intervention strategies, a Statement of Authority allows Infection Prevention to go forth with prevention plans and actions without taking the issues before the P&T/IP Committee.

10. Surveillance Strategies

    a. NHSN Indicators: Since July 2008, SVMC has participated in the NHSN system. Infection Prevention collects data using the definitions, methodology and computer software developed by the CDC. The data are used internally to determine HAI rates, and are also sent on a regular basis to the CDC for inclusion in the national database.

    b. Surgical Site Surveillance Components:

        i. All patients who undergo operative procedures are monitored for surgical site infections.

        ii. For each patient having surgical procedures, information is collected about the patient's underlying condition. This information includes:

            1. American Society of Anesthesiology (ASA) score rated by assessing variables of age, sex, duration of operation, method of approach
            2. Surgical Wound class
            3. Whether the operation was performed as an emergency or as a result of trauma
            4. If multiple procedures were performed through the same incision

    c. Surgical Surveillance:

        i. Objectives:

            1. Identify HAI trends above NHSN benchmark rates
            2. Evaluate procedures, policies, and practices, looking for preventable risk factors when infection trends are identified
            3. Reduce infection by reducing risk factors

        ii. Methodology:

            1. Infection Prevention collects data on an ongoing basis
            2. Numerator: Number of patients developing surgical site infection following surgery
            3. Denominator: Total number of patients undergoing surgery

4. Stratification of patients by risk factors as recommended by NHSN (utilizing intrinsic patient risk as evidenced by ASA score, wound class, and duration of surgery).

iii. Data Sources:

1. Daily surgery schedule
2. Monthly report of all procedures
3. Daily admission report from the computer data systems
4. Concurrent and/or retrospective chart review by Infection Prevention if there is an occurrence of infection
5. Communication from the surgical nursing staff
6. Post discharge communication is quarterly during the year, from surgeons to Infection Prevention via a follow-up letter

iv. Defining Indicators for Infections:

1. Infections occurring following surgery at SVMC
2. NHSN definition for surgical site infection

v. Follow-up:

1. Reports are provided quarterly to P&T/IPC, participating surgeons, and other committees with a vested interest in these rates
2. When SVMC rates exceed NHSN rates, Infection Prevention makes a determination as to significance
3. Information is shared with Surgical Services and the Performance Improvement/Patient Safety (PIPS) Committee
4. If the infection rate is significant, an evaluation of relevant procedures, policies and practices is undertaken by Surgical Services and Infection Prevention.
5. A report is presented by Infection Prevention to P&T/IPC describing the result of the evaluation
6. If preventable risk factors are identified, an action plan outlining ways to reduce risk is included in this report

d. Ventilator Associated Pneumonia (VAP)

i. Objectives:

1. Compare with the NHSN VAP infection rate
2. Identify trends above the NHSN benchmark rate and established SVMC rate
3. Evaluate procedures, policies and practices, looking for preventable risk factors when infection trends are identified
4. Maintain "0" rate of VAP
5. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to P&T/IPC and appropriate Directors and Clinical Managers
3. Numerator: Number of patients who develop pneumonia following placement on a ventilator
4. Denominator: Number of ventilator days

iii. Data Sources:

1. Monthly number of ventilator days
2. Daily sputum gram stain and culture and sensitivity (C&S) reports from Microbiology
3. Daily admission report from computer data system
4. Communication from staff to Infection Prevention
5. Communication from physicians to Infection Prevention
6. Concurrent and/or retrospective chart review

iv. Defining Indicators for Infections:

1. Patient developing pneumonia following placement on ventilator
2. NHSN definitions for pneumonia

v. Follow-up

1. Reports are presented quarterly to the P&T/IP Committee, Clinical Director and Managers for presentation to appropriate staff
2. When SVMC rates exceed NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance

3. If it is determined that the pneumonia rate is significant, evaluation of relevant procedures, policies and practices is undertaken by P&T/IP Committee
4. A report is presented by Infection Prevention to the P&T/IP Committee describing the result of the evaluation.
5. If preventable, risk factors are identified and an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

e. Central Line Associated Blood Stream Infections (CLABSI) (NPSG.07.01.01)

i. Objectives:

1. Identify CLABSI rates above NHSN and SVMC benchmark rates
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis.
2. Reports are provided quarterly to the P&T/IPC and Clinical Directors and Managers.
3. Numerator: Number of episodes of CLABSI infections
4. Denominator: Number of CVC days

iii. Data Sources:

1. Monthly report of number of CVC days
2. Daily microbiology reports of blood, site, gram stain and C&S
3. Concurrent and/or retrospective chart review of patients with CVCs

iv. Defining Indicators for Infection:

1. Patient with CVC
2. NHSN definitions for BSI

v. Follow-up:

1. Reports are presented quarterly to the P&T/ IPC and other groups as needed.

2. When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
3. If it is determined that the infection rate is significant, evaluation of relevant procedures, policies and practices is undertaken by IP and critical care, looking for preventable risk factors.
4. If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation, is included in this report.

f. Catheter-Associated Urinary Tract Infections (CAUTI):

i. Objectives:

1. Benchmark with established SVMC rate and NHSN rate
2. Identify CAUTI rates above NHSN and SVMC benchmark rates
3. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
4. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to the P&T/IPC, Infection Prevention and clinical directors and managers
3. Numerator: Number of episodes of CAUTI in patients
4. Denominator: Number of urinary catheter days in patients.

iii. Data Sources:

1. Daily catheter report generated electronically
2. Daily microbiology reports of urine analysis, urine gram stain and C&S
3. Daily admission reports from the computer data system
4. Communication from nursing staff to Infection Prevention
5. Concurrent and/or retrospective chart review of patients with indwelling urinary catheters

iv. Defining indicators for infection:

1. Patients with indwelling urinary catheter
2. NHSN definitions for CAUTI

v. Follow-up:

1. Reports are presented quarterly to the P&T/IPC and nursing units
2. When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
3. If it is determined that the infection rate is significant, an evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors.
4. A report is presented by infection prevention to the P&T/IPC, describing the result of the evaluation.

vi. If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation, is developed.

11. Additional Surveillance Strategies/Other Indicators – in addition to the NHSN indicators, infection surveillance is performed for the following types of infections:

a. Housewide Bloodstream Infections (BSI):

i. Objectives:

1. Identify BSI rates above SVMC benchmark rates
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to the P&T/IPC and nursing units
3. Numerator: Number of bloodstream infections in SVMC patients
4. Denominator: Number of patient days

iii. Data Sources:

1. Quarterly report of the number of bloodstream infection days from the Infection Prevention Department, Radiology, and quarterly report of the number of admissions from the hospital data system
2. Daily microbiology reports of blood cultures
3. Daily admission reports from the computer data system

4. Communication from nursing staff to Infection Prevention
5. Concurrent and/or retrospective chart review of patients with bloodstream infections

iv. Defining Indicators for Infection:

1. Bloodstream infections will meet the NHSN definition for bloodstream infection

v. Follow-up:

1. Reports are presented quarterly to the P&T/IPC and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance
2. If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IPC
3. An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.
4. A report is presented by Infection Prevention describing the result of the evaluation
5. If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation

b. MRSA, VRE and *C. difficile* colonization and infections: (NPSG.07.01.01)

i. Objectives:

1. Identify HAI rates above SVMC benchmark rates
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Data is collected on a daily basis
2. Reports are provided quarterly to the P&T/IPC, nursing units, and other committees as necessary
3. Numerator: Number of episodes of HAI

4. Denominator: Number of patient days

iii. Follow-up:

1. Reports are presented quarterly to the P&T/IP Committee and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
2. If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IP Committee.
3. An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.
4. A report is presented by Infection Prevention describing the result of the evaluation.
5. If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

12. Requirements for Surveillance of All Infections:

All patients admitted with an infection, and those acquiring an HAI, will be reviewed by Infection Prevention on a regular basis in order to determine baseline infection rates and identify any outbreaks in the community and the hospital. Patient infections will be categorized by type of infection utilizing ICD-10 codes and provided to infection prevention. The purpose is to reduce all HAIs and develop an action plan if there is a significant increase in infections.

13. Precautions: (IC.02.01.01 EP 2 & EP 3)

Transmission-based precautions to protect against exposure to a suspected or identified pathogen are utilized. Based on the transmission of a specific pathogen, precautions are selected. Contact, droplet, airborne or a combination is used, depending on the pathogen. Standard precautions are always used with all patients. Personal Protective Equipment (PPE) is used specific to the precaution to reduce the risk of infection.

14. Hand Hygiene Compliance: (NPSG.07.01.01)

Infection Prevention monitors compliance with hand hygiene by unannounced direct observation. At least monthly, one or more patient care departments is chosen. Infection Prevention makes observation for opportunities to wash hands with soap and water and/or use alcohol hand rub. Everyone within the department is observed, including visitors. In addition, each patient care department is assigned a specific number of observations per month (based on Leapfrog Group

criteria) via "secret shoppers" to be reported to Infection Prevention via Huron on a monthly basis. The opportunity is the denominator, the opportunity taken is the numerator, and a percentage rate is assigned. Rates of compliance are established, documented results shared and recommendations for improvement given. Observations are reported to various committees, directors, managers, physicians, and healthcare personnel.

15. Additional Reports to the Pharmacy and Therapeutics/Infection Control Committee

    Infection Prevention and Employee Health are responsible for many other activities to prevent and control infection transmission in the hospital and outpatient areas.

    a. Influenza Vaccinations: The hospital provides an influenza vaccination to all staff and all licensed independent practitioners. (IC.02.04.01).

        i. Education is provided to all staff and licensed independent practitioners about influenza, the vaccine, non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.

        ii. Annually, vaccine is provided through Employee Health Services (EHS) during business hours and after hours. For after hours, vaccine is given at Employee Health Services on designated weekends. On designated days, EHS opens earlier to accommodate night shift staff.

        iii. There was a 78% vaccination rate in the 2022-2023 influenza season with 22% of all staff declining vaccination as indicated by the signed letter of declination. 44% percent of the Medical staff either received the vaccine or declined. Again, 100% of all staff received the vaccine or signed a letter of declination.

        iv. There was an 85% vaccination rate in the 2023-2024 influenza season with 15% of all staff declining vaccination as indicated by the signed letter of declination.

        v. Improvements in the vaccination rate will be made through the use of education, the requirement that unvaccinated staff wear masks while working, and by making vaccine available frequently by taking the vaccine to the staff as well as continuing the present vaccine program.

        vi. The goal for the next four years is to increase and maintain vaccine rate at 100% of staff and licensed independent practitioners by working with Employee Health, Infection Prevention and Human Resources.

    b. Employee Health Reports: Report employee compliance to vaccines annually. A report is provided on a weekly basis to all departments listing compliance of employees' receipt of seasonal influenza vaccinations or declination of vaccination.

c. Sharps Injuries: A report is provided by Employee Health about the number of needle sticks and safety needle devices available, and provides information about review and trials of prospective safety devices. Employee Health provides the report quarterly.

d. Reportable Infections Reports: Infection Prevention is the liaison between the hospital and local, metropolitan and state public health departments for issues related to infectious diseases. Infection Prevention provides information to the appropriate health department for each reportable infectious disease report that is processed by the hospital laboratory. A summary of all infections reported to public health agencies by Infection Prevention is provided quarterly to the P&T/IP Committee.

e. Sterilizer Monitoring Reports: A sterilizer monitor report for all steam, ETO, Sterrad and Steris sterilizers used in the hospital is provided quarterly by Surgery and Central Processing.

f. Microbiology Reports: A report from Microbiology about antibiotic resistant organisms and other relevant topics as determined by the P&T/IP Committee and the microbiology lab is provided quarterly.

g. Pharmacy Reports: A report from the Pharmacy providing information about antimicrobial usage and other relevant topics as determined by the Infection Control Committee and the pharmacy is provided quarterly.

h. Dialysis Water Report: A report from Facilities Management about sterility monitoring of dialysis water is provided quarterly.

i. Ventilation Reports: A report from Facilities Management about ventilation in negative-pressure isolation areas and surgery operating rooms is provided at least annually.

16. Additional Infection Prevention Activities

Infection Prevention has a responsibility for many other activities to prevent and control infection transmission in the hospital and outpatient areas:

a. Healthcare Personnel and Public Education: Government regulations, bioterrorism, and unusual microorganisms such as H1N1 influenza, Ebola, Coronavirus (SARS-CoV-2), Yellow Fever, West Nile Virus, and Zika Virus have greatly increased the need for education and training. Infection Prevention will continue to update and present information as necessary to keep healthcare personnel, volunteers, and the public informed. Annual requirements for healthcare personnel education is maintained in Human Resources.

b. Role as Liaison with Public Health Departments: Infection Prevention is responsible for notifying state, county and local Public Health departments when reportable disease is

identified for all inpatients and outpatients of SVMC. In addition, IP will assist with concurrent and retrospective chart review as necessary for the health departments in gathering epidemiological information.

c. Input on Purchases: Infection Prevention is consulted regarding the purchase of equipment and medical supplies used for patient care, procedures, sterilization, disinfection and decontamination, and regarding any major change in cleaning products and techniques.

d. Resource and Trouble-Shooting: Infection Prevention has responsibility to respond to questions and concerns about infections, hospital practices, isolation requirements, and incidents of exposure to blood and other potentially infectious body fluids, and other topics as requested. In addition, Infection Prevention assists with Employee Health needs when Employee Health is unavailable.

e. Continuing Education and Professional Networking: In order for the Infection Prevention Manager and Infection Prevention Registered Nurse to remain knowledgeable regarding IC issues, and to keep abreast of current information and resources, ongoing formal and informal education is necessary. Participation in the Association of Professionals in Infection Control and Epidemiology (APIC) on the local and national levels, as well as attending educational programs, is an important part of this process.

f. Construction: Infection Prevention has the responsibility to be involved in all hospital renovations and construction. Infection Prevention collaborates with engineering, facilities management, and the Safety Director to ensure a safe environment for patients, personnel, volunteers, and visitors during construction and renovation projects. Before any construction or renovation begins, an infection risk assessment of the project is completed. Based on the assessment, an Infection Control Construction Permit is developed and posted. Monitoring continues on a regular basis during renovations and construction in order to prevent transmission of an infectious disease.

g. Environmental Cleanliness: Working with environmental services, clinical departments, and hospital leadership, the IP Clinical Workgroup was established to better serve the hospital and to meet CMS standards. The IP Clinical Workgroup has many other responsibilities as well, such as determining needed competencies by staff in infection prevention. Education and training will be an integral part of the EVS new hire process and as needed.

17. Unscheduled Reports

a. Focused Studies: Focused studies and identification of infection prevention measures occurs from data generated from targeted hospital surveillance, government regulations, and the recommendations of recognized experts in Infection Prevention such as APIC and the CDC. Focused studies include retrospective and concurrent chart reviews, literature

reviews and surveys of clinical procedures and observations of clinical practices. Infection prevention measures include employee education, revision of policies and procedures when indicated, evaluation and modification of hospital equipment, disinfectants and work practices. Ongoing evaluation and monitoring of infection rates is required to access effectiveness of infection prevention measures.

18. Risk Assessment and Prioritization of Goals: (IC.01.03.01, see Appendix A)

The P&T/IPC, in collaboration with hospital leaders, identifies risks for transmitting and acquiring infections based on the following as discussed below. The Infection Prevention staff in conjunction with the P&T/ IPC will develop a risk assessment at least annually or whenever significant changes occur in the factors noted below using information from all applicable committees and individuals as appropriate. Consideration will be given for those issues that are high risk, high volume, and problem prone, new techniques related to emerging or reemerging trends and other issues as identified. The Infection Prevention Staff, in collaboration with appropriate staff from other units, will develop action plans to address these issues. (See Appendix A for the risk assessment and the current prioritization list). The factors addressed in the risk assessment include at a minimum:

a. Geographic Location and Community Environment

Sierra View Medical Center is located in an agricultural community with high rates of farm workers, migrant and foreign workers. In addition, during drought years, construction sites are potential sources of Coccidioidomycosis in the San Joaquin Valley where SVMC is located. Although Coccidioidomycosis is not infectious from person to person, serious infections may result and patients must be monitored and the disease reported. Additionally, SVMC is geographically located near the Porterville Development Center (PDC), serving a large number of developmentally disabled clients on site and in group homes in the area.

b. Characteristics of the Population Served

SVMC serves a diverse population, with Latinos being the majority, and who have a high incidence of diabetes, hypertension and vascular disease. SVMC also serves a large number of developmentally disabled individuals, as a result of its location.

c. Results of Analysis of Sierra View Medical Center's Infection Prevention, and Control Data

The surveillance results from surgical procedures, device related infections, communicable disease exposure events and environmental incidents are reviewed for variances.

d. Care, Treatment and Services Provided

The organization's plan notes the services that are provided. The high volume and/or high-risk services are assessed for surveillance and adaptable measures that can be followed.

e. Employee Health

SVMC provides a safe working environment for employees through the coordination of infection Prevention and Employee Health to identify potentially infectious conditions that may pose a risk for patients and staff.

f. Emergency Preparedness

The organization works continuously to be ready for an internal or external emergency, including, but not limited to, a short or long term influx of infectious patients.

Table of Goals for 2023

Goal #1: Limiting unprotected exposure to pathogens throughout the hospital (NPSG.07.01.01, IC.02.01.01)

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Improve Hand Hygiene Compliance	Achieve 70% hand hygiene compliance through 2023. Achieve 80% compliance for proper hand hygiene technique	Education Surveillance to monitor compliance On-the-spot reminder of the WHO 5 moments of hand hygiene when needed Provide quarterly compliance reports and feedback to committees and staff Reminders including	Monitor hand hygiene of staff and LIPs with data uploaded to reporting software (Huron) to generate weekly reports for distribution to unit leaders, etc. Generate quarterly reports for distribution at committee meetings and hospital physician leadership	Unit Directors, Managers, IPs, HCW and Medical Staff.	Increase Department Hand Hygiene participation and compliance to 70% from a low of 7.7% in 2022. Obtain a realistic report for "no hand hygiene displayed"

		signage, 5-minute huddles, newsletter campaigns for staff, visitors and other HCWs			

Goal #2: Implement evidence-based practices to prevent HAIs due to community acquired MDRO infections in the hospital (NPSG .07.01.01, IC.02.01.01)

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Implement evidence-based practices to reduce spread of MDROs throughout the hospital (HAIs)	Reduce the incidence of HAI MDROs below1% through 2023	Identify patient on admit or transfer – take appropriate specimen, for laboratory evaluation. Educate staff, patients and families as appropriate to prevent spread. Remind HCW of hand hygiene, standard precautions and contact precautions. Conduct appropriate cleaning and disinfecting of	Report and document education of staff and patient education plans. Monitor hand hygiene and report through uploading data to Huron for further hand hygiene compliance analysis. Conduct surveillance to monitor precaution compliance. Report in a timely manner any infractions to directors, managers, etc.	IPs, department directors and managers, staff, medical staff services director.	Observe evaluation and testing of qualified patients within the 72-hour time window. Observe a reduction of HAIs overall, but specifically MRSA

		patient's environment, use dedicated equipment Use signage, posters and pamphlets to educate and remind those in contact with patient.	for corrective action and on-the-stop advisement of HCW.		

Goal #3: Minimize the risk of infection transmission associated with procedures, the use of medical equipment and devices. (IC.02.02.01)

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Reduce Central Line-associated Bloodstream Infection (CLABSI) in patients	Reduce incidence of CLABSIs to below current incidence rate (see Expected Result)	Collect and analyze surveillance data. Provide feedback via reports to committees, directors, managers, etc. for distribution to HCW. Provide evidence-based practice catheter placement checklist for staff. Review current surveillance tool; compare to currently recommended surveillance tools, if necessary, update and	Monitor changes in incidence rates of infections Monitor adherence to placement checklist. Report CLASI rates to Committees such as AR&L, P&T IP, physicians and leadership quarterly. Conduct annual risk assessment for compliance with evidence-based practices hospital wide.	IPs, Medical staff, central line insertion staff	Reduce incidence of CLABSIs to below 1% through the end of the fiscal year

		implement. Provide supplies and products that facilitate adherence to recommendations.	Strive for 100% compliance rate.		
Reduce catheter-associated urinary tract infections (CAUTIs) in patients	Maintain CAUTIs at or below 0.5% (see Expected Result)	Conduct regular surveillance of catheters; provide annual education of staff to keep catheter usage at a minimum	Monitor CAUTIs. Report to P&T IP committee, IP and clinical unit directors and managers	Clinical departments that utilize catheters, physicians, IPs	Reduce incidence of CAUTIs to below 0.5% through the end of the fiscal year
Reduce surgical site infections (SSIs)	Maintain incidence of SSIs below 1% (see Expected Result)	Education of staff and LIPs involved in surgical procedures upon hire, conduct annual competency reviews, and whenever surgical procedures are added to an individual's job responsibilities. Educate patients and/or patient family about infection prevention after a surgical procedure.	Monitor and report education sign in sheets to support completion of required education. Review nursing care plans for patient education.	Surgical staff, IPs, surgical nursing department, nursing staff and performance improvement.	Maintain incidence of SSIs below 1% through the end of the fiscal year

Goal #4: Limiting unprotected exposure to pathogens throughout the hospital (IC.01.06.01)

Infection Prevention Goal	Measurable Objective	Strategies	Evaluation	Responsibility	Expected Result
Prepare to respond to an influx or risk of influx of infectious patients	Meet 90% or more of the Influx of Infectious Patients Contingency Plan requirements as related to infectious patients	Provide IP representation on the Emergency Preparedness Team. Provide input on IP issues during emergencies, establish communication with local health dept. Utilize resources of the County Health Department, the State Department, and the Public Health System Maintain and/or revise policies and procedures for influx of patients, outbreaks, emerging infection and bioterrorism.	Perform observation during drills. Report compliance to Hospital Emergency Incident Command System, to Safety Committee, hospital leadership and P&T IP Committee.	Infection Prevention Committee	Maintenance and revision of contingency plan policies as needed to be prepared for influx of infectious patients.

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Cross Reference:

- Influx Of Infectious Patients Contingency Plan
- Surge Capacity Plan

Risk Assessment for the Infection Prevention and Control (IP&C) Program
Annual Infection Control Risk Assessment 2023
Year: 2023_
Organization Name: ____Sierra View Medical Center____
Date of Report: ___Nov. 7, 2023_____

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Geography, Community & Populations served													
Increasing Incidence of TB		2				2						0	4
POTENTIAL HAIs / INFECTIOUS DISEASE													
Surgical Site Infection SSI		2			3						1		6
Ventilator Associated Pneumonia VAP			1		3						1		5

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Central Line-Associated Blood Stream Infection CLABSI		2			3							0	5
Clostridioides difficile Infection CDI		2				2						0	4
Catheter-associated Urinary Tract Infection CAUTI			1			2						0	3
MRSA (Hospital acquired)			1			2						0	3
VRE (Hospital acquired)			1			2						0	3
Exposure - specific infection													
Influenza (Seasonal)	3					2					1		6
Emergency Management - Influx of Infectious		2				2					1		5

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Patients													
Infectious Disease Outbreak		2				2					1		5
Ebola Outbreak			1		3					2			6
COVID-19 Outbreak		2				2					1		5
COMMUNICATION													
HAI – Lack of Timely Notification (internal information flow)			1				1					0	2
Employee Illness – Lack of Timely Notification			1				1				1		3
Personnel, lips, Volunteers Surveillance and screening													
Poor Hand Hygiene Compliance	3					2					1		6
Sharps Injury (HCW)		2				2					1		5

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 29 of 32**

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

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Poor TB Screening (Hospital)			1			2						0	3
Poor TB Screening (LIP)		2				2					1		5
Inappropriate Use of Isolation		2				2						0	4
Ineffective Screening of Employees/Contract Staff/LIPs, Volunteers and Students			1				1					0	2
Ineffective Fit Testing (Hospital)			1			2						0	3
Environment of care													
Inappropriate Handling of Biohazard Waste		2			3						1		6
No or Ineffective			1				1					0	2

17

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 30 of 32**

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

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Preconstruction IC Planning (ICRA meeting)													
Ineffective Notification or Communication for Applicable Utilities Issues/Shutdowns (HVAC, etc.)			1				1					0	2
Major Biohazard Spill			1			2						0	3
Failure of Appropriate Air Exchange or Air Pressure Monitoring in Isolation Rooms, ORs or Other Critical Environments			1			2						0	3
Improper Cleaning or Disinfection of		2				2					1		5

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Environment of Care													
supply storage, instrument & medical device cleaning, disinfection & handling													
Improper Storage or Disposal of Supplies			1			2						0	3
Ineffective Reprocessing of Devices		2			3						1		6
Improper Sterilization (Including Positive Biological Controls) of Supplies and Equipment		2			3							0	5

1. **Probability of the event/condition occurring**: determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, and the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.) are considered when determining this score.

GT

2. **Potential Severity, Risk Level of Failure:** determined by review of historical data and infection surveillance data.
3. **Organization's preparedness to deal with the event/condition**: determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

(Developed by and modified from: K. Arias, M. Patrick, K. Delahanty and S. Odachowski)

44

SUBJECT: **BLOOD BANK REFRIGERATOR MAINTENANCE PROCEDURES**	SECTION: **Page 1 of 2**

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

POLICY:

The blood bank refrigerator is used to store blood components, patient samples, and reagents. A recording thermometer, audible alarm, and an emergency power source are required. The refrigerator compartments should be clean, organized, and appropriately labeled. Blood components should be properly arranged to avoid crowding. The temperature inside the refrigerator must be maintained throughout between 1°-6° C. To assure the refrigerator functions properly, quality control and maintenance are performed daily, weekly, and quarterly.

AFFECTED AREAS/PERSONNEL: *LABORATORY, SURGERY*

PROCEDURE:

1. Daily:
   a. Check and record the temperature daily. The automatic recorder must correlate within 1° C of the thermometer.
   b. Perform visual inspection of blood components for any abnormal appearance and expired blood units and initial the blood bank daily check list.
   c. If the above temperature is out of range and the alarm is activated, corrective action must be taken. Refer to the policy on STORAGE OF BLOOD COMPONENTS IN THE EVENT OF THE LOSS OF MONITORED REFRIGERATION #8063 .
2. Weekly:
   a. Every Wednesday morning, the blood bank refrigerator & freezer charts must be replaced.
   b. Remove the chart, date, and initial.
   c. Write the identity of the refrigerator or freezer on each chart, date, initial and stamp the hospital name and address.
3. Quarterly:
   a. Once a quarter, an alarm check is performed. Ice water is used to activate the low temp alarm. Water at a temperature greater than 6°C is used to check the alarm for the high refrigerator temperature and for the freezer. Record the results on the blood bank daily check list.

REFERENCES:

- American Association of Blood Banks, Standards for Blood Banks and Transfusion Services, 33rd Edition, Sections 3.5 through 3.7.

- Fung, Mark K., American Association of Blood Banks Technical Manual, 20th Edition, pp.153-154, 2020.
- The Joint Commission Laboratory Accreditation, QSA.05.03.01, QSA.05.04.01and QSA.05.04.03, (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **COMMUNICABLE DISEASE REPORTING**	SECTION:

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

PURPOSE:

To establish uniform guidelines which comply with state law for reporting communicable diseases.

POLICY:

All patients and personnel diagnosed with a communicable disease shall have that condition reported to the Tulare County Public Health Department in compliance with the List of Reportable Diseases (See California Code of Regulations, Title 17 Section 2500 in references for list.).

AFFECTED AREAS/PERSONNEL: *ALL DEPARTMENTS*

PROCEDURE:

1. Reporting requirements – All health care providers have the duty of reporting communicable/reportable diseases to the local health officer. Health care providers include, but are not limited to, physician, surgeon, podiatrist, nurse practitioner, physician assistant, registered nurse, nurse midwife, or infection control practitioner.

2. The administrator of this facility has designated that the laboratory and the Infection Control Department be responsible for the reporting mechanism. The exception to this is "non-communicable diseases and conditions." This category shall be the responsibility of the attending physician or the attending physician's designee.

3. Refer to the following link for diseases to report and the time frames required for reporting each specific disease: https://tchhsa.org/eng/public-health/communicable-disease-and-other-required-reporting/ .

4. Notify the Infection Prevention Department of the communicable disease case or suspected case.

   The Infection Prevention Manager or designee shall complete the required *Confidential Morbidity Report* (CMR) for Tulare County via CalREDIE (if access is not available for CalREDIE, the form can be found at http://hhsawebdocs.tchhsa.org/File.ashx?id=5537) .

5. The Infection Prevention Manager and/or designee shall keep a log of all cases reported which is located on the SVMC IP Drive under "Tulare County Reported C.M.R List.".

REFERENCES:

- California Code of Regulations (CCR), Title 22, Section 70739. Accessed October 8, 2023, from https://casetext.com/regulation/california-code-of-regulations/title-22-social-security/division-5-licensing-and-certification-of-health-facilities-home-health-agencies-clinics-and-referral-agencies/chapter-1-general-acute-care-hospitals/article-7-administration/section-70739-infection-control-program.

- California Code of Regulations (CCR), Title 17, Section 2500. Accessed October 8, 2023, from http://hhsawebdocs.tchhsa.org/File.ashx?id=5121.
- Tulare County Health & Human Services Agency. *Communicable Disease and Other Required Reporting*. Accessed October 27, 2023, from https://tchhsa.org/eng/public-health/communicable-disease-and-other-required-reporting/.
- The Joint Commission (2023). Laboratory & Point-of-Care accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.02.01.01 EP9
- The Joint Commission (2023). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.02.01.01 EP9

SUBJECT: **CRITERIA FOR SERVICE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide criteria for skilled rehabilitation services.

AFFECTED AREAS/PERSONNEL: *PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY STAFF*

POLICY:

Skilled rehabilitation services will be provided to patients that meet criteria for service.

PROCEDURE:

1. A provider is responsible for ordering therapy services.

2. The licensed therapist evaluating the patient must determine if the patient meets known criteria for service.

3. The patient qualifies for skilled service when:

    a. There is an expectation that the patient's condition will improve in a reasonable period of time based on the provider's assessment of the patient's restoration potential and medical condition.

    Services can only be performed by a qualified therapist or under his/her supervision.

    b. The services must relate directly and specifically to an active written treatment plan established by the physician after consultation with the qualified therapist.

    c. The services must be reasonable and necessary to the treatment of the individual's illness or injury.

    d. Services may not be duplicated by another discipline.

4. If the patient does not qualify for skilled service, the referring physician will be notified and a treatment plan will not be initiated.

REFERENCES:

[1] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. *Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage.* Retrieved December 7, 2023, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c12.pdf

[2] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. *Chapter 15 – Covered Medical and Other Health Services*. Retrieved December 7, 2023, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

SUBJECT: **DISCHARGE INSTRUCTIONS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define when discharge instruction will be provided.

POLICY:

Discharge instructions shall be provided to each patient receiving IV therapy.

AFFECTED AREAS/ PERSONNEL: *CHEMOTHERAPY STAFF*

PROCEDURE:

PATIENT IDENTIFICATION: The nurse is to follow the hospital established two-patient identifier process to assure that the information correlates with the patient information on documents before releasing them to the patient.

DISCHARGE INSTRUCTIONS:

1. Verbal instructions and written materials will be provided to the patient
2. Patient will (if able) verbally state understanding of discharge instructions.
3. The patient's caregiver may receive instruction if the patient is unable to comprehend the instructions

DISCHARGE INTERVALS:

The intervals at which the patient will receive ~~these~~ discharge instructions are as follows:

1. Patients receiving single day protocols more than once a month (ex. weekly treatments), discharge instructions will be provided for them once per month. If the protocol changes during the month, a new discharge instruction sheet will be issued.
2. Patients on multi-day protocols will receive discharge instructions on the first day of the protocol.
3. Patients on single-day protocols once every month will receive discharge instructions on the day of treatment.

Documentation of discharge instructions given shall be recorded in the patients' health record.

REFERENCE:

- ~~The Joint Commission (2018). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.~~

Jabaley, Terri, Rizzo, Patricia, Grenon, Nina, *Clinical Journal of Oncology Nursing*, Number 4 / August 2020, Chemotherapy Education and Support: A Model for Use in the Ambulatory Care Setting

Prince, Mariah S., Allen, Deborah, Chittenden, Sarah, *Clinical Journal of Oncology Nursing* Improving Transitional Care: The Role of Handoffs and Discharge Checklists in Hematologic Malignancies (2019)

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SUBJECT:	SECTION:
DISPOSAL, ACCIDENTAL EXPOSURE, AND SPILLS OF CHEMOTHERAPEUTIC AGENTS	**Page 1 of 3**

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

PURPOSE:

Health care personnel, the patient, and the environment will be protected from unnecessary exposure to potentially hazardous substances. A chemotherapy spill requires immediate attention and must be controlled.

POLICY:

- All equipment and unused drugs should be treated as hazardous waste and disposed of accordingly.
- Only personnel with specialized training shall handle disposal of antineoplastic drug waste and spills of antineoplastic drugs.
- Personnel who are pregnant or breastfeeding shall not handle chemotherapeutic agents.

AFFECTED AREAS/ PERSONNEL: *ALL CANCER TREATMENT CENTER STAFF*

PROCEDURE:

A. General Guidelines

1. Dispose of all used drug administration equipment in the puncture-proof chemo waste containers.
2. Do not disassemble the syringe, IV tubing and needles used with chemotherapy. Dispose of all contaminated equipment intact to prevent aerosolization, leaks, and spills.
3. Gloves and gowns used during chemotherapy administration should be disposed of in the container used to dispose of other chemotherapy waste.
4. Chemo waste buckets should be replaced when 2/3 full.
5. Chemo waste buckets are placed in the soiled utility closet for pick up.

B. Accidental Exposure

1. Remove contaminated gloves and/or gown immediately and discard properly.
2. Wash the skin contaminated with a drug with plain soap and water.
3. Flood an eye that is accidentally exposed to chemotherapy with water from an eyewash station. Flush for at least 5 minutes.

4. Notify Director, House Supervisor, or Employee Health as soon as possible to determine if a medical evaluation is needed. Complete electronic occurrence report immediately for follow-up.

C. **Cytotoxic Drug Spills**

1. For any cytotoxic drug spills over 5mL, the Chemo Safety Spill Kit will be used immediately.

2. Open kit. Display spill sign if spill is in a high traffic area.

3. Prevent the spill from spreading:

   - Lay Chemo Sorb Pad over the spill. The pad will absorb the liquid and transform it into a gel, which is more convenient for disposal.
   - Be careful not to touch the spill or to generate any splashes (aerosols).
   - Put on gown, shoe coverings, mask and safety glasses.
   - Double glove with inner latex gloves (blue) and outer (heavy) utility glove.
   - Use Spill Kit box to scoop up gel and any broken glass. Place in blue poly bag.
   - Use spill towels and clean water to rinse the area and pick up the remainder of the gel. Repeat several times.
   - Use remaining spill towels to pick up rinse water and to fully dry the area.

4. Remove shoe coverings and outer utility gloves and discard into the blue poly bag.

5. Seal poly bag while wearing blue gloves and place into white chemo waste poly bag along with gown, shoe coverings, mask, and safety glasses. Remove and discard inner gloves and seal chemo waste bag.

6. Call Housekeeping to clean floor and equipment with detergent and water.

7. Call Maintenance to pick up chemo waste bag.

8. Complete electronic occurrence report and notify Director, House Supervisor, or Employee Health immediately.

REFERENCE:

- Oncology Nursing Society Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice, Second Edition, 2023, Oncology Nursing Press, Inc.

- Oncology Nursing Society, Safe Handling of Hazardous Drugs. Third Edition 2018, Oncology Nursing Press, Inc.

SUBJECT: **DISPOSAL OF INFECTIOUS, CONTAMINATED WASTES**	SECTION: **Page 1 of 3**

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

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to establish plans and guidelines for the safe and effective disposal of infectious waste.

PROCEDURE:

All personnel will be responsible for the following:

A. All disposable waste contaminated in the care and treatment of patients with highly communicable diseases and/or saturated with blood, body fluids containing visible blood or other body fluids to Standard Precautions apply shall initially be placed in a red infectious waste bag by Health Care Provider (HCP) staff. The bag is labeled as biohazardous waste.

B. The bagged waste is taken to a secured storage area (in most instances, the dirty utility room) by HCP until it is retrieved by Environmental Services.

C. Environmental Services will remove waste on a daily basis.

D. Environmental Services will transport wastes in closed container to area for disposal.

SYRINGE AND NEEDLE DISPOSAL

It is the policy of the hospital that syringe and needle disposal be performed according to Universal/Standard precautions / hazardous waste procedures.

PROCEDURE:

HCP will:

A. Use the sharps safety device immediately after sharps use.

B. When the injection is given away from a convenient disposal site, the syringe and needle will be placed in a small tray and carried to the disposal site.

C. Place the syringe and needle in a Sharps Disposal container (rigid, puncture-proof container) specifically designed for this purpose without recapping or clipping or bending needle.

D. Maintain sharps disposal containers in all clinical areas where sharps are used and in a secured environment. (See Environmental Cleaning Procedures, 2020)

E. Call Environmental Services personnel when sharps containers are ¾ full so that they can be replaced with another empty container.

BLOOD AND BODY FLUID SPILLS

It is the policy of the hospital to follow appropriate infection control guidelines when cleaning a blood or body fluid spill.

PROCEDURE:

HCP/Environmental Services:

A. Persons cleaning spills of blood or body fluid must wear gloves.

B. Spills of blood or body fluids or any potentially infectious material will be disinfected with a freshly prepared solution of hospital approved disinfectant/detergent.

C. Small spills may be wiped up with disinfectant solution or the appropriate wipe.

D. Large spills should be flooded with the disinfectant solution by pouring it near the edges so that the solution flows through the spill. Never pour the solution directly onto the spill.

E. Allow solution to stand 10 minutes.

F. Place disposable absorbent paper towels on the spill.

G. Place soiled paper towels in red biohazard bags.

H. Notify housekeeping to mop the entire area with disinfectant solution.

LABORATORY WASTES

It is the policy of the hospital to prudently handle and dispose of waste that has a high risk of being infectious.

PROCEDURE:

Lab personnel and HCP will:

A. Wear gloves at all times when handling blood or body fluids.

B. Place empty, used vacutainer tubes and slides in rigid, puncture-proof containers.

REFERENCES:

Jinadatha C, Bridges A. Cleaning, Disinfection, and Sterilization. In Boston K.M., et al, eds. APIC Text, 2018, revised 2020. Accessed November 27, 2023. Available at: https://text.apic.org/toc/basic-principles-of-infection-prevention-practice/cleaning-disinfection-and-sterilization

Ling, M., Apisarnthanarak, A., Thu, L., Villanueva, V., Pandjaitan, C., & Yusof, M. (2015). APSIC Guidelines for environmental cleaning and decontamination. Retrieved on August 3, 2018 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696151/.

California Code of Regulations Title 8 §5193. Accessed November 27, 2023. Available at: https://www.dir.ca.gov/title8/5193.html

Environmental Cleaning Procedures. (2020). Last Reviewed: May 4, 2023. Accessed November 27, 2023 from Centers for Disease Control and Prevention: https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html

OSHA Biohazard Waste Disposal Guidelines. (2020, October 25). Retrieved from Healthcare Waste Management (HWM): https://www.hwmusa.com/osha-biohazard-waste-disposal-guidelines/

The Joint Commission (2023). Hospital Accreditation Standards Manual. Joint Commission Resources. Oak Brook, IL. IC.01.01.01; IC.01.02.01; IC 01.03.01; IC.02.02.01; IC.02.03.01, and IC02.05.01.

The Joint Commission (2023). Laboratory and Point-of-Care Testing Standards Manual. Joint Commission Resources. Oak Brook, IL. IC.01.01.01; IC.01.02.01; IC 01.03.01; IC.02.02.01; IC.02.03.01.

CROSS REFERENCE:

EXPOSURE CONTROL PLAN – BLOODBORNE PATHOGEN STANDARD– SVMC Policies and Procedures

Code Orange – Internal Hazardous Materials Spill – SVMC Policies and Procedures

SUBJECT: **EDUCATION OF PATIENT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure patients or caregivers understand the care and services provided them by the Cancer Treatment Center (CTC).

POLICY:

The patient shall receive education and training specific to their assessed needs, abilities, learning preferences, and readiness to learn as appropriate to the care and services provided by the CTC.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

1. Each new patient shall complete a Patient History and Physical Questionnaire. Information on the questionnaire shall be used to direct the type of educational resources used. Such resources may include:
   a. Teaching materials such as brochures, instruction manuals, printed sheets, manufacturer guidelines, DVR or downloads, and material in large print.
   b. Verbal instruction, return demonstration by the patient/caregiver, or verbal repetition by the patient.
   c. Other community resources to do the teaching if needed, and referrals to other programs, special devices, interpreters, or others.
2. Prior to and during the course of their treatment, the patient shall receive education regarding their treatment plan and other assessed needs. Education may be provided by:
   a. Cancer Treatment Center staff.
   b. Hospital staff via referral to Dietitian, Social Services, and Chaplain.
   c. Educational Support Group via the hospital, American Cancer Society (ACS) endorsed program.
3. Teaching materials shall be selected as appropriate based on the patient's abilities.
4. Education shall be documented in the patient's chart using the Education Flowsheet.

REFERENCES:

- Oncology Nursing Society (2023). Standards of Oncology Education.. Retrieved from https://www.ons.org/.

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

SUBJECT: **EMERGENCY RESPONSE AND TRANSFER**	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 to staff regarding response in the event of a medical emergency.

POLICY:

The Cancer Treatment Center (CTC) staff shall, at minimum, be Basic Life Support (BLS) certified and respond promptly and effectively during medical emergencies, and should be prepared to initiate and continue Basic Life Support (BLS) until Emergency Medical Transport (EMT's) arrive.

AFFECTED PERSONNEL/AREAS: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

1. The staff person who finds a patient and/or determines that a medical emergency and/or cardiac arrest occurred must:
   a. Stop the infusion or treatment, if applicable.
   b. Assess need for CPR and begin CPR procedure (note the time), following American Heart Association guidelines when appropriate.
   c. Turn call light on and/or call for help. Do not leave the patient – continue basic CPR.
2. The person that receives the alert or call for help must initiate or delegate the following:
   a. Alert the Cancer Treatment Center (CTC) Physician, preferably the ordering physician.
   b. Go to the nearest phone, dial "9" and then "911" for emergency patient transport to the Emergency Department.
   c. Retrieve AED and return to the patient.
   d. Follow appropriate AED procedures.
   e. Upon arrival of ambulance personnel, a report of the patient's condition will be provided and appropriate handoff will occur. The patient shall become the responsibility of the responding agency.
      (1) When preparing for transport, an updated medication list and visit documentation should be given to the EMT's and, when possible, the ordering MD will notify the Emergency Department Physician via phone to discuss relevant history.
3. Document occurrence in the patient's medical record and notify ordering physician.

REFERENCES:

- American Heart Association, "BLS for Healthcare Providers." (2020) Retrieved from https://cpr.heart.org/en/cpr-courses-and-kits/healthcare-professional/basic-life-support-bls-training. 11/28/2023

SUBJECT: **EVALUATION PROCEDURES**	SECTION:

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

PURPOSE:

Functional assessment and evaluation of each identified patient will be conducted in a manner that will insure a systematic and thorough method of data gathering, analysis, interpretation, and professional recommendation.

POLICY:

The Speech Therapist conducts screening and evaluations to diagnose speech, language, cognitive, voice, oral and pharyngeal sensorimotor competencies in a wide variety of patients.

AFFECTED AREAS/ PERSONNEL: *SPEECH THERAPY*

PROCEDURE:

A. INTAKE PROCEDURES

Orders for inpatient speech, language, cognitive, or swallowing evaluation will be by a Physician. Response to orders will be initiated within 24 hours of receipt during regularly scheduled working hours.

Patients referred by an outside source will directly contact the facility for a Speech Pathologist evaluation appointment at a mutually agreeable time.

B. EVALUATION PROCEDURES

1. Complete appropriate assessment in electronic health record (EHR).

2. Discharge Goals

3. Frequency and Duration will be established by the therapist at time of evaluation.

4. Part B evaluations require a physician's signed certification. Keep original(s) evaluation(s) in chart and send copy(ies) plus Certification Form to the physician for signature. A copy of the signed certification plus a copy of the evaluation(s) should be turned in to the facility-billing department. The original signed Certification should be kept in the rehab section of the patient's chart or in the EHR.

5. The speech pathologist will select, from various standardized and non-standardized evaluation materials, the most appropriate instruments to utilize for the evaluation of each specific patient.

C. EVALUATION CONTENT

1. Cognitive/Speech and Language/Voice

a. Patient Identification and Diagnosis

b. Background Information/Medical History

c. Oral Peripheral Examination

d. Speech Production Evaluation

e. Receptive Language Evaluation (including auditory comprehension)

f. Expressive Language Evaluation (including auditory comprehension and reading comprehension)

g. Cognitive Evaluation

h. Voice Evaluation

i. Clinical Impressions and Prognosis

j. Recommendations

k. Goals and patient participation in goal-setting

2. Bedside Swallowing Evaluation:

a. Patient Identification and Diagnosis

b. Background Information/Medical History

c. Oral Peripheral Examination

d. Evaluation of oral and pharyngeal stages of the swallow

e. Clinical Impressions and prognosis

f. Recommendations

g. Goals and patient participation in goal-setting.

3. Modified Barium Swallow or Videofluoroscopic Swallow Study (VFSS):

a. Patient Identification and Diagnosis

b. Background Information/Medical History

c. Videofluoroscopic Swallow Study procedures utilized

d. Radiographic symptoms including evaluation of the oral, pharyngeal, and esophageal stages of the swallow.

e. Clinical Impressions and Prognosis

f. Recommendations

g. Goals and patient participation in goal-setting.

D. COMMUNICATION OF EVALUATION FINDINGS AND RECOMMENDATIONS

1. Urgent findings will be immediately communicated, verbally to the referring physician, attending nurse, or referring facility. These "urgent findings" may include, but are not limited to, aspiration or significant change in a patient's cognitive functioning.

2. Other non-urgent findings are communicated to the physician via a clarification order or a report – verbal or written.

REFERENCES:

[1] American Speech-Language-Hearing Association. *Videofluoroscopic Swallow Study.* Retrieved December 5, 2023 from https://www.asha.org/practice-portal/clinical-topics/pediatric-feeding-and-swallowing/videofluoroscopic-swallow-study/

[2] American Speech-Language-Hearing Association. *Speech-Language Pathology Medical Review Guideline.* Retrieved December 5, 2023 from https://www.asha.org/siteassets/uploadedfiles/slp-medical-review-guidelines.pdf

SUBJECT:	SECTION:
EVENT RELATED STERILIZATION PROCESS (SHELF LIFE)	**Page 1 of 2**

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PURPOSE:

The prime function of a package containing a sterile medical item is to ensure that sterility of the contents is maintained until the package is intentionally opened.

POLICY:

Sierra View Medical Center (SVMC) uses an event-related sterility system. The integrity of a sterile package is the determining factor in establishing the sterility of the enclosed items. All items processed/sterilized by Central Processing will be considered sterile unless the package, pack, tray or container is damaged or wet.

PROCEDURE:

1. Decontaminate and clean items/instruments prior to sterilization process.
2. Double wrap package items for sterilization in paper and/or peel pouch if there are multiple instruments, if the instruments are heavy, or if they have sharp edges.
3. Single wrap package in paper/plastic peel pouches for single instruments.
4. Instruments in container systems are sterilized following manufacturer's instructions.
5. Items used less than once per 6-12 month period should be re-evaluated for routine processing/sterilization. Consider re-sterilizing upon need (see product-specific MIFU for further instructions.)
6. Maintenance or "dust covers" may be needed for items used infrequently.
7. Secure package with chemical change sterilization tape.
8. Package wrapping shall be identified by:
    a. Product identification label
    b. Date of sterilization, sterilizer #, load number, initials of person assembling package.
    c. Event-related label indicating, "Sterile unless opened, damaged or wet".
9. Rotation of stock - all sterilized items will be rotated to assure usage of "oldest" sterile items first, place "oldest" items in front, and most recently processed items in back to maintain an orderly system.
10. Store items in an environment free of moisture, excessive heat or soiled areas. Clean cabinets, cupboards, or other satisfactory spaces may be utilized. Take steps to minimize dust collection in these areas.
11. Shelf life of sterilized items should be event-related (events that may compromise the sterility of a package) unless otherwise specified by the manufacturer's packaging system, labeled expiration date, etc.
12. Minimize the handling of sterilized items/packages.

13. All staff processing and/or using packaged items are responsible for checking the integrity of packaging prior to use.

REFERENCES:

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AORN eGuidlines+: Sterilization. September 1, 2018. Retrieved September 27, 2023, from https://www.aornguidelines.org/guidelines/content?sectionid=173737535&view=book#229141985

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California Code of Regulations, Title 22. Section 70831. Accessed on November 27, 2023 from: https://www.law.cornell.edu/regulations/california/22-CCR-70831

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The Joint Commission (2023). Hospital Accreditation Standards Manual. Joint Commission Resources. Oak Brook, IL. IC.01.03.01; IC.02.02.01; IC.02.03.01.

The Joint Commission (2023). Laboratory and Point-of-Care Testing Standards Manual. Joint Commission Resources. Oak Brook, IL. IC.01.03.01; IC.02.02.01; IC.02.03.01.

SUBJECT: **EXTRAVASATION OF ANTINEOPLASTIC AGENTS**	SECTION: **Page 1 of 9**

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

PURPOSE:

Extravasation of antineoplastic agents can result in severe tissue damage. Prevention of extravasation by appropriate administration techniques is the most important step in preventing injury.

POLICY:

Extravasation of antineoplastic agents shall be managed in an expeditious manner in order to reduce tissue damage. Medications contained in this policy do not reflect every pharmaceutical used in the treatment of oncology patients. In order to be prepared in the event of extravasation staff should reference available resources including but not limited to: Lexicomp, manufacture publications, and Material Safety Data Sheets (MSDS), prior to administration of new medications.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

A. A physician or registered nurse implements the steps outlined here if extravasation of any vesicant or irritant drug is suspected. A vesicant causes blistering which is associated with subsequent cell death and extensive tissue necrosis. Irritants cause pain and inflammation at the site of injection without necrosis.

B. Drugs associated with severe local necrosis (vesicants) include the following:

1. Cisplatin in volumes of >20 ml at concentrations of ≥0.5 mg/ml.
2. Dactinomycin (actinomycin, Cosmegen)
3. Daunorubicin (daunomycin, Cerubidine)
4. Doxorubicin (Adriamycin) – Doxorubicin also produces an infusion reaction that may be mistaken for extravasation. In 3% of doxorubicin infusions, a "flare" reaction may be present with edema and red streaking along the vein. The reaction rarely lasts more than 24 hours.
5. Epirubicin (Ellence)
6. Idarubicin (Idamycin)
7. Mechlorethamine (nitrogen mustard, Mustargen)
8. Melphalan (Alkeran)
9. Mitomycin C (Mutamycin)

10. Mitoxantrone (Novantrone) – May rarely act as a vesicant; more likely to occur if a large amount of concentrated solution is extravasated.

11. Paclitaxel (Taxol) – Rare vesicant; more likely to occur if a large amount of concentrated solution is extravasated.

12. Vinblastine (Velban)

13. Vincristine (Oncovin) – must only be administered intravenously

14. Vinorelbine (Navelbine)

C. Since little information may be available about the risks of extravasation of investigational chemotherapy, treat all as potential vesicants. Some investigational agents that are known vesicants include the following:

1. Amsacrine

2. Amonafide

3. Bisantrene

4. Echinomycin

5. Esorubicin

6. Menogaril (*Tomosar*)

7. Piroxantrone

8. Pyrazofurin (*Pyrazomycin*)

9. Vindesine

D. Irritant drugs may cause phlebitis, but are not known to cause tissue damage with extravasation. Irritant chemotherapy includes the following:

1. Arsenic trioxide (*Trisenox*)

2. Bleomycin (*Blenoxane*)

3. Busulfan (*Busulfex*)

4. Carmustine (*BCNU*)

5. Volumes of cisplatin (*Platinol*) < 20 ml and concentrations < 0.5mg/ml

6. Cladiribine (*Leustatin*)
7. Cytarabine (*ara-C, Cytosar-U*)
8. Cytarabine, liposomal (DepoCyt)
9. Dacarbazine (DTIC)
10. Daunorubicin, liposomal (*DaunoXome*)
11. Docetaxel (*Taxotere*)
12. Dolasetron (*Anzemet*)
13. Doxorubicin, liposomal (*Doxil*)
14. Etoposide (*VePesid*)
15. Fluorouracil, (*Adrucil*)
16. Gemcitabine (*Gemzar*)
17. Ifosfamide (*Ifex*)
18. Irinotecan (*Camptosar*)
19. Mitoxantrone (*Novantrone*)
20. Paclitaxel (*Taxol*)
21. Pamidronate (*Aredia*)
22. Plicamycin (*Mithracin*)
23. Streptozocin (*Zanosar*)
24. Teniposide (*Vumon*)
25. Thiotepa (*Thioplex*)
26. Topotecan (*Hycamtin*)
27. Valrubicin (*Valstar*)

E. Recognition of extravasation. Extravasation should be suspected in the following instances:

1. The patient complains of burning, stinging, pain, or any acute change at the injection site.

2. Induration or swelling at the injection site is observed.

3. No blood return may be obtained.

F. Management of vesicant extravasations follows:

1. Doxorubicin, daunorubicin, epirubicin, and mitomycin-C (does not include the doxorubicin or daunorubicin liposomal formulations; see irritant section below for the management of these agents).

   a. Stop the infusion immediately.

   b. If possible, withdraw 3 to 5 ml of blood to remove some of the drug.

   c. Remove infusion needle.

   d. Apply dimethyl sulfoxide (DMSO) solution by the following:

   - Using a saturated gauze pad, gently paint 99% DMSO solution onto an area twice the size of the extravasation.
   - Allow to dry.
   - Repeat every 6 hours for 14 days.
   - Do not cover with a dressing: Severe blistering may result.
   - Apply DMSO so soon as possible. However, if signs of an extravasation do not appear until sometime later, still apply DMSO. Even when administered in such a delayed fashion, DMSO appears to be effective.
   - Storage: DMSO should be stocked in 50ml bottles in the pharmacy, in the outpatient pharmacy, and in the pharmacy storeroom. Page the floor pharmacist when product is needed. Write an order in the chart.
   - If the patient is discharged prior to receiving the entire 14-day course of DMSO, instruct the patient in its application. Instruct the patient to report any blistering or excessive irritation and to discontinue use of DMSO until given further instructions. Inform the patient of the distinctive breath odor that can occur with DMSO use and that the odor will disappear when treatment is completed. Remind the patient not to cover the area with a dressing under any circumstances. Before leaving the hospital, the bottle must be labeled by pharmacy for outpatient use.

e. Ice compresses may be applied to the site for 15 minutes every 6 hours for 24 hours.

f. Elevate the extremity for 48 hours. Elevate above the level of the heart using pillows, a sling, or a stockinette dressing with an "observation window" cut in it. Avoid any pressure or friction to the skin that may aggravate the injury.

g. Immediately inform the Oncologist on-call of the extravasation.

h. Delineate the infiltrated area on the patient's skin with a felt tip marker.

i. Document the occurrence of the extravasation in the medical record by noting the location of erythema and induration, the size (diameter) of the erythematous or blanched area, and the presence or absence of pain or blood return. Also note management procedures. Complete an incident report.

j. Observe the wound closely for the next several days for signs of increased erythema, pain, or skin necrosis. If increased pain, erythema, or necrosis occurs, obtain a plastic surgery consult. If the patient is sent home after an extravasation, the physician responsible for the patient's outpatient care will maintain communication with the patient either in person or by telephone until resolution occurs.

k. After 48 hours, encourage the patient to use the extremity normally to promote full recovery of the area.

2. Vincristine, vinblastine, and vinorelbine.

a. Stop the infusion immediately.

b. If possible, withdraw 3 to 5 ml of blood to remove some of the drug.

c. Leave the needle in place if a local antidote will be administered. Administer the local antidote through the needle. If the needle was removed, administer the local antidote subcutaneously around the extravasation area.

d. Administer hyaluronidase (Wydase): Use promptly within the first few minutes to 1 hour after extravasation.

NOTE: Recent drug shortages have made hyaluronidase frequently available. Consult with the floor pharmacist to verify product availability. If not available, proceed with other steps.

- Storage: Hyaluronidase will be stocked on the oncology unit refrigerator, in the outpatient oncology clinic and in the pharmacy.

- Preparation: Reconstitute the 150 unit vial of hyaluronidase with 1 ml of 0.9% Sodium Chloride per package instructions.
- Cleanse the extravasation site with povidone-iodine.
- Administration: Inject hyaluronidase locally by subcutaneous or intradermal route using a 25-gauge needle or smaller. The dose is 150 units given as 0.2-ml injections into the extravasation site at the leading edge, changing the needle after each injection.

e. May apply warm compresses for 15 minutes every 6 hours for 24 hours.

f. Elevate the extremity above the level of the heart using pillows, a sling, or a stockinette dressing with an "observation window" cut in it. Avoid any pressure or friction to the skin that may aggravate injury.

g. Immediately inform the on-call oncologist of the extravasation.

h. Delineate the infiltrated area on the patient's skin with a felt tip marker.

i. Document the occurrence of the extravasation in the medical record by noting the location of erythema and induration, the size (diameter) of the erythematous or blanched area, and the presence or absence of pain or blood return. Also note management procedures. Complete an incident report.

j. Observe the wound closely for the next several days for signs of increased erythema, pain, or skin necrosis. If increased pain, erythema, or necrosis occurs, obtain a plastic surgery consult. If the patient is sent home after an extravasation, the physician responsible for the patient's outpatient care will maintain communication with the patient either in person or by telephone until resolution occurs.

k. After 48 hours, encourage the patient to use the extremity normally to promote full recovery of the area.

3. Cisplatin in volumes of >20 ml and concentrations of $\geq$ 0.5 mg/ml, or mechlorethamine:

a. Stop the infusion immediately.

b. If possible, withdraw 3 to 5 ml of blood to remove some of the drug.

c. Administration of sodium thiosulfate: Use promptly within the first few minutes to 1 hour after extravasation.

- Storage: Sodium thiosulfate will be stocked on the oncology unit in the outpatient oncology clinic, and in the pharmacy.

- Preparation: Administer a 1/6 molar solution. Dilute 4 ml of 10% sodium thiosulfate with 6 ml Sterile Water for Injection to make a 1/6 molar solution. Dilute 1.6 ml of 25% sodium thiosulfate with 8.4 ml of Sterile Water for Injection to make a 1/6 molar solution.
- Cleanse the extravasation site with povidone-iodine.
- Administration of sodium thiosulfate for mechlorethamine: The dose of sodium thiosulfate is based on the amount of mechlorethamine that has extravasated. Administer a dose of 0.5 ml of 1/6 molar solution for every estimated milligram of mechlorethamine extravasated. Administer sodium thiosulfate through the extravasated IV site if possible; it may be injected SC around the site of extravasation.
- Administration of sodium thiosulfate for cisplatin in volumes >20 ml at concentrations of >0.5 mg/ml: The dose of sodium thiosulfate is based on the estimated amount of cisplatin that has extravasated. Inject 2 ml of sodium thiosulfate is based on the estimated milligram of cisplatin extravasated. If possible, administer sodium thiosulfate through the extravasated IV site and inject SC around the site of extravasation.

d. May apply cold compresses for 15 minutes every 6 hours for 24 hours.

e. Elevate the extremity for 48 hours. Elevate above the level of the heart using pillows, a sling, or a stockinette dressing with an "observation window" cut in it. Avoid any pressure or friction to the skin that may aggravate the injury.

f. Immediately inform the on-call oncologist of the extravasation.

g. Delineate the infiltrated area on the patient's skin with a felt tip marker.

h. Document the occurrence of the extravasation in the medical record by noting the location of erythema and induration, the size (diameter) of the erythematous or blanched area, and the presence or absence of pain or blood return. Also note management procedures. Complete an incident report.

i. Observe the wound closely for the next several days for signs of increased erythema, pain, or skin necrosis. If increased pain, erythema, or necrosis occurs, obtain a plastic surgery consult. If the patient is sent home after an extravasation, the physician responsible for the patient's outpatient care will maintain communication with the patient either in person or by telephone until resolution occurs.

j. After 48 hours, encourage the patient to use the extremity normally to promote full recovery of the area.

4. Dactinomycin, idarubicin, mephalan, all other vesicants:

a. Stop the infusion immediately.

b. If possible, withdraw 3 to 5 ml of blood to remove some of the drug.

c. Remove the infusion needle.

d. Elevate the extremity for 48 hours. Elevate above the level of the heart using pillows, a sling, or stockinette dressing with an "observation window" cut in it. Avoid any pressure or friction to the skin that may aggravate the injury.

e. May apply ice compresses to the site for 15 minutes every 6 hours for 24 hours.

f. Immediately inform the on-call oncologist of the extravasation.

g. Delineate the infiltrated area on the patient's skin with a felt tip marker.

h. Document the occurrence of the extravasation in the medical record by noting the location of erythema and induration, the size (diameter) of the erythematous or blanched area, and the presence or absence of pain or blood return. Also note management procedures. Complete an incident report.

i. Observe the wound closely for the next several days for signs of increased erythema, pain, or skin necrosis. If increased pain, erythema, or necrosis occurs, obtain a plastic surgery consult. If the patient is sent home after an extravasation, the physician responsible for the patient's outpatient care will maintain communication with the patient either in person or by telephone until resolution occurs.

j. After 48 hours, encourage the patient to use the extremity normally to promote full recovery of the area.

G. Measures for managing extravasation of irritant chemotherapy:

1. Stop the infusion immediately.

2. If possible, withdraw 3 to 5 ml of blood to remove some of the drug.

3. Delineate the infiltrated area on the patient's skin with a felt tip marker.

4. Elevate the extremity for 48 hours. Elevate above the level of the heart using pillows, a sling, or a stockinette dressing with an "observation window" cut in it. Avoid any pressure or friction to the skin that may aggravate the extravasation.

5. Immediately inform the on-call physician of the extravasation.

6. Document the occurrence of the extravasation in the medical record by noting the location of the erythema, swelling, and induration; the size (diameter) of the erythematous or blanched area; and the presence or absence of pain or blood return. Also note management procedures. Complete an incident report.

7. Observe the wound closely for the next several days for signs of increased erythema, pain, or skin necrosis. If increased pain, erythema, or necrosis occurs, obtain a plastic surgery consult. If the patient is sent home after an extravasation, the physician responsible for the patient's outpatient care will maintain communication with the patient either in person or by telephone until resolution occurs.

8. After 48 hours, encourage the patient to use the extremity normally to promote full recovery of the area.

REFERENCES:

- Polovich, M., Olsen, M., & LeFebvre, K.B. (Eds.). (2019). *Chemotherapy and immunotherapy guidelines and recommendations for practice*. Pittsburgh, PA: Oncology Nursing Society.
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- Kim, Jung Tae, Park, Jeong Yun and Lee, HyunLee. (2020) *Journal of Educational Evaluation for Healthcare Professionals*, Guidelines for the management of extravasation

SUBJECT:	SECTION:
GENDER PREFERENCE FOR EXAM/TREATMENT PROVIDER	**Page 1 of 1**

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

PURPOSE:

To provide health care provider of the same sex for those patients who undergo procedures that require exposure of the genitalia, breast, or any other body parts normally covered by a gown.

SUPPORTIVE DATA:

Direct visualization, palpitation, and insertion of foreign objects into body cavities are necessary tools of the patient care staff in the performance of some exams/treatments.

POLICY:

Exams/treatments that require the insertion of any object (endovaginal/rectal probes, etc.) or direct contact with or observation of the patient's genitalia should be performed by a healthcare provider of the same sex. If this is not possible due to the unavailability of the same sex for any procedure, the following procedure must be followed:

1. There must be an observer (observer must be an employee of Sierra View Medical Center) of the same sex as the patient in the exam room at all time while performing an exam on a patient of the opposite sex whenever the following conditions apply:

    a. Insertion of any foreign object into a body cavity is required.

    b. Direct contact with or observation of the patient's genitalia/breast is required.

    c. The patient requests a technologist of the same sex, but a technologist of the same sex is not available.

2. The observer's name and title must be documented in the patient care record. The time that the observer was in the room must be documented also.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

REFERENCES:

- The United Nations website. https://www.un.org/gender/content/strategy. Accessed November 2023

Fink, Madelinn, Klein, Kendall, Sayers, Kia. Journal Primary Care Community Health (2020). Objective Data Reveals Gender Preferences for Patients' Primary Care Physician

SUBJECT: **IDENTIFICATION OF PATIENT'S REQUESTS AND SAMPLES (BLOOD BANK)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide instructions on how to identify specimens for blood bank laboratory orders.

POLICY:

A. Request Forms: Done in order entry on the hospital computer system.

1. The electronic requisitions requesting blood bank (BBK) studies contain the following information to ensure positive identification of the patient and accurate processing of the blood bank orders in adherence to the Association for the Advancement of Blood & Biotherapies (AABB) Standards and TJC Accreditation Requirements.

NOTE: All patients will be issued an ID wristband, which will include a unique BBK (Blood Bank) number for positive ID.

a. Patient's first and last name

b. Patient's medical record number

c. Patient's account number

d. Patient's date of birth (DOB)

e. Physician of record

f. Patient's location

g. Test(s) required

h. Blood products requested, if any

i. Date/time specimen draw

j. Two initials required on blood tubes labeled at bedside to validate witnessed phlebotomy with correct ID and correct BBK#.

(For Inpatient and Emergency Department (ED), any combination of phlebotomist, nurse, and/or physician initials are acceptable. For Outpatient, phlebotomist and lab clerk initials can be used.)

k. If tests are to be performed on newborns, the medical record number of the mother is also available on the baby's requisition.

l. Additional information, such as clinical diagnosis, ordering physician, medication, date and time blood products are needed for transfusions and the initials of the nursing personnel placing the order, are also required.

m. Incomplete orders will not be accepted by the blood bank for processing. This includes any sample missing a second set of initial's from witness, BBK number of the patient obtained from the wristband and time of collection.

B. Blood Samples:

1. The patient and the blood sample shall be positively identified at the time of collection by comparing the information on the blood bank specimen label with the information on the patient's ID wristband. The technician will verify the patient's name verbally with the patient, family member, or nurse when the patient is unable. In cases such as an ED emergency, a stat admit kit with temporary ID will be used. Blood specimens drawn will be labeled at the bedside with the computer generated or handwritten label containing the following:

a. Patient's first and last name

b. Patient's account number

c. Patient's DOB

d. BBK Number (handwritten by phlebotomist – found on patient's wristband) All specimens drawn for blood bank testing will be obtained and labeled by a certified/licensed lab personnel or licensed personnel in the presence of a second licensed personnel. All personnel involved in obtaining the specimen will each initial the specimen labels and/or additional forms as required, and confirm that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label. The outpatient lab setting may use a lab clerk as the second personnel.

e. Date/time specimen drawn (handwritten by phlebotomist)

f. Initial of phlebotomist (handwritten by phlebotomist)

C. Identifying Information:

1. Before a specimen is used for blood bank test processing, the blood bank CLS shall confirm that all identifying information on the blood bank order is in agreement with that on the blood bank sample tube label.

2. A properly labeled BB specimen is defined as containing the above list of identification points. Any deviation from the above accurate identification will result in specimen rejection and another specimen must be obtained.

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

REFERENCES:

- American Association of Blood Banks (AABB) STDS, 33rd Ed, pgs. 38-39, 5.11.1 - 5.11.3, 2022.
- The Joint Commission (2023). Hospital accreditation standards (DC.01.01.01 and DC.01.03.01). Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
INPATIENTS RECEIVING RADIATION THERAPY SERVICES	**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 transport of inpatients determined to need or continue radiation therapy treatment. Trained personnel appropriate to the acuity/stability of the patient will assure transport in a safe and orderly manner.

PROCEDURE:

Before a patient is brought for treatment, the physician, nursing staff and radiation therapist will determine if the patient should be transferred by wheelchair or gurney. Radiation therapists may transport patients deemed appropriate for wheelchair. Patients requiring gurney transport should be transported to or from the Cancer Treatment Center (CTC) through assistance of a medical transport company in line with the needs of the patient.

Appropriate radiation staff will transport the patient back to his/her room upon completion of treatments.

Following are the basic safety precautions for transport of radiation therapy patients:

1. Schedule in advance with the charge nurse or assigned nurse and discuss the best time and method of transport.
    a. Discuss with the assigned nurse and patient the scheduled procedure and determine if the patient can tolerate the process. Ex. lying flat without breathing difficulties, maintaining position for extended duration.
2. Use two patient identifiers to confirm identity when preparing the patient for transport.
3. Protect patient privacy by ensuring patients are covered while being transported.
4. If a patient has an IV, use extra caution not to disturb the IV site. Should problems arise, call the nurse assigned to the patient immediately.
5. IV pumps should be disconnect prior to patient transport. Inform the nurse assigned to the patient and plan around scheduled treatments when possible.
6. Assess and provide for specialty equipment prior to transport.
7. Observe safety procedures at all times when transporting patients. Patients will not be left unattended/unobserved at any time.
8. All patients scheduled for transport to a procedure and requiring Fi02 50% (6-7L) or greater will be evaluated by both the patient's registered nurse (RN) and respiratory therapist (RT). They will collegially determine that the patient is safe for transport and if the RT should be in attendance during transport. Minimally, the following will be evaluated together:
    a. Stable vital signs
    b. Type of delivery device

c. Initial flow rate
d. Adequate oxygen source and supply for transport

AFFECTED AREAS/PERSONNEL: *RADIATION THERAPY STAFF*

REFERENCE:

- California Code of Regulations (2020). Title 22. §70215(a)(2). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCE:

- Intrafacility Patient TransportHand-Off Communication – Patient Care Services Policy & Procedure Manual
- Fall Prevention, Adult & Pediatric – Patient Care Services Policy & Procedure Manual

SUBJECT: **INTRA-AORTIC BALLOON PUMP THERAPY**	SECTION: ***Patient Care Services*** **Page 1 of 4**

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

PURPOSE:

To provide safety guidelines for staff caring for patient with a requiring counter pulsation by Intra-Aortic Balloon Pump (IABP).

DEFINITIONS:

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

Critical Care Registered Nurse define in this policy: A registered nurse competent in intensive care management with specific competency in IABP management. These RN's include the ICU and Cardiovascular Cath Lab.

POLICY:

A. Only IABP patients with catheter placed for augmentation will be consider for admission to ICU patients. Patients with high potential for cardiac surgery needs should not be admitted but transferred to higher level of care.

Indications but not limited to the following:

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

Contraindications but not limited to the following:

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

B. The patient with an IABP will be cared for by a critical nurse as defined by this policy. The patient will be considered high acuity and received 1:1 nurse to patient ratio as needed by a nurse who has IABP competency.

C. Revalidation of IABP knowledge and skills will be done annually.

D. IABP will be inserted in the cardiac cath-lab and stabilized for transport before transfer to the ICU.

E. Cardiovascular Cath Lab leadership will attempt to put a cath lab team on call for emergent issues requiring the patient to return to the Cardiovascular Cath Lab for further intervention. This team will need to be on call until the catheter is removed. If an on call team is not available, must consider transferring patient to another facility for higher level of care. *Note: If the patient cannot*

be transferred, leadership will be made aware. The Cardiovascular Cath Lab leadership and Critical Care Services leadership will work together to construct a safe plan for the patient's needs.

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

EQUIPMENT:

- IABP, helium gas supply.
- ECG and arterial pressure monitoring supplies.
- Single-Pressure transducer system.
- Emergency equipment available for immediate use.

PROCEDURE:

A. Before transfer to ICU: Counter pulsation should began immediately after insertion and verification by X- ray in the procedure room

B. Review manufacture manual for IABP equipment use which is kept attached to the IABP machine.

C. Keep limb straight to not kink tubing, use log roll technique to maintain straight limb

D. Head of bed should be kept 30-45 degrees to avoid aspiration and prevent upward migration of catheter

E. Perform a baseline physical assessment this should include all items that are included in the maintenance monitoring section of this policy:

F. **Maintenance Monitoring**

a. Assessment of circulation, including capillary refill on pedal and left radial pulses. This should be done every 15 minutes for the first hour then hourly. *(The IABP or thrombus can obstruct flow to distal extremities; if the catheter migrates to high, it can obstruct flow to the left subclavian artery.)*

b. Monitor blood pressure and MAP during counter pulsation every hour and every 15 minutes during vasoactive drip titration

c. Presence of dorsalis pedialis posterior tibial pulses (these can be marked with indelible ink to facilitate checks) Distal pulses should be checked every 15-30 minutes for the first 6 hours then hourly with VS to monitor for limb ischemia.

d. Monitor Vital Signs (VS) every 15-30 minutes for the first 6 hours then hourly until catheter is removed.

e. Arterial balloon pressure and cardiac output index every hour (can use NICOM for continuous value recording)

f. Neurological checks every hour

g. Urine output every hour

h. Insertion site and dressing evaluation, every hour for 8 hours then every 4 hours monitoring for oozing and hematoma. *(if abnormal finding contact provider immediately)*

i. Palpate extremity with regular physical assessment to monitor for swelling and tension every 4 hours

j. Auscultate bowel sounds every 4 hours with regular physical assessment to detect evidence ischemia Ankle brachial index (ABI) every 4 hours

k. ECG and IABP waveform every 4 hours and prn, print and place strip in the patient chart

l. Observe skin temperature color, sensation, and movement of extremity *(notify provider if dusky, cool, mottled, painful, numb or tingling)*

m. Strict and accurate intake and output daily

n. Monitor weight daily

G. **Ankle Brachial Index (ABI):**

a. Obtain a brachial systolic pressure
b. Record the highest pressure as the "B" brachial pressure
c. Place the blood pressure cuff on the ankle same side at the IABP catheter
d. Using a Doppler find the posterior tibial artery or dorsalis pedis, inflate cuff and listen for the first sound record this as "A" systolic ankle pressure
e. Then divide the "A" ankle by "B" brachial
Example: ankle systolic pressure= 110
Brachial systolic pressure =140
110 divided by 140= .78= 78% flow

(Normal ABI is 097-100%) nursing should contact physician if ABI is below 60% or if patient has signs of vascular compromise

f. **Interpreting Result:** greater than 1.3 results may not be reliable because of calcified vessels such as someone with diabetes, this will show falsely elevated pressures.
1.01 to 1.3: correlate with history
0.97 to 1 normal
0.8 to 0.96 mild ischemia
0.4 to .079 moderate to severe ischemia
0.39 or less severe ischemia in danger of limb loss

H. **Trouble Shooting:**

a. **Suspected Balloon Pump leak:**

*Observe for loss of augmentation or lack of normal pressure waveform (gas could be gradually leaking from the balloon)
*Check for blood in the catheter or connecting tubing.
* Notify physician, you may need to stop counter pulsation. Prepare for removal of IABP

b. **Actual Balloon perforation (blood in catheter)**
*place IABP on standby
*Clamp catheter
*Disconnect the catheter from the IABP console
*Notify physician and prepare for removal/replacement

c. **ALARMS:**
* Refer to Operators Manuel

REFERENCES:

- Maquet Getinge Group. (2018, December). Mechanisms of Counterpulsation Clinical Support Manual. Wayne, New Jersey, United States of America: Datascop Corp.
- Nettina, S. M. (2019). Lippincott Manual of Nursing Practice 11th edition. Philadelphia: Wolters Kluwer.
- Weigand, D.L. (2017). AACN Procedure Manual for High Acuity, Progressive, and Critical Care 7th edition. St. Louis: Elsevier.

CROSS REFERENCES:
Intra-Aortic Balloon Pump (IABP) Management

PURPOSE:

- To define the key components of laser safety and practice within surgery.
- To provide a safe environment for patients and staff when a surgical laser is in use.

POLICY:

Only physicians with laser privileges are permitted to perform laser surgery. All cases requiring a laser will have a Laser Operator solely dedicated to operating the laser and who has completed all competency requirements for the position.

AFFECTED PERSONNEL/AREAS: *SURGICAL SERVICES STAFF/OPERATING ROOM*

PROCEDURE:

KEY PERSONNEL AND DUTIES:

The Laser Safety Officer:

1. Enforces laser safety rules and regulations.
2. Ensures laser safety education for all intraoperative staff and additional competency completion for all Laser Operators.
3. Reviews policy and procedures as needed.
4. Ensures completion of periodic preventative maintenance.

The Laser Operator

1. Will complete laser specific education and successfully perform 3 demonstrations for initial competency.
2. Will not function concurrently as a scrub or circulator.
3. Will determine Nominal Hazard Zone (NHZ) for each procedure and ensure safety measures are carried out at all times.
4. Will not leave the Laser Treatment Control Area (LTCA) while the laser is in use unless relieved by another Laser Operator. If the Laser Operator leaves the LTCA, the laser will be turned off and/or the Laser Operator will take the key to the laser.
5. Is responsible for completing all laser documentation (in communication with the Circulating Nurse).

6. Is responsible for reporting laser issues to appropriate departments (i.e., the contracted laser service provider for machine problems, Materials Management for supplies).

SAFETY MEASURES:

1. The keys for the lasers will be kept in the locked blue laser cart and only Laser Operators will have access to the key.

2. A preoperative equipment check and laser testing per manufacturer's guidelines must be performed before the first laser procedure of the day and any time the laser unit is shut down and moved.

3. The operator's manual will be kept in the laser cart and available to all Laser Operators.

4. A wavelength-specific laser danger warning sign must be posted on all entrances to the operating room, indicating a specific laser is in use. These danger signs must display the required International Label. A pair of eyewear (of the optical density [O.D.] to match the wavelength of the laser in use) is to be affixed to the doors of the operating room in which the laser is being used to protect staff that may need to enter the room while the laser is in use.

5. A smoke evacuator or suction with in-line filter must be used **during free hand $C0_2$ laser procedures, i.e. genital warts or condyloma excision, in order** to minimize plume inhalation. It shall be the primary method of control of Laser Generated Airborne Contaminants (LGAC).

6. The laser beam will not be directed toward any person in the room, even while in the "stand-by" mode.

7. No water or solutions will be placed on the laser unit.

8. A fire extinguisher must be immediately available to the procedure room.

9. All persons within the NHZ must wear eyewear specific to the O.D. of the laser wavelength being used unless the NHZ is determined to be entirely within the patient i.e., ureteroscopy procedures. The patient is always assumed to be within the NHZ, therefore, moistened eye pads secured with tape should be used for patients under general anesthesia.

10. Flammable gases, such as oxygen and nitrous oxide, should be avoided or used at their lowest possible concentration without compromising the patient's respiratory status while in close proximity to the operative site (e.g. larynx). Anesthetic gas mixture will be determined by the anesthesia provider based on patient condition.

11. For procedures of the perineum or peri-rectal area, the rectum should be covered with a wet towel or lightly packed with a wet gauze pack.

12. Non-reflective (anodized or ebonized) instruments should be used when contact with the operative site and possible contact of the laser beam and the instrument is likely.

13. Laser-safety endotracheal tubes should be used, when applicable.

14. Saline or water-saturated towels/gauzes should be used around laser operative site, when applicable.

15. Non-flammable prepping solutions should be used for skin prep.

16. Avoid pooling of prep solution.

17. Allow prep area to dry before draping.

18. The laser must be maintained in the standby position when not in use.

19. The foot pedal must be placed so that only the operating physician has direct access to it. All other foot pedals should be placed in such a manner as to prevent confusion as to which piece of equipment is currently in use.

20. When appropriate, high-filtration masks shall be made available to all staff in the LTCA to minimize plume inhalation, however, smoke evacuation is to be considered the first line of defense against LGAC.

21. Communication between all members of the surgical team is of paramount importance to prevent laser accidents in the operating room.

PREOPERATIVE:

1. Obtain appropriate laser unit and associated items (i.e., laser console, key, fibers).

2. Verify laser usage, fiber and patient position with the physician.

3. Check smoke evacuator for clean filter and operation status, if applicable.

4. Position and plug in equipment.

5. Check and test the laser before the patient is brought into the room.

6. Ensure all laser supplies are available and in proper working order and when appropriate, sterile, before patient is brought into the room.

7. Check for presence of fire extinguisher immediately available to the procedure room.

8. Check that basin of water is immediately available in the room.

9. Post signs and a pair of O.D. appropriate laser eyewear on doors.

10. Check consent for laser usage.

INTRAOPERATIVE

1. Ensure that LTCA doors are closed. The entire room is considered the LTCA and is potentially exposed to the laser beam. The Laser Operator determines the NHZ within the LTCA.
2. Ensure that all personnel in the NHZ are wearing O.D. specific laser eye protection.
3. Ensure that the patient has moistened eye pads secured with tape and/or laser specific glasses covering patient's eyes.
4. Ensure all personnel in the room have high filtration masks available, if indicated.
5. Position foot pedal as requested for the surgeon, and encase foot pedal in fluid-resistant cover.
6. Laser is to remain on "standby" mode when not being activated by physician. An announcement will be made that the laser is in either "ready" or "standby".
7. Select mode, watts, and/or joules, as requested by the physician.
8. The Laser Operator cannot leave the LTCA when the laser unit is on.
9. Maintain communication with physician while operating the laser. The Laser Operator must announce that the laser is in operation as well as the current laser settings.
10. Smoke evacuation apparatus is located within 1-2 cm of laser vaporization site. Smoke evacuation filters will be changed after 90 minutes of use, or as appropriate. Minutes of evacuator usage is to be noted on the side of the smoke evacuator canister.
11. Control traffic in the LTCA to minimize exposure.
12. Request anyone who does not follow laser safety measures to leave the LTCA immediately.
13. Where there are any improper techniques of laser operation, the Laser Operator shall shut down the laser and remove the key.
14. All incidents or hazardous use of the laser shall be immediately reported to the OR Clinical Manager or Director of Surgical Services.

POSTOPERATIVE:

1. Turn off the laser machine and/or remove the key.
2. Move laser away from the operative field.
3. Wipe the laser clean, including attachments and cords per manufacturer's guidelines. Clean the CO_2 Micro-manipulator and F-125 laser lens with a cotton-tipped applicator and/or appropriate

lens wipe. Only 98% dehydrated alcohol acquired from Pharmacy and kept in blue laser cart is to be used for this purpose.

4. Return all items to proper storage area.

5. Discard smoke evacuator hose in biohazard trash, if used. The smoke evacuator canister or in-line filter should also be discarded in the biohazard trash when the time comes.

DOCUMENTATION OF INTRAOPERATIVE CARE:

The following information is to be documented in both the patient record and on the laser log, which is maintained in the OR Department).

- Length of time laser is used; Times: start, stop, and total time laser used;
- Laser settings and mode of delivery;
- Patient protective precautions; Safety measures taken;
- Complications, if any;
- Patient name and ID number;
- Surgeon;
- Procedure and date;
- Power density used;
- Laser Safety Officer

CARE AND MAINTENANCE OF LASER EQUIPMENT:

1. General maintenance and preventative maintenance (PM) is provided by the contracted maintenance service provider as per each laser unit's manufacturers' recommendation(s) and maintenance schedule.

2. Laser equipment is safety inspected prior to its use in the facility and annually by the biomedical engineer, or contracted service provider. In the event that a problem should be encountered, the contracted service provider shall be notified.

3. Surgical Services personnel shall:

   a. Clean the cabinet with a damp cloth; DO NOT USE SPRAYS.

b. Keep the unit covered when not in use.

c. Avoid using the laser cabinet as a tabletop.

d. Clean CO_2 laser lenses with 98% dehydrated alcohol.

e. Not lean on the unit.

f. Not move or grasp the laser unit by its articulating arm.

g. Clean filters and grates after each use, keeping them dust free.

h. Check all cords, plugs, and receptacles for integrity prior to and after each use. If any damage is noticed, the unit shall not be used until safety inspected.

i. Use caution when moving the unit from point of use to storage, avoiding raised thresholds as much as possible. Storage area must provide proper temperature and humidity. Care shall be taken to store the laser where it will not be accidentally bumped.

EMERGENCY PROCEDURE:

If an emergency occurs while the laser is in use, the laser must be shut down immediately. If a fire with the patient occurs, it will be extinguished immediately with the water or saline from the operative field. The patient will then be treated according to established medical practice.

Should a fire of the laser equipment occur, the "panic" button on the laser unit will be struck (if possible) or the power supply at the wall will be disengaged to shut off power to the laser unit.

NOTE: *The fire extinguisher from outside the procedure room will be used to extinguish flames only of the laser unit, not of the patient.*

REFERENCES:

- Rothrock, J. C. (2017). Alexander's Care of the Patient in Surgery. 16th ed. Elsevier. P. 234-242.
- AORN Perioperative Standards and Recommended Practices, 2020 Edition, P. 101-107.
- AORN Perioperative Standards and Recommended Practices, 2020 Edition; Laser Safety in Practice Settings.
- ANSI Z136.3. Laser Safety Standards, 2018 Edition; Safe Use of Lasers in Health Care Facilities.

SUBJECT: **LEGAL MEDICAL RECORD STANDARDS**	SECTION:

PURPOSE:

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record. Patient medical information is contained within multiple electronic records systems, in combination with financial and other types of data. This policy defines requirements for those components of information that comprise a patient's complete "*Legal Medical Record.*"

DEFINITIONS:

Medical Record: The collection of information concerning a patient and his or her healthcare that is created and maintained in the regular course of Sierra View Medical Center (SVMC), in accordance with hospital policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

- The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.

- The medical record excludes health records that are not official business records of SVMC as personal health records managed by the patient.

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. The information may be from any source and in any format, including, but not limited to, print medium, audio/visual recording, and/or electronic display.

The Medical Record may also be known as the "*Legal Medical Record*" or *"LMR*" in that it serves as the documentation of the healthcare services provided to a patient by a SVMC service area, physician or provider and can be certified by the SVMC Record Custodian(s).

The Legal Medical Record is a subset of the *Designated Record Set* and is the record that will be released for legal proceedings or in response to a request to release patient medical records. The Legal Medical Record can be certified by SVMC in a court of law.

Designated Record Set ("DRS"): A group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity for each individual that receives care from a covered individual or institution. The DRS includes:

1. The medical records and billing records about individuals maintained by or for a covered health care provider (can be in a business associate's records).

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

3. The information is used, in part or in whole, to make decisions about individuals.

Any research activities that create PHI should be maintained as a part of the DRS and are accessible to research participants unless there is a HIPAA Privacy Rule permitted exception.

Protected Health Information ("PHI"): PHI is individually identifiable health information that is transmitted or maintained in any medium, including oral statements.

Authentication: The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a recorded entry or document.

Clinic Record / Shadow File: A folder containing COPIES ONLY of information from the medical record used primarily by clinicians in their office or clinic setting. These COPIES of the relevant documents from the original medical record are NOT part of the legal medical record.

Macros: Macros allow a provider to record and replay a series of typed characters or other keystrokes (e.g., hot keys, one or more keys at the same time, or one-word commands) in a manner that makes it possible for a physician or a provider to quickly document an entire medical note while avoiding the cost of transcription and/or the time of repetitive documentation.

POLICY:

I. Maintenance of the Medical Record

A. A Medical Record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient of SVMC.

B. Currently, the Medical Record is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the Medical Record may physically exist in separate and multiple locations in both paper-based and electronic formats. (See Appendix A).

C. The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient-identifiable source information, such as photographs, films, digital images, and fetal monitor strips and/or a written or dictated summary or interpretation of findings.

D. The current electronic components of the Medical Record consist of patient information from multiple Electronic Health Record source systems. The intent of SVMC is to integrate all electronic documents into a permanent electronic repository.

E. Original Medical Record documentation must be sent to the designated Medical Records department or area. Whenever possible, the paper chart shall contain original reports.

Shadow files maintained by some clinics or care sites contain copies of selected material, the originals of which are filed in the patient's permanent Medical Record.

PROCEDURE:

II. Confidentiality

The Medical Record is confidential and is protected from unauthorized disclosure by law. The circumstances under which SVMC may use and disclose confidential medical record information are set forth in the Notice of Privacy Practices and in other SVMC Privacy Policies and Procedures.

III. Content

A. Medical Record content shall meet all state and federal legal, regulatory and accreditation requirements including, but not limited to, Title 22 California Code of Regulations, sections 70749, 70527 and 71549, and the Medicare Conditions of Participation 42 CFR Section 482.24. Appendix A contains a listing of required Medical Record documentation content, and current electronic or paper format status.

B. Additionally, all hospital records and hospital-based clinic records must comply with the applicable hospital's Medical Staff Rules and Regulations requirements for content and timely completion.

C. All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name, SVMC Unit number, and SVMC account number. Each page of double-sided or multi-page forms must be marked with both the patient's full name, SVMC Unit number and SVMC account number, since single pages may be photocopied, faxed or imaged and separated from the whole.

D. All Medical Record entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in the Medical Record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

IV. Medical Record vs. Designated Record Set

A. Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health (medical record) information that is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual. In accordance with the HIPAA Privacy Rule, SVMC has defined a "designated record set" to mean the group of records maintained for each individual who receives healthcare services delivered by a healthcare provider, which is comprised of the following elements:

- The Medical Record, whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips when a written or dictated summary or interpretation of finding has not been prepared.
- Billing records, including claim information; and
- All physician or other provider notes, written or dictated, in which medical decision-making is documented, and which are not otherwise included in the Legal Medical Record (e.g., outside records, email, when applicable for treatment).

B. The Medical Record generally excludes records from non-SVMC providers (i.e., health information that was not documented during the normal course of business at SVMC or by a SVMC provider). However, if information from another provider or healthcare facility, or personal health record, is used in providing patient care or making medical decisions, it may be considered part of the SVMC Designated Record Set and may be subject to disclosure on specific request or under subpoena. Disclosures from medical records in response to subpoenas will be made in accordance with applicable Campus policies.

V. Who May Document Entries in the Medical Record

Only the following types of SVMC employees and/or employees of SVMC-contracted clinical and social services providers may document entries in the Medical Record:

1. Child Life Specialists
2. Clinical Social Workers/Social Service Providers
3. Dentists
4. Dietitians/Diet Technicians
5. Emergency Trauma Technicians
6. Fellows
7. Home Health Coordinators
8. Clinical Care Partners
9. Hyperbaric Technicians/Observers
10. Interns
11. Interpreters (Employees of SVMC)
12. Lactation Specialists
13. Licensed Vocational Nurses
14. Medical Assistants
15. Medical Ethicists
16. Nurse Practitioners
17. Nurses employed by physicians (exceptions)
18. Occupational Therapists
19. Osteopathic Students
20. Pastoral Care Providers
21. Pharmacists

22. Physical Therapists
23. Physician Assistants
24. Physicians, including MD's and DO's
25. Podiatrists
26. Psychologists
27. Registered Nurses
28. Mental Health Practitioners
29. Licensed Psychiatric Technicians
30. Midwives
31. Residents
32. Respiratory Therapists
33. Clinical/Ancillary Faculty
34. Speech Pathologists
35. Students, e.g., MD, RN, Occupational Therapy, etc. (Notations in the record must be co-signed by a supervising clinician)
36. Students, e.g., MD, RN
37. Certified Nurse Assistants (CNA)
38. Others as designated by Medical Center Policies and /or Medical Staff Bylaws

VI. Completion, Timeliness and Authentication of Medical Records

A. All relevant documents and entries should be entered into the medical record at the time the service is rendered. Delayed entries should be entered within a reasonable timeframe (24-48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain circumstances prevented the generation of the note at the time of service.

B. All inpatient Medical Records must be completed within 14 days from the date of discharge (California Code of Regulations, Title 22, section 70751). Additional requirements may also be included in the applicable SVMC hospital Medical Staff By-Laws and/or Rules and Regulations.

C. All operative and procedure reports must be completed immediately after surgery.

D. All Medical Record entries are to be dated, the time entered, and signed.

E. Certain electronic methods of authenticating the Medical Record, including methods such as passwords, access codes, or key cards, may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with SVMC electronic signature standards (See Section XII below: Authentication of Entries). The entries may be authenticated by a computer key, in lieu of a medical staff member's signature, only when that medical staff member has placed a signed statement with the Medical Staff Office to the effect that the member is the only person who will use the key (or sequence of keys). The use of signature stamps is not allowed within the medical record.

F. Fax signatures are acceptable.

VII. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations ("TPO")

The Health Information Management Services staff will process routine requests for Medical Records. All charts physically removed from the Medical Record storage areas will be logged, e.g., using a computerized tracking system.

Only authorized SVMC workforce members may access Medical Records. SVMC Workforce members who access Medical Records for payment or healthcare operations are responsible to access only the amount of information in medical records which is necessary to complete job responsibilities.

A. Access to Medical Records for Treatment Purposes.

B. Healthcare providers who are directly involved in the care of the patient may access the full Medical Record.

C. Payment Purposes.

D. Authorized and designated SVMC workforce members may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

1. Coding and abstracting.

2. Billing, including claims preparation, claims adjudication and substantiation of services.

3. Utilization Review; and

4. Third Party Payer Reviews (including Quality Improvement Organization reviews).

E. Healthcare Operations. Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:

1. Peer Review Committee activities.

2. Quality Management reviews, including outcome and safety reviews.

3. Documentation reviews; and

4. Teaching.

F. Requests for Electronic Components of the Medical Record.
Personnel who access the electronic Medical Record are required to have a unique User ID and password, and access to information is limited according to the minimum necessary rule and managed by role, as approved by designated management personnel.

VIII. Ownership, Responsibility and Security of Medical Records

A. All Medical Records of SVMC patients, regardless of whether they are created at, or received by, SVMC, and patient lists and billing information, are the property of SVMC. The information contained within the Medical Record must be accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative.

B. Responsibility for the Medical Record. The SVMC Director of Health Information Management (Medical Records) is designated as the person responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other health care professionals are responsible for the documentation in the medical record within required and appropriate time frames to support patient care.

C. **Original records may not be removed from SVMC facilities and/or offices except by court order, subpoena, or as otherwise required by law.** If an employed physician or provider separates from or is terminated by the hospital for any reason, he or she may not remove any original Medical Records, patient lists, and/or billing information from SVMC facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to SVMC.

D. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate. Records will be released from Health Information Management only in accordance with the provisions of this policy and other SVMC Privacy Policies and Procedures.

E. Special care must be exercised with Medical Records protected by the state and federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing and AIDS research.

F. Chronology is essential and close attention shall be given to assure that documents are filed properly, and that information is entered in the correct encounter record for the correct patient, including appropriate scanning and indexing of imaged documents.

IX. Retention and Destruction of Medical Records

All Medical Records are retained for at least as long as required by state and federal law and regulations, and SVMC policies and procedures. The electronic version of the record must be maintained per the legal retention requirements as specified in our consult with Legal Counsel.

X. Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the Record Management policy.

Handwritten entries should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

XI. Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of Medical Records must not otherwise be edited, altered, or removed. Patients may request a medical record amendment and/or a medical record addendum.

A. Documents created in a paper format:

1. Do not place labels over the entries for correction of information.

2. If information in a paper record must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and signature of the person making the revision.

3. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above in (2), and rescanning the document.

B. Documents that are created electronically must be corrected by one of the following mechanisms:

1. Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.

2. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong work type, wrong date, wrong

attending assigned). If the preliminary document is visible to providers other than the author, then this document needs to be part of the legal health record.

3. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, location, duplicate documents, incomplete documents, or other errors. The amended version must be reviewed and signed by the provider.

4. Sometimes it may be necessary to re-create a document (e.g., wrong work type) or to move a document, for example, if it was originally posted incorrectly or indexed to the incorrect patient record.

C. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

1. Identify the new entry as a "late entry."

2. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.

3. Identify or refer to the date and circumstance for which the late entry or addendum is written.

4. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapses, the less reliable the entry becomes.

D. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.

1. Document the date and time on which the addendum was made.

2. Write "addendum" and state the reason for creating the addendum, referring to the original entry.

3. When writing an addendum, complete it as soon as possible after the original note.

E. Errors in Scanning Documents

If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:

1. Reprint the scanned document.

2. Rescan the document to the correct date or patient and void the incorrectly scanned document in the permanent document repository.

F. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.

1. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.

2. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.

3. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

G. Copy and Paste Guidelines

The "copy and paste" functionality available for records maintained electronically eliminates duplication of effort and saves time but must be used carefully to ensure accurate documentation and must be kept to a minimum.

1. Copying from another clinician's entry: If a clinician copies all or part of an entry made by another clinician, the clinician making the entry is responsible for assuring the accuracy of the copied information.

2. Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical provider is responsible for ensuring the copied data is relevant and accurate.

3. Copying for re-use of data: A clinician may copy and paste entries made in a patient's record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.

XII. Authentication of Entries

A. Electronic signatures must meet standards for:

1. Data integrity to protect data from accidental or unauthorized change (for example "locking" of the entry so that once signed, no further untracked changes can be made to the entry).

2. Authentication to validate the correctness of the information and confirm the identity of the signer (for example, requiring signer to authenticate with password or other mechanism).

3. Non-repudiation to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).

At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed. *

B. Electronic signatures must be affixed only by that individual whose name is being affixed to the document and no other individual.

C. Countersignatures or dual signatures must meet the same requirements and are used as required by State law and Medical Staff Rules and Regulations.

D. Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.

E. Rubber stamp signatures: *Refer to Section VI (D).*

F. Documents with multiple sections or completed by multiple individuals should include a signature area on the document for all applicable staff to sign and date. Staff who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.

G. No individual shall share electronic signature keys with any other individual.

H. *Macros & Checklists*. Pre-printed forms, checklists, patient questionnaires, and word-processing macros can be used to supplement written or dictated notes. When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation, if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized, patient-specific information that is sufficient to support a medical necessity determination. The note in the record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros which do not contain patient-specific information. Medical record macros and checklists may be used to supplement provider written or dictated notes.

XIII. Designation of Secondary Patient Information

The following three categories of data contain secondary patient information and must be afforded the same level of confidentiality as the LMR but are not considered part of the legal medical record.

A. Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. They often are maintained at the department level in a separate location or database and are retrievable only upon request. Examples:

1. Photographs for identification purposes
2. Audio recordings of dictation notes or patient phone calls.
3. Video recordings of an office visit, if taken for other than patient care purposes

** Acknowledge that there may be older systems that do not have this capability. There are future plans for all systems to meet this minimum requirement.*

4. Video recordings/pictures of a procedure, if taken for other than patient care purposes
5. Video recordings of a telemedicine consultation
6. Communication tools (i.e., Kardex, patient lists, work lists, administrative in-baskets messaging, sign out reports, FYI, drafts of notes, or summary reports prepared by clinicians, etc.)
7. Protocols/clinical pathways, best practice alerts, and other knowledge sources.
8. A patient's personal health record is provided by the patient to his or her care provider.
9. Alerts, reminders, pop-ups and similar tools are used as aids in the clinical decision making process. The tools themselves are not considered part of the legal medical record. However, the associated documentation of subsequent actions taken by the provider, including the condition acted upon and the associated notes detailing the exam, are considered a component of the legal medical record. Similarly, any annotations, notes and results created by the provider as a result of the alert, reminder or pop-up are also considered part of the legal medical record.

Some source data are not maintained once the data has been converted to text. Certain communication tools are part of workflow and are not maintained after patient's discharge.

B. Administrative Data is patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include, but are not limited to:

1. Authorization forms for release of information
2. Correspondence concerning requests for records.

3. Birth and death certificates.

4. Event history/audit trails.

5. Patient-identifiable abstracts in coding system.

6. Patient identifiable data reviewed for quality assurance or utilization management.

7. Administrative reports.

C. Derived Data consists of information aggregated or summarized from patient records so that there is no means to identify patients. Examples:

1. Accreditation reports

2. Best practice guidelines created from aggregate patient data.

3. ORYX reports, public health records and statistical reports.

4. Draft Documents / Work in Progress. Electronic processes and workflow management require methods to manage work in progress. These work-in-progress documents often are available in the system as "draft documents, viewable to a limited number of users. They generally are not viewable to clinicians until the document is sent for final signature. Draft documents are not considered an official medical record document until it has been signed by an authorized signer.

XIV. ENFORCEMENT, CORRECTIVE & DISCIPLINARY ACTIONS

Compliance with the above policy is monitored by SVMC Department of Health Information Management (HIM). Violations of any of the above policy will be reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with SVMC Medical Staff By Laws, and Human Resource / Personnel Policies.

CROSS-RELATED POLICIES

- Designated Record Set Policy
- Notice of Privacy Practices Policy
- Patient's Right to Amend
- Authorization for Uses and Disclosures of Protected Health Information (PHI)
- Verbal & Telephone Orders – Persons Permitted to Accept, Read Back, and Authentication of
- Documentation and the Use of Abbreviations, Acronyms and Symbols
- Medical Record Retention and Destruction: Disposal of Protected Health Information

- Medical Record- Unacceptable Abbreviations & Symbols
- Ownership of Medical Records
- Patient Access to Medical Records
- Records Management
- Release of Patient Information
- Signature, Initials or Computer Key Identification

REFERENCES:

- Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164 (2013). https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/administrative/combined/hipaa-simplification-201303.pdf.

- California Medical Information Act, California Civil Code Section 56 et seq. (1988). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=56.10.&lawCode=CIV.

- Medicare Conditions of Participation, 42 CFR Section 482.24 (2020). https://www.law.cornell.edu/cfr/text/42/482.24.

- Title 22 California Code of Regulations, Sections 70749, 70527, and 71549 (2020). https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Business Records Exception, Federal Evidence 803(6) (2014). https://www.law.cornell.edu/rules/fre/rule_803.

- California Code of Regulations, Title 22, Section 70751 (2020). https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- California Hospital Association Consent Manual – Authentication sections (2019). https://www.sierra-view.com/documents/consent2019_enterprisenew.pdf

- The Joint Commission. (2023). Hospital accreditation standards. 01.03.01. Joint Commission Resources. Oak Book, IL.

Appendix A
Documentation Contents of the Medical Record

The medical record shall include, at a minimum, the following items (if applicable):

A. Identification information, which include, but are not limited to, the following:

1. Name
2. Address on admission
3. Identification number (if applicable)
   - Medicare Number
   - Medi-Cal
   - Hospital Number
   - Social Security Number
4. Age
5. Sex
6. Marital status
7. Legal status
8. Mother's Maiden name
   - Patient's Mother's maiden name
   - Place of Birth
9. Legal Authorization for admission (if applicable)
10. School Grade, if applicable
11. Religious Preference.
12. Date and time of admission (or arrival for outpatients).
13. Date and time of discharge (departure for outpatients).
14. Name, address and telephone number of person or agency responsible for patient.
15. Name of patient's admitting/attending physician.
16. Initial diagnostic impression.
17. Discharge or final diagnosis and disposition.
18. Allergy records.
19. Advance Directives (if applicable).
20. Medical History including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients, a neonatal history.
21. Physical examination.
22. Consultation reports.
23. Orders, including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services.
24. Progress notes, including current or working diagnosis (excluding psychotherapy notes).
25. Nurses' notes, which shall include, but not be limited to, the following:
    - Nursing assessment including nutritional, psychosocial and functional assessments.
    - Concise and accurate record of nursing care administered.

- Record of pertinent observations, including psychosocial and physical manifestations and relevant nursing interpretation of such observations.
- Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
- Record of type of restraint and time of application and removal.
- Record of seclusion and time of application and removal. (NPH)

26. Graphic and vital sign sheet.
27. Results of all laboratory tests performed.
28. Results of all X-ray examinations performed.
29. Consent forms for care, treatment and research, when applicable.
30. Problem List (outpatient records only).
31. Emergency Department record.
32. Anesthesia record, including preoperative diagnosis, if anesthesia has been administered.
33. Operative and procedures report, including preoperative and postoperative diagnosis, description of findings, technique used, and tissue removed or altered, if surgery was performed.
34. Pathology report, if tissue or body fluid was removed.
35. Written record of preoperative and postoperative instructions.
36. Labor record, if applicable.
37. Delivery record, if applicable.
38. Physical, occupational and/or respiratory therapy assessments and treatment records, when applicable.
39. Patient/Family Education Plan (NPH Only)
40. Clinical Data Set from other providers.
41. Master Data Sets (as applicable to record type) including but not limited to: MDS (Skilled Nursing).
42. Patient photographs when used for identification or treatment.
43. Master Treatment Plan and Reassessment (NPH only).
44. Discharge Instructions
45. A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on discharge and the recommendations and arrangements for future care. If applicable, it shall include diet and self-care instructions.
46. Copies of letters to patients.
47. Email communications between the patients and the provider regarding the care and treatment of the patient.
48. Telephone Encounters. Documentation is required for telephone encounters with patients and/or their caregivers, or other care providers that:
    - Provide new or renewal of prescription for medications
    - Alter the current plan of care, including treatments and medications
    - Identify a new system or problem and provide a plan of care
    - Provide home care advice for symptom/problem management
    - Provide authorization for care
    - Provides or reinforces patient education

Documentation should include the date and time of call, name of caller and relationship to patient (if different from patient), date and time of the response (or attempts to return call), the response given, and the signature and professional title of provider or clinic staff handling the call

49. Primary Language

SUBJECT:	SECTION:
LOANER INSTRUMENT STERILIZATION PROCESS	***Surveillance, Prevention, Control of Infection (IC)***

PURPOSE:

To provide guidelines to assure that loaner instrumentation are sterile and in good working order before being used on surgical patients.

DEFINITIONS:

Vendor loaner instrumentation is defined as any instrument or set of instrumentation that is owned by the vendor.

POLICY:

1. All loaner instrumentation will be signed into the Central Processing Department in accordance with approved guidelines prior to being put into the unit for processing.
2. Central Processing will accept **no** responsibility for vendor loaner instrumentation which has not been signed in compliance with this guideline.
3. All loaner instrumentation will be decontaminated and sterilized by the Central Processing Department (CPD) before being used for surgical procedures.
4. Loaner instrumentation is to be brought to CPD at least 24 hours in advance to allow the use of conventional sterilization methods.
5. Loaner instruments should be requested from the appropriate vendor when the surgery is scheduled to allow for sufficient time for decontamination, inspection and sterilization.
6. If loaner instrumentation is to be used on more than one procedure in a day, the procedures should be alternated with others to allow enough time for conventional sterilization methods, rather than flash sterilization.
7. In the event that there is no Inventory Count Sheet is provided at sign-in, CPD will not be responsible for incorrect inventory or lost instrumentation.

AFFECTED AREAS/ PERSONNEL: *CENTRAL PROCESSING DEPARTMENT (CPD), AMBULATORY SURGERY DEPARTMENT (ASD), SURGERY STAFF*

PROCEDURE:

1. Before loaner instruments are received, the manufacturer's instructions for handling and reprocessing should be obtained to determine the process for adequate reprocessing.
2. Loaner instrumentation will be logged in upon arrival and when returned to the vendor.

3. Before decontamination in the washer/decontamination unit, all moving parts, tips, box locks, ratchets, screws and cutting edges should be examined for defects and to ensure proper working order.

4. The loaner instruments will be decontaminated and sterilized according to the manufacturer's written instructions.

5. When returned from surgery, the loaner instrumentation is decontaminated and re-assembled before being picked up by the manufacturer's rep. (Reps usually put instrument trays together)

6. When the manufacturer's rep picks up the instruments, he/she also inspects the trays to assure that all pieces are in place and in apparent working order.

REFERENCES:

- American National Standards Institute (ANSI)/ Association for the Advancement of Medical Instrumentation (AAMI) ST79 & ST79 (2023).
- Association of Perioperative Registered Nurses (AORN) Perioperative Standards and Recommended Practices (2023).

SUBJECT:	SECTION:
MANAGEMENT OF INFUSION REACTIONS TO CANCER CHEMOTHERAPY AND BIOTHERAPY AGENTS	***[Enter manual section here]*** **Page 1 of 4**

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

PURPOSE:

Anticancer agents have the potential to initiate infusion reactions. Infusion reactions may be prevented and/or treated and should be dealt with promptly and efficiently.

DEFINITIONS:

1. Standard Infusion Reaction (SIRs) - unexpected reactions that cannot be explained by the known toxicity profile of the drug.

2. Hypersensitivity reaction (HSR) - an allergic or nonallergic reaction that occurs following exposure to a triggering agent such as a drug. The triggering agent stimulates the release of histamine and other substances, causing the symptoms of the reaction. Anaphylaxis is a severe systemic HSR and can be life threatening.

3. Cytokine Release Syndrome (CRS) - A reaction to biotherapy agents due to cytokines being released from targeted cells or immune system cells.

POLICY:

Infusion reactions may occur with any anticancer drug. Infusion reactions may be the result of hypersensitivity or cytokine release. Infusion reactions occur within a few minutes to hours following exposure to a triggering agent and can be mild to severe. There should be prompt intervention for any infusion-related reaction. All interventions should be based on the specific symptoms experienced by the patient. Drugs with potential for allergic response should be administered under supervision with adequate personnel to ensure optimal patient management.

- Drugs more likely to cause SIRs include the following:
  - Ado-trastuzumab
  - Asparaginase
  - Bleomycin
  - Carboplatin
  - Cetuximab
  - Cisplatin
  - Docetaxel
  - Etoposide
  - Ixabepilone
  - Liposomal doxorubicin
  - Oxaliplatin
  - Paclitaxel

  - Rituximab
  - Temsirolimus
  - Trastuzumab
- Drugs associated with CRS include the following.
  - All monoclonal antibodies
  - Denileukin diftitox
  - Interferons
  - Interleukins
- Patient risk factors for infusion-related HSRs include the following.
  - History of allergy or anaphylaxis
  - Asthma
  - Cardiovascular disease
  - Treatment with beta-blockers or angiotensin-converting enzyme inhibitors

1. Emergency medications and equipment will be available when patients are receiving chemotherapy and biotherapy agents.
2. All patients will be monitored for reactions during infusions of chemotherapy and biotherapy.
3. Infusions will be stopped immediately when a reaction is suspected.
4. The physician will be notified whenever an infusion reaction occurs.
5. Treatment will be initiated or emergency personnel called and transport initiated.
6. Infusions may be resumed following a reaction upon physician order.

AFFECTED PERSONNEL/AREAS: *CANCER TREATMENT CENTER REGISTERED NURSES AND INFUSION PERSONNEL*

PROCEDURE:

Pretreatment Interventions

1. Assess patient and anti-cancer agent risk factors prior to infusion start.
2. Inform patients of the possibility of an infusion reaction and instruct them to report any symptoms that might signal a reaction.
3. Take and document baseline vital signs.
4. Administer premedications as ordered to reduce the occurrence or severity of infusion reactions or verify they were self-administered by the patient when applicable.

Monitoring During Infusions

1. Take and document vital signs during the infusion of any drug for which an infusion reaction is likely.
2. For first infusions of drugs known to cause SIRs, monitor vital signs every 15 minutes for the first hour, then every 30 minutes.
3. For first infusions of drugs known to cause CRS, monitor vital signs every 30 minutes.
4. For subsequent infusions, monitor vital signs before and at the completion of the infusion.
5. Closely observe the patient for signs of a reaction and ask the patient about symptoms of a reaction throughout the infusion.
6. For first infusions of drugs known to cause infusion reactions, stay with the patient for a few minutes after initiation of the infusion and visually check the patient throughout the procedure.

When a Reaction Occurs

1. Stop the infusion at the first sign of an infusion reaction.
2. Stay with the patient and call for help.
3. Notify the physician of the reaction.
4. Assess the patient's airway, breathing, circulation, and level of consciousness.
5. Position the patient flat unless there is vomiting or respiratory distress. Elevate the patient's legs.
6. Maintain an IV line with normal saline or the appropriate solution.
7. Monitor vital signs (pulse, respirations, blood pressure, and oxygen saturation) continuously or every few minutes until stable, then every 15 minutes for 30 minutes.
8. Initiate treatment based on signs and symptoms of the reaction, evaluation by physician and orders given.
9. Assess the patient for resolution of the signs and symptoms of the reaction. If the reaction is not resolving or when deemed necessary, phone 911 and resume appropriate care until EMS arrive.
10. Consult the physician for the appropriateness of resuming the infusion.
11. Document the reaction and all interventions in the medical record.
12. Provide discharge instructions regarding symptoms to report and instruct the patient on whom to contact.

Table 1. National Cancer Institute *Common Terminology Criteria for Adverse Events* Grading Scale for Infusion Reactions

Grade	Description
1 (mild)	Mild reaction, such as transient flushing or rash; no intervention, including infusion interruption, needed.
2 (mild)	Infusion interruption required, but symptoms respond promptly to treatment (e.g., antihistamines).
3 (moderate)	Prolonged reaction, not rapidly responsive to symptomatic treatment or infusion interruption; symptoms recur following initial improvement; hospitalization required.
4 (severe)	Life-threatening consequences; urgent intervention required.
5 (severe)	Death

Note. Based on information from National Cancer Institute Common Terminology Criteria for Adverse Events (CTCAE)

REFERENCES:

- Infusion Reactions to Systemic Chemotherapy, UpToDate, https://www.uptodate.com/contents/infusion-reactions-to-systemic-chemotherapy, viewed November 30, 2023.
- National Cancer Institute Cancer Therapy Evaluation Program. (2017). *Common terminology criteria for adverse events* [v.4.03]. Retrieved from https://ctep.cancer.gov/protocolDevelopment/electronic_applications/ctc.htm (Accessed November 30, 2023).

SUBJECT: **MODALITIES: HOTPACKS**	SECTION:

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

PURPOSE:

To establish guidelines for the safe and correct use of Hot Packs.

AFFECTED AREAS/PERSONNEL: *PHYSICAL THERAPY PERSONNEL*

PROCEDURE:

1. Preparations:

   a. Determine the type of pack to be used.

   b. Check the hydrocollator.

   - The water should be hot – between 158° to 167°F.
   - The water should cover the packs at all times. If water needs to be added, add it at the end of the day.

   c. Check the packs.

   - The proper size packs should be ready to use.
   - The packs should be thoroughly soaked.
   - Allow from 10 to 15 minutes for the packs to heat between patients. (Department routine may be to place the used packs in the rear of the unit.)
   - Tongs will be needed for removing heat packs form the hydrocollator.

2. Starting the treatment:

   a. Explain the procedure to the patient.

   - The heat from the packs should be comfortably warm, not hot.
   - It may take several minutes for the patient to feel the warmth.
   - If the packs are too hot or too heavy, or if any other discomfort develops, the patient should call you immediately.
   - The patient should not move, as unwrapped packs can cause burns.
   - Use caution – the packs are hot and heavy and the patient can be easily burned.

b. Check the skin for any unusual marks before the treatment is started.

- Check the skin sensation. Use hot packs with extreme caution if sensation is lacking or diminished.
- No part of the unpadded pack should touch the patient. For hygienic purposes, commercial pack covers are used over a towel.
- Do not allow the patient to lie on the pack with the possible exception of a neck pack. More toweling may be needed with a neck pack.
- After 5 minutes, check the patient's report and inspect the area being treated for excessive redness, blistering, or other signs of burning. Discontinue thermotherapy in the presence of signs of burning. If any signs of burning are noted, brief application of a cold pack or an ice pack is recommended to curtail the inflammatory response.
- More toweling may be needed between the pack and the patient no matter which technique is used.

3. Procedures:

a. Remove the correct size heated pack from the hydrocollator and allow the excess water to drip into the hydrocollator tank.

b. Place the pack on the center of the cover and close the hydrocollator lid.

- More than one pack may be used.
- Wrap each pack separately.
- Lay wrapped hot pack onto a double-folded commercial wrap for extra safety.

c. Place the wrapped pack on the area to be treated over a single towel.

4. Additional points of consideration:

a. Do not allow packs to dry out, as they will become hard and brittle.

b. New packs should be soaked overnight.

c. Hydrocollator Cleaning: Proper procedures must be followed and appropriate agents used when cleaning and maintaining the hydrocollator. Follow the manufacturer's specifications for cleaning, located in the Physical Therapy Department.

d. Soiled wet towel is placed in dirty linen basket and collected daily by EVS.

REFERENCES:

- Cameron, M. (2023) *Physical Agents in Rehabilitation* (6th ed., pp. 146-168). St. Louis, Missouri: Elsevier. (pp 153-156).

SUBJECT: **MODIFIED BARIUM SWALLOW**	SECTION:

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

PURPOSE:

To establish guidelines for dysphagia patients requiring videofluoroscopic studies (modified barium swallow)

POLICY:

1. The videofluoroscopic studies provide the Radiologist and Speech pathologist information regarding the patient's safe transfer of foods and liquids through the oral cavity and the pharynx.

2. Prognostic statements and dietary recommendations are made based on these findings.

AFFECTED AREAS/PERSONNEL: *SPEECH THERAPY.*

PROCEDURE:

1. The modified barium swallow is done with the patient in the upright position.

2. The Speech Pathologist delivers foodstuffs or liquids impregnated with barium to the patient using a metal spoon.

3. Dietary services will prepare the food stuffs in the following consistency:

    a. 3cc's of nectar thick

    b. 5 cc's pudding thick

    c. 5cc's thin liquid and

    d. 3cc's honey consistency

4. The radiology staff will record the procedure for review.

5. The Speech Pathologist and Radiologist will review the assessment together for the following symptoms:

    a. Reduced tongue function

    b. Absent or delayed swallowing reflex

    c. Reduced laryngeal closure? Airway protection.

    d. Cricopharyngeal hypertonicity.

    e. Aspiration

6. The Speech Pathologist and Radiologist will write independent evaluation reports

7. The Speech Pathologist makes recommendations to the referring physician for his input regarding:

   a. Aspiration precautions

   b. Positioning during and after feeding

   c. Diet levels

   d. Treatment goals

8. The Speech Pathologist establishes and conducts treatment based on the physician's orders.

REFERENCES:

[1] American College of Radiology's *Practice Parameter for the Performance of the Modified Barium Swallow.* Retrieved December 5, 2023 from https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Modified-Ba-Swallow.pdf

[2] American Speech-Language Hearing Association, *Videofluoroscopic Swallow Study.* Retrieved December 5, 2023 from https://www.asha.org/practice-portal/clinical-topics/pediatric-feeding-and-swallowing/videofluoroscopic-swallow-study/

SUBJECT: **NUTRITIONAL HEALTH SERVICES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To screen patients for nutritional risk and provide referrals for nutritional counseling.

POLICY:

The Cancer Treatment Center (CTC) shall provide, as ordered by a physician, nutritional counseling to patients so that they may reach their optimal nutritional level. Nutritional counseling services are provided to the CTC via Sierra View Medical Center Food and Nutrition Services Department. Such services are ordered by the physician and are given by or under the supervision of a dietitian.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

1. If any of the following are present, the staff member completing the data collection will request a consultation from a registered dietitian.

   a. Unintentional weight change > or = 10 pounds in one month, > or = to 15 pounds in 6 months (use MST Malnutrition Screening Tool)

   b. Mucositis grade > or = 2

   c. Chronic problems with nausea, vomiting, constipation or diarrhea > or = 5 days

   d. High-risk diagnosis: Gastrointestinal (GI), head, neck, or throat cancer.

2. Referring Patients

   a. Request for consultation will be entered via the electronic health record.

   c. The Dietitian shall contact the patient within three (3) working days after physician orders have been made to arrange for a consultation or coordinate with CTC staff to see the patient at the next scheduled visit

3. Dietitian's responsibilities include:

   a. Assisting the physician and other treatment personnel in evaluating the dietary needs of the patient.

   b. Assisting the patient and family in understanding, accepting and following dietary modifications ordered by the physician.

   c. Instructing, supervising or counseling the treatment staff regarding the dietary care of the patient.

d. Participating in care conferences when requested.

REFERENCE:

de Las Peñas R, Majem M, Perez-Altozano J, et al. SEOM clinical guidelines on nutrition in cancer patients (2018). *Clin Transl Oncol*. 2019;21(1):87-93. doi:10.1007/s12094-018-02009-3

ESPEN practical guideline: Clinical Nutrition in Cancer, 2021: https://doi.org/10.1016/elsevier_cm_policy

SUBJECT:	SECTION:
PHYSICAL AND SPEECH THERAPY MEDICAL RECORDS STORAGE AND SAFE KEEPING	***[Enter manual section here]***

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

PURPOSE:

To define the Medical Records Storage Policy for the Outpatient Physical Therapy Department.

DEFINITIONS: N/A

POLICY:

1. All medical records will be stored in the Medical Records storage area. This area will be locked at all times unless a staff member is present.

2. Medical records for current patients undergoing treatment will be stored in the Therapist work area and returned to the medical records storage area at the end of the work day. This area will be locked at all times unless a staff member is present.

3. All individuals engaged in the collection, handling or dissemination of patient health information shall be specifically informed of their responsibility to protect patient confidentiality and use the guidelines outlined under HIPPA regulations.

4. Evaluations, Daily notes and Discharge Summaries are stored / written electronically.

AFFECTED PERSONNEL/AREAS: *OUTPATIENT PHYSICAL & SPEECH THERAPY STAFF*

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. IM.02.01.03. Joint Commission Resources. Oak Brook Terrace, IL.

SUBJECT: **PHYSICIAN NOTIFICATION CRITERIA**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define when treatment should be held pending physician notification.

POLICY:

Treatment shall be held and MD notified when patient presents with symptoms of being clinically unstable. Such symptoms may be:

1. Abnormal vital signs:
   a. Temperature: >100° Tympanic
   b. Blood Pressure: Systolic <85 >180
   c. Pulse: <50 (45 if on beta blocker)
   d. Respiration: >30
2. Changes in mental status:
   a. Lethargic
   b. Dizziness
   c. Confusion
3. Loss of function
4. Increased neuropathy such as numbness/tingling paralysis
5. Productive cough with yellow/green sputum
6. ↑ SOB over baseline
7. Uncontrolled nausea and vomiting
8. Uncontrolled diarrhea >6 stools
9. Severe fatigue "3" on a scale of 0-3
10. Symptomatic anemia:
    a. ↑ Dizziness
    b. Fainting

c. ↑ SOB

d. Chest Pain

11. Bladder symptoms:

a. Burning with urination

b. ↑ Frequency

12. Skin alterations:

a. Rash

b. Infection

c. Severe burn or laceration

13. Abnormal labs:

a. Anc: <1.5

b. Hgb: <8

c. Plt: <100

14. Mucositis >1

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

After physician notification, document actions taken in patient medical record.

REFERENCE:

- National Comprehensive Cancer Network. Antiememis (Version 2.2023).
- https://www.nccn.org/professionals/physician_gls/pdf/antiemesis.pdf Accessed November 30, 2023
- National Comprehensive Cancer Network. Cancer Related Fatigue Version 2.2024 https://www.nccn.org/professionals/physician_gls/pdf/fatigue.pdf Accessed November 30, 2023
- National Comprehensive Cancer Network. Prevention and Treatment of Cancer Related Infections (Version 2.2023). https://www.nccn.org/professionals/physician_gls/pdf/infections.pdf Accessed November 30, 2023ONS Symptom Intervention and Guidelines https://www.ons.org/explore-resources?source=1506&display=results&sort_by=created&items_per_page=50 Accessed November 30, 2023

SUBJECT: **PROCESSING OF MEDICATION ORDERS AND DISPENSING OF MEDICATIONS**	SECTION: **Page 1 of 8**

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

PURPOSE:

To ensure that the preparation and dispensing of medications is consistent with all applicable State and Federal laws and regulations. In addition, to establish the requirements that medications are dispensed safely and accurately, and under the direct supervision of a licensed pharmacist.

POLICY:

The Pharmacy Department at Sierra View Medical Center (SVMC) will prepare and dispense medications for patients served by the facility as safely and accurately as possible. Preparation and dispensing is accomplished under the following conditions:

- Meets all the state and federal laws and regulations.
- Is under the direct supervision of a licensed pharmacist, who prepares and dispenses all medications or monitors medication preparation and dispensing performed by non-pharmacist personnel.
- A licensed pharmacist reviews orders prior to dispensing.
  Exceptions: Physician or other licensed practitioner who controls the ordering, preparation and administration of the medication, or when a delay would harm the patient in a n urgent situation (including sudden changes in a patient's clinical condition), in accordance with law & regulation.
- Prescriber's orders are verified/clarified when questions arise.
- Medications are dispensed in as ready-to-administer form possible (unit dose).
- The labeling of medication complies with all State laws.
- Medications administered are recorded on the Electronic Medication Administration Record (eMAR), which is a permanent part of the patient's medical record.
- Medications dispensed by the prescriber to ambulatory patients in the Emergency Department meet all laws and regulations.

AFFECTED AREAS/PERSONNEL: *PHARMACY, PHARMACY TECHNICIANS, PHARMACY CLERICAL PERSONNEL*

PROCEDURE:

1. Inpatient Order Processing

   a. The order must contain the following:

      - Patient's Name

- Room Number
- Admission Account Number
- Medical Record Number
- Sex
- Age
- Date of Birth
- Admitting Physician's Name
- Weight (if available, but will be required in the event the order is weight based)
- Allergies

b. Valid prescriber's medication orders must include:

- Name and strength of medication
- Route of administration.
- Frequency of administration
- Duration of administration, if appropriate
- Indications for use if an "As needed" (PRN) order
- Other directions, as appropriate to ensure clear & accurate orders
    a. Medication titration orders must also include the following:
        i. Initial rate of infusion
        ii. Incremental units to which rate or dose may be increased or decreased
        iii. How often rate or dose may be changed
        iv. The maximum rate or dose of infusion
        v. Objective clinical measure to be used to guide changes
            1. Examples: CPOT, RASS, CAM, Blood Pressure
- Cannot contain range of dosages or overlapping pain scales

2. Allergy Information

   a. The patient's height, weight and allergy information is entered by nursing personnel into electronic medical record (EMR) as text. If the patient has no known allergies, then the code: "NKA" or text: "No Known Allergies" is entered. The (EMR) alerts the Pharmacist of additions or changes to this information. The pharmacist evaluates (and verifies the information if necessary) and codes the allergy information in the pharmacy module. Once the allergy is coded, the system checks all medication orders against the patient's listed allergies and alerts the pharmacist of possible patient allergies to the medication being entered.

   b. When an allergy statement appears, it must be clarified with the physician or through patient history, prior to dispensing the medication. If a true allergy to the medication exists, the prescriber will be contacted to provide an alternate medication.

   c. No medication is dispensed until valid patient allergy information is obtained.

3. Height and Weight

   a. Patient's height and weight are entered into the eMAR system as soon as it is obtained by nursing personnel. This information is required to be available in the health information system (HIS) system by the second day of admission. If required by pharmacokinetic calculation, the pharmacist will contact nursing personnel to obtain the information immediately.

4. Drug-Drug Interaction Screening

   a. When a medication order is entered into the pharmacy module of the EMR, the system checks the new medication against the active medications on the patient's profile by First Data Bank interaction code. The pharmacist is alerted if an interaction is noted and must acknowledge the interaction as acceptable or not valid or contact the prescriber to change or discontinue one of the medications involved in the interaction.

5. Pharmacy Technicians

   a. Under the direct control and supervision of a pharmacist, may perform packaging, manipulative, repetitive or other non-discretionary tasks, while assisting the pharmacist. These tasks include:

      - Removing the drug from stock
      - Counting, pouring or mixing pharmaceuticals & Placing the product into a container
      - Affixing the label or labels to the container

- Packaging and repackaging

6. Clarification of Unclear Orders

   a. Medication orders are sent electronically to the pharmacy for review and approval. If any prescriber's orders are received that are written and are not legible or clear in intent or rationality as applied to standard practices and literature, they will be clarified with the prescriber. The Pharmacist will contact the physician directly, or as applicable, will contact the transcriber of a verbal or telephone order for clarification of the order.

7. Pharmacist Review

   a. All medication orders are reviewed and checked by a licensed Pharmacist before the medication is dispensed, unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication. For medication orders written during downtime after the pharmacy is closed, the orders will be remotely entered by a pharmacist for entry into the EMR. A pharmacist is available on-call during the times that the pharmacy is closed. Pharmacists will ensure to review patient allergies/sensitivities, potential interactions, appropriateness of medication order, impact of laboratory values, therapeutic duplication, and other contraindications.

8. Unit Dose System

   a. Sierra View Medical Center Pharmacy uses a "unit-dose" system of dispensing medications to patients within the facility. Medications are dispensed in either single unit containers or in as "ready-to-administer" form as possible. The exceptions are bulk, patient-specific items, such as topical creams and ointments, eye, ear and nose preparations, metered dose inhalers, etc., where it is either not practical to dispense a unit-of-use amount or prohibited for infection control considerations.

9. Label Requirements: Must occur whenever medications are prepared but not immediately administered. An immediately administered medication is one that is prepared or obtained and administered to patient without a break in the process.

   a. Computer-generated medication labels will contain the following:

      - The name, address and telephone number of the pharmacy
      - The patient's name, account number, unit location and room number
      - Unique identifying prescription numbers
      - Generic name of the medication

- Strength of the medication
- Trade name of the medication, if available
- Dose of medication
- Administration frequency
- Date of and time of dispensing
- Quantity of the medication dispensed
- Line for lot number and expiration date for extemporaneously prepared or repackaged medications

b. Computer-generated IV medication labels will contain all of the above, and:

- The volume of the base solution
- The rate
- Trade and/or generic name of any additives
- Dose/amount of any additives
- Bag sequence number and date and time due
- Date prepared & expiration date
- Special instructions as required
- Auxiliary sticker noting compounds made in hospital pharmacy
- Beyond Use Date
- Affix an auxillary label with any pertinent handling or precautions

10. Initial Order Dispensing

    a. Pharmacists will process the initial physician order and create a computer-generated label. The computer-generated label is used by the pharmacy technician or pharmacist to prepare the product. The final product is checked by the pharmacist and sent to the nursing unit.

    b. Bulk containers – Medications that are not available or cannot be packaged in a unit of use container will be extemporaneously repackaged with no more than a 72-hour supply of the medication. Exception: Bulk packages provided by the manufacturer in direct dispensing packaging may be dispensed for more than a 24-hours supply in the original container. In addition to the standard label requirements, the manufacturer's lot number and expiration date up to 1 year or the manufacturer's date, whichever is less. For bulk topical, ophthalmic, otic, and nasal preparations and inhalers, the label is applied directly to the product, not to the outside packaging. When a medication is replaced from a bulk container by a Pharmacy Technician, the bulk container is left with the repackaged product to be checked by a Pharmacist prior to the medication being dispensed.

11. Electronic Medication Administration Record (eMAR)

    a. An eMAR is maintained on all patients. The eMAR contains the following information:

    - Patient name, account number, age, sex, location and attending physician
    - Diagnosis
    - Allergies & Sensitivities
    - Unique prescription number
    - Current Medications trade and generic name
    - Dose of the medication
    - Route of administration
    - Height and weight (when necessary)
    - Pregnancy and lactation information (when necessary)
    - Laboratory results (when necessary)
    - Directions (schedule) for use

- Comments, precautions or additional directions
- Times of administration (for scheduled meds) & Start and stop date for the order

b. Nursing personnel documents in the eMAR by initials and signature the time of administration of all medications. Also noted is if the dose has been held for any reason.

12. If a pharmacist has a conscientious objection to dispensing a medication, then that pharmacist must notify SVMC in writing of their objection and the pharmacist in charge will work with Human Resources to make reasonable accommodations as necessary.

13. Pharmacists will take their required 30 minute lunch break prior to any anticipated or foreseen situation where there will only be one pharmacist on duty in the pharmacy. In the event only one pharmacist is on duty and a temporary absence for a meal break is required as per California Labor Code Section 512:

a. The pharmacist may leave the pharmacy temporarily for breaks without closing the pharmacy and removing ancillary staff, if the pharmacist reasonably believes the security of the dangerous drugs will be maintained in his or her absence.

i. During the absence;
   1. No medications shall be compounded or dispensed.
   2. Ancillary staff (pharmacy technicians) may ONLY continue to perform non-discretionary tasks (cleaning, stocking, answering phone calls, etc).

ii. Upon Return
   1. The pharmacist is required to check all nondiscretionary work done in his or her absence.

REFERENCES:

- Hospital Accreditation Standards. (2023). Oak Brook, IL: Joint Commission Resources, Inc.
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    - MM.01.01.01 EP1
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SUBJECT:	SECTION:
RADIATION THERAPY GENERAL REQUIREMENTS	**Page 1 of 1**

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

PURPOSE:

To insure adequate histologic substantiation of diagnosis.

POLICY:

All cancer cases accepted for both curative or palliative radiation therapy shall have adequate histologic substantiation in the form of a pathology report confirming the cancer diagnosis prior to administration of radiation therapy.

Exceptions will be made ONLY if convincing alternative evidence for diagnosis is presented to the Radiation Oncologist prior to administration of radiation, with informed consent from the patient or patient's legal representative.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER*

REFERENCES:

- American Society for Radiation Oncology. Safety is no accident - a framework for quality radiation oncology and care.; Available at: https://www.astro.org/ASTRO/media/ASTRO/Patient%20Care%20and%20Research/PDFs/Safety_is_No_Accident.pdf

SUBJECT: **SCOPE OF PHYSICAL THERAPY**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish guidelines for the scope of physical therapy practice.

POLICY:

1. Scope of Practice:

   a. Physical Therapy is a profession which develops, coordinates and utilizes select knowledge and skills in planning, organizing and implementing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury.

   b. This leads to the selection and implementation of appropriate therapeutic procedures to maintain, improve or restore these functions. Services are provided to outpatients and inpatients on acute and sub-acute units.

2. Types of Patients:

   All types of orthopedic conditions and soft tissue injury, neurological conditions, wound care for diabetic and venous stasis ulcers, and medical conditions if the condition impacts activities of daily living (ADL).

3. Age of Patients:

Middle Childhood	6-12 years
Adolescence	13-18 years
Middle Adult	19-65 years
Late Adult	over 65

4. Services:

   Physical Therapy (PT) services include, but are not limited to:

   a. Evaluation and assessment prior to the provision of services.

   b. Determination and development of a treatment program established to prevent or reduce disability or pain and to restore loss of function.

   c. Interventions that focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, pain and activities of daily living.

   d. Procedures that include application of heat or ice, ultrasound, electrical stimulation, massage, mobilization and therapeutic exercises.

e. Training in locomotion, including use of assistive or prosthetic devices as appropriate.

5. Hours of operation:

Outpatient physical therapy (PT) services are provided Monday through Friday from 0800–1700.

6. Department Goals:

a. Goals are to provide effective and efficient patient care, increase professional and lay awareness and encourage ongoing education and research in the field of physical therapy.

b. Physical therapy incorporates a broad spectrum of activities such as direct patient care, multidisciplinary interchange, supervision, teaching, administration, research, and community service.

c. It also accepts responsibility for education at many levels, recruitment of personnel and ethical standards of practice for the welfare of patients and its own members.

7. Staffing Plan:

a. Services are provided by full-time hospital employees during the week and there is per diem, as well as contract services, for weekend coverage.

b. The staff consists of:

- Administrative Director of Physical and Speech Therapy Services who oversees all therapy personnel.
- Physical Therapists (PTs)
- Physical Therapy Assistants (PTAs)
- Physical Therapy Aides

8. Patient Priority and Staffing Guidelines

In the event that staffing reaches inadequate levels, there will be a method to prioritize patient needs and provide safe and effective basic services to patients requiring rehabilitation services.

a. The following plan of action will be implemented during times that there is a loss of staff, reduction in productive hours, sudden increase in patient demand on the service or in times found difficult to secure appropriate numbers of qualified individuals to perform basic care services.

b. Should it become necessary to increase existing staff, Physical Therapy staff shall be called to work until adequate staffing needs are met.

c. Patient Priority:

- All new outpatient admissions will be cancelled.
- All outpatients, who are able, will be rescheduled in order to more evenly distribute the patient care workload over the week.
- Wound Patients and Special procedures
- Pain-related treatments
- All others

d. Staff members will be required to work overtime if necessary.

9. Qualifications of Staff

a. PT and PTAs are licensed through an accredited program, and possess a California State license.

b. All staff will have basic life support (BLS) certification.

AFFECTED AREAS/PERSONNEL: *ALL PHYSICAL THERAPY STAFF*

REFERENCES:

[1] California Code of Regulation. *Existing Title 22 Rehabilitation, Outpatient, and Supportive Services Regulations.* Retrieved December 7, 2023, from https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/ExistingTitle22_GACH_Rehab_Outpatient_Supp.pdf

[2] California Legislative Information. *Business and Professions Code.* Retrieved December 7, 2023, from https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=5.7.&article=2.