decreased in laboratory studies at low doses	D	_X_ Skin contact __ Ingestion _X_ Inhalation _X_ Injection	**Receiving:** single pair of gloves **IV preparation:** double gloves (ASTM D6978), protective gown, N95 mask, head cover, CAI, signed acknowledgement forms for prospective child-bearing workers **IV administration:** double gloves, protective gown	Exposure is relevant if injected.

REFERENCE:

1. The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
2. NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016. https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. Accessed 2023.

SUBJECT: **PANDEMIC COVID-19 MANAGEMENT PLAN**	SECTION: **Page 1 of 17**

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

INTRODUCTION:

In early 2020, a Public Health Emergency (PHE) was declared by the U.S. Government due to the SARS-CoV-2/COVID-19 Pandemic. Since that time, the PHE was renewed more than 10 times. Throughout the world, a public health emergency was declared "to catalyze timely evidence-based action to limit public health and societal impacts of emerging and re-emerging disease risks while preventing unwarranted travel and trade restrictions." Recently, Governor Newsome ended California's COVID-19 PHE based in part on CDC recommendations. As a result, the updated policy reflects these changes *but still includes items that may be re-implemented* should another COVID-19 PHE were to be enacted. As of the writing of this policy, most of the items within the policy are not in use.

PURPOSE:

- Currently, California's State of Emergency has been terminated. As a result, the majority of the items found within this document have been kept to have a record on how to proceed should another COVID-19 Public Health Emergency be declared within California or the United States.
- To describe processes that would ensure the safety of patients, visitors, volunteers, and healthcare personnel in the event of another COVID-19 pandemic.
- To review the CDC's mitigations strategies then to select the best options within a continuum of options to address shortages, including staffing shortages
- Due to concerns of increased transmissibility of the SARS-CoV-2 variants, to update protection for healthcare personnel (HCP), patients and visitors that align with current CDC recommended guidelines (According to the current CDC website, "...updates will be refined as additional information becomes available to inform recommended actions.")

POLICY:

A. This plan is an essential extension of the hospital's existing Emergency Management Plan and it is a living document that will be updated based on changes from Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH) and/or directives from Tulare County Public Health.

B. Enhanced surveillance and reporting will be conducted *when directed* by the Tulare County Health and Human Services Agency (TCHHSA).

C. Patients that fall within the following categories are considered high risk for severe illness from COVID-19:

1. People 65 years and older.
2. People who live in a congregate arrangement, such as a nursing home, group home and/or long-term care facility.
3. People with underlying medical conditions such as:

- Chronic lung disease or moderate to severe asthma
- Serious heart conditions
- Immunocompromised (people receiving cancer treatment, smoking, or taking immune weakening medications)
- Severe obesity (body mass index of 40 or higher)
- Diabetes
- Chronic kidney disease undergoing dialysis
- Liver disease
- Hypertension

D. Should another COVID-19 PHE be declared, the following patients, regardless of vaccination status, should be evaluated for possible COVID-19 infection:

1. Fever and signs or symptoms of lower respiratory illness (e.g., cough, difficulty breathing), repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, persistent pain or pressure in chest, new confusion or inability to arouse, bluish lips or face.

2. Close contact with any person, including health care workers, who had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset.

E. In the event of COVID-19 PHE, and both clinical and epidemiologic criteria for suspected COVID-19 have been met, the hospital will immediately proceed with the following actions:

- Implement transmission based precautions.
- Obtain clinical specimens for COVID-19 testing.
- Results, if required, will be reported to TCHHSA by the lab via CalRedie, the Command Center, and/or the Infection Prevention Department.
- Triage to the appropriate level of care.
- Provide necessary clinical evaluation and management services, including monitoring the patient appropriately for complications.
- Assist the TCHSSA with the identification of potentially exposed contacts including healthcare workers, as requested.

F. Prepare to activate the COVID-19 Hospital Pandemic Plan as necessary.

G. Identify and isolate all potential patients with COVID-19.

H. In the event of another COVID-19 pandemic, the Sierra View Medical Center (SVMC) administrator will discuss with the local health department how and when an "Altered Standards of Care in Mass Casualty Events" (influx of cases or deaths) will be invoked.

I. Hospital Emergency Incident Command System (HEICS) may be activated by volume of flu-like symptoms (COVID-19), increase of inpatient census, and/or staff shortages.

J. If necessary, cohort COVID-19 patients.

K. Infection prevention education will be provided to staff via new hire orientation, annual competency exams, training sessions, staff meetings, on the spot training during daily rounds, use of posters, messages uploaded to the intranet, and/or email correspondence.

L. Enhanced assessment of supplies and equipment inventory will be conducted in an effort to avoid shortage of materials.

AFFECTED PERSONNEL/AREAS: *ALL HEALTH CARE WORKERS AND HOSPITAL STAFF*

PREPARATION & IDENTIFICATION

Triggers that identify a potential COVID-19 influx:

- A local, state or national health department alert of a potential increase in admissions of infectious patients requiring isolation.
- A rapidly increasing COVID-19 incidence within hours or days in a normally healthy population.
- Emergency Department (ED) report of an increase in patients with potential COVID-19 symptoms/conditions.
- Infection Control, Nursing Supervisors, Emergency Department, or Urgent Care personnel note an unusual increase in the number of people seeking care, especially with fever, shortness of breath, chills, muscle pain, sore throat, new loss of taste and smell complaints.

COMMUNICATION

If the potential for a new COVID-19 influx is identified, then:

- The Vice President of Patient Care Services, the Chief of Staff, the Safety Officer, Infection Prevention Manager/Nurse, the Hospital Supervisor and other appropriate individuals will review the available information and determine whether additional action is needed.
- Current resource availability will be assessed using the Surge Capacity Management Plan.
- The Vice President of Patient Care Services, Chief of Staff, or other designee, will determine if the facility's HEICS Plan needs to be activated, and if so, will notify the Safety Officer and other appropriate individuals.

Ongoing communication considerations will include the needs for:

- Frequent updates for managers, physicians, and other hospital personnel.

- Infection Prevention Nurse visits to units to assess situations and offer assistance regarding infection prevention and control issues.
- Initial notification and continued communication with local Public Health Services.
- Requests for assistance from the local or state health departments and/or other support agencies.

EVALUATION

The Vice President of Patient Care Services, Chief of Staff, Safety Officer, Infection Prevention Nurse, Chair of Infection Prevention/Control Committee and other appropriate individuals will evaluate the situation on an ongoing basis to determine:

- If other patient admissions need to be suspended.
- If elective procedures, including surgery, need to be cancelled.
- If the facility's visiting policy needs to be temporarily revised or suspended depending on the CDC COVID-19 Community Transmission rates within California
- Appropriate patient placement, including alternative sites for patient holding, triage, treatment and morgue facilities, as needed.
- When the COVID-19 influx Contingency Plan is no longer needed.

VISITATION

SVMC will follow current visitation guidance provided through Public Health Orders or CDPH AFLs. Due to the variability in COVID-19 surges and the multiple variants, visitation policies are subject to change in order to protect staff and patients and ***may, at times***, be more stringent than current guidance based on CDC COVID-19 community transmission rates.

PATIENT MANAGEMENT

A. Initial Management of Persons with COVID-19 Conditions

To aid in the detection of persons entering the facility who may have COVID-19, the following interventions will be implemented:

1. Visual alerts, in appropriate languages, will be posted at all appropriate entrances to the facility instructing all persons with signs/symptom of infectious disease, especially respiratory, to:

    a. Inform reception and healthcare personnel when they first register for care that they may be infectious.
    b. Practice respiratory hygiene/cough etiquette
    c. Wear a mask (or face shield if diagnosed with a severe respiratory disease.)

2. Patients calling SVMC for advice will be instructed to avoid making unnecessary visits to the hospital.

3. As the number of infectious patients increases, measures will be implemented to reduce the spread of infection within the facility:

   a. A triage officer will be assigned responsibility for managing patient flow, including deferral of patients who do not need emergency care.
   b. A separate waiting area will be designated for patients with respiratory symptoms to sit at least 6 feet away from other patients and visitors.

4. Signs that promote respiratory hygiene/cough etiquette will be placed in waiting areas, cafeterias, etc., where they serve as reminders to all persons in the facility. The signs will instruct persons to:

   a. Cover the nose/mouth when coughing or sneezing.
   b. Use tissues to contain respiratory secretions.
   c. Dispose of tissues in the nearest waste receptacle after single use.
   d. Patients will be given masks upon entry to the facility with instructions to wear them until they have been evaluated and admitted or discharged, if the symptoms/syndrome suggests that airborne and/or droplet transmission is a possibility.
   e. Perform hand hygiene after contact with respiratory secretions.
   f. Practice physical distancing:

      - Avoid "congregate settings" as much as possible
      - Avoid mass gatherings
      - Maintain distance of 6 feet form others when possible

5. SVMC will facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability, if in supply, of appropriate materials mentioned above in waiting areas for patient and visitors.

6. Visitors will be screened for signs/symptoms of infectious disease before entry into the facility:

   a. Symptomatic visitors will be excluded from the facility.
   b. Family members who accompany patients with infectious illness to the hospital will be assumed to have been exposed to the infectious condition and will be asked to don masks
   c. Visitors will be limited to 1 person for the patient's emotional well-being and care.
   d. Visitors will be required to wear appropriate Personal Protective Equipment (PPE) while visiting an infected patient.
   e. Visitors will be instructed on hand hygiene practices.

B. Isolation Precautions and PPE

In the early stages of a new influx of patients, it may not be clear that patients have been exposed to COVID-19. Therefore, precautions consistent with all possible etiologies must be implemented for suspect or confirmed cases. Standard precautions, combined with contact, droplet and/or airborne precautions will be implemented until a diagnosis is established. Staff will be instructed to don PPE before patient contact to avoid the need to make PPE adjustments and the risk of self-contamination during use. Careful removal of PPE will also be stressed. An Assessment Tool will be used during training for each staff member to insure PPE donning and doffing competency.

1. GLOVES

a. Disposable gloves are to be worn when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids.

b. Gloves should be donned immediately prior to performing patient care and removed immediately, without touching uncontaminated surfaces, when the task is complete.

c. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

d. Remove and dispose of gloves after use on a patient..

e. Staff will be reminded to avoid touching their eyes, nose or mouth with contaminated hands, gloved or ungloved.

2. FACIAL PROTECTION

FACE MASK:

a. Universal Source of Control Measures: Use medical/surgical facemask (FDA cleared medical/surgical masks) to cover person's mouth and nose to prevent spread of respiratory secretions when breathing, talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommend for everyone in the healthcare facility:

- Patients and visitors will be given an approved mask upon arrival to use throughout their stay in the facility. If they do not have a face covering, they will be offered a facemask

  - Patients may remove their facemask when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or when leaving their room.

- Facemasks should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- Visitors who are not able to wear or tolerate a mask should be encouraged to use alternatives to on-site visits with patients (e.g., telephone or internet communication), particularly if the patient is at increased risk for severe illness from SARS-CoV-2 infection.

b. All staff and HCP should wear a medical/surgical facemask at all times while they are in the healthcare facility including and especially patient care areas.

c. Staff will be required to wear an N-95 respirator when entering a PUI or COVID-19 confirmed patient's room.

- N-95 respirators will be worn once and then discarded
- N-95 respirators will be removed or discarded if soiled, damaged, or hard to breathe through.

Contingency Capacity Strategies:

- Consider removing all facemasks from public area.
- Facemask can be provide to asymptomatic and symptomatic patients upon check in at screening points.
- Consider placing mask in a secure and monitored site.
- Implement extended use of face mask (Wearing the same facemask for repeated close contact encounters with several different patients, diagnosed with COVID-19 without removing the facemask between patient encounters).
- Facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- On the spot teaching and training healthcare providers regarding not touching or adjusting their facemask when providing patient care.
- Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose.

Crisis Capacity Strategies:

- Cancel all elective and non-urgent procedures and appointments for which a facemask is used by healthcare provider.
- Use facemask beyond the manufacturer-designated shelf life during patient care activities.
- The user should visually inspect the facemask prior to use and discard if the mask is visibly soiled, damaged, or hard to breathe.
- Implement limited re-use of facemask (using the same facemask by one healthcare provider for multiple encounters with different COVID-19 patients but removing when COVID-19 patient encounters are completed.
- Review proper donning and doffing of masks, ensuring that healthcare providers do not touch outer surfaces of the mask during care, and removal and replacement of mask.

- Healthcare providers will leave patient care area if they need to remove the facemask.
- Facemask will be carefully stored between uses in a clean paper bag or breathable container.
- Hand hygiene will be performed upon touching or discarding a used mask.

Prioritize facemasks for selected activities such as:

- For provision of essential surgeries and procedures.
- During care activities where aerosol-generation, splashes and sprays are anticipated.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.
- For performing aerosol-generating procedures, if respirators are no longer available.

When No Facemasks Are Available, Options Include:

- Exclude healthcare providers who may be at higher risk for severe illness (e.g., older in age, those with chronic medical conditions, or those who may be pregnant) from caring for patients with confirmed or suspected COVID-19 patients.
- Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.
- Consider use of expedient patient isolation rooms for risk reduction.
- Consider the use of HEPA filtration to reduce the risk to individuals entering the room without respiratory protection.

3. FACE SHIELD/GOGGLES (EYE PROTECTION)

Eye protection provides a barrier to infectious materials entering the eye and is often used in conjunction with other personal protective equipment (PPE) such as gloves, gowns, masks or respirators.

a. All staff and HCP should wear eye protection (goggles or face shields)
- Screening areas
  - When no glass/Plexiglas barrier is in place
  - When physical distance is not feasible
- When providing care to patients in COVID-19 areas
  - Any staff (including auxiliary staff e.g. Environmental Services (EVS), Respiratory Therapist (RT), Lab Technician) entering patients' room.

b. Conventional capacity strategies:
- Use eye protection according to product labeling and local, state, and federal requirements.

c. Contingency capacity strategies:

- Selectively cancel elective and non-urgent procedures and appointments for which eye protection is typically used by healthcare providers.

- Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields). Staff will clean and disinfect goggles and face shields between uses.
- Consider the use of powered air purifying respirators (PAPRs).
- Implement extended use or eye protection (wearing the same eye protection for repeated close contact encounters with several different patients without removing eye protection between patient encounters).
- Extended use of eye goggles/face shields can be applied to disposable and reusable devices.
- Eye protection should be removed, cleaned, and disinfected if it becomes visibly soiled or difficult to see through.
- If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- Healthcare providers should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.
- Healthcare providers should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

d. Crisis capacity:

- Cancel all elective and non-urgent procedures and appointments for which eye protection is typically used by healthcare providers.
- Use eye protection devices beyond the manufacturer-designated shelf life during patient care activities.
- Visually inspect the goggles/face shield, if there are concerns (such as degraded materials), discard googles/face shield.
- Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of eyes.
- Exclude healthcare providers at higher risk for severe illness (older age, those with chronic medical conditions, or those who may be pregnant) from COVID-19 from contact with known or suspected COVID-19 patients.

4. <u>GOWNS</u>

a. Conventional Capacity Strategies:

- Use isolation gown alternative that offers equivalent or higher protection.
- In time of gown shortages, surgical gowns should be prioritized for surgical and other sterile procedures.

b. Contingency capacity strategies:

- Selectively cancel elective and non-urgent procedures and appointments for which a gown is typically used by healthcare providers.
- Consider reusable (e.g., washable) gowns.
- Ensure that healthcare providers do not touch outer surfaces of the gown during care.
- Train healthcare providers in donning and doffing of reusable gowns.
- Inspect and replace reusable gowns when needed (e.g., when they are thin or ripped).
- Consider the use of coveralls.
  - Train and practice in their use, prior to using during patient care

c. Crisis Capacity Strategies:

- Consider extended use of isolation gowns (gowns worn by same healthcare worker when interacting with more than one patient known to be infected with COVID-19).
- Re-use of cloth isolation gowns among healthcare worker for multiple patients.
- Any gown that becomes visibly soiled during patient care should be disposed of or cleaned.
- Surgical gowns should be prioritized for surgical and other sterile procedures.
- Consider suspending use of gowns for endemic multidrug resistant organisms (e.g., MRSA, VREM ESBLE-producing organisms)

d. Prioritize Gowns:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol-generating procedures.
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:
  - ➢ Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care.

e. When No Gowns Are Available:

- Consider using gown alternatives that have not been evaluated as effective.
- Disposable laboratory coats.
- Reusable (washable) patient gowns.
- Routinely inspect and replace reusable gowns when needed (e.g., when they are thin or ripped).

Discontinuation of Transmission-Based Precautions and isolation for patients with confirmed COVID-19 infection will be made using a symptom-based strategy as described below. The time period used depends on the patient's severity of illness and their immune status (patient is immunocompromised).

Note: Meeting criteria for discontinuation of Transmission-Based Precautions is <u>not</u> a prerequisite for discharge from a healthcare facility.

A. Patients with mild to moderate illness who are not severely immunocompromised:
   - At least 10 days have passed since symptoms first appeared and
   - At least 24 hours have passed since last fever without the use of fever-reducing medications and
   - Symptoms (e.g., cough, shortness of breath) have improved

Note: For patients who are ***not* severely immunocompromised** and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test

B. Patients with severe to critical illness or who are severely immunocompromised:
   - At least 10 days and up to 20 days have passed since symptoms first appeared and
   - At least 24 hours have passed since last fever without the use of fever-reducing medications and
   - Symptoms (e.g., cough, shortness of breath) have improved
   - Consider consultation with infection control experts

Note: For **severely immunocompromised** patients who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

Discontinuation of Empiric Transmission-Based Precautions for Patients Suspected of Having COVID-19 Infection

The decision to discontinue empiric <u>Transmission-Based Precautions</u> by excluding the diagnosis of current COVID-19 infection for a patient with suspected COVID-19 infection can be made based upon having negative results from at least one respiratory specimen tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

A. If a higher level of clinical suspicion for COVID-19 infection exists, consider *maintaining* Transmission-Based Precautions and *performing a second test for SARS-CoV-2 RNA.*

Disposition of Patients with COVID-19 Infection

Patients can be discharged from the healthcare facility whenever clinically indicated:

A. If discharged to home:

   - The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations.

B. If discharged to a nursing home or other long-term care facility (e.g., assisted living facility), **AND**

- If Transmission-Based Precautions *are still required*, the patient will go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19 infection.
- If Transmission-Based Precautions *have been discontinued*, the patient does not require further restrictions based upon their history of COVID-19 infection.

DEFINITIONS AND OTHER IMPORTANT INFORMATION

COVID-19: (2019 Novel Coronavirus (2019-nCov) and Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

- An infectious disease caused by a recently discovered coronavirus, which infects the respiratory tract. COVID-19 spreads from person to person through droplets of saliva or discharge form the nose when an infected person coughs or sneezes. Most people infected with COVID-19 will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are at higher risk for developing serious complications. People with COVID-19 may have a wide range of symptoms reported, ranging from no symptoms, to mild symptoms or severe illness. Symptoms may appear 2-14 days after exposure to the virus.

Common symptoms:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- The list of symptoms may change according to the SARS-CoV-2 variant

Emergency warning signs:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion

- Inability to wake or stay awake
- Bluish lips or face

Prevention:

- Wash hands regularly with soap and water, or clean them with alcohol-based hand rub.
- Maintain social distancing (at least 6 feet distance) from others especially in enclosed spaces.
- Avoid touching face (eyes, nose, and mouth).
- Cover your mouth and nose when coughing or sneezing.
- Stay home if you feel sick.
- Refrain from smoking and other activities that weaken the lungs.
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.

ALTERED STANDARDS OF CARE IN MASS CAUALTY EVENTS:

- Volume of COVID-19 symptoms
- Increase in inpatient census
- Staff shortage

PROCEDURE:

A. A multidisciplinary planning committee with responsibility for pandemic COVID-19 preparedness and response will include the following SVMC HCW and Staff:

- Emergency Department
- Marketing
- Chair of Environment of Care (EOC)
- Safety Officer
- Materials Management
- Clinical Leaders
- Human Resources (HR)/Employee Health
- Engineering
- Education
- Respiratory
- Laboratory
- Administration
- Environmental Services
- Information Technology
- Ambulatory Clinics
- Radiology
- Infection Prevention
- Security

- Infectious Disease Physician
- Community Physician Task Force

B. If COVID-19 is noted in local area any or all of the following may be implemented:

- Command Center will establish contact with Tulare County Health and Human Services Agency (TCHHSA).
- Conduct hospital surveillance of COVID-19.
- Monitor healthcare personnel who might be infected with COVID-19. Department director/manager will monitor all employee sick calls in accordance with current updated Centers for Disease Control & Prevention (CDC) guidelines & the local Health Officer.
- Reinforce infection prevention procedures in accordance with CDC guidelines & local Health Officer.
- Accelerate staff education.
- Implement activities to increase capacity in accordance with CDC guidelines & local Health Officer:
  - Plan for isolation zones to prevent further spread of the disease.
  - Consider how to handle, treat, and isolate patients with no COVID-19 illness.
- Emergency Department will triage in the designated area and place patients in the isolation area for persons with symptoms of COVID-19.
- Limit the number of visitors to those essential for patient support in accordance with CDC guidelines and the local Health Officer.
- Defer elective admissions and procedures until the local epidemic declines in accordance to guidelines of the CDC and the local Health Officer.
- Cohort patients admitted with COVID-19.
- Consider furlough or reassignment of high risk staff.
- Consider reassigning non-essential staff to support critical hospital services or placing them on administrative leave.
- Consider assigning staff recovering from COVID-19 to care for COVID-19 patients.
- Screen staff prior to the start of each shift.
- Provide staff access to appropriate PPE.
- If widespread transmission is seen within the community and hospital:
  - Redirect personnel resources to support patient care.
  - Recruit community volunteers.
  - Consider placing on administrative leave all non-essential personnel who cannot be reassigned to support critical hospital services.
  - Consider cross-training programs.
  - Explore options for alternative healthcare workers (e.g., retirees, trainees, family members, or others) as supplemental staff.
  - Prepare for just-in-time training of non-clinical staff, if possible.
  - Consider the need to replace high-risk personnel (e.g., immunocompromised workers) during an outbreak.

C. Infection Prevention General Guidelines

- Refer to SVMC's Policy Library for specific policies and details on infection prevention measures.
- Use of standard, droplet and airborne precautions and hand hygiene policies is indicated.
- Implement Dietary Plan.
- Soiled linen/laundry, environmental cleaning, and solid waste disposal are performed as defined by policy/procedure.
- Respiratory hygiene/cough etiquette:
  - Signage will be posted at entrances, waiting rooms and other areas that patients visit.
  - Guidelines include:
    - Cover your cough.
    - Wear a mask and or face covering.
    - Perform thorough hand hygiene using soap and water if available. If not, use alcohol-based hand sanitizer. Keep patients with coughs at least 6 feet from other individuals in waiting rooms.

- Contact/Droplet/Airborne Precautions: Place patients with COVID-19 in a private room or cohort with other COVID-19 patients. Keep the door closed.
- COVID-19 shall be laboratory confirmed.
- Wear an N-95 mask, gown, goggles/face shield, and gloves for entry into patient rooms that are suspected or confirmed COVID-19 positive.
- Patient transport: See Standard Operating Procedure on ***Transport or Transfer a Patient Under Investigation or Confirmed with COVID-19.***
  - Limit patient movement outside of room to medically necessary purpose.
- When aerosol-generating procedures are necessary:
  - Place patient in negative pressure room, when possible.
    - If negative pressure room is not available, use a private room with the door closed and a portable HEPA filter (when available)
  - Healthcare workers need to wear gloves, gown, face/eye protection, and an N-95 mask/PAPR.

D. Laboratory Procedures:

Outpatient:

- Collect and handle all clinical specimens from suspect COVID-19 patients while wearing a gown, gloves, N-95 mask, face and eye protection.
- Collect nasal swab and place swab into vial of transport media.
- Label each specimen with the following information:
  - Patient identifier information.
  - Date/time specimen collected.
  - Person Under Investigation (PUI) number.
  - Complete the ***Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) AND Case Report Form***.

Inpatient:

- Label each specimen with the following information:
  - Patient identifier information.
  - Date/time specimen collected.
  - Staff initials.

E. Post Emergency Event Actions:

- Reinstate normal facility, personnel and patient operations according to local, state and federal guidelines.
- Dissolve the Command Center.
- Resume usual use of space and clinical areas.
- Resume normal practice for supplies, medications and equipment.
- Resume usual staffing patterns.
- Conduct post-evaluation and review of performance and operations.
- Debriefing.

REFERENCES:

- Wilder-Smith A, Osman S. Public health emergencies of international concern: a historic overview. J Travel Med. 2020 Dec 23;27(8):taaa227. doi: 10.1093/jtm/taaa227. PMID: 33284964; PMCID: PMC7798963.
- Centers for Disease Control and Prevention. (2023, March 15). *CDC Museum Covid-19 Timeline*. Centers for Disease Control and Prevention. Retrieved April 19, 2023, from https://www.cdc.gov/museum/timeline/covid19.html#
- CALHHS information on the end of California's COVID-19 state of emergency and the Federal Public Health Emergency for covid-19. (2023, March 02). Retrieved April 19, 2023, from https://www.chhs.ca.gov/end-of-covid-emergency/
- Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic. Retrieved on April 18, 2023, Updated Sept. 27, 2022. From: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fdisposition-hospitalized-patients.html

CROSS REFERENCES:

- INFLUX OF INFECTIOUS PATIENTS CONTINGENCY PLAN
- INFLUENZA A+B (BD VERITOR SYSTEM)
- EMERGENCY OPERATIONS PLAN

SUBJECT: **PHARMACY ORGANIZATION**	SECTION: **Page 1 of 2**

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

POLICY:

The Sierra View Medical Center (SVMC) Hospital Pharmacy is under the direction of a licensed pharmacist with the responsibility to meet standards of care for pharmaceutical services. The Director of the Pharmacy is charged with responsibilities assigned by the Sierra View Local Health District Board of Directors through the hospital's Vice President of Patient Care Services.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

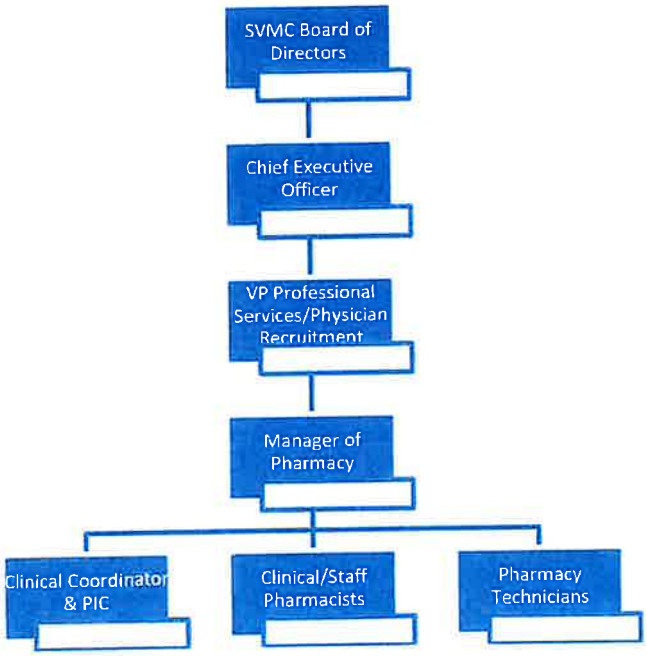
The Manager of Pharmacy, in conjunction with the Pharmacy and Therapeutics Committee, will initiate and develop policies and procedures pertaining to the pharmaceutical services of the hospital. These policies and procedures will meet the approval of Administration, the Medical Staff, and Board of Directors.

Standards of care for pharmaceutical services are those defined by the *American Society of Health-System Pharmacist.* These standards, in conjunction with State and Federal Law, will be used to develop all procedures pertaining to the acquisition, distribution, storage, dispensing and use of pharmaceuticals within the organization.

The chain of command is as follows:

- Sierra View Medical Center Board of Directors
- Chief Executive Officer
- Vice President of Professional Services
- Manager of Pharmaceutical Services
- Pharmacy Clinical Coordinator & PIC
- Clinical/Staff Pharmacist
- Licensed Pharmacy Technicians

Department of Pharmaceutical Services – Organizational Chart



REFERENCES:

- Pharmacy Law: California Edition.(2023) San Clemente, California: LawTech Publishing Group.

SUBJECT: **PYXIS ACCESS**	SECTION: ***Medication Management (MM)*** **Page 1 of 3**

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

PURPOSE:

To describe the management of Pyxis access privileges, to define what personnel will have access to Pyxis, and the termination process.

POLICY:

1. Access privileges to Pyxis shall be managed to ensure adequate security for medications, including controlled substance, to provide for proper and appropriate documentation of medication use.

2. A Pyxis user is defined as anyone with access to Pyxis. User templates will be created based on job titles; each user will be assigned user templates with specific access rights based upon their job duties.

3. Access privileges will be terminated immediately whenever the employee no longer works for the hospital.

4. Staff to complete a Pyxis Tutorial prior to Pyxis access being granted.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, RESPIRATORY THERAPY, ANESTHESIA, EDUCATION*

PROCEDURES:

Access Definition

1. User access may be requested for the following hospital staff:

    a. Pharmacist

    b. Pharmacy Technician

    c. RN Clinical Director/ Manager/Chief Nurse Executive

    d. Charge Nurse

    e. Staff Nurse

    f. Nursing Instructor

    g. Respiratory Therapist

    h. Anesthesiologist

    i. CRNA (Certified registered nurse anesthetist)

j. Medical Assistants in Urology Clinic

k. Medical Assistants in Rural Health Clinic

l. Medical Assistants at Academic Health Center

m. Medical Assistants at Surgery Clinic

n. IR Technician

o. Medical Imaging Technologist

p. Ultrasonographers

2. The pharmacy department shall designate an individual as the system manager. The system manager or designee will be responsible for creating and maintaining user template. The template will be reviewed and approved by the pharmacist in charge prior to activation.

Request Access

1. Regular

a. Access to Pyxis will be requested by the department director and/or manager on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the FormStack database for an existing employee.

b. Access Right will be assigned by Pharmacy System Manager based on employee's position.

c. Anesthesiologist, Midwife, and CRNA

- Access to Pyxis will be requested by Medical Staff on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the Formstack database for an existing employee.

2. Travelers

a. Access by travelers will have access for only the length of their contract. Their access will automatically terminate on the date their contract expires.

b. Upon hire, human resources will initiate the Access Request form with the Traveler's name, user name, and date the contract will begin and expire.

c. Once the Access Request has been approved by Department Director, and sent to pharmacy via IT, access will be assigned by Pharmacy System Manager.

d. If a traveler's contract is extended beyond the original time specified, an Access Update form will be initiated by Human Resources at the time the contract is renewed. The form, which including the new contract dates (beginning and expiration dates), will be sent on for approval in the usual manner.

3. Temporary

a. A charge nurse may set up temporary users. These temporary users are given access to the particular Display Terminal (DT) for a limited timeframe (14 hours) with specified rights.

b. Temporary users include any nurse that has floated to a department where access has not been assigned.

c. Float Nurses and Registry Nurses will be given access for 14 hours to cover assign shift in the department only.

d. Traveling Nurse may be given Temporary Access for up to 14 hours if access for length of contract has not yet been approved.

Termination of Access

1. For routine voluntary termination, once the department director or manager receives the notice, a Termination Notice form located in the Approval Database in the Formstack database will be filled out by department director or manager and sent to Human Resources. Human Resources will forward this information to Pharmacy System Manager. Pharmacy System Manager will disable the user's login privileges at the end of the last scheduled day of work.

2. For immediate termination without advance notice, human resources will contact pharmacy immediately. Pharmacy System Manager or designee will disable the user's access privilege right away. The department director or manager will still need to fill out the Termination Notice form. If immediate access removal is needed after pharmacy operating hours, the house supervisor will contact the on-call pharmacist who will remove Pyxis access for that user.

REFERENCE:

- Hospital Accreditation Standards. (2021). Oak Brook, IL: Joint Commission Resources, Inc.

SUBJECT:	SECTION:
PYXIS MEDICATION OVERRIDES AND DISCREPANCY	***Medication Management (MM)*** **Page 1 of 8**

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

PURPOSE:

To define the use of the override function in the PYXIS automated dispensing cabinets and identify the best practices associated with its use.

POLICY:

Medications available via the override function shall be limited to those drugs which may result in patient harm due to a delay in administration. The override list shall be reviewed and approved annually by the Pharmacy and Therapeutics Committee.

AFFECTED AREAS/PERSONNEL: *PHARMACY; NURSING*

PROCEDURES:

A. The override groups will include the following categories:

1. **Basic**- Includes controlled substances, over the counter (OTC) medications, respiratory medications.
2. **Emergent-** Includes the Basic group, plus those medications that require special training beyond the scope of the floor nurse to administer.
3. **Nursing House Supervisors**- Access to all medications house wide.
4. **OB Group**- Obstetric and Gynecological-related medications.
5. **RT Group**- Only access to respiratory medications.

B. Pharmacist Review of Override Medications

1. All medications removed via the override function shall be reviewed by the pharmacist the following day. Such review shall include:
   a. Verifying that there was a physician order for the over-ridden medication.
   b. Verifying that the nurse did not remove the medication on override after the order had been entered by a pharmacist.
   c. Verifying that the nurse did not override a medication using one route of administration, while the order was actually for another route.
   d. Verifying that the medication was not withdrawn on override after it had been discontinued or had expired.

e. Verifying proper dose, allergy status, and that interactions with other medications have not occurred.

2. Problems or issues with inappropriate use of the override function shall be documented in the hospital's medication event database and sent to the Nurse Managers for investigation, review and action.

3. Unresolved discrepancies shall be investigated by the Nurse Manager and the Pharmacy Director, as appropriate, and reported via the hospital medication event database and notification of the Chief Nursing Officer, as warranted.

4. For unresolved discrepancies involving controlled substances, refer to the procedures outlined in the Controlled Substances Procurement, Administration and Documentation policy.

Override Group Name	Generic Name	Trade Name
Basics	ACETAMINOPHEN	Tylenol Supp
Basics	ACETAMINOPHEN	Tylenol
Basics	ACETAMINOPHEN	Tylenol Soln
Basics	ACETAMINOPHEN	Tylenol Supp
Basics	ACETAMINOPHEN	Tylenol Es
Basics	ACETAMINOPHEN DROPS	Tylenol Drops
Basics	ACETAMINOPHEN INJ	Ofirmev Inj
Basics	ACETAMINOPHEN W/COD 300-30	Tylenol W/Cod #3
Basics	ACETAMINOPHEN W/COD ELIX	Tylenol w/Cod Elix
Basics	ANAPHYLAXIS KIT	Anaphylaxis Kit
Basics	ATROPINE SULF INJ	Atropine Inj
Basics	CALCIUM CHLORIDE 10% INJ	Calcium Chloride 10% Abboject
Basics	DEXAMETHASONE SOD PHOS INJ	Decadron Inj
Basics	DEXTROSE 50%-WATER INJ	D50w Inj Abboject
Basics	DIAZEPAM	Valium Inj
Basics	DIGOXIN ELIX	Lanoxin Elix

Basics	DiphenhydrAMINE INJ	Benadryl Inj
Basics	EPINEPHRINE INJ	Epinephrine Inj
Basics	ETOMIDATE INJ	Amidate Inj
Basics	FENTANYL CIT INJ	Sublimaze Inj
Basics	FENTANYL PCA	Sublimaze PCA
Basics	FLUMAZENIL INJ	Romazicon Inj
Basics	FOSPHENYTOIN SOD INJ	Cerebyx Inj
Basics	FUROSEMIDE INJ	Lasix Inj
Basics	GUAIFENESIN SYRUP	Robitussin Syrup
Basics	GUAIFENESIN/CODEINE PHOSPHATE	Robitussin Ac Syrup
Basics	HALOPERIDOL LACT INJ	Haldol Inj
Basics	HEPARIN in D5W	Heparin in D5w Ivpb
Basics	HEPARIN SOD INJ	Heparin Inj
Basics	HydrALAzine INJ	Apresoline Inj
Basics	HYDROCOD BIT/APAP ELIX 10/300	LORTAB ELIX (10/300)
Basics	HYDROCORTISONE SOD SUCC INJ	Solu-Cortef Inj
Basics	HYDROMORPHONE HCL	Dilaudid Inj
Basics	HYDROMORPHONE-HP INJ	Dilaudid Pca
Basics	INSULIN 75/25 NPL/LISP	HUMALOG 75/25 INSULIN
Basics	INSULIN ASPART	NovoLOG INSULIN
Basics	INSULIN GLARGINE INJ	Lantus Inj
Basics	INSULIN HUMAN REGULAR PER UNIT	Novolin-R U-100 (Billed Per Un
Basics	INSULIN LISPRO	HUMALOG INSULIN
Basics	KETOROLAC INJ	Toradol Inj
Basics	LIDOCAINE HCL 2% - MPF	Xylocaine 2% - MPF Inj
Basics	LIDOCAINE INJ 2%	Xylocaine Inj 2% Abboject

Basics	LIDOCAINE PF 1%	Xylocaine-Mpf Inj 1%
Basics	LORAZEPAM	Ativan Inj
Basics	MAGNESIUM SULF	Magnesium Sulf
Basics	MAGNESIUM SULFATE IVPB	MAGNESIUM IVPB
Basics	MEPERIDINE INJ	Demerol Inj
Basics	MethylPREDNISolone SOD SUC-CL	Solu-Medrol Inj
Basics	METOCLOPRAMIDE INJ	Reglan Inj
Basics	MG HYD/AL HYD/SIM ES SUSP	Maalox Es Susp
Basics	MIDAZOLAM INJ	Versed Inj
Basics	MORPHINE SULF INJ	Morphine Sulfate Inj
Basics	MORPHINE SULF LIQD	Morphine Sulf Liqd
Basics	MORPHINE SULF PCA	Morphine Sulf Pca
Basics	NALOXONE INJ	Narcan Inj
Basics	NIFEdipine	Procardia
Basics	NITROGLYCERIN	Nitrostat 1/150
Basics	NITROGLYCERIN INJ	Nitroglycerin Inj.
Basics	NITROGLYCERIN OINT 2%	Nitro-paste Oint 2%
Basics	ONDANSETRON INJ	Zofran Inj
Basics	PHENOBARBITAL INJ	Phenobarbital Inj
Basics	PROMETHAZINE INJ	Phenergan Inj
Basics	SOD POLYSTYRENE SULFON SUSP	Kayexalate Susp
Basics	SODIUM BICARB INJ 8.4%	Sodium Bicarbonate Inj 8.4%
Basics	SODIUM CHLOR, BACTERIOSTATIC	NaCl Bacterostatic Inj
Basics	STERILE WATER	Sterile Water
Basics	THIAMINE INJ	Vitamin B-1 Inj
Basics	TICAGRELOR	Brilinta

Basics	WATER FOR IRRIGATION,STERILE	Sterile Water Irrig
Emergent	ACETYLCYSTEINE RT SOL 10%	Mucomyst Rt Sol 10%
Emergent	ACETYLCYSTEINE RT SOL 20%	Mucomyst Rt Sol 20%
Emergent	ADENOSINE INJ	Adenocard Inj
Emergent	ALBUMIN HUMAN 25%	Albuminar-25 Ivpb
Emergent	Alteplase 100mg Vial	Activase
Emergent	AMIODARONE HCL/DEXTROSE	Nexterone IVPB
Emergent	AMIODARONE INJ	Cordarone Inj
Emergent	ANTIVENIN, CROTALIDAE	Crofab Inj
Emergent	ANTIVENIN, CROTALIDAE (EQUINE)	Anavip Inj
Emergent	ASPIRIN	Aspirin Chew
Emergent	ASPIRIN EC	Ecotrin
Emergent	BENZOCAINE Spray 20% (Topex)	Topex Spray
Emergent	BUMETANIDE INJ	Bumex Inj
Emergent	CLOPIDOGREL	CLOPIDOGREL
Emergent	COCAINE HCL TOP SOL 4%	Cocaine Topical 4%
Emergent	DEXMEDETOMIDINE/D5W 400MCG IV	PRECEDEX 400MCG/100ML
Emergent	DEXTROSE 5%-WATER (AVIVA)	D5w (Aviva)
Emergent	DILTIAZEM INJ	Cardizem Inj
Emergent	DOBUTamine INJ	Dobutrex Inj
Emergent	DOPamine in D5W IVPB	Intropin in D5w Ivpb
Emergent	DOPamine INJ	Intropin Inj
Emergent	ENALAPRILAT INJ	Vasotec Inj
Emergent	ENOXAPARIN SOD INJ	Lovenox Inj
Emergent	EPTIFIBATIDE INJ	Integrilin Inj
Emergent	EPTIFIBATIDE IVPB	Integrilin Ivpb

Emergent	ESMOLOL INJ	Brevibloc Inj
Emergent	ESOMEPRAZOLE INJ (NON-FORM)	Nexium Inj
Emergent	FAT EMULSIONS 20% IV	Liposyn II 20% Iv
Emergent	FENTANYL in NS (Premix)	Sublimaze in NS Premix
Emergent	FLUORESCEIN/PROPARACAINE OPTH	Flucaine Op Sol
Emergent	Glucagon Inj	Glucagen
Emergent	GLYCOPYRROLATE INJ	Robinul Inj
Emergent	INSULIN REG 100 UNITS / 100 ML	Myxredlin premixed
Emergent	KETAMINE HCL INJ	Ketamine Inj
Emergent	KETAMINE HCL INJ SYRINGE	Ketamine HCl Inj Syringe
Emergent	LABETALOL INJ	Trandate Inj
Emergent	LACOSAMIDE	Vimpat
Emergent	LIDOCAINE in D5W IVPB	Xylocaine in D5w Ivpb
Emergent	MAGNESIUM SULF INJ 50%	Magnesium Sulfate 50% Inj
Emergent	MANNITOL INJ 20%	Mannitol Inj 20%
Emergent	METOPROLOL TARTRATE INJ	Lopressor Inj
Emergent	MIDAZOLAM in NS (Premix)	Versed in NS Premix
Emergent	MIDAZOLAM SYRUP	Versed Syrup
Emergent	NITROGLYCERIN in D5W	Nitroglycerin in D5w Ivpb
Emergent	NITROPRUSSIDE SOD INJ	Nitropress Inj
Emergent	NOREPINEPHRINE IN D5W INJ	Levophed in D5W Inj
Emergent	NOREPINEPHRINE IN NS	Levophed in NS
Emergent	OCTREOTIDE ACET INJ	SandoSTATIN Inj
Emergent	PANTOPRAZOLE INJ	Protonix Inj

Emergent	PHENOBARBITAL ELIX	Phenobarbital Elix
Emergent	PHENYLEPHRINE INJ	Neo-synephrine Inj
Emergent	POTASSIUM CHLOR IVPB	Kcl Ivpb
Emergent	POTASSIUM PHOSPHATE IVPB	Potassium Phosphate IVPB
Emergent	PROCAINAMIDE 100MG/ML 10ML	PROCAINAMIDE 100MG/ML 10ML
Emergent	PROPOFOL INJ	Diprivan Inj
Emergent	PROPOFOL INJ	Diprivan Ivpb
Emergent	PROTHROMBIN CMPLX CONC (HUMAN)	Kcentra Kit - 1000 units/kit
Emergent	RIVAROXABAN	Xarelto
Emergent	ROCURONIUM INJ	Zemuron Inj
Emergent	SODIUM BICARB INJ 8.4%	Sodium Bicarbonate Inj 8.4%
Emergent	SODIUM BICARBONATE 4.2%	Sodium Bicarbonate 4.2%
Emergent	SUCCINYLCHOLINE INJ	Anectine Inj
Emergent	TENECTEPLASE INJ	Tnkase Inj
Emergent	TRANEXAMIC ACID INJ	Tranexamic Acid
Emergent	TRANEXAMIC ACID IVPB	Tranexamic Acid IVPB
Emergent	VASOPRESSIN INJ	Pitressin Inj
Emergent	VECURONIUM INJ	Norcuron Inj
Emergent	VERAPAMIL INJ	Calan Inj
OB	AMPICILLIN INJ	Ampicillin Inj
OB	BETAMETHASONE (CELESTONE) INJ	Celestone Inj
OB	CARBOPROST TROMETH INJ	Hemabate Inj
OB	CEFAZOLIN in DEXTROSE	Ancef/Dextrose Ivpb
OB	CEFOXITIN SOD INJ	Mefoxin Inj
OB	CITRIC ACID/SODIUM CITR	Bicitra Soln
OB	CLINDAMYCIN PHOS INJ	Cleocin Inj
OB	CLINDAMYCIN PHOS/D5W	Cleocin/D5w Ivpb
OB	EPHEDRINE SULF INJ	Ephedrine Sulfate Inj

OB	FAMOTIDINE INJ	Pepcid Inj
OB	GENTAMICIN INJ	Gentamicin Inj Ped
OB	KETOROLAC INJ	Toradol Inj
OB	MAGNESIUM SULF IVPB	Magnesium Sulfate Ivpb
OB	METHYLERGONOVINE INJ	Methergine Inj
OB	MISOPROSTOL	Cytotec
OB	MORPHINE SULF PF INJ	Duramorph-Pf Inj
OB	MORPHINE SULFATE PF	Duramorph-PF Inj
OB	Oxytocin 20 Units in LR	Pitocin in LR
OB	Oxytocin 30 Units in LR	Pitocin in LR
OB	OXYTOCIN INJ	Pitocin Inj
OB	PHYTONADIONE	Vitamin K Inj
OB	PORACTANT ALFA INHALANT	Curosurf
OB	RANITIDINE HCL	Zantac Inj (Ped)
OB	RANITIDINE INJ	Zantac Inj
OB	TERBUTALINE SULF INJ	Brethine Inj
RT	ALBUTEROL RT	Proventil Rt Sol
RT	ALBUTEROL/IPRATROP RT 3ML NEBU	Duoneb RT 3ML NEBU
RT	EPINEPHRINE RT SOL 2.25%	RACEPINEPHRINE 2.25%
RT	LEVALBUTEROL RT	Xopenex Rt Sol
RT	SODIUM CHLORIDE 3% RT SOL	Sodium Chloride 3% RT Sol
RT	SODIUM CL RT SOL 0.9%	Normal Saline Rt Sol

REFERENCE:

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

SUBJECT: **RADIATION PROTECTION AND SAFETY**	SECTION: **Cath Lab** **Page 1 of 2**

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

PURPOSE:

To establish guidelines to keep exposure at a minimum and protection against radiation hazards for both staff and patients.

POLICY:

1. All personnel are required to wear an exposure monitor (dosimeter)
2. A record on exposure amounts will be kept in the Imaging Department.
3. Cath Lab doors will be closed during fluoroscopy and cine procedures.
4. All personnel required to be present in the room during the procedure will wear lead aprons.
5. Personnel not directly involved in the procedure will remain outside the room during exposure.
6. Shielding evaluation will be made of the structures to comply with state and federal regulations.
7. Evaluation records will be kept on file in the Cardiac Cath Lab.
8. Any malfunction of equipment will be immediately reported to the Cath Lab Director.
9. Operators will know the location of all emergency off and on switches.
10. All staff will have taken the Radiation Safety Module in E-Learning
11. All X-ray equipment will be maintained and preventative maintenance will be done per manufacturer's guidelines.
12. Fluoroscopy checks will be done and recorded on a weekly basis.

AFFECTED PERSONNEL/AREAS: *ALL CATH LAB STAFF*

EQUIPMENT:

- Lead Apron
- Thyroid Collar
- Protective Glasses
- Film Badge
- Other Protective Shields

PROCEDURE:

1. Film badges will be issued to each individual who enters the Cardiac Cath Lab that is likely to receive, in any calendar quarter, a dose exceeding 300 millirems to the whole body, or 5 rems to the hands and forearms, or feet and ankles, or 2 rems to the skin of the whole body.

2. All Cardiac Cath Lab personnel and physicians must wear their film badge at all times when they are in the department.

3. Film badges, when not in use, must be placed on the racks provided in the break room. They should not be left on the lead aprons, and should not be taken outside the facility.

4. Under no circumstance shall an employee or physician be permitted to use a film badge other than their own.

5. The X-ray unit in Cath Lab will be turned on at the beginning of each day and left on throughout the day to allow for adequate operation.

6. All Cath Lab staff will use caution in the fluoroscopy rooms between procedures and while prepping patients to ensure no exposure to radiation by accidentally stepping on the fluoroscopy pedal.

7. The designated staff will verify fluoroscopy time automatically documented for each case.

8. Each Cath Lab staff member must assume responsibility for adequately protecting themselves and others in the procedure room with lead aprons and protective accessories during procedures and must follow As Low As Reasonably Achievable (ALARA).

9. A designated Imaging Services Employee will be responsible for the distribution of the film badges, the procedures governing their use, and the maintenance of permanent radiation records on each individual.

10. Reports will be provided to any individual of their radiation exposure data at their request and in writing.

11. Quarterly film badge reports will be posted in the Imaging Department break room.

REFERENCES:

- California Department of Public Health (2020). Radiologic Health Branch. Retrieved from https://www.cdph.ca.gov/Programs/CEH/DRSEM/pages/rhb.aspx.

- California Health and Safety Code: Sections 114960 and 106965 (Radiation Control Law). Added by Stats. 1995, Ch. 415, Sec. 6. Effective January 1, 1996.

SUBJECT: **ROUTINE PATIENT CARE IN THE POST-ANESTHESIA CARE UNIT (PACU)**	SECTION: **Page 1 of 3**

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

POLICY:

Routine patient care will be provided to patients in the Post-Anesthesia Care Unit (PACU).

PROCEDURE:

- Start oxygen 6-10 L via mask post general anesthesia, if indicated call Respiratory, unless other orders received by anesthesia provider.
- Vital signs are taken on admission, then every five (5) minutes X3,then, if stable, every 10-15 minutes for the first hour, then every thirty (30) X4. Notify the anesthesiologist if vital signs have not stabilized fifteen minutes after admission or immediately if there is a sudden change during the PACU stay. The temperature will be taken within the first 30 minutes, then every hour, and at discharge.
- Pain medication will only be given as ordered by the anesthesiologist/surgeon.
- The IV solution from surgery will be followed with the IV solution specified in the post-operative orders.
- If there are no post-operative orders for an IV, the present IV may be discontinued prior to transfer unless contraindicated by the patient's condition. If this situation occurs, the surgeon or anesthesiologist must be contacted for orders.
- Cardiac monitoring will be initiated on admission and a printed rhythm strip documentation of the cardiac rhythm will be obtained and placed on the PACU record.
- The Aldrete Scoring System for discharge will be used:

Post Procedure Monitoring and Discharge Criteria:

Documentation of the Aldrete Score will be completed prior to patient discharge. The score must return within 2 points of the baseline assessment before the patient may be released from the procedure area. The range is 10 for complete recovery to 0 in comatose patients. Evidence that the patient has met discharge criteria must be clearly documented in the medical record.

1. Motor Activity:

   Muscle activity is assessed by observing the ability of the patient to move his/her extremities spontaneously or on command.

   a. Score:

      2 – Moves 4 extremities voluntary/command

1 – Moves 2 extremities voluntary/command

0 – moves 0 extremities voluntary/command

2. Respiration:

Respiratory efficiency is evaluated in a form that permits accurate and objective assessment without complicated physical tests.

a. Score:

2 – Able to deep breathe and cough freely

1 – Dyspnea or limited breathing

0- Apneic

3. Circulation:

Use changes of arterial blood pressure from pre-anesthetic level.

a. Score:

2 – B/P + or – 20mmHg of pre-procedure level

1 – B/P + or – 20-50 mmHg of pre-procedure level

0 – B/P + 50 mmHg of pre-procedure level

4. Neurologic Status

Determination of the patient's Level of Consciousness.

a. Score:

2 – Fully awake and oriented

1- Arousable on calling-drifts to sleep

0- Not responding or responds to pain

5. Oxygen Saturation Aldrete

   a. Score:

   2- 02 sat > or = to 92% on room air

   1 – Needs 02 for 02 sat > or =90%

   0- 02 sat < 90% even with 02

All outpatients who receive sedation for any procedure must be observed and monitored for a minimum of 30 minutes~~1 hour~~ after the last medication given prior to being discharged home. Vital signs (heart rate, respiratory rate, blood pressure, ETCO2, and temperature) are recorded at 10~~5-30~~ minute intervals.

RESPONSIBILITY:

- PACU personnel are responsible for the initiation of all routine patient care in the PACU. Any patient who does not meet the criteria established for a "normal" recovery period (approximately 1 hour) must be reported to the anesthesiologist for evaluation.
- The anesthesiologist has responsibility for all patient care ordered in the PACU in collaboration with the surgeon. Post-anesthesia evaluation to be done prior to discharge by an anesthesiologist.
- Discharge Aldrete score must be within 2 points of total pre-op score.

REFERENCES:

- Aldrete Score 2018-2019, Meditech 6.1 PP3, Copyrights Protected and SVMC has contract on file
- Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements, The American Society of Post Anesthesia Nurses,. 2021~~18~~-2022~~19~~.

SUBJECT: **SCOPE OF SERVICE – CARDIAC CATH LAB**	SECTION: **Cardiac Cath Lab** **Page 1 of 2**

PURPOSE:

To provide elective, scheduled, diagnostic and interventional outpatient cardiac catheterization services for adult and geriatric patients.

AFFECTED PERSONNEL/AREAS: *ALL CATH LAB STAFF*

POLICY:

The Cardiac Catheterization Laboratory (CCL) provides services for diagnostic and angiography studies. These services consist of:

- Right and left heart catheterization
- Angiography of the coronary arteries, left ventricle, and aorta
- Coronary and peripheral intervention, including balloon angioplasty and stenting
- Pacemaker/device placement and extraction
- Myocardial biopsy
- Electrophysiological studies
- Intra vascular ultrasound (IVUS)
- Fractional flow reserve (FFR)

The CCL is comprised of physicians who specialize in interventional cardiology, and/or maintain the appropriate credentials to exercise specific procedural privileges. These physicians are ultimately responsible for care of the patients pre-procedurally, intra-procedurally, and post-procedurally.

Hours/Days of Operation: 0700-1600 Monday - Friday

CCL Admit/Recovery Areas: Provides care for CCL patients during the pre- and post-procedure periods under RN oversight.

Scope of Patient Care Needs: The CCL department provides a safe and comfortable environment for both patients and personnel in order to provide optimum assistance to the physicians in meeting the health needs of the patients. The CCL staff provides quality-conscious, competent, and cost-effective care with respect for life and dignity. Patients' physical, psychological, and social needs are assessed, evaluated, and documented prior to admission, upon admission, prior to discharge, and as needed throughout their stay in the CCL department.

Staffing Patterns: CCL procedures will only be performed if the necessary staff and equipment are available.

A. The CCL team consists of Registered Nurses (RNs) and Radiological Technologists (RTs).

B. Admit/Recovery is staffed by two RNs.

C. CCL procedure suite staffing includes one sedation Registered Nurse, one Radiological Tech, and one transcriber/monitor RN and/or RT.

D. During procedures where moderate sedation is administered, the policy titled "Procedural Sedation" will be adhered to.

E. Staff Accountability/Responsibility:

1. Medical Director: Directly accountable and responsible to the Department of Radiology/Pathology and the Governing Board.

2. Department Director: Directly accountable and responsible to the Administrative Director of Radiology and the Vice President of Physician Recruitment & Professional Services for all aspects of CCL operations.

3. RN: Accountable to the Department Director and is responsible for direct patient care and other duties as per job description.

4. RT: Accountable to the Department Director and is responsible for duties as per job description.

F. CCL equipment and supplies shall include the following, or include alternate equipment which meet the intent of the prescribed equipment:

- X-ray machine
- Image intensifier
- Pulse generator
- Camera
- Spot film device
- Videotape viewing equipment of fluoroscopic procedures
- Magnetic tape recording and playback equipment
- Motor-driven cardiac table
- Cinefluorography and radiography equipment
- Monitoring and recording equipment
- Pressure transducers
- Equipment for determining cardiac output
- Appropriate cardiac catheters and accessory equipment
- Resuscitation equipment
- GE Innova flat panel C-Arm
- Hemodynamic monitoring equipment
- Power injector

REFERENCES:

- California Code of Regulations (2019). Title 22. §70433-70439. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Procedural Sedation

SUBJECT: **STANDARD MAINTENANCE OF WATER TREATMENT SYSTEM**	SECTION: **Page 1 of 2**

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

PURPOSE:

To assure proper water system maintenance and to routinely produce high quality treated water (Association for the Advancement of Medical Instrumentation (AAMI) Standards).

POLICY:

Water Treatment system will be serviced and tested in accordance with AAMI guidelines.
Routine monitoring of microbiological contamination in dialysis water system focusing on preventing the development of growth in the system.

AFFECTED PERSONNEL/AREAS:

BIOMEDICAL PERSONNEL; DIRECTOR/FACILITY ADMINISTRATOR; MEDICAL DIRECTOR

PROCEDURE:

DAILY:

1. The daily maintenance log of the outpatient water system.
   a. A daily maintenance log to be completed by Sierra View Medical Center (SVMC) dialysis personnel.
   b. A daily total chlorine test to be done on the water system by SVMC dialysis personnel.

MONTHLY:

1. A monthly bacteria culture of the hemodialysis water system.
2. A monthly bacteria culture of the hemodialysis dialysate.
3. A monthly endotoxin culture of the hemodialysis water system.
4. A monthly disinfection of the Reverse Osmosis (RO) Unit system following operation and maintenance manual guidelines.
5. A monthly Preventative Maintenance Inspection performed by dialysis biomedical personnel.
6. A monthly Preventative Maintenance Inspection of Domestic Water Booster Pump performed by facilities engineering.
7. A monthly sanitization of the hemodialysis water system.

a. Additional sanitization of the water system is necessary if any of the following apply:

- Promptly any time the levels of bacteria or endotoxin exceed action levels.
- Promptly any time the water system has been shut down for more than 8 hours.

b. The disinfection process will be performed only by trained personnel.

c. A bacteria and Limulus Amoebocide Lysate (LAL) culture will be obtained promptly after disinfect.

NEW EQUIPMENT:

- The hemodialysis water system will have four bacteria and endotoxin cultures perform before use.

MONITORING AND DOCUMENTATION:

Review documentation and monitoring results monthly at CQI meetings.

REFERENCES:

- Water Quality Standard for Hemodialysis American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI) 13959:2014.
- Quality of Dialysis Fluid for Hemodialysis and Related therapies, ANSI/AAMI/ISO 11663:2009.
- Guidance for the Preparation and Quality Management of Fluids for Hemodialysis and Related Therapies ANSI/AAMI/ISO 23500:2011.
- Mar Cor Purification. (2016). Millennium reverse osmosis unit. Operations and maintenance manual.

SUBJECT: **TRACHEOSTOMY CARE- DP/SNF**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the procedure for maintaining the patent airway during tracheostomy care, decreasing the opportunity for infection, and securing resident comfort.

POLICY:

All residents with tracheostomies will receive tracheostomy (trach) care twice a day and PRN. This will be performed to ensure that the dressing is clean and dry and to prevent infection and breakdown of the skin.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), RESPIRATORY CARE PRACTITIONER (RCP), LICENSED VOCATIONAL NURSE (LVN)*

EQUIPMENT:

- Suction catheter
- Cleaning solutions: 0.9% NaCl and H202
- 4 x 4 gauze sponge
- Sterile split 4 x 4 gauze
- One pair of sterile gloves (for tracheostomy < 30 days old)
- One pair of clean gloves (for tracheostomy ≥ 30 days old)
- Tracheostomy ties
- Tracheostomy collar
- Sterile cotton swabs (optional)
- Sterile disposable inner cannula (if inner cannulas are used)

PROCEDURE:

1. Prepare a clean work area.
2. Gather supplies and wash hands.
3. Explain the procedure to the resident.
4. Position resident in a semi-fowler position, if possible.
5. Put on clean gloves and suction oropharyngeal airway and tracheostomy.

6. Remove soiled tracheostomy dressing and discard dressing and gloves.

7. Wash hands, put on sterile gloves, and prepare a sterile field for tracheostomies < 30 days old and/or clean gloves and a clean field for tracheostomies ≥ 30 days old.

8. Place 4 x 4 gauze sponge, tracheostomy tie, and sterile split 4 x 4 on sterile or clean field.

9. If the tracheostomy tube has an inner cannula, remove it and discard. Replace with a new disposable inner cannula.

10. Clean the tracheostomy incision, if needed. Remember to use sterile technique for tracheostomies < 30 days and clean technique for tracheostomies ≥ 30 days old.

11. Apply sterile split 4 x 4 next to skin around tracheostomy tube.

12. Replace the tracheostomy collar. Always hold the tracheostomy in place while the tracheostomy collar is being changed. Ask for assistance if needed.

13. Attach tracheostomy to tubing of suction catheter at T-piece using tracheostomy ties.

14. Discard all contaminated items in the trash.

15. Be sure the resident is clean and comfortable before leaving.

16. The tracheostomy stoma requires daily care. Assessments of the stoma include observations for signs of infection and breakdown of the skin.

INFECTION CONTROL:

1. Change tracheal suction tubing each Tuesday and Saturday night and as needed.

2. Change suction canister liners every three (3) days, odd rooms on night shift and even rooms on day shift. Change suction canister liners as needed when three (3) quarters full. Date when changed.

3. Change Yaunkers every Tuesday and Saturday, if opened, and as needed.

4. Change tracheostomy tube each month (by RCP), and as needed for dislodgment and cuff failure.

DOCUMENTATION:

Each time the tracheostomy dressing is changed, the procedure will be documented in the resident record in the electronic medical record (EMR). This includes assessment of the site pertaining to skin integrity, drainage, and how the patient tolerated the procedure.

REFERENCES:

- American Cancer Society (October 16, 2019). Caring for a tracheostomy. https://www.cancer.org/search.html?q=cleaning+the+tracheostomy

- AACN Publishing. *Critical Care Guidance for Tracheostomy Care during Covid-19 Pandemic: A Global, Multidisciplinary Approach,* Am J Crit Care (2020) 29 (6): e116-e127, Vinciya Pandian, Phd, MBA, APN, RN, ACNP-BC.

- Arakawa-Sugueno, L. (2017). *What Is the Best Way to Take Care of a Patient with a Tracheostomy Tube?* Tracheostomy, 377-390. doi:10.1007/978-3-319-67867-2_22.

    - American Cancer Society, Oct 2019, *Caring for a Tracheostomy,* retrieved from: https://www.cancer.org

SUBJECT: **TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE FROM CARDIAC CATH LAB**	SECTION: **Page 1 of 2**

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

PURPOSE:

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

POLICY:

A. Patients treated at the CCL who require a higher level of care due to unexpected complications, or who are in need of medical services not offered at SVMC, will be transferred to the accepting hospital for further medical treatment.

AFFECTED PERSONNEL/AREAS: *CARDIAC CATH LAB, RESPIRATORY THERAPY*

EQUIPMENT:

- Intra-Aortic Balloon Pump (IABP)
- Portable Ventilator

PROCEDURE:

A. Emergency Transfer

1. Immediately contact the CCL Director and notify of emergency.
2. Obtain order from attending Cardiologist to transfer patient to desired Hospital.
3. Cath lab personnel will contact contracted facilities for higher level of care and obtain acceptance from the facility and physician.
4. Call accepting facility and give report to transfer center or emergency department RN.
5. Contact EMS and advise dispatcher of need for emergency transfer from CCL to requested or nearest accepting facility.
6. Stabilize and prepare patient for transfer.
7. Obtain the following documentation:
   - Physician Transfer Certification Form (Pink) completed by RN and MD (copy goes with patient)

- Physician Certification Statement (White copy stays at SVMC, yellow copy goes with ambulance)
- Written copy of Transfer Agreement (copy goes with patient)
- CD of Images
- Copy of MAC lab reports
- Copy of patient's face sheet
- List of medications
- Copy of patient's history and physical

8. Notify patient's family if Physician has not already done so.
9. Patients requiring an IABP will be accompanied by a SVMC RN competent with management of IABP.
10. Patients requiring portable ventilators will be accompanied by a respiratory therapist.

REFERENCES:

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

Senior Leadership Team	6/27/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	6/27/2023

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SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
June 27, 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. Business Associate Agreement	1-15	
2. Meal Discount	16-17	
3. Patient Safety Plan	18-24	
4. Personal Conduct	25-29	
5. Release of Medical Information	30-33	
6. Release of Patient Information	34-39	
7. Rental Policy	40-42	
8. Safety Education	43-45	
9. Victim Trafficking	46-47	

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SUBJECT: **BUSINESS ASSOCIATE AGREEMENT**	SECTION: *Compliance* **Page 1 of 15**

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

PURPOSE:

To ensure that Sierra View Medical Center (SVMC) is in compliance with the Health Information Portability and Accountability Act (HIPAA) Privacy Regulations and to establish guidelines for SVMC to identify those vendor/business relationships that meet the definition of "Business Associate" (BA) or subcontractor and provide direction in establishing formalized "Business Associate Agreements" (BAA). To define the permissible uses and disclosures that a BA may make regarding the protected health information (PHI) that it creates or receives in providing services to or on the behalf of SVMC as a covered entity (CE).

DEFINITIONS:

Protected Health Information (PHI): Any oral, written or electronic individually identifiable health information collected or stored by a facility. Individually identifiable health information includes demographic information and any information that relates to past, present or future physical or mental condition of an individual.

Business Associate (BA): A BA is not a member of SVMC's workforce and is a person or entity, who on behalf of SVMC:

- Performs or assists SVMC with a function or activity and reporting /accounting of disclosures regulated by HIPAA involving the creation, receipt, maintenance, use, disclosure, or transmittal of PHI. These activities include, but are not limited to: claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management or re-pricing;

- Provides any of the following functions or activities involving the use or disclosure of PHI to or for SVMC: e.g., legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services, where the provision of services involves the disclosure of individually identifiable health information from SVMC;

- Provides data transmission of PHI to SVMC, and requires access on a regular basis to such PHI;

- Stores, transmits, or maintains PHI physically within their facilities or electronically within the information systems.

Business Associate Agreement (BAA): An agreement entered into by SVMC and a third party that establishes permitted and required uses and disclosures of PHI requiring the BA to appropriately safeguard PHI, protect the privacy and provide for the security of PHI. (Exceptions to the Business Associate standard are found in the HIPAA Privacy Rule 45 CFR 164.502)

A BAA is NOT required in the following circumstances:

- Disclosures by SVMC to a health care provider concerning the treatment of an individual. Including, but not limited to, the PHI being disclosed for treatment purposes (e.g., primary/referring physician, contract physicians or specialists, x-ray technician, laboratory analysis, hospice care provider, contract nursing staff, contract rehab staff, ambulance, home health, dentist, etc.)

- Disclosures to a group health plan for payment purposes to the plan sponsor.

- Uses or disclosures by a health plan that is a government program providing public benefits, if eligibility for, or enrollment in, the health plan is determined by an agency other than the agency administering the health plan, or if the PHI used to determine enrollment or eligibility in the health plan is collected by an agency other than the agency administering the health plan.

AFFECTED AREAS/PERSONNEL: ADMINISTRATION, CONTRACT MANAGEMENT, COMPLIANCE, MATERIALS MANAGEMENT, VENDORS, DEPARTMENT LEADERSHIP

POLICY:

SVMC will not contract with a BA until satisfactory assurances are received that the BA will appropriately safeguard PHI, and they have met the requirements established by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the **HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "**HIPAA Regulations**") (collectively, "**HIPAA**") and other applicable laws.

- Under the Privacy Rule, SVMC cannot disclose PHI to its business associates without having a written contract in place that includes specific privacy protections. A written BAA is required (other than the contract) that documents these assurances.

- SVMC legal counsel has developed a standard HIPAA Business Associate template to be used in newly established business associate relationships or any contracts with existing relationships that are being renewed. (See attachment A HIPAA Business Associate Agreement). The BAA is generally an addendum to the main contract; however, it may be embedded into the main contract.

- Any BAA that is not the SVMC BAA template (ie; the Business Associate's version) when compared to the SVMC BAA is found to be materially different or material changes to the SVMC BAA template are requested by the Business Associate must be reviewed and approved by SVMC external legal counsel.

PROCEDURE:

Required Business Information:

When SVMC has determined that a BA relationship exists (or will exist for a new vendor/business relationship, the relevant Department Leader will contact SVMC's Contracts Administrator or designee to initiate a BAA. The following information will need to be provided:

- A description of the type of service(s) being provided by the BA, which should be consistent with the underlying service agreement (if applicable);
- Consistent with the service(s) being provided by the BA, list all permitted uses and disclosures of PHI;
- The date the BA will begin creating, receiving, maintaining or transmitting PHI should be simultaneous to the effective date of the service agreement;
- Point of contact information for the operational contacts of the BA. The individual(s) listed on a Point of Contact form should be able to represent the organization's interests and policies/practices pertaining to HIPAA compliance, and PHI breach notifications/investigations;
- Any additional BAA provisions requested by SVMC.

SVMC's Contracts Administrator or designee shall be responsible for overseeing the management of BA relationships and BAAs. SVMC department leaders are responsible for assessing existing and future vendor/business relationships to determine whether a BAA is required.

Contract Administrator or designee will:

- Evaluate the relationship and/or need for a BAA. If it is unclear, whether a relationship requires a BAA contact SVMC's Privacy Officer or legal counsel;
- Determine the existence of a signed, current BAA by reviewing the contract management data base;
- If a BAA (or core contract addressing BAA requirements) is not on file, provide the Business Associate with the SVMC Business Associate Agreement. (Attachment A);
- If the Business Associate proposes edits or alterations to the BAA, or want to use their own BAA or indicate that negotiations are needed, it will need to be reviewed and approved by SVMC external legal counsel, if there are material differences with the SVMC BAA.

Term of BAA:

The BAA shall be effective for the length of the relationship between the BA and SVMC, unless otherwise terminated under the provisions outlined in the BAA.

Termination:

If SVMC or the BA chooses to terminate the main agreement, the BAA will be terminated as outlined in the BAA. Please note, HIPAA requires only that the BAA outline termination options for the CE. While mutual termination may be included in BAAs, this is not required under HIPAA.

REFERENCES:

- Health Insurance Portability and Accountability Act of 1996
- Health Information Technology for Economic and Clinical Health Act 2009
- 45 C.F.R. Section 160.103
- 2017 California Health Information Privacy Manual. 11 Business Associate Contracts (Vol. 8, PP 11.1-11.9.). Sacramento, CA: California Healthcare Association

CROSS REFERENCES:

- PATIENT PRIVACY-PROGRAM REQUIREMENTS
- ORGANIZED HEALTH CARE ARRANGEMENT

ATTACHMENT A

HIPAA BUSINESS ASSOCIATE AGREEMENT

This **HIPAA BUSINESS ASSOCIATE AGREEMENT** (this "**BA Agreement**") is made by and between **Sierra View Medical Center** ("**Sierra View**") and _____ ("**Business Associate**") and is effective as of _____ 1, 2023 ("**Effective Date**"). Capitalized terms used in this BA Agreement without definition shall have the respective meanings assigned to such terms by the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended by HITECH (as defined in Section 1.3 of this BA Agreement).

RECITALS

WHEREAS, Sierra View and Business Associate are parties to a Services Agreement that requires Business Associate to have access to Protected Health Information (the "**Services Agreement**"); and

WHEREAS, it is the intent of Sierra View and Business Associate to amend the Services Agreement, as described in this BA Agreement, for the parties to comply with HIPAA.

WHEREAS, Sierra View wishes to disclose certain information to Business Associate pursuant to the terms of this BA Agreement, some of which may constitute Protected Health Information ("**PHI**") (defined herein).

WHEREAS, Sierra View and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this BA Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the **HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "**HIPAA Regulations**") (collectively, "**HIPAA**") and other applicable laws.

WHEREAS, as part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined herein) require Sierra View to enter into an agreement containing specific requirements with Business Associate prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BA Agreement.

NOW, THEREFORE, in consideration of the mutual premises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Sierra View and Business Associate agree as follows:

DEFINITIONS

a. **Breach** shall have the meaning given to such term under the HITECH Act and HIPAA Regulations at 42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402.

b. **Breach Notification Rule** shall mean the HIPAA Regulation that is codified at C.F.R. Parts 160 and 164, Subparts A and D.

c. **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. **Electronic Protected Health Information** means PHI that is maintained in or transmitted by electronic media.

h. **Electronic Health Record** shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. PHI includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

l. **Protected Information** shall mean PHI provided by Sierra View to Business Associate or created, maintained, received or transmitted by Business Associate on Sierra View's behalf.

m. **Security Incident** shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

AGREEMENT

I. GENERAL PROVISIONS

Section 1.1. **Effect**. The provisions of this BA Agreement shall control with respect to PHI that Business Associate receives from or on behalf of Sierra View, and the terms and provisions of this BA Agreement shall supersede any conflicting or inconsistent terms and provisions of the Services Agreement, including all exhibits or other attachments thereto and all documents incorporated therein by reference, to the extent of such conflict or inconsistency. This BA Agreement shall not modify or supersede any other provision of the Services Agreement.

Section 1.2. **No Third Party Beneficiaries**. The Parties have not created and do not intend to create by this BA Agreement any third party rights, including, but not limited to, third party rights for Sierra View's patients.

Section 1.3. **HIPAA Amendments**. The parties acknowledge and agree that the HITECH Act and its implementing regulations impose new requirements with respect to privacy, security and breach notification applicable to business associates (collectively, the "**HITECH BA Provisions**"). The provisions of HITECH and the HITECH BA Provisions are hereby incorporated by reference into this BA Agreement as if set forth in this BA Agreement in their entirety effective on the later of the effective date of this BA Agreement or a subsequent date as may be specified in HITECH.

Section 1.4. **Regulatory References**. A reference in this BA Agreement to a section in HIPAA means the section as it may be amended from time-to-time.

II. OBLIGATIONS OF BUSINESS ASSOCIATE

Section 2.1. **Use and Disclosure of Protected Health Information**. Business Associate may use and disclose PHI as permitted or required under this BA Agreement or as Required by Law, but shall not otherwise use or disclose any PHI. Business Associate shall assure that its employees, other agents and contractors do not use or disclose PHI received from Sierra View in any manner that would constitute a violation of HIPAA if so used or disclosed by Sierra View (except as set forth in Section 2.1(a) and (b) of this BA Agreement). To the extent Business Associate carries out any of Sierra View's obligations under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to Sierra View in the performance of such obligations. Without limiting the generality of the foregoing, Business Associate is permitted to use or disclose PHI as set forth below:

(a) Business Associate shall disclose Protected Information only for the purpose of performing Business Associate's obligations under the Services Agreement and as permitted or required under the BA Agreement, or as required by law.

(b) Business Associate shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Sierra View. However, Business Associate may disclose Protected Information as necessary (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as required by law; or (iv) for Data Aggregation purposes relating to Health Care Operation of Sierra View. If Business Associate discloses Protected Information to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BA Agreement and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches, suspected breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with Section 2.6 of this BA Agreement, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)].

(c) Business Associate shall not use or disclose PHI other than as permitted or required by the Services Agreement or this BA Agreement, or as required by law. Business Associate shall not use or disclose Protected Information for fundraising or marketing purposes. Business Associate shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a); 45 C.F.R. Section 164.522(a)(vi)]. Business Associate shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of Sierra View and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2) and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by Sierra View to Business Associate for services provided pursuant to the Services Agreement.

Section 2.2. Safeguards. Business Associate shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted or required by the Services Agreement or this BA Agreement. In addition, Business Associate shall implement Administrative Safeguards, Physical Safeguards and Technical Safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Section 164.308, 164.310 and 164.312, [45 C.F.R. Section 164.504(e)(2)(ii)(B); 164.308(b)] that reasonably and appropriately protect the Confidentiality, Integrity and Availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Sierra View. Business Associate shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316. [42 U.S.C. Section 17931]. Business Associate shall comply with the HIPAA Security Rule with respect to Electronic Protected Health Information.

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Section 2.3. **Minimum Necessary Standard**. To the extent required by the "minimum necessary" requirements of HIPAA, Business Associate, its agents and subcontractors shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. Business Associate understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance by the Secretary with respect to what constitutes "minimum necessary." To the extent practicable, Business Associate shall not request, use or disclose any Direct Identifiers (as defined in the limited data set standard of HIPAA) and comply with the minimum necessary guidance to be issued by the Secretary pursuant to HITECH.

Section 2.4. **Mitigation**. Business Associate shall take reasonable steps to mitigate, to the extent practicable, any harmful effect (that is known to Business Associate) of a use or disclosure of PHI by Business Associate in violation of this BA Agreement or HIPAA.

Section 2.5. **Subcontractors**. Business Associate shall enter into a written agreement meeting the requirements of 45 C.F.R. §§ 164.504(e) and 164.314(a)(2) with each Subcontractor (including, without limitation, a Subcontractor that is an agent under applicable law) that creates, receives, maintains or transmits PHI on behalf of Business Associate. Business Associate shall ensure that the written agreement with each Subcontractor obligates the Subcontractor to comply with restrictions and conditions that are at least as restrictive as the restrictions and conditions that apply to Business Associate under this BA Agreement and implement the safeguards required in Section 2.2 above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2)(ii)(D); 45 C.F.R. Section 164.308(b)]. Business Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation [see 45 C.F.R. Section 164.530(f); and 164.530(e)(1)].

Section 2.6. **Reporting Requirements**.

(a) Business Associate shall notify Sierra View by reporting to the Compliance Officer at Sierra View, within twenty-four (24) hours of any suspected or actual breach of Protected Information; any use or disclosure of Protected Information not permitted by the Services Agreement or this BA Agreement; any Security Incident (i.e., any attempted or successful unauthorized, disclosure, modification, or destruction of information or interference with system operations in an information system) related to Protected Information, and any actual or suspected use or disclosure of data in violation of any applicable federal or state laws by Business Associate or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each Individual whose unsecured Protected Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, used, or disclosed, as well as any other available information that Sierra View is required to include in notification to the Individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this section or promptly thereafter as information becomes available. Business Associate shall take (i)

prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)].

(b) Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(ii), if the Business Associate knows of a pattern of activity or practice of an agent or subcontractor that constitutes a material breach or violation of the agent's or subcontractor's obligations under the Services Agreement or this BA Agreement or other agreement, the Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Business Associate must terminate the Services Agreement or other arrangement if feasible. Business Associate shall provide written notice to Sierra View of any pattern of activity or practice of an agent or subcontractor that Business Associate believes constitutes a material breach or violation of the agent's or subcontractor's obligations under the Services Agreement or this BA Agreement or other agreement within five (5) days and shall meet with Sierra View to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

(c) Business Associate shall reimburse Sierra View for all costs, expenses (including reasonable attorneys fees), damages and other losses resulting from any breach of this BA Agreement, unauthorized use or disclosure, Security Incident or Breach involving PHI maintained by Business Associate, including, without limitation: fines or settlement amounts owed to a state of federal government agency; the cost of any notifications to Individuals or government agencies; credit monitoring for affected Individuals; or other mitigation steps taken by Sierra View to comply with HIPAA or state law. This reimbursement obligation shall survive the expiration or earlier termination of the Services Agreement and this BA Agreement.

Section 2.7. **Access to Protected Health Information**. Within five (5) business days of a request by Sierra View for access to PHI about an Individual contained in any Designated Record Set of Sierra View maintained by Business Associate or its agents or subcontractors, Business Associate shall make available to Sierra View such PHI for so long as Business Associate maintains such information in the Designated Record Set. Timely access will be provided to enable Sierra View to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If Business Associate maintains Protected Information in electronic format, Business Associate shall provide such information in electronic format as necessary to enable Sierra View to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. Section 164.524. If Business Associate receives a request for access to PHI directly from an Individual, Business Associate shall forward such request to Sierra View within (5) five business days. Sierra View will be responsible for making all determinations regarding the granting or denial of an Individual's request for PHI and Business Associate will make no such determination. Only Sierra View will release PHI to the Individual pursuant to such a request.

Section 2.8. **Availability of Protected Health Information for Amendment**. Within ten (10) business days of receipt of a request from Sierra View for the amendment of an Individual's PHI contained in any Designated Record Set of Sierra View maintained by Business Associate or its agents or subcontractors, Business Associate shall provide such PHI to Sierra View for amendment and incorporate any such amendments in the PHI (for so long as Business Associate maintains such information in the Designated Record Set) as required by 45 C.F.R. § 164.526. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall forward such request to Sierra View within five (5) business days. Sierra View will be responsible for making all determination regarding amendments to PHI and Business Associate will make no such determinations.

Section 2.9. **Accounting of Disclosures**. Within ten (10) business days of notice by Sierra View to Business Associate that it has received a request for an accounting of disclosures of PHI (other than disclosures to which an exception to the accounting requirement applies), Business Associate or its agents or subcontractors shall make available to Sierra View such information as is in Business Associate's possession and is required for Sierra View to make the accounting required by 45 C.F.R. § 164.528 and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(c) as determined by Sierra View. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by Business Associate and its agents and subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that Business Associate maintains an Electronic Health Record.

(a) Disclosure Records. Business Associate will keep a record of any disclosure made to its agents, subcontractors or other third parties for purposes other than:

(1) Disclosures to health care providers to assist in the treatment of patients;

(2) Disclosures to others to assist Sierra View in obtaining payment; and

(3) Disclosures to others to assist Sierra View in conducting its health care operations as defined in 45 C.F.R. § 164.501.

Business Associate will maintain this disclosure record for the term of the BA Agreement and for six (6) years from the effective date of termination of this BA Agreement.

(b) Data Regarding Disclosures. For each disclosure for which Business Associate must maintain documentation under Section 2.9.a, Business Associate will record and maintain the following information:

(1) The date of disclosure;

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

(3) A description of the PHI disclosed; and

(4) A brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

Section 2.10. **Availability of Books and Records**. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Sierra View available to the Secretary of the U.S. Department of Health and Human Services (the "**Secretary**") for purposes of determining Sierra View's and Business Associate's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)].

Section 2.11. **Restrictions; Limitations in Notice of Privacy Practices**. Business Associate shall comply with any reasonable limitation in Sierra View's notice of privacy practices to the extent that such limitation may affect Business Associate's use or disclosure of PHI. Business Associate shall comply with any reasonable restriction on the use or disclosure of PHI that Sierra View has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Section 2.12. **Audits, Inspection and Enforcement**. Within ten (10) days of a request by Sierra View, Business Associate and its agents and subcontractors shall allow Sierra View or its agents or subcontractors to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use and disclosure of Protected Information pursuant to this BA Agreement for the purpose of determining whether Business Associate has complied with this BA Agreement or maintains adequate security safeguards; provided, however, that (i) Business Associate and Sierra View shall mutually agree in advance upon the scope, timing and location of such inspection, (ii) Sierra View shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Sierra View has access during the course of such inspection; and (iii) Sierra View shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by Business Associate. The fact that Sierra View inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this BA Agreement, nor does Sierra View's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Sierra View's enforcement rights under the Services Agreement or this BA Agreement. Business Associate shall notify Sierra View within five (5) days of learning that Business Associate has become the subject of an audit, compliance review, or compliant investigation by the Office of Civil Rights or other state or federal government entity.

III. TERMINATION OF AGREEMENT

Section 3.1. **Termination Upon Breach of this BA Agreement**. Any other provision of the Services Agreement notwithstanding, Sierra View may terminate the Services Agreement and this BA Agreement upon thirty (30) days advance written notice to Business Associate in the event that Business Associate breaches this BA Agreement in any material respect and such breach is not cured within such thirty (30) day period. If termination of the Services Agreement and this BA Agreement is not feasible, Sierra View may report the breach to the Secretary.

Section 3.2. **Return or Destruction of Protected Health Information upon Termination**. Upon expiration or earlier termination of the Services Agreement, Business Associate shall, at the option of Sierra View, either return or destroy all PHI received from Sierra View or received by Business Associate and its agents and subcontractors on behalf of Sierra View and which Business Associate still maintains in any form and shall retain no copies. Notwithstanding the foregoing, to the extent that Sierra View reasonably determines that it is not feasible to return or destroy such PHI, the terms and provisions of this BA Agreement shall survive termination of the Services Agreement and Business Associate shall continue to extend the protections and satisfy the obligations of Article II of this BA Agreement to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If Sierra View elects destruction of the PHI, Business Associate shall certify in writing to Sierra View that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

IV. DISCLAIMER

Sierra View makes no warranty or representation that compliance by Business Associate with this BA Agreement, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

V. AMENDMENT TO COMPLY WITH LAWS

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Services Agreement or this BA Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA Regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that Sierra View must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BA Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA Regulations or other applicable laws. Sierra View may terminate the Services Agreement upon thirty (30) days written

notice in the event (i) Business Associate does not promptly enter into negotiations to amend the Services Agreement or this BA Agreement when requested by Sierra View pursuant to this section or (ii) Business Associate does not enter into an amendment to the Services Agreement or this BA Agreement providing assurances regarding the safeguarding of PHI that Sierra View, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

VI. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

Business Associate shall notify Sierra View within forty-eight (48) hours of any litigation or administrative proceedings commenced against Business Associate or its agents or subcontractors. In addition, Business Associate shall make itself, and any subcontractors, employees and agents assisting Business Associate in the performance of its obligations under the Services Agreement or this BA Agreement, available to Sierra View, at no cost to Sierra View, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Sierra View, its directors, officers or employees based upon a claimed violation of HIPAA, the HITECH Act, the HIPAA Regulations or other state or federal laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

VII. NO THIRD-PARTY BENEFICIARIES

Nothing express or implied in the Services Agreement or this BA Agreement is intended to confer, nor shall anything herein confer, upon any person other than Sierra View, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

VIII. EFFECT ON CONTRACT

Except as specifically required to implement the purposes of this BA Agreement, or to the extent inconsistent with this BA Agreement, all other terms of the Services Agreement shall remain in force and effect.

IX. INTERPRETATION

The provisions of this BA Agreement shall prevail over any provisions in the Services Agreement that may conflict or appear inconsistent with any provision of this BA Agreement. This BA Agreement and the Services Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA Regulations and other state and federal laws related to security and privacy. The parties agree that any ambiguity in this BA Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the HIPAA Regulations and other state and federal laws related to security and privacy.

X. COUNTERPARTS

This BA Agreement may be executed in two counterparts, each of which shall be deemed an original but both of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile transmission or scanned and sent by email are deemed to be originals for purposes of execution and proof of this Amendment.

XI. NOTICES

Any notices required under this BA Agreement will be sent to the parties at the following addresses by first class mail, fax or hand delivery:

Sierra View:
Sierra View Medical Center
465 West Putnam Avenue
Porterville, CA 93257
Attn: Compliance Officer

Business Associate:

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have duly executed this BA Agreement.

COVERED ENTITY:

Sierra View Medical Center

By: _____

Name: _____

Title: _____

Date: _____

BUSINESS ASSOCIATE:

_____

By: _____

Name: _____

Title: _____

Date: _____

SUBJECT: **MEAL DISCOUNT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish meal discount guidelines for personnel working.

POLICY:

Personnel who are working and wearing their Sierra View Medical Center (SVMC) badge will receive a meal discount when eating food from the café. The Food and Nutrition Service (FNS) Director is responsible to monitor department costs and present meal cost analysis to the Senior Leadership Team.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PHYSICIANS, VOLUNTEERS, ON SITE SECURITY GUARDS & STUDENTS*

PROCEDURE:

1. Personnel must be wearing their SVMC badge and be on duty to receive discounted meal prices. Regular pricing will apply to employees without a SVMC badge and/or who are off-duty.

2. Items eligible for discount are established by the FNS Department, and pre-set and maintained in the Point of Sale (POS) computer software system.

3. Personnel (including, but not limited to, hospital staff, physicians, volunteers, security guards and students) are eligible for meal discounts.

4. Complimentary coffee and brewed tea made in the Café is provided for all personnel on duty at no charge.

5. Complimentary (free) meals:
   a. The following personnel are eligible:
      i. Emergency Department Physicians
      ii. Hospitalists
      iii. Intensivists
      iv. Anesthesiologists & CRNA's
      v. Surgeons
      vi. Food Service Staff

   b. Convenient food items such as chips, pre-packaged items, bottled beverages, etc. are excluded and must be purchased.

   c. One meal per four (4) hour shift is permitted. Complementary meals may not be given or shared with non-eligible personnel.

6. The café will charge for all to-go containers.

7. The café offers fountain soda refills for a reduced cost, with proof of receipt for the same day.

8. An appropriate charge for condiments and disposable products will be charged for customers utilizing these products for foods purchased off-site.

9. Bulk food purchases have the potential to deplete prepared food supplies for staff, visitors and physicians working and will not be permitted.

10. Discounted pricing applies to personnel as specified above, and may not be extended to friends or family of qualifying personnel.

11. With the assistance of the FNS Director, the Senior Leadership Team will review meal cost analysis a minimum of annually and adjust prices as necessary.

SUBJECT: **PATIENT SAFETY PLAN**	SECTION: *Leadership (LD)* **Page 1 of 7**

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

PURPOSE:

To establish an organizational-wide patient safety plan that promotes a culture of quality and patient safety.

POLICY:

To provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety throughout the organization. This will be accomplished through the establishment of a Patient Safety Committee whose responsibilities will be to:

- Support effective responses to Patient Safety Events;
- Integrate patient safety as a priority into new processes and the redesign of existing processes, functions, and services;
- Minimize individual blame or retribution for involvement in a patient safety event and reporting;
- Champion organization-wide education related to safety, risk reduction, and reporting of potential unsafe events or adverse outcomes;
- Promote an ongoing proactive approach to reducing risk.

AFFECTED AREAS/PERSONNEL:

ALL EMPLOYEES, MEDICAL STAFF, CONTRACTORS, STUDENTS, VOLUNTEERS.

DEFINITION:

Patient Safety Event: An adverse sentinel or potential adverse sentinel event, as described in HSC § 1279.1(b), that is determined to be preventable, e.g. to include misconnection of intravenous, enteral and epidural lines as well as preventable healthcare-associated infections (HAIs) as defined by the National Healthcare Safety Network or the Healthcare Associated Infection Advisory Committee. Refer to House-wide Policy & Procedures: *Patient Safety Event, and Serious Clinical Adverse Event.*

CORE PRINCIPLES AND RESPONSIBILITIES:

A. Performance Improvement and Patient Safety Committee (PIPS)

1. The Board of Directors has the ultimate authority and responsibility to require and support a patient safety program. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California Evidence Code, Section §1157.

2. The Performance Improvement/Patient Safety (PIPS) Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from other committees, departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization.

3. The PIPS Committee shall recognize and reinforce that members of the medical staff are responsible for making medical treatment decisions for their patients.

Membership:

The Patient Safety Committee will report to the PIPS Committee quarterly. The Patient Safety Committee consists of the following members and others as the committee may call on, to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

- Vice President of Quality and Regulatory Affairs (Executive Sponsor)
- Patient Safety Officer
- Patient Safety Nurse
- Wound Care Nurse
- Director of Pharmacy
- Performance Improvement Specialist
- Maternal Child Healthcare Leadership
- Medical Surgical Nursing Unit LeadershipCritical Care Services Leadership
- Surgical Services Leadership
- Emergency Department Leadership

Responsibilities:

The Patient Safety Committee will meet at least quarterly, shall maintain a record of its proceedings and activities, and shall report findings, conclusions, recommendations and follow-up to Performance Improvement/Patient Safety Committee, Medical Executive Committee and the Board of Directors.

The Committee will do all of the following:

Receive and review reports of patient safety events to include, but not limited to:

a. All serious clinical adverse events (Patient Safety Events). (Refer to House-wide policy: *Serious Clinical Adverse Event).*

b. Hospital acquired infections (HAI) that are determined to be preventable. (Refer to House-wide policy, Infection Prevention Plan).

Monitor implementation of corrective actions for patient safety events.

Make recommendations to eliminate future patient safety events. The Patient Safety Committee has adopted the failure mode and effects analysis model for proactive process redesign.

Review and revise the Patient Safety Plan at least annually and more often if necessary to evaluate and update the patient safety plan and to incorporate advancements in patient safety practices.

B. Reporting System for Patient Safety Events

The facility has established a reporting system for patient safety events that allows anyone involved, including, but not limited to, healthcare practitioners, employees, patients and visitors, to make a report of a patient safety event to the hospital. Refer to House-wide policy, *Serious Clinical Adverse Event.*

C. Analysis of Adverse Events

The facility has defined and established a policy that outlines the actions to be taken in response to an adverse event. (Refer to House-wide policies *Patient Safety Event and Serious Clinical Adverse Event).*

D. Culture of Safety

Sierra View Medical Center has adopted a just culture model that supports and encourages occurrence reporting, whereby enabling the hospital to carry out its responsibility for providing quality care in a safe environment.

E. Education and Training

Staff and healthcare practitioners receive education and training on hire and during initial and annual orientation on issues regarding job-related aspects of patient safety, including Just Culture and Systems Theory. Records of such education are maintained.

F. Disclosure

Patients, and when appropriate, their families, are to be informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. (Refer to House-wide policy and procedures, *Serious Clinical Adverse Event).*

G. National Patient Safety Goals

Implement the Joint Commission recommended goals through education and monitoring activities to ensure compliance with the standards.

H. Leadership (LD 03.01.01)
Consider information from patient, family, staff and other individuals related to their opinions, needs and perceptions of risks to patients and suggestions for improving patient safety.

SCOPE OF ACTIVITIES

Performance/Quality Improvement

1. Establish measurable objectives for improving patient safety and quality. Measurable objectives shall be based on the elements of patient safety and error reduction, which are described in this plan.

2. Review and disseminate available information about the Joint Commission Sentinel Event Alerts. Review current process and analyze recommendations listed in the Sentinel Event Alert. Implement appropriate action to improve processes related to patient safety.

3. Assure that prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.

4. Assure that when organizational processes are designed or redesigned, information from other organizations related to potential risk to patient safety, including occurrence of sentinel events, is reviewed and risk reduction strategies are incorporated.

5. Perform a Healthcare Failure Mode Effect Analysis (HFMEA) as required and selected based on information published by the Joint Commission related to patient safety and medical errors and/or through identification of a high-risk problem prone process.

Patient Safety

1. Perform an annual risk assessment and prioritize goals in collaboration with hospital leaders to reduce the risk of patient safety events. (Refer to House wide Policy & Procedure, *Risk Management Plan*).

2. Develop an organization-wide approach to the reporting and evaluation of unusual occurrences.

3. Review all occurrence reports, and when appropriate, develop a thorough and credible root cause analysis, appropriate plan of correction and follow up plan. (Refer to House Wide Policy & Procedure, *Serious Clinical Adverse Event*). All sentinel events will be reported to, evaluated and monitored for completion by the Patient Safety Committee and will be reported to the Performance Improvement/Patient Safety Committee.

4. Develop procedures for immediate response to unusual occurrences, including care of the affected patient, care of involved clinicians, containment of risk to others and preservation of factual information for subsequent analysis.

5. Develop systems for internal and external reporting of information relating to unusual occurrences.

Aggregate and trend all risk management information/data to identify patterns in processes or outcomes, which may lead to untoward patient events. Evaluate patient grievances and complaint trends and patterns.

Human Resources

1. Assure patient safety information is presented to all new employees as part of the New Hire Orientation Program.

2. Define a mechanism for the support of staff that are involved in medical errors and sentinel events. Provide individuals emotional and psychological support through Care for the Caregiver Program and/or Employee Assistance Program (EAP). Members of the Medical Staff can be referred to the Care for the Caregiver program and/or Medical Staff Office for assistance.

Education

1. Ensure all staff members participate in ongoing in-services, education, and training to increase his or her knowledge of job-related aspects of patient safety. Patient safety information is included in staff annual orientation and training.

2. Assure that ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.

Infection Prevention

1. Perform an annual risk assessment and prioritize goals in collaboration with hospital leaders to reduce the risk of transmission of infections and prevent Hospital Acquired Infections (HAI). (Refer to House wide Policy & Procedure, *Infection Prevention Plan*)

2. Conduct infection prevention activities and surveillance to monitor HAI as outlined in the Infection Prevention Plan.

3. Assist with methods to reduce surgical site infections as designed in the Surgical Care Improvement Project.

4. Monitor infections related to indwelling lines, to include but not be limited to, intravenous, enteral, and epidural lines and indwelling catheters.

Pharmacy

1. Ensure safe and optimal use of medications to improve patient's clinical outcomes.

2. Assist with procurement, distribution, storage, dispensing and safe use of pharmaceuticals for patients.

3. Assure that process and product-purchasing decisions support the safe use of intravenous lines to include safeguards such as unique connection ports that prohibit the use of any intravenous, epidural, or enteral feeding line to be used for anything other than its intended purpose except in emergent situations.

4. Facilitate improvement initiatives through the Medication Safety Committee that reduce medication-related patient safety events.

Environment of Care (Safety Officer)

1. Assure that measurements related to patient safety and error reduction are incorporated in the seven (7) plans of the Environment of Care.

2. Aggregate, assess and report organizational data related to patient safety events, intervention and follow-up.

National Patient Safety Goals for Hospitals:

Sierra View Medical Center will follow and educate yearly on patient safety goals, released by the Joint Commission.

National Quality Forum's Four Safe Practices:

Develop structures, programs, policies, and practice that support the National Quality Forum's (NQF) four safe practices involved in creating and sustaining a patient safety culture which includes:

1. Improve the accuracy of patient identification

2. Improve the effectiveness of communication among caregivers,

3. Improve the safety of using medications,

4. Reduce the harm associated with clinical alarm systems.

Compliance with this goal will be guided by the principles as outlined within the Consensus Report: NQF Safe Practices for Better Healthcare – 2010 Update, and monitored by the Patient Safety Committee with results reported to and measured annually by the Leapfrog Group via the Leapfrog Group's Hospital Safety Score.

REFERENCES:

- California Evidence Code 1157, § Title 22 (2017).

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Health and Safety Code § 1279.1(b), 1279.6 and 1279.7.
- Meyer, G., Denham, C. R., Battles, J., Carayon, P., Cohen, M. R., Daley, J., McAuliffe, M. (2010). Safe Practices for Better Healthcare-2010 Update. National Quality Forum Safe Practices, 1-406.

CROSS REFERENCES:

- SERIOUS CLINICAL ADVERSE EVENT
- ANNUAL INFECTION PREVENTION PLAN
- JUST CULTURE
- PATIENT SAFETY EVENT
- RISK MANAGEMENT PLAN

SUBJECT: **PERSONAL CONDUCT**	SECTION: **Page 1 of 5**

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

PURPOSE:

To establish standards for acceptable and expected conduct and behavior of Sierra View Medical Center (SVMC) staff and volunteers, and to define the process to be followed in the event of reported violations of such standards.

POLICY:

All staff is expected to conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, allied health professionals, nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients' family members and friends, visitors, volunteers and others. Such conduct is necessary to promote high quality medical care, maintain a safe work environment, and avoid disruption of Hospital operations. Disruptive, discriminatory, or harassing behavior, as defined below, will not be tolerated.

Just Culture is characterized by open and respectful communication among all members of the healthcare team in order to provide quality, safe patient care services. It is a culture that supports a commitment to collaborate in order to continually improve safety and the work environment for staff.

As part of SVMC's commitment to a Just Culture, quality patient care and providing our staff with a team-focused and collaborative work environment, all staff members are expected to promote acceptable behaviors and adhere to the District's Code of Conduct. Inappropriate behaviors, which include lateral violence and workplace bullying, are considered to be disruptive to the work environment.

SVMC maintains a zero-tolerance policy for disruptive behaviors including lateral violence and bullying in the workplace. Any violations of the policy will be taken seriously and addressed in a timely fashion with the employee(s) involved.

DEFINITIONS:

Disruptive Behavior is repeated inappropriate behavior, direct or indirect, either verbal, physical or otherwise, exhibited by one or more persons towards another or others in the workplace, which is impeding the individual's ability to effectively perform their job and/or is disrespectful and undermining their right to dignity at work. It is behavior that interferes with effective communication among healthcare providers and negatively impacts performance and outcomes.

Lateral Violence is defined as peer-to-peer aggression. Some of the most common forms of lateral violence in healthcare settings are: non-verbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy and broken confidences.

Workplace Bullying is an offensive abusive, intimidating, malicious or insulting behavior, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset,

threatened, humiliated or vulnerable, undermining self-confidence. Bullying is typically persistent, systematic and ongoing.

UNACCEPTABLE BEHAVIORS:

Some examples of inappropriate and disruptive behaviors, lateral violence, and workplace bullying include, but are not limited to the following examples:

- Shouting, screaming or yelling
- Threatening or violent behavior
- Profane or disrespectful language
- Isolated incidents of verbal abuse, such as the use of derogatory remarks, insults, and epithets, verbal or physical conduct that a reasonable person would find threatening, intimidating, or humiliating, or the gratuitous sabotage or undermining of a person's work performance.
- Criticism of performance and/or competency delivered in an inappropriate location (i.e., not in private) and/or not aimed at performance improvement
- Inappropriate arguments with patients, family, staff, other physicians and/or volunteers
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial, ethnic or discriminatory jokes/slurs
- Slamming or throwing objects in anger or disgust
- Hostile, condemning, or demeaning communications
- Other behavior demonstrating disrespect, dishonesty, intimidation, or disruption to the work environment
- Refusing to cooperate with other healthcare providers
- Repeated failure to respond to phone calls or pages
- Retaliation against any person who reports or addresses unacceptable behavior
- Personal experiences, brought into the work environment, that create a negative or disruptive work environment for staff, patients, visitors, and/or volunteers

- Any act of gross misconduct (stealing, blatant disregard for the standard of patient care)

EXAMPLES OF EXPECTED BEHAVIORS:

- Communication will take place in a timely fashion, involving the appropriate person(s), in an appropriate setting.
- Communications, including telephone conversations, spoken remarks, written documents, and e-mails, will be honest and direct and conducted in a professional, constructive, respectful and efficient manner.
- Telephone communications will be respectful and professional.
- Cooperation and availability are expected of all staff whenever serving in a professional capacity.
- When individuals are paged, they will respond promptly and appropriately.
- Recognition that a variety of experience levels exists, and that tolerance for those who are learning is expected.
- Compliance and support of SVMC's values.
- Engage in conduct that is representative of respect and dignity, honesty and integrity and promotes a comfortable and engaging work environment conducive for optimal outcomes.

AFFECTED PERSONNEL/AREAS: *SVMC STAFF, CONTINGENT WORKFORCE, MEDICAL STAFF, STUDENTS, VOLUNTEERS, INDEPENDENT CONTRACTORS*

PROCEDURE:

EXPECTED ACTION IF UNACCEPTABLE BEHAVIOR OCCURS:

1. In situations where unacceptable behaviors occur, staff member(s) are expected to recognize their unacceptable behavior and apologize to all parties involved. In addition, the staff member is expected to take remedial measures, on his/her own initiative, as necessary to prevent the recurrence of such unacceptable behavior.

2. SVMC is committed to addressing and eliminating disruptive behavior through the following strategies:

    - Leaders, managers and supervisors adopt and model professional and ethical behaviors.
    - Recognize and appropriately address disruptive behaviors through conflict management/resolution, and/or individual or team interventions.

- Work to ensure our Mission, Values, and Code of Conduct, reflect standards to eliminate disruptive behavior.
- Promote a Culture of Safety through Just Culture that encourages open and respectful communication among all healthcare providers and staff.
- Provide support to any individual impacted by disruptive behaviors, lateral violence and/or workplace bullying.
- Provide education and information to all staff regarding Lateral Violence/Workplace Bullying.

3. Department Directors and Managers shall educate and talk with their staff about these behavior expectations and proactively seek ways to reinforce appropriate conduct.

4. In addressing unprofessional conduct, the primary objective is to restore a productive and safe environment conducive to working, learning and providing quality patient care. If after appropriate coaching and counseling has occurred, the staff member fails to respond to interventions, any continued inappropriate behaviors occurring will result in disciplinary action, up to and including termination of employment.

REFERENCES:

- Dimarino, T. J. (2011). Eliminating Lateral Violence in the Ambulatory Setting: One Centers Strategies. AORN Journal, 93(5), 583-588. doi:10.1016/j.aorn.2010.10.019
- Fostering a Culture of Civility and Respect in Nursing ... (n.d.). Retrieved from https://www.journalofnursingregulation.com/article/S2155-8256(19)30082-1/fulltex
- AB 2053 – Government Code Section 12950.1 (January 1, 2015). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB2053.
- SB 1300: Unlawful employment practices: discrimination and harassment (October 1, 2018). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1300.

CROSS REFERENCES:

- At Will Employment Policy
- Separation of Employment
- Code of Conduct Policy

- Anti-Discrimination, Harassment and Non-Retaliation Policy
- Performance Accountability and Commitment Policy

SUBJECT: **RELEASE OF MEDICAL INFORMATION**	SECTION:

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

POLICY:

Any information of a medical nature in the possession of Sierra View Medical Center (SVMC) must not be revealed by any staff member of the hospital except as outlined in the procedure below.

PROCEDURE:

1. The medical record shall not be used in any manner that will jeopardize the interests of the patient, except that the hospital interests are priority when necessary to defend itself, or its agents, against accusations made by patients or others.

2. Medical records shall not be taken outside of the hospital, except upon receipt of a subpoena, court order, statute, specific written authorization of the administrative offices or for record completion when accompanied by Health Information Management Department staff except as otherwise provided by law.

3. Release of information to attorneys, insurance company investigators and physicians other than those caring for the patient for Worker's Compensation cases:

    a. Medical records may be inspected, or copies furnished, only upon receipt of written authorization signed and dated by the patient or guardian (if a minor), conservator (if mentally incompetent), next of kin, administrator or executor (in case of death). The authorization and a statement as to date and type of information furnished shall be filed with the patient's medical record.

    b. Identification must be shown by the party wishing to inspect the medical record.

    c. A minimum charge of $15.00 shall be made to insurance companies and attorneys wishing copies of the medical record.

4. Release of Information to Medical Staff Physicians:

    a. Members of the medical staff may request that copies be sent to a referring physician, for which there will be no charge.

    b. When a patient is readmitted to the hospital under the care of another physician, all previous records will be made available to the present attending physician(s) and consult(s) on the case.

5. Release of Information to Hospital Staff:

    a. Hospital staff, including volunteers, inspect records only when necessary for their own routine departmental work.

    b. Hospital staff, including volunteers, may inspect the medical records only upon signed, written authorization from the patient.

c. Hospital staff, including volunteers, may inspect the medical records of relatives only upon signed, written authorization from the patient.

Note: Student nurses must have authorization from their supervisor when asking for medical records for case studies.

6. Release to Federal Bureau of Investigation (FBI), Veterans Administration, Induction Centers, Armed Forces, State or National Government Agency:

a. Name of the patient, address and dates of admission and discharge may be released without authorization.

b. It is not required that confidential information be released to governmental or police agencies without a subpoena or a written, signed authorization from the patient.

c. If a person desires to inspect medical records in the name of the above agencies and has proper authorization, identification must be verified. The requester will also need to sign and date the authorization which has been signed by the patient. If copies are requested, there shall be no charge.

7. Release of Information to Other Hospitals:

a. Information may be released to other hospitals, without authorization, upon receipt of a request form from the hospital stating that the patient is presently under their care in their institution.

8. Release of Information on a Patient Transferred to a Skilled Nursing Facility or Extended Care Facility:

a. Requires no authorization after the patient has been accepted by the receiving facility.

9. Upon written request for copies of records from an employer, its insurance company, or its attorney, such request shall be honored, providing that the request states that a Worker's Compensation claim is pending. In this case, the patient's authorization is not required.

10. Confidential Information:

a. Data or information from a record is considered confidential if it may have adverse effect upon an individual's family or hospital staff member. It may be information that:

- Could be prejudicial to a person's mental or physical health
- An individual could not be expected to fully understand or accept because it is contrary to his/her own views

- Contains implications requiring explanation or interpretation to assist in its acceptance and assimilation in order to preclude misinterpretation, adverse reaction or retaliatory consequences toward reaction, or retaliatory consequences toward others
- Could be construed as personally embarrassing to an individual or a member of his/her family
- The four (4) principal categories of confidential, AKA sensitive information are as follows:
  - Medical information including information concerning alcohol abuse, drug abuse, social diseases, sickle cell anemia and/or HIV
  - Psychological/psychiatric information
  - Information in criminal, civil or administrative records
  - Child abuse information for those patients considered to be a minor
- Medical records meeting any of the above criteria will be flagged with a confidential sticker to alert hospital staff to obtain specific authorization from the patient if information is requested from this record.

b. For any additional information regarding release of medical information, please make reference to the current edition of the California Hospital Association Consent Manual. A copy of this manual is housed the Health Information Management (HIM) Department.

c. All correspondence is logged upon receipt in the Electronic Correspondence Log. This will enable ease of answering telephone inquiries without pulling the patient's medical record. The information logged would be the patient name, hospital number, the requester's name, the date of receipt of inquiry, the material sent and the date mailed.

d. The request is then verified for validity, checking signatures, dates, etc. If valid, the medical record and request will be forwarded to the copy service for processing. Please also refer to "Contracted Photocopiers" outlined in this manual.

e. The original request and consent to release information is filed and kept in the HIM Department. It shall contain the date, the information released, and the signature of the person releasing the information.

11. Release of Information for External Database Reporting:

a. Aggregate patient information outcomes may be released for external database reporting without prior consent when patient information is "de-identified". "De-identification" includes listing patient information in statistical format, without any identifying patient

information. Aggregated information only will be released for reporting of performance data. Only external database system vendors approved by the institution for use will receive information. Only authorized staff will have access to the reporting system.

REFERENCES:

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

SUBJECT: **RELEASE OF PATIENT INFORMATION**	SECTION:

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

PURPOSE:

To comply with legal and accreditation standards governing release of medical information and the regulation requirements to protect the security of electronic health information, as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation standards.

POLICY:

1. All persons authorized to release medical records and information must read, understand, and comply with this policy.

2. Sierra View Medical Center and all ambulatory off site departments have a legal and ethical responsibility to preserve the privacy and confidentiality of patient information. All Releases of Information will be processed through the Health Information Management Department. Accordingly, all personnel will adhere strictly to this basic principle: **Prior consent of the patient is required before release or disclosure of patient information except where a specific law of regulation or internal administrative needs of the facility require or permit such access without patient consent.**

3. This policy and the following practices shall be consistent with state and federal laws and regulations that contain provisions relating to the release of information from patient records. The Marketing and Community Relations Department, Risk Management Department and the Director of Health Information Management are responsible for reviewing existing laws and regulations and any new laws and regulations, and amending this policy to comply with changed provisions.

4. Sierra View Medical Center will process requests for information from patient records in a timely and consistent manner as set forth in this policy.

5. Sierra View Medical Center may release information to other hospitals for continuum of care, without authorization, upon notification from the hospital stating the patient is presently under their care in their facility.

6. The following priorities and time frames shall apply to "Release of Information" requests processed by the Health Information Management (HIM) Department:

    a. Emergency requests involving immediate emergency care of the patient will receive immediate processing.

    b. Priority requests pertaining to current care of the patient: within one (1) business day.

    c. Patient request for production of own record: within fifteen (15) business days.

    d. Patient request for access to own record: within five (5) business days.

e. Subpoenas, depositions, and other legal requests: within five (5) business days, unless a shorter period is required by law.

f. All other requests: within fifteen (15) business days.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL*

PROCEDURE:

1. The HIM Department will process all releases of information. All other Departments of Sierra View Medical Center will forward any release of information they receive to the HIM Department for completion.

2. The HIM Department will maintain a computerized log to track the step-by-step process towards completion of each request for release of information. The HIM Department personnel will review and update this log daily to give proper priority to requests to provide early intervention in problem situations. The log shall contain the following information:

   a. Date the HIM Department received the "Request for Information" form.

   b. Name of the patient.

   c. Name and status (patient, parent, guardian) of the person making the request.

   d. Information that was released.

   e. Date the information was released.

   f. Fee charged.

3. Sierra View Medical Center will charge a reasonable fee to offset the costs associated with specific categories of request. Sierra View Medical Center will base the fee on an assessment of such factors as the cost of labor, supplies, postage and preparation of the documents. This follows the designation set forth by the HIPAA Privacy Rule.

   The State of California has established reasonable fees for the production of patient records that is aligned with the HIPAA Privacy Rule.

Requestor Type	Regulated Search/Retrieval Fee	Legal Reference
Health Records (Medi-Cal assistance or Patients SSI/SSP Benefits	• .00¢ per page for the first request. • .25¢ per page for any subsequent requests.	California Health & Safety Code § 123110(d)
Health Records (paper or electronic)	• .25¢ per page	California Health &

		Safety Code § 123110(b)
Health Records from Microfiche or Microfilm	• .50¢ per page.	California Health & Safety Code § 123110(b)
Radiological Examinations/Images	• $10.00 per sheet of film	California Health & Safety Code § 123110(c)
CD's of Radiological Examinations/Images	• .00¢ per CD for continuum of care • $5.00 per CD for personal use	California Health & Safety Code § 123110(b)
Worker's Compensation/ Patient Attorney	• .10¢ per page of standard reproduction of documents of a size 8 ½ by 14 inches or less; • .20¢ per page from microfilm; • Actual costs for the reproduction of oversized documents or the reproduction of documents requiring special processing; reasonable clerical costs for locating and making records available to be billed at $4.00 per quarter hour or $16.00 per hour	California Evidence Code § 1158
Subpoena	• .10¢ per page of standard reproduction of documents of a size 8 ½ by 14 inches or less; • .20¢ per page from microfilm; • Actual costs for the reproduction of oversized documents or the reproduction of documents requiring special processing which are made in response to a subpoena; reasonable clerical costs for locating and making records available to be billed at $6.00 per quarter hour or $24.00 per hour	California Evidence Code § 1563

The Director of HIM may waive fees for good reason and shall note the reason for waiver in the Release of Information computerized tracking log.

4. Unless the request specifies release of the complete medical record, only the specified portions marked on the request will be released.

5. Unless a law or regulation requires a more specific prohibition on re-disclosure, each disclosure outside the facility will contain the following notice:
The attached medical information pertaining to [name of patient] is confidential and legally privileged. Sierra View Medical Center has provided it to [name of recipient] as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law.

6. The HIM Department will retain all original requests and the authorization for "Release of Information" for 6 years.

7. To facilitate the timely processing of "Release of Information" requests, Sierra View Medical Center may use the services of a commercial copying service on terms that protect the integrity and confidentiality of patient information.

8. The HIM Director or designee shall carry out a routine audit of the "Release of Information" at least quarterly, paying particular attention to the following:

   a. Validity of the authorization.

   b. Appropriateness of information abstracted in response to the request.

   c. Retention of authorization, request, and transmitting cover letter.

   d. Procedures for telephone, electronic, and in-person requests.

   e. Compliance with designated priorities and time frames

   f. Proper processing of fees.

   g. Maintenance of confidentiality.

8. The HIM Director or designee shall give periodic in-service training to all employees involved in the release of information process.

9. The HIM Director or designee shall review this policy and associated procedures with the Risk Management and Marketing and Community Relations Departments at lease semiannually.

10. Sierra View Medical Center requires a written, signed, current, valid authorization to release medical information as follows:

PATIENT CATEGORY	REQUIRED SIGNATURE
Adult Patient	The patient or a duly authorized representative, such as court appointed guardian or attorney. Proof of Authorized representative required e.g. notarized Power of Attorney.
Deceased Patient	The Next of kin as stated on the Death Certificate, or provided copy of the authorization or executor/administrator of the deceased's estate.
Un-emancipated minor	Parent, next of kin, or legally appointed guardian/attorney. Proof of relationship required.

Emancipated minor[1]	Same as adult patients above.
Psychiatric, drug, alcohol Program patients/clients	Same as adult patients above
AIDS/HIV or other sexually transmitted disease patients	Same as adult patients above for special requirements.

[1]*State law defines what minors are emancipated, that is, able to act as an adult. Typical factors resulting in emancipation are marriage, pregnancy, earning a living as an adult, and having moved out of the family home.*

11. Written authorization must contain detailed, specific information directing the release of patient information. Authorizations must include the following information:

    a. Name and address of facility.

    b. Name of the patient.

    c. Person or organization, including complete address, to whom the information is to be released.

    d. Purpose of the disclosure.

    e. Signature of the patient or duly authorized representative.

    f. Date signed.

    g. Information to be released.

    h. Signature of witness.

12. The HIM Director shall develop the approved authorization form for Release of Information. The authorized Release of Information form will be used whenever possible. Authorized personnel shall, however, honor letters and other forms, provided they include all the required information.

13. A patient may revoke an authorization by providing a written statement to the facility. The revocation shall become effective when the facility receives it.

14. HIM Department personnel or others authorized to release information will not honor a patient authorization when they have a reasonable doubt or question as to the following:

    a. Identity of the person presenting the authorization.

b. Status of the individual as the duly appointed representative of a minor, deceased, or incompetent person.

c. Legal age or status as an emancipated minor.

d. Patient capacity to understand the meaning of the authorization.

e. Authenticity of the patient's signature.

f. Current validity of the authorization.

In such situations, the employee shall refer the matter to the HIM Director for review and decision.

15. The above requirements apply equally to electronic records. No employee shall release electronic records without complying with this policy.

16. All leadership is responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination from employment in accordance with the facility's Sanction Screening Policy.

REFERENCES:

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

CROSS-REFERENCES:

- Authorization for Uses and Disclosures of Protected Health Information
- Marketing Under HIPAA Privacy Standards/HITECH

SUBJECT: **RENTAL POLICY**	SECTION: ***Supply Chain/Materials Management*** **Page 1 of 3**

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

PURPOSE:

To delineate the process for the rental of items to bolster and support operations for a defined period of time at Sierra View Medical Center (SVMC).

DEFINITIONS:

1. **Rental Equipment:** Any item/device/equipment from a rental provider for temporary support of medical center operations; either medical, maintenance or business purposes.
2. **Inventory Item:** An item/device/equipment which has been purchased for utilization at Sierra View Medical Center, Clinics or Properties (owned or leased).

POLICY:

A. All rental equipment will be requisitioned through the Supply Chain/Materials Management Department. The requesting department must fill out a Rental Request Form to rent required item(s) specifying: Type of equipment; duration; if item is normally carried in our Medical Center Inventory; was item checked for availability, prior to processing request. Upon completion of duration, the rental item(s) must be returned to Supply Chain/Materials Management for return to rental provider.

AFFECTED PERSONNEL/AREAS: *All Sierra View Medical Center Staff*

EQUIPMENT: N/A

PROCEDURE:

A. To initiate the rental process, a Rental Form must be completed prior to any rental being secured by Supply Chain/Materials Management Department (SCMMD) for use at SVMC. (Appendix A)
   1. **Need:** The form will inquire about the need for the item, and, if it is an item currently in the Medical Center's Inventory, was there a problem securing an item for your use.
   2. **Duration:** Duration/Time Limit will be **mandatory** for the completion of the rental form. This identifies how long the item is required. If the Renting Department sees the need to keep the rented item past the duration agreed upon, they shall contact SCMMD for an extension prior to the expiration date of the rental. The Rental Department and their Vice President will be contacted by SCMMD if the department does not comply.
   3. **All Rentals:** Rentals will be affixed with a florescent green tag upon rental. This numbered tag(s) will be entered onto the rental form and the log book kept by SCMMD. This tag must stay with the rented item(s) during its rental period at SVMC and returned with the item to SCMMD at the completion of the rental period.
   4. **Signature on Form:** The form must be signed by the Director of the department. In absence of the Director, their designee.

5. **Electrical Safety Check:** Items utilized for patient care must be checked by Bio Medical Engineering. All other rented items are required to have a safety check performed by Engineering prior to use.
6. **Completion of Rental Period:** Upon completion of the rental utilization or duration period, the rental item must be cleaned properly, per item specifications, prior to delivery to SCMMD.

B. **SCMMD** on a monthly basis will reconcile inventory reports from our rental providers against our active rental log book. This is to verify that all items that are in house are currently in use and in the renting department(s). Any item that is identified in violation will be called to the attention of the renting department Director. If the item cannot be reconciled within a 48 hour period, SCMMD shall elevate this to the department's Vice President and the Chief Financial Officer. Each renting department, as referred to above, is responsible for the rented item(s) during its time period at SVMC.

AFTER HOURS/WEEKENDS

C. If a rental is required after the Supply Chain/Materials Management Department is closed, the following steps shall be followed:

1. Fill out a Rental Request form and deliver to the Nursing House Supervisor.
2. The Nursing House Supervisor will review the form for completeness, then contact the rental provider for fulfillment of the order. When requested for a Purchase Order, the Nursing House Supervisor will utilize a combination of the department's four digit charge code and the current date. (Example: 8XXX010220XX)
3. All Biomedical and Electrical Safety checks must be performed prior to utilization.
4. The Nursing House Supervisor will assure that the completed Rental Request Form and the Purchase Order that they assigned to this rental is delivered to SCMMD on the next business day

(Appendix A)

SIERRA VIEW MEDICAL CENTER **Rental Form**

Requestor Name: _____ Date Requested: _____

Department Name: _____ Department Charge Code: _____

Item Requested: _____

Duration of Rental: _____

Department Director's Signature: _____

Is the item requested equipment that is regularly carried in the hospital? ☐ Yes ☐ No

If Yes, was there a problem with availability? ☐ Yes ☐ No

If Yes, what was the problem? _____

_____

This item is being rented for _____ (*Department Name*), on _____ (*Rental Date*) through _____ (*Rental Date*). This department has the responsibility for _____ (*Tag Number*) for the dates stated above, and must return this item on _____ (*return date stated*) or should request and extension from Supply Chain/Materials Management. Your department will be billed for any missing or delinquent equipment. Thank you in advance for your compliance.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

White - Materials Management **Canary- Renting Department**

Rental Form

SUBJECT:	SECTION:
SAFETY EDUCATION	***Safety Management***

PURPOSE:

To provide a safe environment for employees, patients and visitors and to assure all employees are taught how to work safely.

POLICY:

As part of Sierra View Medical Center (SVMC)'s concern for the safety of employees, patients and visitors all employees and regularly scheduled contract service provider employees are to receive job-related safety education. Safety Education programs will be continually modified or enhanced in consideration of the organization's ongoing experiences.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

A. Education

1. New employees will receive general environmental safety education in the work environment during new hire orientation.

2. Formal, job-related safety education will be given. Safety training checklists will be used to ensure all appropriate topics are covered.

B. The completed Annual Safety Training Checklist, or equivalent, for each employee will be retained in the Education folder.

C. Annually, the Safety Committee will check to ensure safety training is being conducted when they review safety policies and procedures.

D. Safety in-service documentation will be kept on file by the department managers.

E. The following subjects should be included in the Safety Education:

1. Life Safety/fire response procedures (required annually).

2. Emergency preparedness procedures (required annually).

3. Electrical safety for the tasks to be performed (required annually).

4. Hazardous chemical instruction for those employees using them (required annually):

a. Safety Data Sheets (SDS) – what and where they are kept

b. Review of the "Hazardous Materials and Waste Management Program".

c. Procedures for use, storage and disposal.

d. Health hazards of each chemical used.

e. Emergency action procedure for spills and exposures to each chemical used.

5. Review of general and job specific Safety Rules.

6. Review of injury reporting procedures.

7. Review of the Safety Management Program.

8. Task-specific infection control procedures (required annually).

9. Security awareness

10. Task specific safety procedures:

a. Location of personal protective equipment, and when required.

b. The importance of performing tasks according to the written procedure.

c. Retraining as necessary.

d. Location of equipment manuals.

e. Operating procedures and precautions for utilities, mechanical and electrical equipment being used.

11. Safety Education will be provided:

a. To all employees given new job assignments.

b. When new substances, processes, procedures or equipment are introduced and represent a new hazard.

c. Upon awareness of a previously unrecognized hazard.

d. For Supervisors, to familiarize them with the hazards to which employees under their direction may be exposed.

CROSS REFERENCES:

- Electronic Learning – Education
- Employee Orientation

REFERENCES:

- The Joint Commission (2023) Hospital accreditation standards. EC.03.01.01 EP1 Joint Commission ResourcesOakbrook Terrace, IL.