SIERRA VIEW
MEDICAL CENTER

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

AGENDA
November 22, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

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

Call to Order

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

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

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

CLOSED SESSION

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

III. **Closed Session Business**

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

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

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

2. Quality Division Update –Quality Report

3. Compliance Report – Quarter 1

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 22- **001812** (Time Limit – 5 minutes)

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2025 (Time Limit – 10 minutes)

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

3. Compliance Report – Quarter 1
   Recommended Action: Approve/Disapprove

C. Conference with Legal Counsel regarding BETA Claim No. 22- 001812
Recommended Action: Approve/Reject BETA Claim No. 22-001812

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

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

VI. Public Comments

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

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

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

VIII. Approval of Minutes

A. October 25, 2022 Minutes of the Regular Meeting of the Board of Directors

Recommended Action: Approve/Disapprove October 25, 2022 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Recognition of Service of Director Kent Sorrells and Director Ashok Behl

XI. Business Items

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

B. **Investment Report**
Recommended Action: Approve/Disapprove

C. **Quarterly Foundation Report**
Recommended Action: Approve/Disapprove

XII. Announcements:

A. Regular Board of Directors Meeting – December 20, 2022 at 4:30pm

XIII. Adjournment

SPECIAL NOTICE

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

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

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Senior Leadership Team	11/22/2022
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	11/22/2022

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
November 22, 2022
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	**Action**
Policies:		Approve ↓
1. Catering Services	1-2	
2. Compliance Office and Legal Counsel Protocol and Procedures	3-4	
3. Compliance Office Confidentiality Agreement	5-6	
4. Compliance Officer	7-8	
5. Employee Code of Conduct Training	9	
6. Inventory Stocking and Audit	10-13	
7. Post-Issuance Compliance Procedures for Tax-Exempt Obligations	14-20	
8. Project Planning & Management	21-24	
9. Public Records Request	25-32	
10. Purchase Authorization	33-34	
11. Supply Outdates and Management – External Locations	35-37	

SUBJECT: **CATERING SERVICES**	SECTION: **Page 1 of 2**

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

PURPOSE:

Catering services are provided for meetings and special events at Sierra View Medical Center (SVMC).

POLICY:

1. Catering will be provided in support of the Board of Director's meetings, administration and special events approved by administration *(town hall, benefits fair, etc.)*. Physicians may be provided a pre-plated meal when attending meetings during their meal period. A banquet style setup may be provided for meetings such as General Medical Staff Meeting, Medical Executive Committee, Tumor Board, Cancer Support Group, Weekly Physician's Mingler and physician's office staff training.

2. It is the requesting party's responsibility to reserve the conference room for their catered event. SVMC conference rooms may be reserved through Microsoft Outlook.

3. Catering expenses for events are tracked utilizing the catering FormStack request form.

4. Catering requests will be received no less than 7 days prior to the event. Requests for events with attendance of 50 or more will be received 30 days in advance. Short notice requests may be directed to the Café for meal compensation.

5. Linen will only be utilized for hospital approved events. Linen will not be used for department planned events *(Christmas parties, pot lucks, birthday parties, etc.)*.

6. Catering requests from outside vendors or community groups for hospital events must be approved by administration.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS*

PROCEDURE:

1. Catered events will be requested and processed using the catering FormStack on SVMC's intranet. The catering request form is located on the front page of the SVMC intranet, under "Service Requests".

2. If a change occurs (i.e., meeting cancelled, the number of individuals attending changes, room changes, etc.), it is the responsibility of the requesting party to notify the Food and Nutrition Services (FNS) Department immediately at extension 4758.

3. Catering menus will be determined by the FNS Department.

4. If the catering event concludes early, FNS will be notified at extension 4758 for cleanup.

5. To prevent food poisoning incidents, loss of catering equipment, and to meet health department and federal government food guidelines for hazard analysis critical control points (HACCP), left-over food, supplies and equipment will **not** be removed from the catering location.

REFERENCES:

- Human and Health Service Agency, Tulare County Environmental Health Department. Retrieved from https://tularecountyeh.org/eh/.
- Hazard Analysis Critical Control Point (HACCP). Retrieved from https://www.fda.gov/food/guidance-regulation-food-and-dietary-supplements/hazard-analysis-critical-control-point-haccp.

SUBJECT: **COMPLIANCE OFFICE AND LEGAL COUNSEL PROTOCOL AND PROCEDURES**	SECTION: **Page 1 of 2**

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

PURPOSE:

The Compliance Office (CO) and/or Human Resources address the majority of allegations of workplace misconduct that might constitute a violation of criminal, civil or administrative law. Issues occasionally arise that necessitate engagement and direction of legal counsel. This policy establishes guidelines for the coordination of activities between legal counsel and the Compliance Office, related to compliance investigations of potential violations of laws or regulations. For purposes of this policy, the term "legal counsel" refers to outside counsel.

POLICY:

1. Upon independent investigation and reasonable evidence of suspected noncompliance with any criminal, civil, or administrative law or regulation, the Compliance Officer (CO) shall engage legal counsel to:

    a) Conduct legal analyses of risk areas identified in connection with the Compliance Program and provide legal opinions with respect to those areas;
    b) Respond to specific concerns and provide legal opinions in connection with those concerns;
    c) Conduct or oversee investigations based on specifically identified problem areas and render legal advice based on the results of those investigations.

2. The CO may also engage legal counsel to:

    a) Review and approve the Compliance Program, including compliance policies, all supporting organization-wide polices and all compliance plans for legal content;
    b) Conduct education programs for the employees, and certain agents and contractors involving areas of risk identified by the CO; and
    c) Retain outside consultants and auditors to review specific areas of compliance concern.

3. In light of timely reporting requirements, the CO shall consult with legal counsel as expeditiously as possible regarding credible allegations of misconduct related to billing and reimbursement.

4. During the course of investigation of misconduct that might constitute a violation of criminal, civil or administrative law, the CO shall ensure that all relevant evidence is preserved.

5. To the greatest extent possible, communications with legal counsel relating to any compliance investigation shall be conducted in such a way as to preserve the attorney-client privilege and the attorney-work product privilege.

AFFECTED AREAS/PERSONNEL: *COMPLIANCE OFFICER AND COMPLIANCE STAFF*

PROCEDURE:

1. Upon report or notice of suspected noncompliance with any criminal, civil, or administrative law or regulation, the CO will conduct an "initial inquiry" into the alleged misconduct. The purpose of the initial inquiry is to determine whether there is sufficient evidence of possible noncompliance to warrant further independent investigation and notification to legal counsel under attorney-client privilege.

2. If, during the independent investigation, the CO determines that there is sufficient evidence of possible noncompliance, the CO shall fully engage legal counsel.

3. The CO shall coordinate with legal counsel during the investigation and ensure that the results of legal counsel's analysis and recommended course of action is communicated to senior leadership and board of directors, as appropriate.

4. The OIG acknowledges the role of legal counsel in determining whether reporting misconduct to the government is necessary, stating that "The Compliance Officer, under advice of counsel, and with guidance from the governmental authorities, could be requested to continue to investigate the reported violation. As such, legal counsel's involvement is necessary in any case involving a potential violation of law, and in such cases, the investigation may be conducted under legal counsel.

REFERENCES:

- DHHS Federal Register, OIG Supplemental Program Guidance for Hospitals, Notice 63, February 23, 1998
- HHS Federal Register, OIG SupDplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858; January 31, 2005)
- HCCA, Health Care Compliance Professional's Manual, 2021

SUBJECT: **COMPLIANCE OFFICE CONFIDENTIALITY AGREEMENT**	SECTION: ***Compliance*** **Page 1 of 2**

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

PURPOSE:

To define the confidentiality requirements of all individuals who work in the Compliance Office and members of the Compliance Committee.

POLICY:

Employees in the Compliance Office and members of the Compliance Committee (CC) have access to confidential information. This includes patient, employee, and business information of a sensitive nature that is not known to the public and/or the employee population. Anyone assigned to the Compliance Office or CC must not disclose such information to unauthorized individuals. Furthermore, they must agree in writing to take appropriate steps to protect sensitive information from unauthorized access and inappropriate disclosure

Confidential information is defined to mean "all information learned in the course of employment with Sierra View Medical Center (SVMC) and which is unknown to the general public and/or the employee population." This includes, but is not limited to, financial information, technical information, information relating to the contents of contracts, or any other proprietary or valuable information of SVMC and its related entities. This also includes sensitive information concerning patients, employees, and vendors.

AFFECTED AREAS/PERSONNEL: *COMPLIANCE OFFICER, COMPLIANCE EMPLOYEES AND COMPLIANCE COMMITTEE*

PROCEDURE:

1. During their employment with SVMC, employees working in the Compliance Office, and CC members having access to confidential Compliance Office information, must agree in writing not to disclose any confidential information regarding SVMC or its clients to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever; nor shall they make use of such confidential information for personal advantage. This will be accomplished by requiring all Compliance Office employees and CC members to sign a "Compliance Office Confidentiality Agreement."

2. Upon termination of employment with SVMC, employees working in the Compliance Office, and CC members having access to confidential Compliance Office information, must agree not to retain any original or copies of any file, document, record, or memorandum relating in any manner whatsoever to their confidential compliance related employment with SVMC. All such files, documents, records and memoranda in their possession will be immediately returned to SVMC upon termination of employment.

CROSS REFERENCE:

- Compliance Committee Policy

CONFIDENTIALITY AGREEMENT

Any information or documentation I have been furnished by or obtained from or through the Compliance Committee or the Compliance Officer is confidential and sensitive. I will maintain the confidentiality of such information or documentation and will not discuss it with nor furnish it to anyone other than the Compliance Officer, the Attorney for the Hospital, the Compliance Committee (in a meeting of that Committee), the Chief Executive Officer or a member of the Board of Directors of Sierra View Medical Center (SVMC).

In undertaking or participating in any research, review or investigation at the request of or to assist the Compliance Committee or the Compliance Officer, I may develop, use or be involved with personal or confidential information concerning employees, physicians or patients. I will maintain the confidentiality of information, documentation and results derived from or obtained through any such research, review or investigation and will not discuss them with or furnish them to anyone other than the Compliance Officer, the Attorney for the Hospital, the Compliance Committee (in a meeting of that Committee) or the Chief Executive Officer of SVMC.

I further understand that my duty to maintain the information in confidence imposed hereunder shall survive my resignation or termination from this Committee or my termination of employment for whatever reason from this organization.

_____

Signature/Date

_____

Printed Name/Title

_____

Compliance Officer/Date

SUBJECT: **COMPLIANCE OFFICER**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure that Sierra View (SVMC) has a dedicated Compliance Officer (CO) and to ensure SVMC establishes and maintains an effective Compliance Program.

POLICY:

1. Pursuant to the SVMC Board of Directors' Resolution of April 2, 2001; a formal Compliance Program was established. The resolution established that a CO will implement and oversee the Compliance Program, as well as SVMC's compliance with the requirements of federal and state laws and regulations, and health care program requirements.

2. Pursuant to the SVMC Board of Directors Resolution No. 06-28-16/01 establishing the Board of Director's direct oversight of the Compliance Program; the CO is the designated appropriate authority to effectively oversee the Program and has direct access to the Board of Directors.

3. The CO will facilitate a Compliance Committee (CC) to assist with the implementation of the Compliance Program.

AFFECTED AREAS/PERSONNEL:

COMPLIANCE OFFICER, COMPLIANCE DEPARTMENT & COMPLIANCE COMMITTEE

PROCEDURE:

1. The Chief Executive Officer (CEO) of SVMC shall designate an appropriate individual as identified below, to serve as the CO.

2. The CO shall possess the following minimum qualifications:

    a. A Bachelor's Degree with an emphasis in accounting, finance, business or healthcare administration or five (5) years' experience of broadly based, progressive experience of financial and business systems, fraud and abuse laws and regulations.

    b. Makes judgments, coordinates project teams, and takes reasonable action required to accomplish project objectives with minimal direct supervision.

3. The CO will have various job responsibilities regarding the implementation and oversight of the Compliance Program, which include, but are not limited to:

    a. Developing compliance standards and procedures to be followed by employees to reduce the possibility of non-compliant activities;

    b. Communicating compliance standards and distributing the Code of Conduct;

c. Coordinating and monitoring required employee compliance training, and ensuring employee evaluations include a compliance component;

d. Advising colleagues on compliance-related concerns and issues;

e. Initiating and directing compliance-related investigations;

f. Maintaining a system for the reporting of compliance-related concerns and issues by employees, including establishing and supporting a Compliance Hotline for anonymous reports or inquires by employees, and promoting SVMC's non-retaliation policy for good faith reporting;

g. Coordinating and directing system-wide monitoring and auditing procedures;

h. Identifying and encouraging, where necessary, appropriate corrective actions related to compliance;

i. Meeting directly with the Chief Executive Officer (CEO), and/or the Board of Directors (BOD) at any time, should issues require such a meeting, and serving as the liaison to the Board of Directors;

j. Meeting quarterly with the CEO on the status of the SVMC Compliance Program and presenting a Compliance Program report to the Board of Directors on a quarterly basis.

h. Overseeing Compliance Department staff and Compliance Department activities.

REFERENCES:

- Federal Register/Vol 70, No. 19/Monday January 31, 2005
- Federal Register/Vol. 63, No. 35/Monday, February 23, 1998

CROSS REFERENCES:

- COMPLIANCE PROGRAM/PLAN
- COMPLIANCE COMMITTEE

SUBJECT: **EMPLOYEE CODE OF CONDUCT TRAINING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure that employees receive Code of Conduct training.

POLICY:

Sierra View Medical Center (SVMC) requires all employees to read SVMC's Code of Conduct and to receive Code of Conduct training at new hire and annual orientation.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. The Compliance Officer (CO) shall ensure that a process is established for providing each employee with access to read SVMC's Code of Conduct and sign an electronic attestation upon hire and annually. Code of conduct training will also be provided at new hire orientation.

2. An electronic link to the Code of Conduct is provided on the Compliance page of SVMC's intranet, as well as contact information for the CO, Compliance office and Compliance Hotline.

3. New employees will be provided with the name and telephone number of the CO and the Compliance Hotline at new hire orientation.

REFERENCES:

- Federal Register / Vol. 63, No. 35/Monday, February 23, 1998
- The Health Care Compliance Professional's Manual, Chapter 3, 2021

CROSS REFERENCE:

- CODE OF CONDUCT
- COMPLIANCE EDUCATION AND TRAINING

SUBJECT: **INVENTORY STOCKING AND AUDIT**	SECTION: *MATERIALS MANAGEMENT* **Page 1 of 4**

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

PURPOSE:

To develop and disseminate standardized guidelines that assures appropriate stocking procedures that insures the integrity of inventory at Sierra View Medical Center (SVMC).

DEFINITIONS:

1. FIFO – Inventory stocking method defined as "First In First Out". During the stocking process, new items are placed in the back of current items previously stocked, assuring that the first items purchased will be utilized first. FIFO is also used in inventory valuation and accounting. Items hold the value they were originally stocked with.
2. Routine Inventory Location – Areas throughout SVMC which have designated Materials Management Staff stocking routines for regular periodic services.
3. Non-Stock/Non Inventory and Equipment Location – Designated inventory/supply locations managed and controlled by Area's Department Staff. This includes: drawers, cabinets, fixed shelving and closets that are stocked by clinical staff.
4. Par Level – Amount of a supply item(s) stocked by Materials Management in an inventory location based on monitored utilization history. Par levels have a Max Level for stocking and a Minimum Level which triggers and automatic reorder.

POLICY:

Inventory Stocking and auditing of supplies in the Medical Center and Clinics, with the exception of Pharmaceuticals and Food Services, will be maintained by Materials Management staff. A multidisciplinary approach will be used to ensure that the supplies are stored and maintained in a clean environment. This also requires support from the end users of the supplies and environmental services for general cleaning needs such as floors, walls and general area.

AFFECTED PERSONNEL/AREAS:

ROUTINE INVENTORY LOCATIONS; NON-ROUTINE INVENTORY LOCATIONS; MATERIALS MANAGEMENT STAFF

PROCEDURE:

A. Materials Management Inventory Storeroom:

1. All inventory rows will be kept clear of boxes, debris and other impediments.
2. All inventory shelving will be kept neat, orderly and free of dust, dirt and debris. Surplus boxes and containers will be removed from shelving and dispositioned as required.
3. The integrity of the container or packaging will not be compromised and will not show signs of leakage, spoilage, tears or punctures.

4. Items will be stocked in the Materials Management Inventory Area in the following manner:

   a. All inventory items in the Materials Management Area shall be stocked per the FIFO method. New items are placed at the rear of the inventory bin row location, behind previously stocked items occupying the designated location. Items pulled as replenishment stock will be the first (front) item(s) in the stocking location.

   b. Inventory items that have a close resemblance to another item shall not be stored next to each other to limit the accidental picking of an incorrect product.

   c. Hazardous Materials kept in inventory will be clearly marked and stored per manufacturer's instructions. Careful consideration will also be observed in the proximity to other items stored in area.

   d. Heavy cases of inventory will be emptied and stored in bins. If the bin space being utilized is full, the item(s) will be stored on a lower surplus stock location(s) identified by Materials Management Administration. This is for the safety of Materials Management and SVMC Staff.

   e. Items in inventory area will be stocked on the Materials Management shelves in blue, red or yellow bins.

      - Blue Bins – used for general inventory.
      - Red Bins – used for items that have expiration dates and these bins will be checked weekly. Any item within thirty (30) days will be removed from the shelf, segregated, and brought to the attention of Materials Management Administration for disposition.
      - Yellow Bins and Yellow Ventilated Lockers – Hazardous items.

B. Routine Inventory Locations:

1. Items delivered to inventory stock location(s) by Materials Management Distribution Staff will be kept clean and free of dirt, dust and other debris. Item(s) will also be inspected for leaks, broken seals and expiration dates. If item(s) being stocked do not pass this initial inspection, the item(s) will be segregated and brought to the attention of Materials Management Administration for disposition.

2. Items will be stocked utilizing the FIFO method.

3. Materials Management staff stocking the area will be accountable for:

a. Keeping the inventory area neat and orderly; assuring that stock items are in the correct bin(s) or shelf location and not in excess of the par level; supply items will be inspected for leaks, broken seals and expiration dates.

b. Item location shall be kept clean and sanitary. The location will be free of dirt, dust, debris and foreign matter, including the inventory bins/containers.

c. Items will be stocked in the clinical department's appropriate shelves or bins.

C. Non-Stock/Non Inventory and Equipment Location (including all clinic locations):

1. Items stored in Non-Stock/Non Inventory and Equipment Location(s) will be kept clean and free of dirt, dust and other debris. Supply items will also be inspected for leaks, broken seals and expiration dates. If item(s) being stocked do not pass this initial inspection, the item(s) will be segregated and sent to the Materials Management Administration for disposition.

2. Items will be stocked utilizing the FIFO method.

3. Non-Stock/Non Inventory and Equipment Location(s) and Clinics shall be checked regularly by End User Department Staff, and will periodically be checked by Materials Management Staff.

AUDITING:

Auditing for compliance will be conducted as follows:

- Auditing of Non-Stock/Non Inventory and Equipment Locations and Clinics will be managed by the individual departments staffing and periodically inspected by Materials Management Staff.
- Auditing of Materials Management Department Stock (1st floor) will be conducted weekly, for the above mentioned criteria.
- Auditing of stock in the individual departments will be conducted weekly utilizing the EOC/IP rounding schedule. Rounding of the departments can be accelerated to a more frequent schedule as needed to ensure compliance based on the report findings. A member of Materials Management Staff will participate in the weekly EOC/IP rounds; recorded findings are captured in the Huron Rounding Application. Issues identified are immediately transmitted via Huron Rounding to the respective department director/manager for follow up and closure of the issue.

CROSS REFERENCES:

- ENVIRONMENTAL FACILITY CLEANLINESS
- SUPPLY DISTRIBUTION - PAR LEVEL SYSTEM

- Supply Updates and Management – External Locations

PURPOSE:

The purpose of these Post-Issuance Compliance Procedures, established by Sierra View Local Health Care District (the "District"), is to maximize the likelihood that post-issuance requirements of federal income tax law and continuing disclosure regulations applicable to the various issues of tax-exempt obligations (the "Bonds") are met. The District reserves the right to change these policies and procedures from time to time.

POLICY:

Post-Issuance Compliance Requirements

A. External Advisors/Documentation

1. The District shall consult with bond counsel and other legal counsel and advisors, as needed, throughout the Bond issuance process to identify requirements and to establish procedures necessary or appropriate so that the Bonds will continue to qualify for tax-exempt status. The District also shall consult with bond counsel and/or other legal counsel and advisors, as needed, following issuance of the Bonds to ensure that all applicable post-issuance requirements are met. This shall include, without limitation, consultation in connection with any potential changes in the use of Bond-financed or refinanced assets.

   The District shall determine (or obtain expert advice to determine) whether arbitrage rebate calculations have to be made for the Bonds. If it is determined that such calculations are, or are likely to be, required the District shall engage expert advisors (each a "Rebate Service Provider") to assist in the calculation of arbitrage rebate payable in respect of the investment of Bond proceeds. The District shall make any rebate payments required on a timely basis including the signing and filing of appropriate IRS forms (e.g., Form 8038-T). Unless otherwise provided by the indenture (or similar document) relating to the Bonds, unexpended Bond proceeds shall be held by a trustee or other financial institution, and the investment of Bond proceeds shall be managed by the District. The District shall prepare (or cause the trustee or other financial institution to prepare) regular, periodic statements regarding the investments and transactions involving Bond proceeds. These statements shall include a certification of compliance and a summary of information collected by the District.

B. Arbitrage Rebate and Yield

The Chief Financial Officer of the District (the "Chief Financial Officer") shall be responsible for overseeing compliance with arbitrage rebate requirements under federal tax law:

1. If, at the time of Bond issuance, based on the District's reasonable expectations, it appears likely that the Bonds will qualify for an exemption from the rebate requirement, the District may defer taking any of the actions set forth in subsection (2) below. Not

later than the time of completion of construction or acquisition of the capital projects financed with proceeds of the Bonds, and depletion of all funds from the project fund, the District shall make, determine, or cause its Rebate Service Provider to determine, whether any of the Bond proceeds qualified for a spending exception or other exception from the rebate requirements. If a rebate exception is determined to be applicable for all of the proceeds of the Bonds, the District shall prepare and keep in the permanent records of the Bonds a memorandum evidencing this conclusion together with records of expenditure (or other records) to support such conclusion. If the transaction does not qualify for an exception to the rebate requirement, for all of the proceeds of the Bonds, the District shall initiate the steps set forth in subsection (2) below.

2. If, at the time of issuance of the Bonds, it appears likely that arbitrage rebate calculations will be required, or upon determination that calculations are required pursuant to subsection (1) above, the District shall:

- engage the services of a Rebate Service Provider and, prior to each rebate calculation date, cause the trustee or other financial institution investing proceeds of the Bonds to deliver periodic statements concerning the investment of Bond proceeds to the Rebate Service Provider;
- provide to the Rebate Service Provider additional documents and information reasonably requested by the Rebate Service Provider;
- monitor the efforts of the Rebate Service Provider;
- assure the payment of required rebate amounts, if any, no later than 60 days after each 5-year anniversary of the issue date of the Bonds, and no later than 60 days after the last Bond of each issue is redeemed;
- during the construction period of each capital project financed in whole or in part by Bonds, monitor the investment and expenditure of Bond proceeds and consult with the Rebate Service Provider to determine compliance with any applicable exceptions from the arbitrage rebate requirements, including during each 6-month spending period up to 6 months, 18 months or 24 months, as and if applicable, following the issue date of the Bonds;
- retain copies of all arbitrage reports and trustee statements as described below under "Record Keeping Requirements" and, upon request, provide such copies to the trustee; and
- establish procedures to ensure that investments that are acquired with Bond proceeds are so acquired at their fair market value.

C. Use of Bond Proceeds and Bond Financed for Refinanced Assets

The Chief Financial Officer shall be responsible for monitoring the use of Bond proceeds and Bond financed assets:

- monitoring the use of Bond proceeds (including investment earnings and including reimbursement of expenditures made before Bond issuance) and the use of Bond-financed or refinanced assets (e.g., facilities, furnishings or equipment) throughout the term of the Bonds to ensure compliance with covenants and restrictions set forth in the Tax Certificate relating to the Bonds;

- maintaining records identifying the assets or portion of assets that are financed or refinanced with proceeds of each issue of Bonds (including investment earnings and including reimbursement of expenditures made before Bond issuance), including a final allocation of Bond proceeds as described below under "Record Keeping Requirements;"

- consulting with bond counsel and other legal counsel and advisers in the review of any change in use, or potential change in use, of Bond-financed or refinanced assets to ensure compliance with all covenants and restrictions set forth in the Tax Certificate relating to the Bonds;

- maintaining records for any contracts or arrangements involving the use of Bond-financed or refinanced assets as described below under "Record Keeping Requirements"; and conferring at least annually with personnel responsible for Bond-financed or refinanced assets to identify and discuss any existing or planned use of Bond-financed or refinanced assets and to ensure that those uses are consistent with all covenants and restrictions set forth in the Tax Certificate relating to the Bonds; and to the extent that the District discovers that any applicable tax restrictions regarding use of Bond proceeds and Bond-financed or refinanced assets will or may be violated, consulting promptly with bond counsel and other legal counsel and advisers to determine a course of action to remediate all nonqualified Bonds or take other remedial action, if such counsel advises that a remedial action is necessary. All relevant records and contracts shall be maintained as described below.

D. Record Keeping Requirement

The Chief Financial Officer shall be responsible for maintaining the following documents for the term of each issue of Bonds (including refunding Bonds, if any) plus at least three years:

- a copy of the Bond closing transcript(s) and other relevant documentation delivered to the District at or in connection with closing of the issue of Bonds;

- a copy of all material documents relating to capital expenditures financed or refinanced by Bond proceeds, including (without limitation) construction contracts, purchase orders, invoices, trustee requisitions and payment records, as well as documents relating to costs

reimbursed with Bond proceeds and records identifying the assets or portion of assets that are financed or refinanced with Bond proceeds, including a final allocation of Bond proceeds;

- a copy of all contracts and arrangements involving the use of Bond-financed or refinanced assets; and

- a copy of all records of investments, investment agreements, credit enhancement, arbitrage reports and underlying documents, including trustee statements, in connection with any investment agreements, and copies of all bidding documents, if any.

E. Continuing Disclosure Compliance Requirement

The Chief Financial Officer shall be responsible for maintaining the following Continuing Disclosure items for each issue of Bonds Outstanding that contain a Continuing Disclosure Certificate:

- Annual Report (send to Dissemination Agent, if applicable, 15 days prior to the December 31st due dates of each report)
  - Audited financials;
  - Any operating data required by the Continuing Disclosure Certificate.
- Quarterly Reports (send to Dissemination Agent, if applicable, 5 days prior to the due dates of each report): (*see Attachment A for further due date details*)
  - Unaudited quarterly balance sheet and statement of revenues and expenditures.
- Report on EMMA or to the Dissemination Agent, as applicable, any of the following listed events within 10 business days of event:
  - Reportable Significant Events:
    - Principal and interest payment delinquencies.
    - Non-payment related defaults, if material.
    - Unscheduled draws on debt service reserves reflecting financial difficulties.
    - Unscheduled draws on credit enhancements reflecting financial difficulties.
    - Substitution of credit or liquidity providers, or their failure to perform.
    - Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue or other material notices of determinations with respect to the tax status of the security, or other material events affecting the tax status of the security.
    - Modifications to rights of security holders, if material.
    - Bond calls, if material, and tender offers.

- Defeasances.
- Release, substitution, or sale of property securing repayment of securities, if material.
- Rating changes.
- Bankruptcy, insolvency, receivership or similar event of the obligated person.
- The consummation of a merger, consolidation, or acquisition involving the District or an obligated person, or the sale of all or substantially all of the assets of the District or an obligated person (other than in the ordinary course of business), the entry into a definitive agreement relating to any such actions, other than pursuant to its terms, if material.
- Appointment of a successor or additional paying agent or the change of name of a paying agent, if material.
- The incurrence of a financial obligation of the District or other obligated person, if material, or agreement to covenants, event of default, remedies, priority rights, or other similar terms of a financial obligation of the District or other obligated person, any of which affect security holders, if material.
- A default, event of acceleration, termination event, modification of terms, or other similar events under the terms of a financial obligation of the District or other obligated person, any of which reflect financial difficulties.

- Maintain the following "best practices" for upholding the continuing disclosure responsibilities, including, in particular:

  - Establish written policies and procedures to ensure that the District submits all documents, reports and notices required to be submitted to the Dissemination Agent or directly to EMMA/MSRB (Municipal Securities Rulemaking Board) in a timely manner. Review and update these policies and procedures annually, as needed.
  - Review offering documents, including the Continuing Disclosure Certificate, confirm compliance with existing continuing disclosure obligations at the time of each new issue and promptly rectify any continuing disclosure lapses.
  - Disclose in each official statement any instances during the prior five years of any failure to comply in all material respects with applicable continuing disclosure obligations.
  - Implement annual training for personnel involved in the bond offering and disclosure process, including familiarity with the significant events described in the Continuing Disclosure Certificate and an understanding of the District's written policies and procedures governing disclosure practices, including continuing disclosure.
  - Identify an individual or individuals who will be responsible for reviewing and complying with the District's continuing disclosure obligations on a regular basis.
  - Maintain a complete and accurate record of the District's continuing disclosure undertakings and filings, including electronic confirmation of continuing disclosure submissions.

- Confirm with EMMA that all continuing disclosure postings are complete and have been filed in a timely manner.
- Ensure that the District or the Dissemination Agent files its notice with EMMA if the District has been late in filing or missed filing any documents with EMMA.
- Develop a calendar reminder system to track quarterly and annual filing deadlines.
- Consult with counsel as needed to resolve potential issues and address any questions.

F. Education and Training

The District will provide responsible staff with education and training on federal tax requirements for post-issuance compliance applicable to the Bonds. The District will enable and encourage responsible staff to attend and participate in educational and training programs offered by professional organizations and other entities with regard to monitoring compliance with federal tax requirements for the Bonds.

ATTACHMENT A:

Sierra View Local Health Care District Revenue Bonds, Series 2019 and Sierra View Local Health Care District Refunding Revenue Bonds, Series 2020

Annual Report: The District shall, or shall cause the Dissemination Agent to, not later than December 31 provide to the MSRB, in an electronic format as prescribed by the MSRB, an Annual Report that is consistent with Section 4(a) of the Disclosure Certificate.

Quarterly Reports: The District shall, or shall cause the Dissemination Agent to, not later than February 15, May 15, August 15 and November 15, provide to the MSRB, in an electronic format as prescribed by the MSRB, a Quarterly Report that is consistent with Section 4(b) of the Disclosure Certificate.

SUBJECT: **PROJECT PLANNING & MANAGEMENT**	SECTION:

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

PURPOSE:

To set forth the framework that is to be used by Sierra View Medical Center (SVMC) in initiating, planning, managing and completing projects.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL; MEDICAL STAFF*

DEFINITIONS:

Project: Any unique endeavor to produce a set of deliverables within clearly specified time, cost and quality constraints. Projects have a defined timescale, an approved budget, have limited resources, involve an element of risk and achieve beneficial change to the organization. Projects may be capital or non-capital in nature.

Capital Project: Any construction, renovation, alteration, remodeling, equipment or system installation, or other improvement undertaken by SVMC at its main campus or any property it owns or leases which will be capitalized as an asset and then depreciated over future periods.

Non-Capital Project: Projects the cost of which will be expensed in the period incurred. Examples of non-capital projects: Service/Business Line Analysis, Throughput/LOS Study, Staffing Needs Assessment.

Functional Manager: A person at a functional department or project contributor level position that assists in the integration of the project within a department or discipline (e.g., clinical coordinator, informatics, engineering, etc.).

Project Management: Project Management is a formalized and structured method of managing change in a rigorous manner. It focuses on achieving specifically defined outputs that are to be achieved by a certain time, to a defined quality and with a given level of resources so that planned outcomes are achieved.

Project Manager: Responsibilities and duties include as defined in the Project Planning and Management Guide, dependent on the scale of the project:

1. Understand the project requirements and ensure that they are thoroughly and unambiguously documented.
2. Manage the day to day aspects of the project.
3. Resolve planning and implementation issues.
4. Monitor the Project Plan's progress and budget.
5. Identify and manage project risks.

6. Ensure the project team is well organized, adequately staffed, and working well together.
7. Manage project cost, schedule, requirements and design baselines so they are traceable.
8. Report meaningful metrics for cost, schedule, quality and risk.
9. Conduct regular status and design reviews.
10. Ensure the adequacy of project documentation and testing.
11. Maintain meaningful communications among project stakeholders.
12. Manage the project to attain the project goals and achieve stakeholder satisfaction.
13. Manage and monitor the project activity through detailed plans and schedules.
14. Report to the Project Sponsor and Senior Leadership at regular intervals, until completion.
15. Approves all invoices related to the project, within the scope and budget of the project in amounts up to $20,000.

Project Planning and Management Department: The Project Planning and Management Department (PPM) is responsible for planning, facilitating and coordinating all projects for SVMC. The purpose of the department is to maintain accountability in terms of cost, time and resources. The PPM develops a detailed plan of major project phases, milestones, activities, tasks and the resources allocated to each task. The PPM reports functionally and operationally to the Vice President of Professional Services. The PPM also interfaces with the Senior Leadership Team and the Project Sponsor.

Project Sponsor: The person within the organization ultimately responsible for ensuring all project goals and target outcomes are achieved before the project closes. To ensure this accomplishment, all Project Sponsors will be a Vice President at SVMC.

1. Hold the Project Manager(s) accountable for fulfilling the responsibilities listed above.
2. Support the Project Manager in obtaining resources and tools needed to conduct the project.
3. Require regular status briefings and design reviews, in order to pass pertinent information regarding the project up to Senior Leadership.
4. Advise the Project Manager on conditions likely to cause project risks.
5. Is an advocate for the Project Manager and the project team.

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6. Reviews and approves project-related invoices greater than $20,000.

Project Team: The Project Team is led by the Project Manager working for the successful delivery of the project outputs. The composition of the Team may change as the project moves though the various phases. The assessment and selection of people with the requisite skills required for each phase of the project is critical to its overall success. The Project Team is responsible for completing tasks and activities required for delivering project outputs.

POLICY:

Project Approval Process:

Proposals for projects are documented on a *Project Initiation Document (PID)*, which is completed by the Project Initiator. The Project Initiator can be a Functional Manager, Department Head, Director, or Division V.P. The documents must be reviewed and approved by an individual at the V.P. level or the CEO.

After this approval is received, the PID is submitted to the Project Planning Department and is reviewed for completeness including required internal approvals, HCAI, IT, Materials Management, Plant Services and Billing considerations. When deemed complete, the project is submitted to Senior Leadership for evaluation. The Project is evaluated against the scope of the SVMC Strategic or Facility Master Plan. If the project falls within the scope of the strategic or facility master plan and adequate funds are either budgeted or available, Senior Leadership may approve the project. If the Project Plan is denied, it is returned to the Project Initiator and no further action is taken.

The Project Manager then assigns a Functional Manager and Project Team depending on the project size and requirements.

Cost Control, Monitoring and Accounting

The Project Planning and Management Department will be responsible for procedural controls over ALL projects. Under the direction of the Vice President of Professional Services, and in conformity with the *Capital Budgeting Process* and *Capital Equipment Management* Policies, the Project Planning and Management Department will:

- Establish and maintain project cost records and an auditable system for the accounting of all expenditures relative to all projects. Reconciles cost records on a regular basis with the General Accounting Department.

- Establish guidelines with respect to key considerations such as prices to be paid, acceptable vendors and terms, asset quality standards and the provision of funds to finance those expenditures.

- Establish reporting procedures for in progress and completed projects.
- Review of accounting distribution to ensure proper allocation of charges to capital asset and expenditure projects.
- If construction work is performed by contractors, follow procedures to provide for and maintain control over the construction projects and progress billings. This could include, but is not limited to, exercising the right to audit contractor records during project performance.
- Distinguish between capital projects fund expenditures and operating budget expenditures.

SUBJECT: PUBLIC RECORDS REQUEST	SECTION: Page 1 of 8

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

PURPOSE:

The purpose of this policy is to set the guidelines for compliance with the California Public Records Act, commencing at Section 6250 of the California Government Code, and other related applicable statutes and case law, by setting forth the procedures to be followed when making records available to the public. It is the policy of the District that non-exempt public records be open for inspection and made available within a reasonable period of time to the requesting party. Pursuant to Section 6253 of the California Public Records Act, a fee equal to the direct cost of duplication may be charged to any person requesting a copy of a public record.

DEFINITIONS:

1. "**District**" the Sierra View Local Health Care District

2. "**Public Record**" includes any writing which contains information relating to the conduct of the public's business and/or which is prepared, owned, used, or retained by the District.

3. "**Writing**" means any handwriting, typewriting, printing, photostatting, photographing, transmitting by electronic mail or facsimile and every other means of recording upon any tangible thing, any form of communication or representation.

AFFECTED PERSONNEL/AREAS: *ALL STAFF*

RECORDS AVAILABLE TO THE PUBLIC:

Agendas or any other writings, except for records exempt from disclosure (including, but not limited to, the items listed below) under section 6254 of the California Public Records Act, distributed to all or a majority of the members of a legislative body for discussion or consideration at an open session public meeting are disclosable to the public upon request, and shall be made available to members of the public in accordance with the provisions of section 54957.5 of the Ralph M. Brown Act. Confidential document and records reviewed or distributed in a closed session of a public meeting are not required to be made available.

All questions as to whether or not a record is exempt from disclosure according to this policy should be referred to counsel for the District.

RECORDS EXEMPT AND/ OR REQUIRING REFERRAL TO COUNSEL FOR THE DISTRICT:

A. Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the District in the ordinary course of business, if the public interest in withholding those records clearly outweighs the public interest disclosure. Cal. Gov. Code. Sec.6254 (a).

B. Records pertaining to pending litigation to which the District is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, until such litigation or claims have been finally adjudicated or otherwise settled. Cal.Gov. Code Sec. 6254 (b).

C. Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy. Cal. Gov. Code Sec. 6254 (c). HIPAA of 1996, Privacy Act of 1974.

D. Requests for the Joint Commission's final accreditation reports (that are forwarded to the State Department of Health Services) should be referred to counsel for the District.

E. Confidential communications between the District and its attorneys. Evidence Code Section 954.

F. Records of documents covered by the attorney work product privilege, or any other judicially recognized privilege, including but not limited to, the deliberative process privilege covered by the Evidence Code.

G. A memorandum submitted to a state body or the District's Governing Board by it legal counsel pursuant to subdivision (q) of California Government Code Section 11126 or 54956.9 until the pending litigation has been fully adjudicated or otherwise settled. The memorandum shall be protected by the attorney work-product privilege until the pending litigation has been finally adjudicated or otherwise settled. Cal.Gov. Code Sec. 6254.25.

H. Trade Secrets – information claimed to be a trade secret at the time of submittal to the District may be treated as a trade secret in accordance with California Government Code Sec. 6254(k) and California Evidence Code Section 1060. **See below Procedure – Paragraph V.B.**

I. Requests for contracts and rates for inpatient and outpatient services should be referred to counsel for the District.

J. Request for contracts and rates for "major risk" and "managed risk" medical insurance program information should be referred to counsel for the District.

K. Real estate appraisals, engineering or feasibility estimates and evaluations should be referred to counsel for the District.

L. Request for records in which the public interest in non-disclosure outweighs the interest in disclosure Gov. Code Section 6255

M. Materials privileged under some other statute. Cal. Gov. Code Sec. 6254(K)

PROCEDURE:

A. Requesting Copies of Public Records

1. Request for Copies. A public records request may be made in writing, orally in person, or by phone. The requests must be addressed to the Board of Directors of Sierra View Local Health Care District (SVLHCD). Requests may be made in paper or electronic form and may be sent by mail, facsimile, email or personally delivered. All requests must be made with sufficient clarity so as to reasonably describe an identifiable record.

(Cal. Gov. Code Sec. 6253). Requests not meeting these criteria may be returned. Reasonable restrictions may be imposed upon general requests for voluminous classes of documents. Copies will not be provided if the disclosure would infringe a copyright or would constitute an unreasonable burden on the operation of the District or the record is exempt from disclosure under the California Public Records Act.

2. Response Time for Determination. The District shall determine within 10 days after the receipt of a public records request whether to comply with the request and shall immediately notify the requestor of its determination and the reasons therefore. Cal. Gov. Code Sec. 6253. The District may extend the determination period for up to 14 additional calendar days by providing the requestor with written notice of the extension period, (a) if there is a need to search for and collect the requested records from various offices that are separate from the office processing the request, (b) the need to search for, collect and appropriately examine a voluminous amount of separate and distinct records with respect to the request, (c) if there is the need to consult with another agency involving the request determination or (d) if there is the need to compile data, write programming language or a computer program, or to construct a report to extract the data. Cal.Gov. Code Sec. 6253 (c). When the District dispatches the final determination to the requestor, and if the District determines that the request is for non-exempt public records, the District will notify the requestor of the approximate date by which the requested public information will be made available to the requestor. If immediate disclosure of the requested records is not possible, the District must provide the records to the requestor within a reasonable period of time.

B. Exempt Records and Trade Secrets

Records that are exempt from the Public Records Act will normally not be released. Exceptions of this policy may be granted at the discretion of the Chief Executive Officer (CEO), only after giving consideration to waiver of privilege as to those documents as to entire public and after giving consideration as to setting precedent as to future requests. Records claimed by third parties to be trade secrets or to otherwise exempt from disclosure will not be immediately released unless the District determines they are clearly public records.

Only information claimed to be a trade secret at the time of submittal to the District may be treated as a trade secret. California law defines trade secret in Civil Code Sec. 3426.1 (d) as materials that derive economic value from not being generally known or known to those who could use it to obtain value; and is and has been reasonably protected from disclosure. Notice will be sent by certified mail to the third party claiming exempt or trade secret status. Such third party is responsible for providing its current mailing address to the District. The notice shall include a copy of the request, and a request for a detailed and complete justification of the basis for exempt or trade secret status, to be provided within 15 calendar days of the date of the letter. If no justification is timely received, the subject records shall be released as specified herein. Any justification claiming trade secret status must include a sworn declaration that should address the following six factors (Restatement of Torts Sec. 757):

1. the extent to which the information is known outside of the person's business;

2. the extent to which it is known by employees and others involved in the person's business;
3. the extent of measures taken by the person to guard the secrecy of the information;
4. the value of the information to the person's business and to the person's competitors;
5. the amount of effort or money expended by the person in developing the information;
6. the ease or difficulty with which the information could be properly acquired or duplicated by others.

In addition, any justification must be specific enough so as to identify which specific information in a document constitutes a trade secret or is exempt so that it may be blocked out in a document, with the remaining information to be released. As a result, all documents subject to the request should be reviewed by the third party claiming exempt or trade secret status before submitting its justification to enable it to specifically segregate information contained in those documents that may or may not be released. Failure to so segregate may result in the release of all information.

The District shall evaluate the justification and any other information at its disposal and shall determine if the justification supports the claim that the material is in fact exempt or is a trade secret under California Government Code Section 6254 and Section 6254.7, respectively. If the District determines that the claim is bona fide and that the material is exempt or a trade secret, the District Administrative Office shall notify the requestor that the data sought is exempt or a trade secret and therefore cannot be released. The requestor shall be advised of its right to bring appropriate legal action to compel disclosure. Any such action should name the third party claiming an exemption from disclosure as a real party in interest.

If the District determines that the claim of exemption or trade secret is not meritorious or is inadequately supported by the evidence, the District shall promptly notify, by certified mail, the third party who claimed exempt or trade secret status that the justification is inadequate, and that the information shall be released after 10 calendar days from the date of receipt of such notice. Such third party shall also be advised of its right to bring appropriate legal action to prevent disclosure, and of its right to further respond. However, such further response, if inadequate, will not toll the 10-day period for release. In the event the third party cannot be reached at its last listed address with the District, the information shall be released after 15 calendar days of the date of such notice. Any legal action brought by the third party should name the requestor as a real party in interest.

The above procedures regarding exempt records and trade secrets do not apply to requests made by other governmental agencies for purposes of carrying out their official responsibilities, if such agencies agree to treat the disclosed material as confidential pursuant to a written confidentiality agreement with the District. The confidentiality agreement shall designate those persons authorized by the requesting governmental agency to obtain the information. Cal. Gov. Code Sec. 6254.5(e).

The above procedures are also inapplicable if there requestor and the third party enter in to an agreement waiving any objections to the District's release of the requested information. A signed copy of the agreement must be provided to the District.

C. Subpoenas

The Public Records Act is not applicable in situations where subpoenas have been issued against the District for document production. Any such subpoenas shall be referred to District Counsel's Office unless otherwise directed by that office, or handled following the Handling of Subpoenas, Summons, and Complaints Policy.

D. Request for Access to Inspect Specific Files

It is the policy of the District that all records open for public inspection shall be available with the least possible delay and at the expense of the requesting party, except if the law provides an exemption from mandatory disclosure. Public records are open to inspection at all times during the office hours of the District, and every citizen has a right to inspect any public record as defined herein. To permit sufficient time for the District to compile the records for review, an appointment to view the records should be made by the requestor.

Records that are exempt from the Public Records Act and records claimed to contain trade secrets will be handled in the manner described in Subsection V.C. If a delay occurs, the requestor will be notified of the reasons and offered the option of either viewing that portion of the records that is available or waiting until the complete record is available.

The Board Clerk, or a designated representative, will be available to assist the requestor during the inspection. The requestor will be provided with the records and a work space. The Board Clerk or the designated representative will ensure that no records are removed or altered. If the requestor asks for photocopies or the electronic record of certain records, the Board Clerk will arrange for the copies and/or the electronic records to be provided to the requestor within a reasonable time period. The following requirements regarding fees will be applicable.

E. Request for Public Records in an Electronic Format

Per Government Code Section 6253.9

(a) Unless otherwise prohibited by law, any agency that has information that constitutes an identifiable public record not exempt from disclosure pursuant to this chapter that is in an electronic format shall make that information available in an electronic format when requested by any person and, when applicable, shall comply with the following:

1. The agency shall make the information available in any electronic format in which it holds the information.

2. Each agency shall provide a copy of an electronic record in the format requested if the requested format is one that has been used by the agency to create copies for its own use or for provision to other agencies. The cost of duplication shall be limited to the direct cost of producing a copy of a record in an electronic format.

(b) Notwithstanding paragraph (2) of subdivision (a), the requestor shall bear the cost of producing a copy of the record, including the cost to construct a record, and the cost of

programming and computer services necessary to produce a copy of the record when either of the following applies:

1. In order to comply with the provisions of subdivision (a), the public agency would be required to produce a copy of an electronic record and the record is one that is produced only at otherwise regularly scheduled intervals.

2. The request would require data compilation, extraction, or programming to produce the record.

(c) Nothing in this section shall be construed to require the public agency to reconstruct a record in an electronic format if the agency no longer has the record available in an electronic format.

(d) If the request is for information in other than electronic format, and the information also is in electronic format, the agency may inform the requestor that the information is available in electronic format.

(e) Nothing in this section shall be construed to permit an agency to make information available only in an electronic format.

(f) Nothing in this section shall be construed to require the public agency to release an electronic record in the electronic form in which it is held by the agency if its release would jeopardize or compromise the security or integrity of the original record or of any proprietary software in which it is maintained.

(g) Nothing in this section shall be construed to permit public access to records held by any agency to which access is otherwise restricted by statute.

F. Fees for Copies or Electronic Format of Public Records

There is no fee for less than ten (10) pages of public records. For ten or more pages, the fee is .25 cents per page for all pages, including the first nine (9). Staff time will not be charged for providing copies or electronic format of existing identifiable documents.

The Public Records Act requires "payment of fees covering direct costs of duplication, or a statutory fee, if applicable." Cal. Gov. Code Sec. 626253(b). If the charges are estimated to exceed $50.00, the requestor will be notified before the Board of Directors office begins processing the request. If the costs will exceed $200.00, the District will require advance payment before the copies are made. In all other cases, the District Administrative Office will submit an invoice for any remaining charges.

RESPONSIBILITIES

District Administrative Office

The District Administrative Office will have primary responsibility for coordinating the District's compliance with the California Public Records Act. That responsibility includes:

1. Receiving, logging, and tracking all requests for public records
2. Sending copies of requests to all applicable divisions within one business day
3. Assisting the public in understanding what information is available, and what must be done to obtain access to, or copies of, public records
4. Ensuring the District Counsel's Office have reviewed the request if necessary and provided their comments as to whether the requested records may be released
5. Requesting and obtaining the required information from the appropriate division(s)
6. If a record has been identified as a trade secret or appears to be confidential, follow the procedures outlined above dealing with trade secrets
7. Providing the necessary notices and public records is within the appropriate periods as outlined in these guidelines
8. Ensuring that all records are safeguarded
9. Making sure that all originals of records are returned to the appropriate division as soon as possible
10. Ensuring that requests from the media are coordinated with the Marketing Department

The approved records will be provided within ten calendar days of the receipt of the request, unless the volume of the material warrants additional time.

If additional time is necessary, the District Administrative Office will provide the requestor a good faith estimate of when the copies will be available.

District Counsel

The District's Counsel Office will be responsible for providing legal guidance in determining which records may be released under the Public Records Act. The District Administrative Office shall provide District Counsel with those documents that are alleged to be trade secrets or exempt from the Public Records Act.

In addition, the District Administration Office will immediately provide District Counsel with all correspondence relating to the justification of exempt or trade secret status. The District Administrative

Office will then be responsible for maintaining a separate file for those records which may not be released, and for releasing the remaining records pursuant to these guidelines.

REFERENCES:

- California Legislative Information (as of March 2019)Cal. Gov. Code Sec. 6250-6276.48. Retrieved from leginfo.legislature.ca.gov
- Summary of the California Public Records Act 2004 (August 2004). Retrieved from ag.ca.gov

CROSS REFERENCES:

- Subpoenas, Summons, and Complaints Policy, Handling of

SUBJECT:	SECTION:
PURCHASE AUTHORIZATION	***Materials Management Purchasing***
	Page 1 of 2

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) that all items purchased for the operations, administration and upkeep of the hospital and clinic properties, equipment, supplies and services are processed via requisition, purchase order, receipt and invoice and have a corresponding account, administrative authorization or proper signature authority. It is Materials Management's responsibility to assure proper procedures are observed in all purchases except those administered in Dietary, Environmental Services and Pharmacy.

AFFECTED PERSONNEL/AREAS: *ALL SVMC PERSONNEL*

PROCEDURE:

A. Stock

These items are for the department's operational requirements that are housed, ordered and inventoried in the Materials Management Storeroom, stocked and managed by Materials Management Distribution Staff using a Par Replenishment Method in the Meditech MMIS System that is calculated to track utilization of said item(s), utilizes automated reorder points and creates system generated reorders requests. These items are also checked for item integrity and expiration dates. If these items are removed from the designated stocking area that Materials Management Distribution staff stocks in the User Department, the user department staff is accountable for the cleanliness, condition and expiration date of the stock item.

B. Non Stock

Items that are inventoried by Materials Management Distribution Staff in the User Departments designated stocking area. These items, like Stock, have Par Levels and item numbers and have system generated reorder points. The main difference is that these items come directly from the vendor to the User's Department, there is no stock in the Materials Management Storeroom for item replenishment. These items are also checked for item integrity and expiration dates. If these items are removed from the designated stocking area that Materials Management Distribution staff stocks in the User Department, the user department staff is accountable for the cleanliness, condition and expiration date of the stock item.

C. Non-Stock/Non Inventory and Equipment

These items are ordered by the User Department designated staff on a requisition form to Materials Management Purchasing. These items are delivered directly to the requesting department and are the User Department's responsibility. The User Department is responsible for the integrity and expiration dates of said item(s). This items are to be affixed with a Green Label, supplied by Materials Management Administrative Staff

D. Capital Order Purchases

Capital Order purchases are major items procured for the operations of departments that are approved in advance by the Capital Budget Committee, Senior Management and the Board of Directors. These items are scheduled by quarter and calendared.

E. Emergency Capital Orders

Emergency Capital Orders are submitted to the Chief Financial Officer (CFO) for review and approval based on contingency funds and need.

F. Signature Authority

Current guidelines for budgetary signature authority:

Position Title	Threshold Amount
Director	$5,000
Administrative Director	$7,500
Vice President	$15,000
CFO and CEO	>$15,000

CROSS REFERENCES:

- CHECK SIGNING AND CASH DISBURSEMENTS
- OPERATIONAL EXPENSE APPROVAL LIMIT FOR DEPARTMENT DIRECTORS AND ADMINISTRATIVE DIRECTORS

SUBJECT:	SECTION:
Supply Outdates and Management – External Locations	***Standardized Procedures***

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

PURPOSE:

That all products utilized in Clinic Operations that are required to have a shelf life date which clarifies current product is in-date, and is not within 30 days of expiration.

DEFINITION:

POLICY:

All supplies utilized is Clinical Operations, that are affixed with an expiration date, shall be checked monthly to assure that no supply stocked on their shelves, cabinets and any other ancillary storage areas do not display a date that has expired. If a product has an expired date, it should be immediately removed from stock, segregated in an area that is secure, and notification should be sent to Clinical Management. Supplies within thirty (30) days of expiration should immediately be pulled from all stocking areas and sequestered. Clinical Management shall then contact Supply Chain/Materials Management Department for items to be removed from their premises and disposed of in the proper manner.

AFFECTED PERSONNEL/AREAS:

ALL EXTERNAL CLINICAL OPERATIONS, STAFF, PHYSICIANS, AND ADVANCED PRACTICE PROVIDERS

PROCEDURE

Out Date management will be conducted as follows:

1. On a monthly basis, the Clinic Manager or designee will review the medical supply inventory (i.e.: Medical Supplies, Lab Supplies, Lab Kits and Reagents and Sterilized instruments.) and will check those items for expiration dates and document on the Monthly Supply Check List (see below).

Monthly Supply Check List

Month	Date Inventory Checked	Findings (If Applicable)	Staff Initials
January 2022			
February 2022			
March 2022			
April 2022			
May 2022			

June 2022			
July 2022			
August 2022			
September 2022			
October 2022			
November 2022			
December 2022			

2. Pre-packaged items due to expire within the next 60 days will be marked with a red dot which will be marked with the actual expiration date. Use of these items will be prioritized.

3. Items that are due to expire within thirty (30) days will be removed from active inventory, placed in a plastic bin with cover and delivered to the Clinic Manager, who maintains the QAPI records for supply outdates (see Supply Outdate Log below). Clinic Manager will ensure return of the items to the SVMC Supply Chain/Materials Management Department.

Supply Outdate Log

Date	Item Name	Lot	Quantity	Date Sent to MM	Received by	Staff Initials

4. Medication in-date status will be managed via the Pyxis machine and by physical review by the Pharmacy Department. Medications that have neared their expiration date will be removed by Pharmacy staff and replaced with in-date inventory.

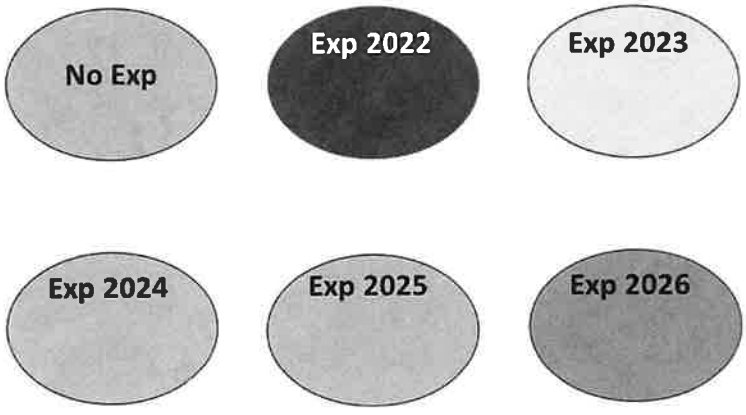
5. Lab reagents and lab testing kits/supplies will be marked with their expiration date upon receipt in the Clinic. Inventory will be checked monthly. Items that will expire within the month or that have expired will be placed in the lab-located basket marked "Do Not Use – Expired Lab Supplies - Return to Lab".

6. Instrument packs that have been sterilized will be checked for expiration dates and package integrity on the same monthly schedule. Packs that are due to expire in less than 30 days or that have damaged packaging, will be unpackaged and returned to SVMC Sterile Processing Department for re-sterilization.

Supply management will be conducted as follows:

1. Supplies will be delivered by Supply Chain/Materials Management Department. Upon receiving supplies clinic staff will conduct a supply inspection checking for any leaks, broken seals and expiration date. If item(s) being stocked do not pass this initial inspection, the item(s) will be segregated and sent to the Supply Chain/Materials Management Administration for disposition.

2. Supplies will be stocked utilizing the colored dot method shown below, which represents the expiration year for that product. This method has a revolving dot cycle of five years, when the year for which each associated color passes, that color will represent the next year in the current five year sequence. For example, when 2021 expired the associated color (Red Orange) became the associated color for 2026. In the case that a product has an expiration period longer than five years staff will consider these situations on a case by case basis and determine the best method for identifying products that expire longer than five years.



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MEDICAL EXECUTIVE COMMITTEE	11/02/2022
BOARD OF DIRECTORS APPROVAL	
	11/22/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
November 22, 2022 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Administration of Pneumococcal Vaccine to Inpatients	1-4	↓
• Changing a Trach Tube on Subacute	5-7	
• Changing a Tracheostomy Tube on Sub-Acute Unit	8-10	
• DP/SNF COVID 19 Policy & Procedure	11-19	
• DP/SNF Resident/Family Council Policy and Procedure	20-21	
• Free Choice	22	
• Interdisciplinary Assessment and Reassessment DPSNF	23-32	
• Mandated Abuse Reporting – DP/SNF	33-40	
• Non-Discrimination on the DP/SNF	41-43	
• Notification and Exercise of Rights and Responsibilities	44-45	
• Precautions for Antibiotic-Resistant Microorganisms	46-51	
• Pressure Ulcer Prevention Plan DPSNF	52-62	
• Range of Motion	63-70	
• Resident Rights – Medical Decisions	71	
• Safe Patient Handling and Mobility	72-75	
• Skin Care Tips for Nursing Assistants	76-77	
• Skin Integrity Team Guidelines	78-79	
• Utilization of Patient's Home Ventilator/CPAP Unit During In Patient Stay	80-81	
• VAC Therapy – Negative Pressure Wound Therapy System DPSNF	82-93	
• Water Pass	94	

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

POLICY

PURPOSE: To provide guidelines for the administration of pneumococcal vaccine to all inpatients who meet criteria established by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

A. **BACKGROUND**: *Streptococcus pneumoniae (S. pneumoniae*) is a gram-positive facultative anaerobe with more than 100 known serotypes. Although most serotypes cause serious disease only a few cause pneumococcal infections such as meningitis, bacteremia and pneumococcal pneumonia. Vaccination opportunities for those with an increased risk of pneumococcal disease are missed during two critical times – regular office visits and during hospitalization. Screening followed by immunization of at-risk hospital patients (see Table 1) would significantly reduce the complications associated with pneumococcal disease, up to and including death.

B. **PREREQUISITES**: Offer to any inpatient who meets criteria in Table 1, especially:

   a. Patients age 65 years or older
   b. Immunocompromised patients including, but not limited to, patients with chronic heart, pulmonary renal, metabolic or liver disease; cancer, anemia, alcoholism, HIV/AIDS, etc. (See Table 1, from Epidemiology and Prevention of Vaccine-Preventable Diseases, CDC)
   c. Any vaccine recipients with more than 5 years since the last vaccination
   d. In 2021, ACIP recommended use of PCV20 for all adults aged ≥65 years who have not previously received a pneumococcal vaccine or whose previous vaccination history is unknown

C. **PRECAUTIONS:** The following should be taken into consideration before administering pneumococcal vaccination:
   a. The patient should wait to be vaccinated if moderately or severely ill
   b. The patient should wait to be vaccinated if the health care provider decides to postpone vaccination

D. **CONTRAINDICATIONS AND RISKS:** The patient should tell the vaccination provider if any of the following conditions exist:
   a. The patient has received two pneumococcal vaccine doses
   b. The patient received the vaccine less than 5 years ago
   c. The patient is allergic to the vaccine or any component of the vaccine
   d. The patient is pregnant – women who are at increased risk of pneumococcal disease and who are candidates for pneumococcal vaccine should be vaccinated before pregnancy, if possible
   e. The patient has had any neurological reaction(s) to the vaccine
   f. The patient is at risk for having less than 50,000 platelets per microliter of blood
   g. The patient has a fever greater than 38°C/100.4°F at the time of vaccination
   h. The patient refused vaccination (notify the physician)
   i. Physician provides orders that the patient not be given the vaccine
   j. Lesser known risks or reactions include pain, redness or swelling at the injection site, mild fever, headache, feeling tired, etc. (Consult product insert for additional lesser known risks)

Conditions for Administration of PCV13 and PPSV23 in Adults

Medical Condition(s)	PCV 13 indicated for age 19 years or older	PSV23 indicated for age 19 through 64 years	PPSV23 revaccination indicated for age 19 through 64 years	PCV13 indicated for age 65 years or older	PPSV23 indicated for age 65 years or older
None	No	No	No	Based on shared clinical decision-making	Yes If PCV13 has been given, then give PPSV23 at least 1 year after PCV13
Chronic heart disease, chronic lung disease, diabetes, alcoholism, chronic liver disease (including cirrhosis), current cigarette smoking, asthma	No	Yes	No	Based on shared clinical decision-making	Yes If PCV13 has been given, then give PPSV23 at least 1 year after PCV13 and at least 5 years after any PPSV23 given at less than age 65 years
Cerebrospinal fluid leak, cochlear implant	Yes	Yes At least 8 weeks after PCV 13	No	Yes If no previous PCV13 vaccination	Yes At least 8 weeks after PCV13 and at least 5 years after any PPSV23 given at less than age 65 years
Functional or anatomic asplenia (including sickle cell disease/other hemoglobinopathies)	Yes	Yes At least 8 weeks after PCV13	Yes At least 5 years after first dose of PPSV23	Yes If no previous PCV13 vaccination	Yes At least 8 weeks after PCV13 and at least 5 years after any PPSV23 given at less than age 65 years
Immunocompromising conditions*	Yes	Yes At least 8 weeks after PCV13	Yes At least 5 years after first dose of PPSV23	Yes If no previous PCV13 vaccination	Yes At least 8 weeks after PCV13 and at least 5 years after any PPSV23 given at less than age 65 years

*Includes congenital or acquired immunodeficiencies, Hodgkin's Disease, lymphoma, leukemia, multiple myeloma, generalized malignancy, and other cancers if on immunosuppressive therapy; HIV infection; chronic renal failure; nephrotic syndrome; organ transplant; and immunosuppressive medications, including chemotherapy and high-dose corticosteroid treatment.

E. RESPONSIBILITIES INCLUDE:

a. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician's Assistant (PA), or a physician (MD or DO)
b. Prior to administering vaccines for the first time at SVMC, the health care professional must conduct an initial review of the CDC immunization criteria and the SVMC Standardized Procedures for Immunizations
c. The Nursing Staff will review the SVMC Standardized Procedures for Immunizations annually during the Competency Fair

d. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language must be provided to the vaccine recipient and recorded in the EMR or office log, along with the publication date of the VIS (See References for link to the VIS)

F. PROCEDURE:

a. Treatment
   i. Assess the inpatient for the need of pneumococcal vaccination.
   ii. Screen all adult inpatients for contraindications and precautions associated with the administration of pneumococcal vaccine.
   iii. If inpatient gives consent provide a copy of the most current Pneumococcal Vaccine Information Statement (VIS) in the language appropriate for the recipient.
   iv. Administer the manufacturer's recommended dose of the pneumococcal vaccine

b. Education
   i. As stated in the treatment section above, provide a copy of the most current VIS. Document in the inpatient's medical record or office log that the VIS was provided, the publication date of the VIS and the date the education was provided (see below for more information on documentation). Provide non-English speakers with a copy of the VIS in their native language if it is available. These may be obtained through the link in the cross-reference below or at the website www.immunize.org/vis

c. Follow-up
   i. Reassess the inpatient within 15 to 30 minutes to make sure that there are no immediate adverse side effects such as anaphylaxis, to any component of the vaccine
   ii. Be prepared to manage any medical emergency related to the administration of the vaccine.
      1. Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). VAERS for reporting only, no medical advice is available. Contact VAERS at **www.vaers.hhs.gov** or call **1-800-822-7967**
   iii. The following items should be available at the time of vaccination:
      1. A written emergency protocol specifically for vaccination reactions
      2. Equipment and/or medication described in the written emergency protocol

d. Documentation
   i. The following items should be documented in the medical administration record
      1. Date of vaccination
      2. The manufacturer and lot number
      3. The vaccination site and route
      4. The name and title of the person administering the vaccine
      5. Note that the VIS was provided (see above in Education)
      6. If the vaccine was not administered, record the reason(s) (e.g. medical contraindication, refusal, etc.)

G. DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

a. The Infection Prevention Committee, the Infection Prevention Manager and the Medical Director of Infection Prevention will participate in the development and approval of the standardized procedure for the administration of pneumococcal vaccine to inpatients
b. The review is to be done on a yearly basis to incorporate any updated or new information on pneumococcal vaccines.

REFERENCES:

Kobayashi M, Farrar JL, Gierke R, et al. Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices — United States, 2022. MMWR Morb Mortal Wkly Rep 2022;71:109–117. DOI: http://dx.doi.org/10.15585/mmwr.mm7104a1external icon.

CDC: Advisory Committee on Immunization Practices (ACIP). GRADE: 20-valent pneumococcal conjugate vaccine (PCV20) for adults aged ≥65 years. (2021) Page last reviewed January 27, 2022, Accessed September 6, 2022 from: https://www.cdc.gov/vaccines/acip/recs/grade/pneumo-PCV20-age-based.html#:~:text=In%20October%202021%2C%20the%20ACIP,previous%20vaccination%20history%20is%20unknown.

CDC: Advisory Committee on Immunization Practices (ACIP). Pneumococcal ACIP Vaccine Recommendations. Page last reviewed January 28, 2022, Accessed September 6, 2022 from: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases – Chapter 17: Pneumococcal Disease (The Pink Book). Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. Accessed September 6, 2022 from https://www.cdc.gov/vaccines/pubs/pinkbook/index.html

CDC: Pneumococcal Vaccine Timing for Adults, Informational Sheet. April 1, 2022, accessed September 2, 2022 from www.cdc.gove/pneumococcal/vaccination.html

CROSS-REFERENCES:

Pneumococcal Conjugate Vaccine: *What You Need to Know* February 4, 2022

Pneumococcal Polysaccharide Vaccine (PPSV23): *What You Need to Know* October 20, 2019

Pneumococcal Vaccine Timing for Adults April 1, 2022

SUBJECT: **CHANGING A TRACH TUBE ON SUBACUTE**	SECTION:

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

PURPOSE:

To define a consistent method for changing a tracheostomy tube while ensuring resident safety and welfare.

POLICY:

The Respiratory Care Practitioner and/or Registered Nurse will be responsible for changing the tracheostomy tube once per month and prn. A Portex D.I.C. non-fenestrated cuffed tracheostomy tube will be used unless another is indicated by the MD. Any resident not utilizing this brand of tracheostomy tube on the DP/SNF Unit must be changed within 48 hours, unless the tracheostomy is less than 30 days old or the MD may have ordered a specialized type of tracheostomy tube for certain residents. Then, the Respiratory Care Practitioner and/or the Registered Nurse will wait 30 days prior to changing the tracheostomy tube. All residents will have the same size or one size smaller tracheostomy tube at his/her bedside.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE*

PROCEDURE:

1. Wash hands thoroughly and wear gloves.
2. Place all necessary pieces of equipment at the resident's bedside.
3. Manually ventilate the resident (if indicated).
4. Hyperextend the resident's neck by placing a folded towel under the neck or remove pillow from behind the head.
5. Suction the tracheostomy tube until clear.
6. If a cuffed tracheostomy tube is being inserted, first check the pilot balloon by injecting with 5cc of air. Withdraw the air and place water-soluble jelly onto tracheostomy tube.
7. Manually ventilate the resident (if on Continuous Mechanical Ventilation). At the end of their inhalation, remove the tube carefully; insert the new tube into the stoma.
8. Tie the trach tube with trach collar around the resident's neck, leaving room for the insertion of two fingers between the resident's neck and trach collar. This is a safety check procedure to assure that the tie is not too tight.
9. Attach trach tube to T-piece/ suction tubing connection with trach tie.
10. Suction resident again, if necessary.

EQUIPMENT:

- Tracheostomy tube (similar size or one size smaller)
- Tracheostomy tube ties/trach collar
- Water soluble jelly
- Sterile gloves
- Suction catheter
- Resuscitation bag with trach tube connection and mask on standby
- 5cc syringe

SPECIAL CONSIDERATION:

The resident has a right to refuse monthly tracheostomy changes. When this occurs, document the patient's refusal in the Electronic Medical Record (EMR).

CONTRAINDICATIONS:

- The tracheostomy tube should not be changed when the resident's condition is too unstable to warrant this procedure.
- The tracheostomy tube should not be changed when there is existence of neck and facial edema sufficient to make the reinsertion of the new tracheostomy tube very difficult.

ASSESSMENT OF THERAPY:

- Breath sounds should be assessed immediately after replacing the tube to determine proper tracheostomy tube placement.
- Heart rate, respiratory rate, and SpO2 will be monitored before and after the procedure.
- Make sure there is another tracheostomy tube (same size or one size smaller) at resident's bedside.

HAZARDS:

- Bleeding
- Tracheostomy tube may not be easily reinserted
- Hypoxia

- Paroxysmal coughing
- Pneumothorax
- Cardiopulmonary arrest
- Infection

REFERENCES:

- Johnson, William A., MD. (2020, February 14) *Clinical Procedures, Tracheostomy Tube Change.* Medscape WebMD. Retrieved from https://emedicine.medscape.com.
- American Association for Respiratory Care (2010). *Endotracheal Suctioning of Mechanically Ventilated Patients With Artificial Airways 2010.* AARC Clinical Practice Guidelines. Retrieved from http://rc.rcjournal.com/content/respcare/55/6/758.full.pdf.

SUBJECT: **CHANGING A TRACHEOSTOMY TUBE ON SUB-ACUTE UNIT**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define a consistent method for changing a Tracheostomy Tube while ensuring patient safety and welfare.

POLICY:

The RCP and RN will be responsible for changing the Tracheostomy tube once per month and prn every patient that has a tracheostomy tube will have a replacement tracheostomy tube hanging on the wall at the head of the bed. This tube will be the same size the patient has inserted or one size smaller if the same size is not available at the time.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE*

PROCEDURE:

1. Wash your hands. Put on clean gloves and eye protection.
2. Remove the replacement tracheostomy tube from its packaging. Take care not to cause any damage to the cuff, the tubing used to inflate the cuffs, or to the control balloon.
3. Remove the inner cannula (if supplied).
4. Use a clean dry syringe to inflate the cuff up to the right volume for the leak test. You will find this volume listed in the package leaflet enclosed with the tube. The air volume can be read off the markings on the syringe.
5. Using the syringe, release all the air again. While doing so, push the cuff carefully off the end of the tube in the direction of the neck flange. Make sure that you remove all air. (This makes it easier to insert the tube.)
6. Thread the tube holder through one of the openings on the neck flange. If appropriate, insert the obturator in the tube (carry out this step before you insert the tube); have a new tracheal compress ready at hand.
7. To make the tube slide in better, coat it with a thin layer of lubricant.
8. Place the tube on a sterile surface.
9. If necessary, suction off any secretions out of the old tube that have collected above the cuff.
10. Using the syringe, release all air from the cuff on the old tube that is still in the trachea. Now remove the tube. If you are not able to remove the old tube, consult your doctor.
    Never apply force.

11. Carefully insert the new tube while the patient is inhaling. Advance the tube with an arching motion first towards the back and then downwards. While doing this, insert the tube at an angle and push it with a slight turning movement into a central position. Positioning the patient with the neck extended to bring trachea forward should be done on all patients unless contraindicated (ie cervical spine injury).

12. Remove the obturator immediately while holding the tube in place with your fingers.

13. Now use the tube holder to secure the tube in place.

14. Insert the new inner cannula, making sure that it is fastened properly. You will find further instructions on how to do this on the package leaflet enclosed with the tube.

15. Inflate the cuff to the correct pressure using a cuff pressure monitor (cpm). Your doctor will tell you what pressure to use. Recommended value: 25 mmHg, do not exceed 30 mmHg.

16. Check the cuff pressure using the cuff pressure monitor (cpm).

17. Carry out stoma care as usual; perform suctioning once more as required.

EQUIPMENT:

- Tracheostomy tube (similar size and one size smaller than patient)
- Tracheostomy tube ties
- Water soluble jelly
- Sterile gloves
- Suction catheter
- Resuscitation bag with mask on standby
- 5cc syringe

CONTRAINDICATIONS:

- The patient's condition is too unstable to warrant this procedure.
- The existence of neck and facial edema sufficient to make the reinsertion of the new Tracheostomy tube very difficult.

ASSESSMENT OF THERAPY:

- Breath sounds should be assessed immediately after replacing the tube to determine proper Tracheostomy tube placement.
- Heart rate, respiratory rate, and SpO2 will be monitored before and after the procedure.
- Make sure there is another Tracheostomy tube (same size or one size smaller) at patient's bedside.

HAZARDS:

- Bleeding
- Tracheostomy tube may not be easily reinserted
- Hypoxia
- Paroxysmal coughing
- Pneumothorax
- Cardiopulmonary arrest
- Infection

INFECTION CONTROL:

Universal precautions

REFERENCES:

- Tracheostomy education: Tracheostomy tube changes. (2019, June 5). Retrieved from https://www.tracheostomyeducation.com/tracheostomy-tube-changes/

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

Introduction

The policy and procedures (P&P) within this document help create a uniform process for facility employees to follow regarding infection prevention and control (IPC) for patients with confirmed Coronavirus Disease 2019 (COVID-19) or persons under investigation for COVID-19 (PUIs). Note, this document does NOT expound upon treatment of suspected or confirmed cases, and leaves treatment considerations to the clinical expertise of those qualified providers using contemporary treatment standards and their professional judgement.

This policy and procedures document is sourced by CDC recommendations and specified to the long term care (LTC) setting per the Post-Acute Long-Term Care (PALTC) guidance offered by AMDA. This P&P serves as a template for facilities to edit and adopt to the specifications most appropriate for their unique circumstance(s). It contains sample documents to utilize when building a facility specific program. It is founded on the full but currently limited information available as this infectious outbreak remains a dynamic epidemiologic scenario. Judicious policy updates can be issued as more information becomes available. This P&P follows an aggressive approach, assuming an abundance of caution, and is modeled after past respiratory infection threats.

Background

The disease COVID-19, caused by the virus SARS-CoV-2 (colloquially termed "coronavirus"), induces flu-like symptoms and may lead to acute respiratory illness.

Due to its highly communicable nature, recent increases in transmission rate across national borders, and lack of antiviral treatment options and a developed vaccine, it is imperative that clients rapidly employ standardized infection prevention and control (IPC) policies and procedures to respond to the growing COVID-19 threat.

Clinical presentation: Fever, cough, shortness of breath.

Clinical course: Varies from asymptomatic/mild infection to severe and potentially fatal illness. As with other infectious diseases, immunocompromised patients are at greatest risk. Mortality increases with advanced age. Pneumonia, dyspnea, and acute respiratory syndrome may develop.

Virus transmission: Initially, contaminated livestock/food products (exposure to Huanan seafood market considered likely source of initial Wuhan province outbreak); now, person-to-person transmission via close physical contact and respiratory droplets.

Policy

Facility personnel are responsible for appropriately triaging patients suspected of COVID-19 and implementing IPC measures to minimize infection transmission. Each facility will designate a

single qualified person or committee of qualified persons to ensure adherence to the following procedures as the COVID-19 IPC Champion(s).

Responsibilities

a. All facility personnel will be charged with complying with the following procedures for maximal infection prevention and control.
b. Facility administrator will designate a facility agent(s) who will champion the employment of the following IPC measures.
c. IPC Champion(s) will institute the following procedures in the facility, assign corresponding responsibilities to appropriate facility staff as needed, and be responsible for requisite reporting to outside sources.

Procedures

1. **Minimize Exposure Opportunities**

i. Place visual alerts for hand hygiene, respiratory hygiene, facemask placement, and COVID-19 symptoms.

ii. Provide supplies (as available – record instances of critical shortages that prevent availability) for respiratory hygiene and cough etiquette in same areas.
    1. 60%-95% alcohol-based hand sanitizer (ABHS)
    2. Tissues
    3. No touch receptacles for disposal
    4. Facemasks

iii. Inform staff at unit from which prospective residents are transferred, in cases of brief acute hospitalization, to proactively inform facility if patients have symptoms of respiratory infection

iv. Assume high clinical suspicion of COVID-19 for new admissions/readmissions until infection risk is ruled out. Place on droplet precautions x 14 days, preceded by Covid Testing and provision of results prior to discharge. If result is positive, patient/resident will stay in Acute Covid Unit.

v. Initiate quick and consistent triage of incoming patients per CDC evaluation guide to identify potential PUIs (Persons Under Investigation)
   1. Assess patient for following symptoms
      a. Fever
      b. Cough
      c. Shortness of Breath
   2. Inquire into potential infection among patient's family/close contacts
   3. Inquire into patient's travel history to areas experiencing sustained SARS-2-CoV transmission
   4. Utilize the CDC's clinical criteria for assigning a PUI with **suspected-case diagnosis of COVID-19** *(figure 1)*

Figure 1

Clinical Features	&	Epidemiologic Risk
Fever[1] or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including healthcare workers[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas[5] (see below) within 14 days of symptom onset
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)[6]	AND	No source of exposure has been identified

2. Manage suspected and confirmed cases of COVID-19

a. Placement of PUIs
   i. Place individuals meeting CDC-suspected case definition in a designated, isolated, negative-pressure room
      1. If facility does not have such a quarantine room readily available, place individual in a private room, with droplet precaution implemented, follow fever/respiratory-illness applicable algorithm which includes influenza A & B and Covid testing. Trained staff will perform testing. Further steps mentioned herein are specified accordingly in proceeding segments.

ALGORITHM FOR FEBRILE PATIENT

IF TEMPERATURE > 100.0 FROM ANY SOURCE

- **IMMEDIATELY PLACE THE RESIDENT IN DROPLET PRECAUTIONS**
- **OBTAIN CONTINUOUS PULSE OXIMETER FROM RESPIRATORY THERAPY; RT WILL SET UP.**
- **NOTIFY MD AND OBTAIN ORDERS FOR TYLENOL 650mg AND LABS AS LISTED BELOW**
- **PERFORM COOLING MEASURES**
- **NOTIFY DP/SNF LEADERSHIP; NOTIFY COMMAND CENTER @ EXT 3730 - COMMAND CENTER WILL ASK FOR RESIDENT FACE SHEET AND ORDER COVID-19 TESTING. IF COMMAND CENTER ORDERS COVID-19 TEST KIT WE MUST WRITE AN ORDER; *"Perform RNA COVID-19 test due to elevated temperature." If CXR done & results are available you may include in order; "Perform RNA COVID-19 test due to elevated temperature & CXR results."***

If resident is afebrile without aid of antipyretics (Tylenol and/or Ibuprofen as ordered) for 72 hours; may discontinue Isolation/Droplet Precautions (72 hour protocol established with DP/SNF Medical Director)

AFTER ONE HOUR TEMPERATURE BELOW 100.0

NO

If resident tolerates tube feeding, continue current order for tube feeding;

If NOT:
- Keep NPO x 6 hours
- Insert saline lock
- D5 ½ NS @ 75ml/hour; DC after 6 hours & maintain saline lock

If tube feeding held:
- Restart @ ½ goal rate over 4 hours as tolerated
- Do the following:
  1. **CBC with Manual Differential**
  2. **Blood cultures x 2**
  3. **UA, C&S if indicated**
  4. **Sputum C&S**
  5. ***Perform testing for Influenza A&B & COVID-19 as noted above.***
  6. ***If respiratory status worsens, order CXR***

YES

Monitor Vital Signs and SpO2 every four hours and record in EMR if temperature <99.0

- **For sustained temperature >= 99.0 monitor and record every 2 hours.**
- **If temperature >=100.0 begin protocol as above**

OR

- **For sustained episodes of SpO2 below 92% (SOB, change in secretions) within the 72 hour observation period; Take & record all vital signs and inform MD and RT**

- **RESIDENT WILL REMAIN IN DROPLET PRECAUTIONS & NOTIFICATION WILL BE MADE TO DP/SNF LEADERSHIP AND M.D.**

ii. ONLY healthcare professionals (HCPs) essential for providing direct patient care will enter room
   1. Adhere to the hand hygiene and PPE guidance
   2. Keep log to record all HCPs who encounter suspected case patient(s)

iii. Perform timely specimen collection for laboratory testing and diagnosis confirmation/rule out
   1. Testing will be conducted in designated and isolated room
   2. Collection will consist of nasopharyngeal swab

3.Consult CDC's Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 for detailed guidance

a. Notification
   i. Notify infection control personnel at facility level and state or local health department if a patient is classified as a PUI for COVID-19
      1. Notification should take place for any residents with severe respiratory infection, or a cluster of respiratory illness (e.g., >or = 3 residents or HCP with new-onset respiratory symptoms within 72 hours), per CMS guidance

   ii. State health departments: complete a PUI and Case Report form for any suspected or confirmed cases

   ✓ Confirmed Covid positive Patients/Residents will be reported accordingly to the local health department and all guidelines duly implemented. After then, the positive patient/resident will be transferred to the covid unit of the hospital to allow for appropriate isolation , and also provide all required space for staff during and between provision of care.

b. Hand Hygiene
   i. Perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves
      1. Use Alcohol Based Hand Sanitizer (ABHS) – or –
      2. Wash with soap and water for at least 20 seconds
         If hands are visibly soiled, use soap and water before returning to ABHS

c. Personal Protective Equipment (PPE) to Adhere to Standard, Contact, and Droplet P recautions, including the Use of Eye Protection
   i. Facility's HCPs will utilize PPE per CDC PPE COV-19 FAQs when in direct contact with PUIs or Confirmed COVID-19 infected patients

   ii. Training will be provided and documented and relevant HCPs must demonstrate proficiency of usage per CDC PPE guidance

   iii. PPE will include:
      1. Gloves
         a. Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
         b. Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.

2. Gowns

    a. Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled.

    b. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.

3. Respiratory Protection

    a. Use respiratory protection (i.e., a respirator) that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator before entry into the patient room or care area.

    b. Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator.

    c. If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.

    d. Non-N95 masks may be used ON PUI to minimize exposure of virus transmitting respiratory secretions, but note these are not rated to be used on well-individuals as a means of infection protection.

4. Eye Protection

    a. Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area.

    b. Remove eye protection before leaving the patient room or care area.

    c. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.

✓ Refer to CDC Guidelines when implementing Strategies for Optimizing PPEs.

3. Manage Visitor Access and Movement Within the Facility

a. Signage

Facility will post signs denoting who should refrain from entering the facility

b. Screening

i. Facility will initiate proactive visitor screening against the aforementioned criteria

ii. Facility will keep record of these forms documenting visitor acknowledgements

c. Visitor Access within Facility

✓ Related to COVID-19, SVMC DP/SNF will adhere to guidance by Centers for Disease Control, Centers for Medicare and Medicaid Services, and California Department of Public Health. It will be periodically refined/updated as more information becomes available and as response needs change in the United States.

i. Non compassionate-care visitors will be rescheduled and controlled to allow for outbreak resolution prior to being permitted within facility

ii. Visitors granted facility access will be instructed to limit their movement within the facility to only the resident they have signed in to visit

1. Visitors will be educated on hand/respiratory hygiene, and provided CDC-recommended PPE for their time in the facility

iii. Facilities will maintain a logbook record of all visitors who enter patient rooms

iv. If a resident is diagnosed with COVID-19, the facility visitor log will be assessed to determine if he/she had any visitors within the prior 14 days

1. Those visitors will be notified and guided to follow up with their primary care provider (PCP) and to contact the local health department.

2. Monitor and Manage Ill and Exposed Healthcare Personnel

a. Facility will adopt CDC guidance on HCP exposure to COVID-19 in the healthcare setting

i. Facility will apply the above CDC guidance to employee risk stratification for relevant HCPs and engage in corresponding active monitoring and work restriction

ii. Facility employees will be supported in utilizing non-punitive sick leave procedures and refraining from entering facility if sick.

4. Train and Educate Healthcare Personnel

a. Relevant HCPs will be provided:
   i. Job-specific education on the prevention of infectious diseases
   ii. Training on the use of and fitting of respiratory devices whenever available
   iii. Disease-state specific education regarding COVID-19

5. Implement Environmental Infection Control

a. PUIs will have dedicated medical equipment assigned to them

b. All non-dedicated, non-disposable equipment will be cleaned and disinfected according to manufacturer instructions or facility policies, whichever are more stringent

c. Routine disinfecting procedures of surfaces will be done at a frequency adequate to keep high-traffic and high-touch areas clean

d. An EPA-registered, hospital-grade disinfectant will be routinely applied to these high contact areas according to product specifications
   i. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19.

6. Establish Reporting within Healthcare Facilities and to Public Health Authorities

a. IPC Champion will coordinate with local and state health departments to keep them apprised of PUIs and confirmed cases of COVID-19.
   i. CDC recommends that nursing homes notify their health department about residents with severe respiratory infection, or a cluster of respiratory illness (e.g., > or = 3 residents or HCP with new-onset respiratory symptoms within 72 hours).

7. Self-Assessment

a. Following implementation of this P&P, IPC Champion will conduct facility specific self-assessment on a sufficiently frequent basis, so as to ensure adherence to CDC guidelines,
   i. IPC will use the COVID-19 Focused Survey for Nursing Homes as self- assessment tool

REFERENCES:

- California Department of Public Health, All Facilities Letters (2020). Retrieved from CA.gov>CDPH>Pages>LNCAFL20.
- Preparing for COVID-19 in Long Term Care Facilities, CDC (August 24, 2020) Infection Control Guidance. Retrieved from https://www.cdc.gov>hcp>nursing, https://www.cdc.gov>long-term-care.
- COVID-19 Long Term Care Facility Guidance-CMS, April 2,2020, pg 1-3, CMS(.gov)>files>document.

SUBJECT: **DP/SNF RESIDENT/FAMILY COUNCIL POLICY AND PROCEDURE**	SECTION: **Page 1 of 2**

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

PURPOSE:

For the residents living in the Sierra View Medical Center (SVMC) Distinct Part-Skilled Nursing Facility to have the right to form and run a self-governing council.

This council provides the residents with opportunities to participate in decision making through voicing their views and will help resolve issues and concerns.

POLICY:

The Resident Council is the voice of the individuals who reside in the facility. Many who cannot voice their opinions will rely on those who are capable and interested to speak for them.

PROCEDURE:

1. A president, vice president and secretary/treasurer should be elected from the residents willing to participate in the Council.

2. During a survey, the surveyors will ask to speak with the president and/or vice president, and also will lead a Resident Council meeting with only the residents involved to determine whether there are any issues the residents might want to confide in them without staff present.

3. The regular monthly meeting will consist of all interested residents, representative from the Ombudsman Program, any representatives of the residents choosing to speak for them and a staff member responsible for assisting the resident council.

4. The resident council members need to approve the staff member or visitors to the meetings. They can also request no staff members to attend if they want to meet to discuss issues confidentially.

5. The Resident Council is required to take place once a month. The chairperson keeps the minutes of these meetings and a list of attendees. The chairperson (activity coordinator) must document the facts and issues, be specific, and not include long narratives verbalized by the council members.

6. A copy of the minutes always goes to the administrator for review so they are always current on issues, concerns and resolutions.

7. The chairperson (activity coordinator) is responsible for scheduling the monthly meetings, announcing the meetings, creating an agenda, facilitating the meeting, recording the minutes and taking the issues and concerns to the responsible department head for review and resolution.

8. Agenda should consist of:

   a) Welcome
   b) Attendance
   c) Review of the last month's minutes

d) Review of past month's resolutions to issues
e) Review of specific departments involved
f) New business and issues
g) Request for visitors for the next month's meeting

9. All grievances and concerns need to be resolved by the identified departments. The department must write a plan of action, date it and sign it on the council's form, then return it to the chairperson.

10. All minutes must be filed and made available for surveyor review, administrative review and ombudsman review. They are a legal document.

11. Family Council:

- The day of Resident Council a list of family members, significant others, or resident representatives for the non- responsive residents (those who cannot speak for themselves) are called to discuss any concerns or issues they would like brought forward to the Interdisciplinary Team. The Chairperson will go over the resident's activity care plan, discuss what has been done for the resident for activities and to see if they have any new recommendations for the pertaining resident.

- The survey comment form is filled out with who was contacted and any concerns they may present. If unable to reach the resident representative on file, a message is left if able and documented as such.

- Documentation is made in the PCS Activity Participation Record, Resident Council section, the person who was contacted and if a Plan of Correction was filled out because an issue/ issues were brought forward by them.

AFFECTED PERSONNEL/AREAS: *DIRECTOR, MANAGER, ACTIVITY COORDINATOR, SOCIAL SERVICE DESIGNEE, LICENSED NURSES, CNA, DIETARY, RESPIRATORY, THERAPIES, MAINTENANCE*

REFERENCES:

- The National Long-Term Ombudsman Resource Center at the National Consumer Voice for Quality Long Term Care (2021). https://theconsumervoice.org/.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations. 483.15(c)(6), 483.15(c), United States of America, Med Pass Inc.

SUBJECT: **FREE CHOICE**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure the resident's right to free choice and self-determination in decision-making and care and treatment.

POLICY:

The resident will have the right to choose a personal attending physician. The resident will be fully informed in advance about care and treatment and any changes in that care or treatment that may affect his or her wellbeing. Unless adjudicated incompetent or otherwise found to be incapacitated under state law, the resident will participate in planning care and treatment or changes in care and treatment.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, PHYSICIAN, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. During the admission process, the Social Worker Designee will inform the resident of their right to choose an attending physician. This process will be implemented in accordance with the policy and procedure" Physician Services."

2. The Social Worker Designee will inform the resident or significant other of the interdisciplinary team processes and the right to attend the meetings with staff and physician to participate in his/her plan of care. The Social Worker Designee will ensure the resident and responsible party is invited to the meetings routinely and is represented, as needed, when unable to attend.

3. The physician will ensure the resident/responsible party receives information necessary about his/her medical status to make health care decisions, including options, alternatives, benefits and risks, as needed, to make informed consent prior to initiation (refer to procedures for "Informed Consent").

4. The Interdisciplinary Team will inform and consult with residents with impaired decision-making and those formally declared incompetent to the extent practicable about their personal preferences (i.e., schedules, activities, care planning).

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, Resident's Rights, 42 CFR § 483.10, United States of America, Med Pass Inc.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: PHYSICIAN'S SERVICES

SUBJECT: **INTERDISCIPLINARY ASSESSMENT AND REASSESSMENT DPSNF**	SECTION: **Page 1 of 10**

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

PURPOSE:

To define initial resident assessment and reassessment parameters, a process to prioritize resident care, and criteria that all members of the healthcare team utilize during the assessment process.

To develop a database of information regarding the resident in order to provide the necessary information to plan, coordinate, delegate, and supervise the care of the resident.

POLICY:

1. All residents entering Sierra View Medical Center (SVMC) will receive an initial assessment, which takes into account their immediate and emerging DP/SNF needs. The data gathered will be analyzed to create information needed for care decisions concerning any need for further assessments, treatment, interventions, and reassessments.

2. Each admitted resident's initial assessment is conducted within a time frame identified by the service. Reassessment occurs throughout the care process and the purposes, key reassessment points and/or time intervals are defined.

3. Assessments are performed by each discipline within its scope of practice, state licensure laws, applicable regulations, or certification.

4. A registered nurse (RN) shall assess the patient's need for nursing care in all settings where nursing care is provided.

5. Care decisions will be based upon data and information gathered in assessments and reassessments. This data will be utilized in prioritizing patient care needs and selecting appropriate interventions.

6. Prioritizing resident care will be as follows:

    a. Emergent needs

    b. Actual needs

    c. Potential needs

    d. Educational needs

AFFECTED PERSONNEL/AREAS: *NURSING, RESPIRATORY THERAPY, NUTRITIONAL SERVICES, REHAB SERVICES, DISCHARGE PLANNING, SOCIAL SERVICES, PHARMACY, ACTIVITIES, PHYSICIAN (WHEN AVAILABLE, CHAPLAIN)*

PROCEDURE:

NURSING

1. ***Initial Assessment*** – will be performed by a Registered Nurse (RN) and other members of the Interdisciplinary Team to include the following:

   a. Physical Status (medication history and allergies)

   b. Psychological Status

   c. Social Status

   d. Spiritual Status

   e. Cultural Status

   f. Risk for Injury (Fall Risk Assessment)

   g. Nutritional Status Screen

   h. Functional Screen

   i. Skin Assessment

   j. Functional/Environmental Needs

   k. Anticipated Discharge Planning Needs

   l. Initial Anticipated Educational Needs and any Barriers to Learning

   m. Pain Assessment

   n. Abuse/Neglect Screening

2. Each nursing unit/department has established a time frame for completing the admission assessment interview, taking into consideration the following factors based on the major patient population of each department:

   a. The anticipated length of stay

   b. The complexity of nursing care needs

   c. The dynamics of the resident's condition(s)

3. Family involvement in the admission process will be encouraged /facilitated by the admitting RN whenever possible.

4. The RN can delegate data gathering aspects of the admission process to licensed vocational nurses (LVNs) and certified nursing assistants (CNAs), according to their practice guidelines, but the RN must analyze the data and formulate a nursing diagnosis and plan of care in collaboration with the resident and other clinical disciplines.

5. The RN/Social Service Designee will document or delegate documentation of the disposition of resident's valuables. This is particularly important when the resident is physically or mentally unable to keep track of personal property. The problem can be partially resolved by encouraging the resident's family to take personal belongings home.

6. The admission assessment will be documented on the Admission Intervention in the electronic medical record (EMR).

7. The scope and intensity of the assessment will be determined by:

   a. Resident diagnosis

   b. Care setting to which the resident is admitted

   c. Resident desire for care and interventions

   d. Resident response to treatment, procedures, and interventions.

9. ***Reassessment***

   a. The resident will be reassessed:

      - To determine response to treatment(s)/procedure(s)
      - When there is a significant change in condition
      - When there is a change in diagnosis
      - When there is a change in the level of care
      - Any time as deemed necessary
      - Minimally every shift and at unit specified intervals related to the care setting and course of treatment

   b. Documentation of the reassessment will be located on the RN Weekly Summary Intervention in the EMR.

c. Reassessments are completed by RNs. The information for reassessment will be gathered from residents, families, other healthcare professionals and physician input.

d. Procedural reassessment is continuous during procedures in OR, Endoscopy, and Diagnostic Radiology.

RESPIRATORY CARE

1. ***Initial Assessment***

a. Initial assessment will be initiated within 15 minutes of notification of a STAT physician order or within 2 hours of notification for routine physician order and completed within 2 hours by a Respiratory Care Practitioner (RCP).

b. The resident is evaluated by:

- Diagnosis
- History
- Physical Assessment
- Clinical Data – ABGs, Pulse Oximetry, Breath Sounds, Chest X-ray
- Resident's ability to perform ordered procedures
- Necessity for teaching home care

c. The ordered therapy is initiated and an assessment made as to the effectiveness of therapy and its appropriateness to the resident's condition and abilities. Treatments and patient's response are documented on the Respiratory Therapy Record.

2. ***Reassessment***

a. As long as the patient is receiving therapy, the therapist will reassess the resident prior to, during, and following each treatment to determine response to medication and occurrence of significant changes. The following areas will be monitored:

- Breath sounds
- Heart rate
- Respiratory rate
- Secretions

- How well treatment was tolerated
- Clinical data
- Continuing need of current therapy
- Evaluation of mode and frequency

NUTRITIONAL SERVICES

1. ***Initial Assessment***

   a. The purpose of the nutritional assessment is to evaluate the resident's nutritional status, develop a plan of nutritional care, and evaluate the efficiency of nutritional support. The need for a nutritional assessment is determined following a nutritional screening process completed by a Registered Dietitian/RN during the initial resident assessment.

   b. All inpatients are screened within 24 hours of admission, which triggers a referral to a Registered Dietitian (RD), who will assess residents in a time frame according to high, moderate or low risk identification.

   - Physician-ordered nutritional consults are completed within 24 hours of order.
   - Nursing referrals identified from the nutritional screening on nursing initial assessment form will be prioritized for nutritional risk by 48 hours.
   - All residents identified to be at high/moderate nutritional risk receive a nutritional assessment by a Registered Dietitian.

2. ***Reassessment***

   a. Residents will be reassessed by the Registered Dietitian.

   - High Risk patients, 2-3 days- TPN /PPN assessment will be completed in collaboration with lab data ordered twice weekly.

     Residents re-evaluated every 30 days or as deemed appropriate at last evaluation or Consult.

   - When ordered by a physician
   - More often as deemed necessary by the Registered Dietitian

   b. The reassessment will document the resident's response to care. At the time of reassessment, the Registered Dietitian may determine that the resident is no longer at a

certain nutritional risk level. This change of nutritional risk will be documented in the medical record.

c. All resident reassessments are documented in a narrative format on the resident's medical record in the EMR.

PHYSICAL THERAPY

1. ***Initial Assessment***

a. Residents need to be assessed by a Physical Therapist (PT) within 48 hours of receipt of physician order and may include the following:

- Resident interview
- Chart review
- Evaluation of:
  - balance/coordination
  - bed mobility
  - transfers
  - gait
  - strength
  - range of motion
  - neurological
  - posture

2. ***Reassessment***

a. Functional status and needs are reassessed with each treatment to determine the resident's response to interventions.

b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physical input. Reassessment documentation will be located in the Therapy progress notes.

OCCUPATIONAL THERAPY/With Physician Order

1. ***Initial Assessment***

   a. All inpatients are screened for the need of further assessment within 48 hours of admission. Residents needing assessment will be assessed by an Occupational Therapist (OTR) within 24 hours of receipt of physician order and may include the following:

   - Resident interview
   - Chart review
   - Evaluation of:
     - ADLs
     - Upper Body Function
     - Transfer
     - Cognitive-Visual Perceptual Motor Skills

2. ***Reassessment***

   a. Reassessment of functional status and needs are ongoing with each treatment given to determine the resident's response to interventions.

   b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located in the Therapy progress notes.

SPEECH THERAPY

1. ***Initial Assessment***

   a. All residents are screened for the need of further assessment within 5 days of admission. Residents needing immediate assessment will be performed by a Speech Therapist (SLP) within 48 hours of receipt of physician order and may include the following:

   - Resident interview
   - Chart review
   - Evaluation may include:
     - Dysphasia
     - Cognition

– Communication

2. ***Reassessment***

a. Reassessment of the functional status and needs are ongoing with each session given to determine the patient's response to interventions.

b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

DISCHARGE PLANNING

1. ***Initial Assessment***

a. A Discharge Evaluation will be done by the Social Service Designee on admission, every 6 months thereafter, and on discharge from the facility.

b. The need for Discharge Planning Service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

c. A Social Service Designee will assess residents when given notification by nursing or upon review of the patient's medical record that indicate risk factors which warrant further discharge planning activities.

d. The resident is evaluated for:

- Diagnosis
- Physical ability
- Resident's goals for discharge
- Social setting at place of residence (i.e.; lives alone, in Board & Care/ECF, etc.)
- Resident's ability to safely return to previous living arrangements
- Providing availability and education of Community Resources (assisting resident/family with discharge planning that requires specific resources).

2. ***Reassessment***

a. The Discharge Planner reviews care and progress on assigned residents as often as deemed necessary, but no less than every 3 days, and documents discharge planning progress notes on the worksheet and medical record.

b. Coordinates multi-disciplinary communication to facilitate reassessment and revision of the plan of care when necessary.

c. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the medical record.

SOCIAL SERVICES

1. ***Initial Assessment***

a. The need for social service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

b. Intervention will be performed by a Social Worker within 1 day for high-risk patients and within 2 days for moderate risk patients, or upon request for services.

- Residents meeting high risk criteria:
  - Domestic Violence
  - Suspected abuse/neglect
- Residents meeting moderate risk criteria:
  - Newly diagnosed catastrophic illness
  - Homelessness

2. ***Reassessment***

a. Reassessment by the Social Worker occurs at least every 3 days.

b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

PHARMACY

1. ***Initial Assessment***

a. Assessment will be performed by a Pharmacist (Pharm. D.) within 30 days.

b. Assessment will include:

- Body Stats: Height, weight, ideal body weight (IBW), age
- Pertinent labs
- Pertinent medications
- Allergies
- Goals of treatment

c. Assessment will be performed by a pharmacist for all residents receiving medications upon physician order for therapeutic appropriateness.

d. Residents receiving parenteral nutrition are assessed upon initial order.

2. ***Reassessment***

a. Reassessment by the Pharmacist is ongoing on a monthly basis to determine the resident's response to interventions.

b. Reassessment will be performed to assure designated medications are administered to achieve therapeutic drug levels.

c. Information for reassessment will be gathered from residents, families, other healthcare professionals, and physician input. Reassessment documentation will be located in the progress notes for drug dosing/monitoring protocol.

REFERENCES:

- Centers for Medicare/Medicaid Services RAI Manual (2019). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.
- The Improving Medicare Post- Acute Care Transformation Act (IMPACT ACT) of 2014 Data Standardized Patient Assessment Data Elements, CMS.gov
- https://www.ncbi.nlm.nih.gov>pmc

SUBJECT: **MANDATED ABUSE REPORTING- DP/SNF**	SECTION: **Page 1 of 8**

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

PURPOSE:

To define the Sierra View Medical Center (SVMC) process for handling and reporting of patient/resident suspected or actual abuse by those involved in operations of the District.

POLICY:

It is the policy of SVMC's DP/SNF to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act (ACA), §6703(b)(3).

The Director of DP/SNF for SVMC will be held accountable for following the established guidelines for screening, training, preventing, identifying, investigating, protecting and reporting and/or responding to all alleged events of suspected abuse.

For the purposes of this policy, the following definitions apply:

"Abuse" - Is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish to the resident. Examples may include but not be limited to: deprivation by a caretaker of goods and services that are necessary, to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

"Alleged Violation" - Is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliant with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

"Exploitation" - As defined at 483.5 means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"Immediately" – Reporting must be made immediately, and no later than 2 hours, this applies to ANY abuse (whether actual, alleged or potential), including abuse resulting in serious bodily injury. All other conduct must be reported no later than 24 hours.

"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when both of the following criteria are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

"Misappropriation of resident property" - As defined at 483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

"Mistreatment" - As defined at 483.5, is "inappropriate treatment or exploitation of a resident".

"Neglect" - As defined at 483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

"Sexual Abuse" - Is defined at 483.5, as "non-consensual sexual contact of any type with a resident".

"Verbal Abuse" - Is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

"Physical Abuse" - Includes, but is not limited to: hitting, slapping, pinching and kicking, controlling behavior through corporal punishment.

"Mental Abuse" - Includes but is not limited to: humiliation, harassment, threats of punishment or deprivation.

"Involuntary Seclusion" - Includes separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

"Covered Individual" - Refers to any individual (or staff) who is an owner, operator, employee, manager, agent or contractor of a long-term care facility (DP/SNF).

"Retaliation against an Employee" - Refers to when the employer discharges, demotes, suspends, threatens, harasses, or denies a promotion or any other employment-related benefit to an employee, or in

any other manner discriminates against an employee within the terms and conditions of employment because the employee has met their obligation to report a suspicion of a crime.

AFFECTED PERSONNEL/AREAS: *DP/SNF STAFF, CONTRACTORS, MEDICAL STAFF*

PROCEDURE:

Screening of Potential Staff:

To protect the residents/patients of SVMC, all directors will coordinate in the post-employment criminal background screening with SVMC's Human Resources Department to determine eligibility for employment or assignment. *(See: "Criminal Background Screens for Employment" – Human Resource Policy & Procedure Manual)*

Staff, Resident, and Family Education/Training:

1. All staff (e.g. "covered individuals") will annually receive a copy of their obligation to comply with the law and these policies and procedures.

2. All staff who will care for or work around the DP/SNF residents, including but not limited to, EVS, Respiratory and Floats from other departments will be given an in service on the DP/SNF Abuse Policy and will be guided to the appropriate Mandated Reporting Communication Board for information and appropriate forms.

3. All new staff, as part of their New Hire Orientation to work at SVMC, shall receive a copy of their obligation to comply with the law and this policy and procedure.

4. Staff will be taught how to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur. This in-service will be given to all employees who work with or around the residents on the DP/SNF Unit on hire and every 6 months. All staff will also be taught to document their assessment of the involved resident, initially upon report of the witness, then each shift for seven (7) days from the day of the incident, in the resident's notes via the electronic medical records. All other residents will also be assessed to ensure their safety and comfort. This assessment will be entered in the EMR on the day of the incident.

5. Residents, families, and staff will be given information on how and to whom they may report concerns, incidents and grievances without the fear of retribution/retaliation; and provide feedback regarding the concerns that have been expressed.

6. *Cameras/ Cell Phones:* Staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of

equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media.

Prevention

1. Identify, correct and intervene in situations in which abuse and /or neglect and/or misappropriation of residents property is more likely to occur.

Identification of Suspected Abuse:

1. Any employee who suspects abuse of a resident by SVMC staff, who identifies any suspicious bruising, repeated occurrences, patterns and trends that may constitute abuse are to report such items to their supervisor immediately, and complete an organization Occurrence Report in the PAVISSE, which will be forwarded to the unit's department director and SVMC's Risk Management Department.

The initial report (SOC 341) of suspected abuse must be completed and reported to the Ombudsman and CDPH within 24 hours of the event. During after hours, weekends or holidays, the Nursing House Supervisor will notify the DP/SNF Unit Director or designee of the event. The SOC 341 must be faxed to both the Ombudsman and CDPH. The hard copy of the SOC 341 will be mailed to CDPH within 24 hours of completing the form.

CDPH Licensing and Certification
4540 California Avenue, Suite 200
Bakersfield, CA. 93309
(O): 661-336-0543
(F): 661-336-0529

Long Term Care Ombudsman Services
1197 S. Drive
Hanford, CA. 93230
(O): 559-583-0333
(F): 559-589-0608

Porterville Police Department
350 North D. Street
Porterville, CA. 93257
(O): 559-782-7400

2. Risk Management will coordinate with the DP/SNF Unit Director and Human Resources to initiate the investigation process.

Protection of Resident:

In order to protect the resident, the employee and/or staff member under investigation will be immediately removed from the unit.

Suspension:

If abuse is suspected and/or witnessed, the Nursing House Supervisor, Unit Director and/or the Human Resources representative will immediately suspend and remove the individual from the District grounds.

Investigation:

1. SVMC's Risk Management and Human Resources Departments will conduct a thorough investigation of the incident in collaboration with the Unit Director.

2. You must also report investigation results for all allegations – within five (5) working days of the incident. This can be done by written form.

Staff Reporting Requirements:

1. The facility administrator (or designee) is to report all incidents to CDPH Licensing and Certification and the Administrative Director of Care and Quality. If the administrator is absent, reporting is required from whoever is officially acting on the administrator's behalf.

2. Reporting should be made by telephone and /or fax copy of the SOC 341.

3. Keep a copy of the fax confirmation. Also, if the report is via phone, make sure to document who was spoken to and the time of the call.

4. When staff suspects a crime has occurred against a resident of the DP/SNF, they must report the incident to the physician, facility administrator, unit director/abuse coordinator. Appropriate state agencies will also be contacted/notified as part of the mandated reporting process.

5. Staff must report a suspicion of a crime to the state survey agency and at least one local law enforcement entity within a designated time frame by e-mail, fax, or telephone. The individual does not need to determine which local law enforcement entity to report a suspicion of crime; but, must report to at least one local law enforcement entity. This will meet the individual's obligation to report.

6. Suspected abuse not resulting in serious bodily injury by a resident with a diagnosis of Dementia:

   - Report the incident to the local Ombudsman and local law enforcement agency by telephone as soon as possible.
   - A written report must follow within 24 hours to the local Ombudsman and the local law enforcement agency.

7. If the suspected abuse does not result in serious bodily injury, the mandated reporter must:

   - Report the incident by telephone within 24 hours to local law enforcement agency

- Provide a written report to the local Ombudsman, the L & C Program and the local law enforcement agency within 24 hours.

8. If suspected abuse results in serious bodily injury, then facility must do the following:

   - Report the incident immediately and no later than 2 hours by telephone to local law enforcement. Send a written report within 2 hours to the local law enforcement agency, L & C Program and the Ombudsman.

9. Staff can either report the same incident as a single complaint, or multiple individuals may file a single report that includes information about the suspected crime from each staff.

10. If, after a report is made regarding a particular incident, the original report may be supplemented by additional staff that become aware of the same incident. The supplemental information may be added to the form and must include the name of the additional staff along with the date and time of their awareness of such incident or suspension or suspicion of a crime. However, in no way will a single or multiple person report preclude an individual from reporting separately. Either an individual or joint report will meet the individual's obligation to report.

11. To ensure correction is achieved and sustained in regards to providing evidence of investigation, an assessment entry will be made in the involved patient's note for seven (7) days from the day of the incident. This will serve as evidence of all measures undertaken and of the investigation that transpired. Such process will be an included instruction in the routine abuse training for all staff.

12. Failure to report in the required time frames may result in disciplinary action, including up to termination.

13. The Compliance RN will monitor for compliance of the investigation/monitoring process, through the nurse's daily assessment notes, for each shift x seven (7) days from the day of the incident, as documented in the EMR. The result of the monitoring will be reported on QA/PI report for the specific quarter that the incident has transpired.

***There may be instances where a report is required under 42 CFR 483.12(C) [f609], but not under 42 CFR 483.129(b) (5)/Section 1150B of the Act [F608]. The following table describes the different requirements:

	F608 42 CFR 483.12(b)(5) and Section 1150B of the Act	F609 42 CFR 483.12(C)
What	Any reasonable suspicion of a crime against a resident.	1.All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. 2.The results of all investigations of alleged violations.
Who is required to report	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility.	The facility.
To whom	State Agency and one or more law enforcement entities for the political subdivision in which the facility is located (i.e., police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners).	The facility administrator and to other officials in accordance with State law, including to the State Agency and the adult protective services where state law provides for jurisdiction in long-term care facilities.
When	Serious bodily injury – Immediately, but not later than 2 hours after forming the suspicion. No serious bodily injury – Not later than 24 hours.	All alleged violations – Immediately, but not later than: 3) 2 hours – if the alleged violation involves abuse or results in serious bodily injury. 4) 24 hours – if the alleged violation does not involve abuse and does not result in serious bodily injury. **Results of all investigations of alleged violations will be submitted within 5 working days of the incident.

*Reporting requirements under this regulation are based on real (clock) time, not business hours.

The regulations related to Abuse were written to provide protections for the health, welfare and rights of each resident residing in the facility. The facility ensures prohibition and prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property. This is achieved through implementation of the following seven (7) components within this policy, to include: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response.

Posting Requirements:

1. The DP/SNF unit will post in an appropriate location, a sign specifying the rights of the employees under Elder Justice Act. This sign shall include both:
   - The reporting requirements of each staff member.
   - A statement that an employee may file a complaint with the state survey agency against a long-term care facility that retaliates against an employee for filing, and information how to file such a complaint to the State Agency.
2. The sign will be posted in the same area where other required employee signs are posted.

REFERENCES:

- MedPass Inc., (2001) (Updated February 6, 2015) *Facility Guide to OBRA Regulations*. 483.12(b)(5), 483.12(c), 483.13 (b). Abuse, United States of America, MedPass Inc.
- State of California (2021). Long Term Care Ombudsman. Retrieved from https://www.aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/.
- Thomson Reuters (Revised edition April 1, 1990) Barclays California Code of Regulations, San Francisco, California, Title 22.
- Help Guide, *Elder Abuse and Neglect*, Lawrence Robinson. Joanna Saisan MSW, and Jeanne Segal PhD, Updated June 2019.
- FindLaw, Elder Justice Act Reporting Requirements, Updated May 17, 2021, Thomson Reuters.

CROSS REFERENCES:

- "CRIMINAL BACKGROUND SCREENS FOR EMPLOYMENT " – Human Resources Policy & Procedure Manual

SUBJECT: **NON-DISCRIMINATION ON THE DP/SNF**	SECTION:

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

PURPOSE:

To demonstrate compliance with applicable federal and state requirements pertaining to non-discriminatory practices on the DP/SNF Unit at Sierra View Medical Center (SVMC). The DP/SNF does not discriminate and does not permit discrimination, including, but not limited to, bullying, abuse, or harassment, on the basis of actual or perceived sexual orientation, gender identity, gender expression, or HIV status, or based on association with another individual on account of that individual's actual or perceived sexual orientation, gender identity, gender expression, or HIV status.

DEFINITIONS:

Senate Bill (SB) 219 Long-Term Facilities: Rights of Residents. AFL 17-24

- This bill enacts the Lesbian, Gay, Bisexual, and Transgender Long-Term Care Facility Residents' Bill of Rights. Among other things, the bill makes it unlawful, except as specified, for any long-term care facility to take specified actions wholly or partially on the basis of a person's actual or perceived sexual orientation, gender identity, gender expression, or human immunodeficiency virus (HIV) status, including, among others, willfully and repeatedly failing to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronouns, or denying admission to a long-term care facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging or evicting a resident from a facility. The bill also provides certain protections to all residents of long-term care (LTC) facilities during, among other things, physical examinations or treatments, relating to bodily privacy. The bill defines long-term care facility for purposes of these provisions to include skilled nursing facilities, intermediate care facilities, and residential care facilities for the elderly. The bill also, among other things, requires each facility to post a specified notice regarding discrimination alongside its current nondiscrimination policy in all places and on all materials where the nondiscrimination policy is posted. The bill requires a violation of these provisions to be treated as a violation under the Long-Term Care, Health, Safety, and Security Act of 1973, the California Residential Care Facilities for the Elderly Act, or specified provisions providing for the licensure and regulation of health facilities, which may include the imposition of civil penalties. By expanding the definition of existing crimes, the bill imposes a state-mandated local program.

POLICY:

1. SB 219 (Chapter 483, Statutes of 2017) prohibits LTC facility staff from taking any of the following discriminatory actions against a resident or a potential resident, on the basis of a person's actual or perceived sexual orientation, gender identity, gender expression, or HIV status:

    - Denying admission to a long-term care facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging or evicting a resident from a facility.

    - Denying a request by residents to share a room.

- When rooms are assigned by gender, assigning or refusing to assign a room to a transgender resident other than in accordance with the transgender resident's gender identity, unless at the transgender resident's request.

- Prohibiting a resident from using, or harassing a resident who seeks to use or does use, a restroom available to other persons of the same gender identity, regardless of whether the resident is making a gender transition or appears to be gender-nonconforming. Harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity.

- Willfully and repeatedly failing to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronouns.

- Denying a resident the right to wear or be dressed in clothing, accessories, or cosmetics that are permitted for any other resident.

- Restricting a resident's right to associate with other residents or visitors of the resident's choice, including the right to consensual sexual relations, unless the restriction is uniformly applied to all residents in a nondiscriminatory manner.

- Denying or restricting medical or nonmedical care that is appropriate to a resident's organs and bodily needs, or providing medical or nonmedical care in a manner that demeans the resident's dignity or causes avoidable discomfort.

2. A complaint may be forwarded to the Office of the State Long-Term Care Ombudsman if you believe that you have experienced this kind of discrimination.

Long-Term Care Ombudsman
Physical Address: 10953 14th Avenue
Armona, Ca. 93202

Mailing Address: PO Box 598
Armona, Ca. 93202

Tel (559) 852-2823
(800) 293-9714

Fax (559) 582-9627

E-mail: maribel.martinez@kccoa.org

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL PERSONNEL*

REFERENCES:

- Center for Health Care Quality, MS 0512. P.O. Box 997377. Sacramento, CA 95899-7377 (916) 324-6630. (916) 324-4820 FAX, Department Website (cdph.ca.gov).
- Health and Safety Code- HSC, Division 2. Licensing Provisions [1200-1796.63], Chapter 2. Health Facilities [1250-1339.59] Article 3. Health Facilities [1275-1289.5].
- Med Pass, Inc., (updated February 6, 2015) Facility Guide to OBRA Regulations, United States of America, Med Pass Inc.
- Senate Bill No. 21, CHAPTER 483, [Approved by Governor October 04, 2017. Filed with Secretary of State October 04, 2017.] LEGISLATIVE COUNSEL'S DIGEST SB 219, Wiener. Long-term care facilities: rights of residents.
- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 1338.4, 1439.50, 1439.51, 1439.52, 1439.53, 1439.54, and 1569.318, San Francisco, California, Title 22.

CROSS REFERENCES:

- MANDATED ABUSE REPORTING - DP/SNF

SUBJECT: **NOTIFICATION AND EXERCISE OF RIGHTS AND RESPONSIBILITIES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To assure that residents are informed of his/her rights within the facility, to ensure protection in exercising rights, and to provide notification of changes in rights under federal or state law.

POLICY:

Residents will be informed both orally, using an interpreter when needed, and in writing, in a language he/she understands, of the rights and rules and regulations governing conduct and responsibilities while residing in the facility. All residents' rights information will be relayed prior to and upon admission (signed verification maintained in the medical record), periodically and when changes occur in resident rights. Residents will be encouraged and assisted in exercising his/her rights as a resident and a citizen.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, ACTIVITIES, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Resident rights and responsibilities will be reviewed with each resident/responsible party upon admission, a copy of the list of rights and responsibilities will be provided to the resident, and a signed verification of sufficient understanding and receipt of rights and responsibilities will be obtained (Cross Reference Policy: Resident Admission).

2. Residents' rights and responsibilities will be reviewed periodically with resident/responsible party, taking into consideration factors such as health and cognitive status, age, culture, language and educational level (resident and family council meetings, during the Interdisciplinary Team Meetings, during exercising of rights, individual contact, etc.)

3. Residents will be informed, both orally and in writing, of any changes in federal and state rights, and of changes in facility rules and regulations affecting the excision of his/her rights within the facility.

4. Residents will be informed of the Minimum Data Set (MDS) process and transmission policy, which includes review of the Privacy Act Notification Statement at the time of admission.

5. Residents will be informed of the manner of participation and assisted in exercising his/her rights within the facility with freedom from discrimination, coercion or reprisal (e.g., how resident may voice grievances and recommend changes, how they wish to organize their day, process for participation in state elections, choices and input in care procedures and activities, informed consent, notification of changes, etc.).

6. Residents' rights and responsibilities will be posted in resident areas (consumer board, bulletin boards, etc.) and included in the admission agreement, to allow direct access to rights information.

7. Residents/responsible party will be provided information regarding how to contact state and local advocacy and protection agencies for the exercise of resident rights, including the following: Ombudsman, Department of Health Services, Mental Illness and Developmental Disabilities, Adult Protective Services, Medicare/Medicaid, etc. A listing of these agencies is a part of the admission packet and will be signed by the resident/responsible party as an acknowledgement of receipt of this information. A listing of state and local agencies will be posted in the resident area, i.e., Consumer Information Board.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 United States of America, Med Pass Inc.
- California Department of Public Health (CDPH) (2017, October 6). *Nursing Home Residents' Rights.* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NursingHomeResidentsRights.aspx.
- California Advocates for Nursing Home Reform (CANHR) (2021, May 11). *Residents' Rights Fact Sheet: Long Term Care Justice and Advocacy*. Retrieved from http://www.canhr.org/factsheets/resrights_fs/html/fs_resrights.htm.

SUBJECT: **PRECAUTIONS FOR ANTIBIOTIC-RESISTANT MICROORGANISMS**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 1 of 6**

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

PURPOSE:

To provide isolation guidelines for the management of patients with active or a history of recent infection with Multi Drug-Resistant Organisms (MDROs). Some examples of MDROs include Methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Enterococcus* (VRE), Carbapenem-resistant *Enterobacteriaceae* (CRE), *Streptococcus pneumoniae* and other MDROs (see Table 1 for other common examples, from North Carolina Department of Health and Human Services, NC SHARPPS Program).

The CDC recommends the implementation of a "multifaceted, evidence-based approach with four parallel strategies: infection prevention; accurate and prompt diagnosis and treatment; prudent use of antimicrobials; and prevention of transmission." Thus, prevention of hospital-acquired infections (HAIs), especially from MDROs is achievable through consistent implementation of the appropriate isolation precautions which are presented within this SMVC policy.

POLICY:

Patients with an active MDRO infection shall be placed in isolation under the appropriate precautions as soon as possible. Patients with a history of an MDRO shall be placed in isolation under the appropriate precautions until determined to be free of the MDRO utilizing the guidelines provided. A patient who has a "colonized/non-infectious" MDRO such as MRSA in the nares does not need to be in Contact Precautions because the patient is not considered infectious.

AFFECTED AREAS/PERSONNEL:

A. It is the responsibility of the physician and the nursing staff to place any patient positive for an MDRO culture in isolation under Contact Precautions until it is determined that the patient is no longer infectious.

B. It is the responsibility of the Infection Prevention Department staff to monitor any patient positive for an MDRO infection through surveillance and to serve as a resource for the nursing and medical staff when determining patient room placement. The Infection Prevention Department will provide education regarding MDRO upon request or as needed when determined through surveillance. Electronic Medical Record (EMR) documentation of MDRO education by Registered Nurse or Physician is mandatory and must be placed in the appropriate area within the EMR.

PROCEDURE:

A. Patients with a positive MDRO culture (other than "nasal") shall be placed in isolation under Contact Precautions.

B. Implement Contact Precautions as stated in Infection Prevention policy, including:

    a. A private room

b. The use of gown and gloves whenever the staff enter the patient's room

Table 1. Examples of common MDROs, laboratory evidence for detection, and precautions to consider.

Type of MDRO	Definition	Laboratory Evidence*	Precautions†
Carbapenem-resistant Enterobacteriaceae (CRE)	Enterobacteriaceae are a family of Gram-negative bacteria that normally live in the human gut. CRE are Enterobacteriaceae that have developed resistance to last-resort antibiotics called carbapenems.	Any member of the bacterial family Enterobacteriaceae (e.g. *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter* species) with susceptibility results that indicate resistance (R) to ertapenem, doripenem, imipenem, and/or meropenem.	Standard + Contact
Clostridioides difficile (formerly *Clostridium difficile*: C. diff)	Spore-forming, Gram-positive bacteria that can cause inflammation of the colon (colitis).	Positive laboratory result for *Clostridioides difficile* toxin A and/or B or toxin-producing *Clostridioides difficile* organism	Standard + Contact Use soap and water to clean hands. Alcohol-based hand rub is not effective against *Clostridioides difficile*
Extended Spectrum Beta-Lactamase Producers (ESBLs)	Extended-spectrum beta-lactamase is an enzyme (chemical tool) that allows bacteria to become resistant to a wide variety of antibiotics including penicillins and cephalosporins. Several types of Gram-negative bacteria can produce these enzymes and be classified as ESBLs.	Not all laboratory test results specifically confirm ESBL-positive specimens. The Clinical Laboratory Standards Institute (CLSI) has developed broth microdilution and disk diffusion ESBL screening and confirmation tests using selected antimicrobial agents. Contact your laboratory for details.	Standard + Contact
Methicillin-resistant *Staphylococcus aureus* (MRSA)	Gram-positive bacteria that are resistant to several types of antibiotics.	Positive result for laboratory test for MRSA detection or culture of *S. aureus* with susceptibility results that indicate resistance (R) to oxacillin, cefoxitin, or methicillin.	Standard + Contact
Multidrug-resistant *Acinetobacter*	Gram-negative bacteria that are resistant to several types of antibiotics.	Any *Acinetobacter* species testing non-susceptible (either resistant (R) or intermediate (I)) to at least one agent in at least 3 of the following 6 antimicrobial classes: aminoglycosides (amikacin, gentamicin, tobramycin); carbapenems (imipenem, meropenem, doripenem); fluoroquinolones (ciprofloxacin, levofloxacin); beta-lactam/beta-lactam beta-lactamase inhibitor combination (piperacillin, piperacillin/tazobactam); cephalosporins (cefepime, ceftazidime); sulbactam (ampicillin/sulbactam)	Standard + Contact
Vancomycin-resistant Enterococci (VRE)	Enterococci are Gram-positive bacteria that are normally present in the human gut and can sometimes cause infections. When enterococci become resistant to the drug vancomycin, they are called vancomycin-resistant enterococci (VRE).	Positive result for laboratory test for VRE detection or culture of *Enterococcus faecalis*, *Enterococcus faecium*, or *Enterococcus species unspecified* with susceptibility results that indicate resistance (R) to vancomycin.	Standard + Contact

*Multidrug-Resistant Organisms & Clostridium difficile Infection (MDRO/CDI) Module Protocol, January 2018. Available from https://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf.

†Decisions regarding use of Contact Precautions should be based on guidance provided in "When should residents be placed on Contact Precautions?" and Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006.

c. Strict adherence to hand hygiene – especially the use of hand washing with soap and water when working with a *C. difficile* patient

d. The use of any additional personal protective equipment (PPE) described under each specific type of precaution, such as contact precautions, airborne precautions, droplet precautions, etc.

e. The use of dedicated non-critical equipment or devices such as stethoscopes, etc.

C. Readmission Diagnosis

a. If a readmission diagnosis is related to the MDRO infection, follow contact precautions until two cultures, collected 48 hours apart are negative

b. If a subsequent readmission diagnosis is unrelated to the MDRO infection, isolation is unnecessary if all of the following conditions are met:

i. A culture from the previously infected MDRO site is negative

ii. The patient has no symptoms related to the previous admission

D. Cohort

a. If the resistance pattern of the MDRO for two patients is the same and neither patient has any other potentially transmissible infection, then the patients may cohort

b. If a private room is not available and cohorting with a patient with the same resistance pattern is not possible, then it is important to consider the site of infection and mode of transmission of the infecting pathogen and select roommates carefully. Consultation with Infection Prevention is advised before patient placement. Items for consideration during the decision process should include:

i. The source patient's hygienic habits,

ii. Contamination of the environment or

iii. Cognitive impairment.

iv. The roommate's condition, including non-intact skin, renal failure, immunocompromised condition or cognitive impairment.

E. Patient Transport

a. Limit the movement and transport of the patient from the isolation room to essential purposes only.

b. If transport or movement is necessary, ensure that the appropriate precautions are maintained to minimize the risk of transmission of microorganisms to other patients, the environment or

equipment. Insure that this information is included in the hand-off report given to staff *prior* to transporting the patient.

c. The patient should be transported directly to the procedure room and immediately returned to the patient's room. The patient should not be in a holding room/area prior to or after the procedure.

d. Exceptions include but are not limited to:

   i. Patients that need to be kept in the Post Anesthesia Care Unit (PACU) for recovery

   ii. A lack of available beds

   iii. A backlog in the procedure schedule

e. For planning assistance, call the Infection Prevention Department at ext. 3781 or ext. 4722

F. Duration of Isolation and/or Contact Precautions

a. The patient is considered infectious and should be placed in isolation under the appropriate precautions for the duration of the MDRO-associated illness. For instance, until lesions have healed and the wound has stopped draining. A patient positive for *C. difficile* should remain in contact isolation until there have been no symptoms (i.e. loose stools) for 48 hours

b. If the original MDRO culture site is no longer accessible (such as a closed wound, peritoneal or pleural fluid, catheter site, etc.) and the patient is asymptomatic for that site, then isolation is no longer necessary

c. A colonized patients is any person found to be positive for an MDRO but has no signs or symptoms of infection. The inpatient does not need to remain in isolation if there is no display of signs or symptoms. However, the isolation signage must remain up so that housekeeping is made aware to use to the appropriate cleaning and disinfecting products.

G. Discharge from Hospital

a. If the patient is being transferred to an extended care facility, then the discharge is per the receiving facility's admission criteria.

b. If the patient is discharged to home, then it is at the discretion of the M.D. Patient education must be provided on MDROs and home care. Administration of MDRO/home care education must be documented in the EMR.

c. If the patient is still in isolation and decides to leave the hospital against medical advice (AMA) *and* the patient poses a health risk to the community due to a communicable MDRO, a representative of the Infection Prevention Department or the House Supervisor (during

afterhours or the weekend) shall notify the Tulare County Public Health Department, Communicable Diseases at (559) 685-5720.

H. Cleaning of the Patient's Room

a. Don appropriate protective equipment (gown, gloves, etc.) prior to entering the patient's room

b. The Occupied Room:

i. High-touch environmental surfaces should undergo thorough cleaning at least daily using a hospital-approved detergent disinfectant. Surfaces are left wet for a certain amount of time (contact time) depending on the disinfectant's instruction for use.

ii. Materials, such as the bucket of disinfectant, mop heads and rags, are changed after cleaning the room for the following (but not limited to) MDROs such as MRSA, VRE CRE or C. difficile. .

c. Terminal Cleaning (when the patient is discharged from the room or when isolation is discontinued)

iii. Clean the patient room with added attention to high-touch horizontal surfaces. Detailed cleaning of handrails, telephones, call lights, light switches, bed controls, furniture, bathroom facilities and sinks, *etc.*, with hospital-approved detergent disinfectant is essential. Surfaces are left wet for 10 minutes (contact/dwell time may vary depending on the product's instructions for use) before being wiped dry with a clean low lint towel.

iv. The materials used during the cleaning/disinfecting process, such as the bucket of disinfectant, mop heads and rags, *etc.,* are changed after cleaning a room that housed a patient with an MDRO such as MRSA, VRE, CRE or C. difficile. .

v. Some items may require cleaning in Central Processing.

vi. Curtains are to be removed, placed in a plastic bag and laundered with approved disinfectant. Replace with clean curtains after the room has been terminally cleaned.

c. Prior to exiting cleaned area, remove PPE. Place in the trash bag. Wash hands for a minimum of 20 seconds with soap and water following the hand hygiene procedure.

REFERENCES:

Centers for Disease Control (CDC) and Prevention (2019). Antimicrobial Resistance. Last reviewed: December 17, 2021. Retrieved August 30, 2022 from: https://www.cdc.gov/drugresistance/

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. (2007, updated May, 2022.) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Accessed August 30, 2022. Available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

Centers for Disease Control (CDC) and Prevention. COVID-19: U.S. Impact on Antimicrobial Resistance, Special Report 2022. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2022. https://www.cdc.gov/drugresistance/covid19.html
DOI:https://dx.doi.org/10.15620/cdc:117915

North Carolina Department of Health and Human Services, NC SHARPPS Program. Multidrug-Resistant Organisms (MDROs) Toolkit for Long-Term Care Facilities. 2019. Accessed August 30, 2022. From: https://epi.dph.ncdhhs.gov/cd/docs/MDROToolkit_080819.pdf

Cross Reference:

Standard Precautions

Contact Precautions DP/SNF

Isolation and Standard Precautions

SUBJECT:	SECTION:
PRESSURE ULCER PREVENTION PLAN ~~DPSNFPRESSURE INJURY PREVENTION PLAN~~ ~~DPSNFPRESSURE ULCER PREVENTION PLAN~~ ~~DPSNF~~	Page 1 of 11

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PURPOSE:

To define the facility's Pressure Injury~~Ulcer~~ Prevention and Wound Care Program. Sierra View Medical Center Distinct Part/ Skilled Nursing Facility (DP/SNF) will provide care, treatment, and services to promote the prevention of wound development including pressure injury~~ulcer~~ development and to promote the healing wounds including ~~of~~ pressure injuries~~ulcers~~.

This Pressure Injury~~Ulcer~~ P~~p~~revention P~~p~~lan will include:

1. The process of identifying residents at risk for pressure injury~~ulcer~~ development.
2. To identify residents at risk for developing pressure injuries~~ulcers~~ who would benefit from preventative interventions and the specific factors placing them at risk.
3. To maintain and improve tissue tolerance to pressure in order to prevent injury.
4. To protect against the adverse effects of pressure, friction, shear and moisture.
5. To reduce the incidence of pressure injuries~~ulcers~~.
6. To effectively treat existing pressure injurie~~ulcer~~s through the use of a comprehensive and research-based pressure injury~~ulcer~~ management program.
7. To provide staff guidelines for documenting, assessing, and preventing pressure injuries~~ulcers~~.
8. To provide general procedures for skin care, pressure injurie~~ulcer~~s, and wound management.

POLICY:

It is the policy of Sierra View Medical Center DP/SNF that all residents admitted to the unit shall receive a complete head-to-toe assessment, at which time a thorough examination of the skin will be done. The following steps will be taken:

1. The "Braden Scale" will be utilized for predicting skin breakdown/pressure ulcer risk and will be used to evaluate all residents for risk of skin breakdown. This will be performed on admit, weekly thereafter for four weeks, and quarterly by the MDS nurse. If the resident is identified at risk for skin breakdown with a Braden score of 186 or below, implement the pressure injury~~ulcer~~ prevention plan.
2. Consult the Wound Care Specialist as indicated.
3. Complete nutritional screening by RN/LVN with appropriate referral if indicated.

4. Complete a nutritional assessment by Registered Dietitian so that the nutritional needs of the patient are met.

5. Implementing individualized, comprehensive plan of care (interventions) to attempt to stabilize, reduce, or remove underlying risk factors.

6. Maintaining and improving tissue tolerance to pressure, in order to prevent injury.

7. Protecting against the adverse effects of external mechanical forces.

8. Monitoring the effectiveness of interventions.

9. Modifying the interventions as appropriate.

10. Education will be provided to the patients and their families.

11. Staff will be provided with educational in-services regarding the prevention and treatment of pressure ulcers.

12. The assessment of care and treatment needs of the resident will be ongoing throughout the stay.

AFFECTED PERSONNEL/AREAS:

RN, LVN, CNA

DEFINITION:

1. The National Pressure Injury~~Ulcer~~ Advisory Panel (NPI~~U~~AP) defines a pressure ulcer as, "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."

~~1. a localized injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated."~~

~~2.~~

~~3.~~2. Pressure injuri~~ulcer~~s can occur whenever pressure has impaired circulation to tissue. Pressure injuries~~ulcers~~ develop when soft tissues are compressed between a bony prominence and the surface of an object, i.e. mattress, seat of a chair, catheter compressed between patient's thighs.

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4.3. Pressure injuri~~ulcer~~s are usually located over a bony prominence, such as a sacrum, heel, the greater trochanter, fibular head, scapula, and ankle.

5.4. Pressure injuri~~ulcer~~s and non-pressure related wounds are described as:

Stage I:

a. **Non-blanchable erythema of intact skin.** Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. ~~Non-blanchable erythema of intact skin is the heralding lesion of skin ulceration. Discoloration of skin, warmth, edema, or hardness, pain or itching may be indicators of a pressure ulcer in patients.~~ These indicators will be evident after the pressure on the area has been removed for 30-45 minutes.

b. Dark pigmented skin may not have visible blanching; the color may be different from the surrounding area.

c. The area may be firm, soft, painful, warmer or cooler than the adjacent tissue.

Stage II or partial thickness skin loss:

~~a. Partial-thickness skin loss involving the dermis. The ulcer is a superficial open ulcer with a red-pink wound bed. No slough or bruising (bruising indicates suspected deep tissue injury) of the wound bed is visible. The ulcer may present clinically as an abrasion, intact or open serum-filled blister or shallow ulcer.~~

a. **Partial-thickness skin loss with exposed dermis**. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

b. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

~~b. According to the NPUAP, Stage II classification should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.~~

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Stage III or full thickness skin loss:

a. **Full-thickness skin loss**. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epiboly (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. ~~Full-thickness tissue loss. Subcutaneous fat may be visible. Bone, tendon or muscle is not exposed. The ulcer may include undermining and tunneling. Slough may be present but the depth of tissue loss can still be seen.~~

~~b. Stage III pressure ulcer depth is different according to anatomical location. Stage III ulcers can be shallow on the bridge of the nose, ear, occiput and malleolus due to lack of subcutaneous fat.~~

~~c. Anatomical areas where there is a significant amount of adipose tissue can develop very deep Stage III pressure ulcers.~~

~~d. Bone/tendon is not seen or directly palpable.~~

Stage IV or full thickness skin loss with exposed structures:

~~a. Full-thickness tissue loss with extensive destruction, tissue necrosis or damage to fascia, muscle, bone or supporting structures (i.e. tendon, joint capsule) is involved which may lead to osteomyelitis. Sinus tracts and undermining may be present. Slough and/or eschar may be present on areas of the wound bed but do not obscure the base of the wound.~~

a. **Full-thickness skin and tissue loss.** Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury

~~b. The depth of Stage IV pressure ulcers is different according to anatomical location.~~

~~c. Exposed bone/tendon is seen or directly palpable.~~

~~Suspected~~ Deep Tissue Injury:

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~~a. Purple or maroon in color, localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or sheer.~~

a. **Persistent non-blanchable deep red, maroon or purple discoloration.** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

b. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

~~b. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.~~

c. Deep tissue injury may be difficult to detect in patients with dark skin tones. Evolution of the injury may include a thin blister over a dark wound bed. The wound may evolve further and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Un-stageable:

~~a. Full-thickness tissue loss.~~

a. **Obscured full-thickness skin and tissue loss.** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

b. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

c. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Additional Pressure Injury Definitions: **This describes an etiology.**

a. **Medical device related pressure injuries** result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally

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conforms to the pattern or shape of the device. The injury should be staged using the staging system.

b. **Mucosal Membrane Pressure Injury**: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

~~b. The base of the ulcer is covered with slough which can be yellow, tan, gray, green or brown in color and/or eschar which can be tan, brown or black in color, in the wound bed.~~

~~c. Staging cannot be determined until enough of the slough and/or eschar has been removed to expose the base of the wound~~

~~Note: Stable eschar on a patient's heels should not be removed. The eschar, in this situation, acts as the body's natural cover.~~

PROCEDURE:

1. Assessments: All bony prominences of at-risk residents will be assessed once a day (i.e. occiput, sacrum, heels, ischial ~~tuberositiestuberosity's~~, coccyx, ~~trochanterand trochanter~~).

2. Changes in skin condition: Staff will remain alert to potential changes in resident's skin condition and will evaluate and document identified changes. Changes in the resident's skin condition will be reported to the attending physician when applicable.

3. Nutritional screening: Shall be done by the RN/LVN on every admission. Residents with pressure ulcers will need a referral to the dietitian.

4. Nutritional assessment: Shall be completed by a Registered Dietitian and may include, among other recommendations, an estimation of calorie, protein and fluid needs, the need for supplementation with vitamin/minerals, and/or the need for oral, enteral or parenteral feeding.

5. Interventions will be incorporated into the resident's plan of care, evaluated and revised as the condition of the resident indicates.

6. Prevention: Prevention of pressure injuries~~ulcers~~ is primarily a nursing responsibility. The most effective means of preventing skin breakdown are relief of pressure on the skin, maintenance of adequate circulation, hydration and an adequate diet.

   a. Staff will continue preventative measures when a resident has a pressure injury~~ulcer~~ to prevent the development of additional pressure injuries~~ulcers~~.

   b. Residents who are dependent on the staff for repositioning will need to be repositioned every 2 hours and as needed, depending on the resident's condition. Turning will be

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documented on the CNA flow sheet. CAUTION: Do not drag the resident across the sheets as this reduces shear forces.

7. Preventative interventions for all residents at risk:

   a. Use of pressure reduction surfaces, wheelchair/Geri-chair cushions, zero pressure boots or pillows (to off load heels) when appropriate. **Do not use donut type devices.**

   b. Place a pillow(s) under the resident's lower leg(s), suspending the heel(s), to decrease the pressure placed on the resident's heels.

   c. Apply skin protectant cream~~repair cream~~ to the resident's dry skin after each bath to decrease friction. Apply protectant/barrier~~Nutrashield~~ cream to the buttocks, perineal area of incontinent resident's skin to prevent incontinent associated dermatitis. Do not massage vigorously over bony prominences.

   d. Try to prevent moisture, diarrhea, urinary incontinence and sweating from accumulating because this may cause skin maceration and eventual breakdown

   e. Keep linen wrinkle-free to prevent uneven pressure redistribution. Limit the number of layers between the resident and the bed to a sheet, draw sheet, and pad

   f. Observe the resident for reddened or blanched areas, especially at rims of ears and bony prominences that suggest decreased circulation. If any redness is detected, remove the causative factor(s).

8. **Management of Pressure Injury/Partial thickness/full thickness wounds**: Pressure injury's/other wounds present at the time of admission or developed after admission will be identified. It is important to be aware of factors that lead to the development of a Pressure injury/other types of wounds so that appropriate interventions can be initiated.

~~8. Management of Pressure Ulcers: Pressure ulcers present at the time of admission or developed after admission will be identified. It is important to be aware of factors that lead to the development of a pressure ulcer so that appropriate interventions can be initiated.~~

   a. Nursing staff will take pictures and measure pressure injuries~~ulcers~~:

      - On admission if present or as discovered after admission.
      - Every week thereafter, until healed, on a designated day.
      - PRN changes (i.e. surgical debridement).
      - When healed, transferred to a higher level of care or discharged.

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b. The weekly wound trending record will be completed weekly by the RN/LVN on admission if present or as discovered after admission and every week thereafter, until healed. The trending record should be updated when changes are noted such as following a surgical debridement, when the injury ~~ulcer~~ is healed, or when the patient is transferred to a higher level of care or discharged.

c. The wound trending form will contain the following elements:

- Date
- Location of ulcer and stage, if applicable
- Length, Width and Depth in centimeters
- Presence, location and extent of undermining or tunneling/sinus tract
- Presence of drainage/odor
- Color content of wound bed
- Pain

d. When to call the physician: The physician should be notified when a change in the skin condition or pressure injury~~ulcer~~ requires a change in treatment ~~(see preprinted physician order set)~~.

e. When to call the Wound Specialist: The Wound Specialist is available for assistance Monday through Friday, 0~~8~~700 – 1~~6~~530.

f. Nursing staff will assess, reassess and document the injury~~ulcer~~'s characteristics and observe for infection. This includes, but is not limited to:

- Signs/symptoms of infection
- Purulent exudates
- Peri-wound warmth
- Swelling
- Induration
- Erythema

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- Increased pain or tenderness around the site
- Delayed wound healing

g. Follow physician's orders for treatment of the pressure injury ~~ulcer~~, including cleansing and dressing.

h. Avoid positioning residents on a pressure injury~~ulcer~~.

i. Daily monitoring of Pressure Injury~~Ulcers~~ includes:

- Evaluating the injury~~ulcer~~ even when no dressing is present.
- Evaluate the dressing if present; dressing intact, drainage present
- Evaluate the area surrounding the pressure injury ~~ulcer~~.
- Observe the wound for signs of increasing ulceration, soft tissue infection around the wound, or drainage.
- Pain assessment and management.
- Notify the Wound Specialist and/or physician if pressure injury~~ulcer~~ is not healing.

9.8. Plan of Care: Based upon the assessment and resident's clinical condition and identified needs, the resident's plan of care will include interventions to:

a. Redistribute pressure.

b. Minimize the resident's skin exposure to moisture

c. Keep the skin clean.

d. Provide appropriate pressure redistribution support surface if indicated (i.e. Stage III or IV on the trunk).

e. Maintain or improve nutrition and hydration status if feasible.

DEVICES:

A. **Pressure Redistribution Mattress**: Identify the need for a pressure redistribution mattress per following guidelines:

1. Stage III or IV on the trunk

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2. Stage III or IV must be greater than 2 x 2cm on the trunk, or there must be multiple stage III or IV sites on different turning surfaces.

3. CBC, Total Protein and Albumin or Prealbumin monthly until wound(s) is healed.

4. Dietitian involvement monthly.

5. Wound healing supplements per dietitian.

B. **Mechanical loading, Support Surfaces and Repositioning devices.**

1. Place the resident in a 30-degree lateral position to decrease pressure on the trochanter.

2. The head of the bed is not to be elevated more than 30-degrees unless the resident's medical condition warrants it.

3. Elevating the head of the bed or back of a reclining chair to greater than or equal to 30-degrees creates pressures comparable to that exerted while sitting.

~~SPECIAL CONSIDERATIONS:~~

~~1. The 1994 AHCPR guidelines and current literature indicate that a pressure ulcer that is clean with adequate blood supply and innervation should show evidence of healing or stabilization within 2-4 weeks.~~

~~2. If a pressure ulcer fails to present evidence of progression toward healing within 2-4 weeks, the pressure ulcer and the resident's overall clinical condition should be re-evaluated. Current treatment modalities may need to be changed or modified.~~

~~3. Pressure ulcers may progress or complications can develop such as infection of the soft tissue, infection of the bone, abscess formation, septicemia, or development of a sinus tract or chronic infection despite apparent improvement in the pressure ulcer itself.~~

DOCUMENTATION:

1. Document Braden scale on admit and weekly for 4 weeks, then every quarter thereafter.

2. Document nutritional screening on admission and implement a referral as necessary.

3. Document interventions used to prevent the development of pressure injury~~ulcers~~ on the plan of care.

1. Record nutrition and fluid intake.
2. Document wound assessment in PCS upon admission, on designated day weekly and PRN when applicable.
3. Document wound dressing changes as ordered in PCS, if applicable.

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SUBJECT: **RANGE OF MOTION**	SECTION: *Physical Therapy* **Page 1 of 8**

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PURPOSE:

- To maintain muscle strength and tone.
- To improve muscle strength and tone.
- To prevent progression of contractures.
- To maintain circulatory integrity of the limbs.
- To enhance the utilization of a body part in physical activity.
- To prevent complications and disability attendant upon other physical/emotional dysfunctions and adverse states of well-being.

POLICY:

All residents will receive active and/or passive range of motion once daily, 6 days a week if indicated by the physical therapists/doctors' orders.

DEFINITION:

- Range of Motion (ROM) – The extent to which a particular joint is capable of being moved.
- Active range of motion – The resident independently moves his/her joints, or actively assists with the movement of joints.
- Passive range of motion – The staff performs the movement of the resident's joints.

HIGH-RISK RESIDENTS:

- Unconscious
- Acutely ill
- Unable to move head or extremities
- In severe pain and remaining immobilized
- In cast, brace or other limiting devices
- Paralyzed or having nerve weakness
- Incorrectly positioned or supported

CONTRAINDICATIONS for treatment of residents with contractures:

- Imminent death
- Ankylosis- immobility of joint
- Cancer of bone
- Osteoporosis
- Congenital anomaly
- Joint inflammation

RANGE OF MOTION EXERCISES:

TYPES OF ROM:

- Passive: For parts of the body (i.e., limbs, trunk, digits) the person cannot move for himself /herself; ROM is done for and to the person.
- Active Assisted: When the person can perform a motion with the help of an assistant or a device.
- Active: For the person who can do the motion himself /herself.

NOTE: Physician order is not required for active or passive ROM.

BODY POSITION:

- Supine: Back lying
- Lateral: Side lying

JOINT POSITIONS: (Also known as body positions)

- Extension: Straightening a flexed or bent joint.
- Flexion: Bending a joint to form an acute angle.
- Adduction: Moving arm, leg or finger toward normal resting position (i.e., normal for the patient).
- Abduction: Moving arm, leg or finger away from normal positions

AFFECTED PERSONNEL/AREAS:

RN, LVN, RNA, CNA

PROCEDURE:

1. Physiotherapy is to be called for initial evaluation, if necessary. ROM is a nursing measure; therefore, it may be instituted without physiotherapy evaluation and/or physicians' order.

2. ROM is frequently used in collaboration with other nursing and rehabilitative interventions, e.g., strengthening, gait training, ambulation, etc.

3. ROM exercise does not take the place of position change and support for dependent parts.

4. Explain each step before you do ROM and as you are doing it.

5. Gentle but firm pressure is to be applied during ROM.

6. Do not bring the joint/limb motion to the point of pain.

7. Observe the resident who is unable to communicate for signs and symptoms of discomfort such as facial grimacing, increased sweating, or increased heart rate.

8. The joint area is left free. Limbs are supported and directed through the exercises. See Protocol.

9. Each joint is moved through its range 3 – 5 times per treatment.

REASONS FOR PLACEMENT OF CAREGIVERS HANDS & BODY AS OUTLINED BELOW:

- Trust and reassurance
- Support, safety, guidance
- Observation
- Balance, direction, control of movement

EXERCISE PROTOCOL:

Motions of the Body and Trunk

A. Flexion:

   1. Bending forward from the waist

   2. Standing in front or side of patient

   3. Place both hands on shoulder or one hand on shoulder and one hand on waist

B. Extension:

1. Straightening from the flexed position to the neutral position
2. Standing to the front or side of the patient, place hand on shoulder (one hand on shoulder) and one hand on waist

C. Lateral Flexion:

1. Bending sideways from the waist, to the right and to the left.
2. Standing to front or side of the patient, place one hand on shoulder, one hand on waist or across the patient's back.

D. Rotation:

1. Turning the shoulders, keeping the hips stationary.
2. Stand in front of the patient; place one hand on the patient's hip and one hand on the opposite shoulder. Bring the shoulder gently towards you.

Motions of the Shoulder

A. Flexion and Extension:

1. Place one hand below the patient's elbow; supporting the shoulder and elbow with one hand.
2. Hold the patient's shoulder with the other hand, while ranging.
3. Lift the patient's arm up from the side of the body.
4. Next, carry the arm slowly and gently toward the patient's head as far as you can go without causing pain.
5. If the headboard prevents your carrying the straight arm all the way back, bend the arm at the elbow.
6. Finally, carry the patient's arm back to the standing position.

B. Abduction and Adduction:

1. One hand supports the patient's shoulder joint.
2. Hold the patient's elbow with your other hand.

3. Next, keeping the patient's arm straight, move it away from the patient's body.

4. Then, return to normal position against the patient's body.

C. Internal and External Rotation:

1. Start by placing the patient's arm pointed away from the patient's body, elbow bent. Hold patient's hand with your other hand.

2. Hold patient's upper arm against mattress.

3. Then, lift patient's lower arm and hand.

4. Next, move patient's lower arm and hand slowly and gently back towards the patient's head, as far as you can go.

5. Return patient's arm to starting position.

D. Cross Adduction:

E. NOTE: Important joint function and range for the hemiplegics (post stroke) patient for turning in bed and dressing by self.

1. Start by placing one of your hands on the patient's shoulder.

2. Hold patient's elbow with your hand.

3. Lift patient's arm

4. Carry patient's arm across his/her chest.

5. Return arm to starting position.

F. Elevation and Depression:

G. Lifting the shoulders towards the ears (hunching) and returning to normal position. Right, then left and/or together.

Motions of the Elbow:

A. Flexion and Extension

Note: Important for self-feeding:

1. Place one hand on elbow, one hand supporting forearm and/or hand.

2. Bend elbow, bringing forearm and hand toward shoulder.

3. Return forearm and hand to starting position.

Motions of the Forearm:

A. Supination and pronation:

1. Start by holding the patient's hand with one of your hands.

2. Place the other hand on the patient's forearm.

3. Gently rotate the hand to the right and to the left.

Motions of the Wrists and Fingers:

A. Flexion and Extension:

1. Start by holding the patient's wrist with one hand; avoid heavy pressure which can occlude the arteries and veins.

2. Hold patient's fingers with your other hand.

3. Next, keeping patient's fingers straight, bend patient's hand backward.

4. Then, straighten the hand.

5. Now, bend patient's hand forward, closing patient's fingers to make a fist.

6. Then open patient's hand to starting position.

Motion of the Knee and Hip:

NOTE: Ideally, bed should be flat. Check with the nurse. This ROM can be effective with the head of the bed raised.

A. Flexion and Extension:

1. Place one hand under the patient's knee, upper calf.

2. Place other hand under the heel of the patient's foot.

3. Then, lift leg, bending it at the knee.

4. Move patient's leg slowly back towards the patient's head as far as it will go without hurting the patient. Next, straighten the patient's knee by lifting the foot upward. Lower the patient's leg, gently, to the starting position.

Motions of the Ankle, Foot and Toe

A. Ankle Dorsiflexion and Plantar flexion:

1. Start by holding the patient's heel with your hand, letting the sole of patient's foot rest against your arm; other hand over ankle/instep.

2. Then, press your arm against the bottom of the foot, moving it back toward the leg. At the same time, pull gently on the heel. (Note: Keep the knee straight).

3. Next, move your arm back to the starting position.

4. Move your hand which was over the ankle up the area just before the toes. Push down on patient's foot to point the toes. At the same time, push up against the heel.

B. Foot inversion and Eversion:

1. Place one hand across the ankle.

2. Grasp foot with other hand.

3. Start by turning the whole foot outward.

4. Then, turn the whole foot inward.

5. Return foot to starting position.

C. Toe Flexion and Extension:

1. Pull up on the toes (one hand on sole of foot).

2. Push down on the toes (one hand on heel).

IN-SERVICE EDUCATION:

- All nursing staff are instructed in the techniques of active and passive ROM, during orientation and ongoing (classroom and on the unit), all shifts.

DOCUMENTATION:

RNA Intervention in the EMR.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.25 (e) (1), 483.25 (e) (2), United States of America, Med Pass Inc.

- California Code of Regulations (2021). Title 22. §72315. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **RESIDENT RIGHTS-MEDICAL DECISIONS**	SECTION: Social Services **Page 1 of 1**

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

PURPOSE:

To define the manner in which Sierra View Medical Center's Distinct Part Skilled Nursing Facility (DPSNF) assures the patient's ability to exercise self-determination in medical decision-making throughout their stay in the facility.

POLICY:

Each resident or surrogate completes the POLST (Physicians Orders for Life-Sustaining Treatment) document at the time of admission.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, NURSING*

PROCEDURE:

1. The Social Service Designee shall initiate discussion with the resident/surrogate annually on the anniversary of admission, to determine whether the form still accurately reflects the treatment preferences of the resident/surrogate.

2. If the resident has an Advance Directive, the Social Service Designee shall review it annually with the resident/surrogate, to ensure that it remains current and correct, as to directives stated and any agents that are named. If not, it must be changed as soon as possible and placed in the medical record. If no changes are needed, it may be left as is.

3. When this annual review of the POLST or Advance Directive is completed, the Social Service Designee shall record it in a Progress Note in the resident's medical record.

4. If the resident/surrogate wishes to discuss medical treatment issues in order to clarify their preferences, the Social Service Designee shall refer them to the Medical Director.

5. If the resident/surrogate wishes to clarify their preferences in terms of family values, dynamics, or other psychosocial issues, the Social Service Designee should contact the unit Director to arrange for appropriate consultation.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 72527, San Francisco, California, Title 22.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10, 483.10 (a) and (b). United States of America, Med Pass Inc.

SUBJECT: **SAFE PATIENT HANDLING AND MOBILITY**	SECTION: *Employee Health* **Page 1 of 4**

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

PURPOSE:

To comply with California's Assembly Bill 1136 (AB 1136) under California Labor Code Section 6403.5 and Department of Occupational Health and Safety (DOHS) standard under Title 8, Chapter 4, section 5120. This policy and procedure outlines the standard approach for safe patient handling and mobility and is designed to prevent patient lifting related injuries to hospital personnel, especially injuries that result in lost or restricted work or permanent injury to employees.

DEFINITIONS:

1. **Super User**: an employee responsible for performing, assisting, and educating other staff in patient handling activities who is specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning and lifting devices as appropriate for the specific patient.
2. **Manual patient handling**: lifting, transferring, repositioning or mobilizing a part or all of a patient's body done without the assistance of equipment.

POLICY:

A. The Safe Patient Handling and Mobility (SPHM) policy and procedure provides methods to replace manual lifting and transferring of appropriately identified patients with powered transfer devices and lifting/repositioning devices as specified in Cal OSHA Title 8, Chapter 4, Section 5120.

B. The Safe Patient Handling and Mobility policy is applicable to all employees working at SVMC whose job tasks require direct hands-on patient care. This policy is applicable at all times and for all patient care units for appropriately identified patients. The tasks covered by this policy may include, but are not limited to the identified *5 Areas of Body Exposure* per California's Safe Patient Handling and Mobility legislation, AB 1136:

   a. Vertical
   b. Lateral
   c. Reposition & Boost
   d. Ambulation
   e. Bariatric

AFFECTED PERSONNEL/AREAS: *STAFF IN ALL PATIENT CARE AREAS*

EQUIPMENT:

Vertical Patient Lift (Golvo, Maxi Move, and Tenor)

Powered Sit-to-Stand (Sara 3000)

Non-Powered Sit to Stand (Sara Stedy)

Lateral Transfer Sheets (Sally Tube)

Repositioning Sheet (RepoSheet)

Air-Powered Lateral Transfer Device (Stryker Glide)

PROCEDURE:

A. The Registered Nurse (RN) and/or Physical Therapist will assess the patient's mobility level and plan for patient handling prior to patient handling in all but exceptional or life-threatening situations. Patient handling tasks include:

1. Vertical (lifting a patient)
2. Lateral (transferring a patient from one flat surface to another)
3. Reposition & Boost (turning a patient in bed or boosting a patient up in bed)
4. Ambulation (patient up out of bed to stand and bear weight or walk)
5. Bariatric (a patient that the staff deem unsafe to move based on their size and the patient's ability to be safely handled by staff)

B. RN will assess and document the mobility in the patient's medical record each shift.

C. RN is responsible as the coordinator of care to communicate the mobility assessment level and need for safe patient handling equipment or device to staff during hand-offs to the Certified Nurse Aid (CNA), Physical Therapy, Transporter, Radiology, Surgery, and RNs at change of shift.

D. RN will provide patient/family education regarding patient mobility needs, equipment used, the process to expect and how the patient can assist.

E. Education/Competency Assessment

Patient care employees will receive education upon hire and annually thereafter. Education and competency assessment, at a minimum, will include the following topics:

1. Patient mobility assessment (as applicable by job role)
2. Equipment locations on unit
3. Hands-on equipment training
4. Safe-patient handling techniques

F. All Super Users will complete SPHM E-learning module at least once a year.

G. When new Safe Patient Handling and Mobility equipment is purchased, employees will receive education/training, and competencies will be validated.

H. The Registered Nurse (RN) and/or Physical Therapist (PT) will assess the patient mobility level and communicate that mobility assessment to the team, to determine safe patient handling methods prior to patient handling.

I. Staff will use appropriate handling, mobility techniques, mechanical, non-mechanical, and transfer aids or devices in accordance with education, training, and manufacturer's instructions and guidelines. Staff will refrain from manual lifting methods for safe patient handling tasks and mobility in all but exceptional or life threatening situations.

J. The RN is the coordinator of care for all patient handling and mobility tasks and may delegate patient handling tasks to appropriate staff including Certified Nursing Assistants (C.N.A.) or other designated patient care staff to provide the "team" to perform the safe patient handling tasks. The decision to delegate will depend on several factors including patient medical condition, mobility needs, and acuity.

K. Employees have the right to refuse to lift, reposition, or transfer a patient due to concerns about patient safety, worker safety, lack of education, training, mechanical or non-mechanical equipment, lateral transfer devices or insufficient personnel available to assist.

L. Work Related Patient Handling Injury

After a work-related patient handling injury occurs, the employee must follow proper steps as per Policy (Refer to Injury and Illness Prevention Program Policy & Procedure).
Before returning to work after a patient handling related injury, the employee must obtain medical clearance from physician and Employee Health. In conjunction with Human Resources, Employee Health staff will evaluate any work restrictions and determine return to work status (Refer to Transitional Return to Work Policy & Procedure).

Returning employee will then be assigned to attend SPHM equipment training session again as a remediation and to demonstrate competency A SPHM Skills Check-off list will be utilized and completed with required signatures when competency is demonstrated.

M. Safe patient handling equipment or device must be inspected prior to use by any staff member. If equipment or device appears broken, faulty or not in working order, remove from service and notify Biomed.

N. RN will coordinate with staff for assistance performing safe patient handling and mobility tasks. Staff works together as part of the safe patient handling "team" to perform equipment-assisted lifts, lateral transfers, turns, and repositions of patients in clinical environments from admission to discharge. In addition, they provide on-site instruction to patient and caregiver to ensure safe method of transfer.

O. Extra staff assistance should be used in mobilizing patients in the following activities:

1. Patient unable to assist in own mobility
2. Non-weight bearing per MD orders
3. Every 2 Hours Turn
4. Repositions & Boosts
5. Lateral Transfers
6. Emergency Lift (patient fall)

P. Before staff assistance arrives:

1. Have the necessary equipment/supplies available and ready
2. If patient is returning to bed, ensure bed is clean and made

Q. When staff assistance arrives communicate to assisting staff any special instructions, physical limitations, considerations, or pertinent patient information that will assist in the safe patient handling movement.

R. Cleaning of the Lift Equipment after use:

1. All mechanical equipment, non-mechanical equipment, devices, and slings (unless disposable) will be cleaned between each patient use by staff member using the equipment. Equipment will be cleaned with appropriate/approved cleansers or wipes.
2. Once cleaned, the Lift equipment must be placed in its designated storage area.
3. Electrical equipment that uses a battery must be plugged into an electrical outlet while in storage.
4. Repositioning sheets or slings may be assigned to a patient during patient length of stay. When the reposition sheet becomes soiled, dirty, or the patient is discharged, the sheet is discarded.

S. Equipment Repair

Staff will notify Engineering Department and/or Biomed when an equipment repair is required. An Engineering Service Request will be entered electronically via Intranet. Equipment not working will be placed in a unit specific area and "tagged" with a "Needs Repair" sign on it for Biomed or Engineering department to pick up to repair. Biomed or Engineering will then return item once it has been repaired. If item is not repairable, then Biomed or Engineering will notify that specific unit informing them.

REFERENCES:

- California Occupational Safety and Health Standards Board, Title 8, Chapter 4, §5120. Health care worker back and musculoskeletal injury prevention. Subchapter 7, General Industry Safety Orders; Group 15, Occupational Noise; and Article 106, Ergonomics. (2014). Retrieved on August 28, 2022 from: https://www.dir.ca.gov/title8/5120.html

CROSS REFERENCES:

- Illness and Injury Prevention Program (SVMC)
- Transitional Return to Work Policy & Procedure

SUBJECT:	SECTION:
SKIN CARE TIPS FOR NURSING ASSISTANTS~~SKIN CARE TIPS FOR NURSING ASSISTANTSSKIN CARE TIPS FOR NURSING ASSISTANTS~~	**Page 1 of 2**

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PURPOSE:

The purpose is to assure skin integrity is maintained.

POLICY:

Sierra View Medical Center (SVMC) will utilize protocols for skin care to promote resident comfort and to provide preventive skin care measures.

AFFECTED PERSONNEL/AREAS: *CNAs*

PROCEDURE:

A. INCONTINENT:

1. Check residents at least every 2 hours for wetness. Change as needed. Make a point to check incontinent residents between other duties.
2. Wash perineal area and dry at each change.
3. Use diaper or padding under resident in bed or up in chair; not up between legs. Do not layer incontinent pads between resident and pressure relief devices.
4. Check for redness and report it to the licensed nurse.
5. Toilet residents that are up in chairs at least every 2 hours or according to individualized toileting schedule.

B. CONTACTURES:

1. Practice gentle handling of area; move slowly so you do not hurt the resident.
2. Wash skin gently with wash cloth, dry well and pat with a soft cloth.
3. Check resident's fingernails, and trim if needed so they do not cut into the palms of hands. Check for redness, and report it to the nurse.

C. PRESSURE INJURIES~~ULCERS~~:

1. Turn resident every 2 hours or more often as needed.
2. Do not leave resident on reddened area longer than to bathe or feed.
3. If incontinent, change as soon as wet, wash and dry.

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4. Do not rub reddened area.

5. Any change in skin condition should be reported to the nurse.

D. SKIN:

1. Never rub. Only pat to wash and to dry.

2. Dress slowly, so cloth does not pull skin.

3. Be careful during transfers.

4. Use lotion to keep skin lubricated.

E. SKIN FOLDS:

1. Wash and dry under every skin fold.

2. If a patient is obese, padding may be needed under breast or stomach.

3. If redness is found, report it to the licensed nurse.

F. GENERAL:

1. Tuck linen loosely over residents and pressure relief devices.

REFERENCES:

- California Code of Regulations (2021). Title 22. §72315 (5) (6). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SKIN INTEGRITY TEAM GUIDELINES**	SECTION:

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

PURPOSE:

The purpose of this policy is to provide a systematic interdisciplinary approach to wound care.

The primary purpose(s) of developing a specialized team is to evaluate each pressure area and skin problem and assist the physician to provide the most effective coordination of treatment as well as a baseline of information for the nursing staff and other team management members.

POLICY:

- The wound care team will consist of facility personnel.
- The team will improve overall skin/wound care management and continuity of treatment throughout the facility.
- A comprehensive and ongoing education program will be provided for nursing personnel and all other team members.

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSE (RN); PHYSICIAN; RESPIRATORY THERAPIST (RT); REGISTERED DIETITIAN (RD); CERTIFIED NURSING ASSISTANT (CNA); RN WOUND NURSE

PROCEDURE:

A. SKIN INTEGRITY TEAM RESPONSIBILITIES

1. The Clinical Director will coordinate skin integrity team activities.
2. The team may include the following: Treatment Nurse, Charge Nurse, Clinical Director, RT, RD or Food Service Supervisor, Nursing Assistant, M.D., and RN Wound Nurse.
3. Pressure and dermal ulcers, skin tears and excoriations will be reviewed every week.
4. The RN Wound Nurse and nursing will assess and document the status of skin problems in the electronic medical record (EMR).
5. Nursing will assess for skin risk status on admission and as needed thereafter. This interdisciplinary assessment will include information on nutritional state, incontinency and mental status, mobility and activity.

B. SKIN INTEGRITY TEAM MEMBERS RESPONSIBILITIES

1. Clinical Director/ Manager
   a. Will see that there is a functioning Skin Integrity Team in the facility.

b. Will monitor new admission skin integrity assessments.

c. Will monitor ongoing skin integrity assessments and effectiveness of prevention and treatment procedures.

d. Will play a key role in staff education by the Director of Staff Development (DSD) on an ongoing basis.

e. Will coordinate and periodically review all aspects of skin integrity management in the facility.

f. Review ongoing skin issues weekly during Interdisciplinary Team Meetings.

2. Treatment Nurse/Charge Nurse, RN Wound Nurse

a. Will make recommendations to physicians consistent with current policies and procedures and carry out treatments as indicated.

b. Will provide documentation as indicated.

c. Will supervise nursing assistants to insure an ongoing high quality of direct resident care.

3. Nursing Assistants

a. Will carry out direct resident care with special emphasis on prevention and skin integrity management.

b. Will attend in-service programs related to skin integrity by the DSD.

c. Will communicate to charge nurse any change in skin integrity, using pocket skin sheets or verbally notifying licensed nurse.

REFERENCES:

- Thomson Reuters (2021) Barclay's California Code of Regulations, §72315 (7) , San Francisco, California, Title 22, Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
UTILIZATION OF PATIENT'S HOME VENTILATOR/CPAP UNIT DURING IN PATIENT STAY	**Page 1 of 2**

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

PURPOSE:

To define a procedure and process to allow patients that use home BIPAP or CPAP units to use their own units while hospitalized, and allow for a transition for ventilator dependent patients to transition to an outpatient setting.

POLICY:

Patients may bring their home ventilators, BIPAP, or CPAP units to use while they are hospitalized with a written order from their attending physician. These units must have an electrical safety check upon the patient's admission. Units that are not in good working condition will not be allowed until appropriate corrective and/or preventative maintenance is performed.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE SERVICES, NURSING, ENGINEERING*

PROCEDURE

1. Physician enters order in MediTech to allow patient to use home ventilator, BIPAP or CPAP unit.
2. Upon admission, Engineering will perform an electrical safety check. Respiratory Care Services will provide manual ventilation as necessary during the safety check.
3. Any unit that is visually damaged or is not 100% functional will not be allowed and the patient must use a hospital issued unit.
4. Patients requiring ventilator support needing a transitional period to trial a home care ventilator will be set up on the ventilator they will be using at home by the DME Company. An acute hospital-owned ventilator will be at the patient's bedside on stand-by in the event of equipment failure or patient intolerance. In the event the patient fails or needs to be placed back on the acute care ventilator the physician will be notified immediately.

INFECTION CONTROL:

- Universal Precautions

REFERENCES:

- Stiefel, R. (2010). Non-hospital owned equipment poses challenge. *Biomedical Instrumentation & Technology*. https://doi.org/10.2345/0899-8205-44.5.415

- Willis, D. Lowe, G., Pearce, P., Spray, B. J., Willis, R., Scott, A., Carroll, J. L., & Agarwal, A. (2020). Transition from an ICU ventilator to a portable home ventilator in children. *Respiratory Care, 65*(12), 1791-1799. https://doi.org/10.4187/respcare.07641

SUBJECT: **VAC THERAPY- NEGATIVE PRESSURE WOUND THERAPY SYSTEM DPSNF**	SECTION: **Page 1 of 12**

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

PURPOSE:

The purpose of this policy is to provide guidelines on how to identify residents who would benefit from Vacuum Assisted Closure (V.A.C.) Therapy. This policy provides instruction on how to initiate treatment, conduct continuous monitoring, and discontinue therapy.

Vacuum Assisted Closure Therapy is utilized to:

- Promote rapid granulation tissue formation by increasing blood supply to the wound.
- Remove excessive interstitial fluid, bacteria and wound exudates.
- Convert an open wound to a closed moist wound-healing environment.
- Identifying and evaluating risk factors and changes in the patient's condition that would warrant removal of the V.A.C. (i.e. hemorrhage).

DEFINITION:

V.A.C. therapy is non-invasive active therapy utilizing a controlled localized sub-atmospheric/negative pressure which is applied directly to the wound. The V.A.C. may be applied to one or more wounds to supply negative pressure therapy. The V.A.C. increases blood supply to the wound thereby promoting granulation tissue formation. It stretches cells, enhances epithelial migration and converts an open wound into a controlled closed moist wound healing environment. The V.A.C. removes excessive interstitial fluid, bacteria and wound exudate into a disposable V.A.C. canister.

POLICY:

The wound V.A.C. Therapy program will include:

- Identification of patients whose wound(s) qualifies for V.A.C.
- Monitoring the effectiveness of the V.A.C. each dressing change
- Discontinuance of the V.A.C. if there is no evidence of wound healing
- All licensed nursing staff (i.e. RN, LVN) will complete an initial V.A.C. competency on hire and an annual competency thereafter which includes application, maintenance and troubleshooting.

AFFECTED PERSONNEL/AREAS: *PHYSICIANS, REGISTERED NURSES (RNs), LICENSED VOCATIONAL NURSES (LVNs)*

PROCEDURE:

A. The wound will be assessed by the RN Wound Specialist or Physician. An order will be written with the following information included:

1. When to initiate V.A.C. therapy
2. Location and number of wounds to receive V.A.C. therapy
3. Negative pressure setting in mmHg (125 mmHg) or desired pressure. If no pressure setting is specified, the default setting of 125 mmHg will be delivered until clarification can be obtained.
4. Mode of therapy (Continuous or Intermittent). If no mode of therapy is written, the default setting of Continuous will be delivered until clarification can be obtained.
5. Size and type of wound dressings.

B. Contact KCI at 1-800-275-4524 to initiate the process of ordering the Wound V.A.C. along with appropriate resident supplies. **Please note that it may take some time to obtain insurance authorization for V.A.C. use.**

C. A qualified, competent staff member will apply the V.A.C.

D. KCI is to be notified immediately upon discontinuance of V.A.C. therapy so billing can be stopped and arrangements can be made for V.A.C. pickup.

E. Nursing will return the V.A.C. pump to the "dirty" side of Central Processing when V.A.C therapy is discontinued. If Central Processing is closed, the V.A.C. will be placed in the dirty utility room and the day shift unit clerk advised so that it can be returned during normal business hours.

NEGATIVE PRESSURE WOUND THERAPY CONSIDERATIONS

1. **Indications:**

- Acute surgically dehisced wounds (Orthopedics)
- Traumatic Wounds
- Dehisced Incisions
- Pre/Post Split Thickness Meshed Grafts and Flaps
- Stage III and IV Pressure Ulcers

- Enteric Fistulas
- Partial-Thickness Burns

2. **Contraindications:**

- Presence of necrotic tissue
- Greater than 30% necrotic tissue (slough) present in the wound
- Untreated Osteomyelitis (May initiate V.A.C therapy 24 hours after initiation of systemic antibiotic therapy)
- Cancer within the wound bed or its margins
- Unexplored non-enteric fistulas
- DO NOT place foam dressing directly over exposed veins or arteries

3. **Precautions:**

- Uncontrolled active bleeding
- Difficult hemostasis of wound
- When anticoagulants are being administered
- Enteric Fistula
- When placing the dressing in close proximity to blood vessels, ensure all vessels are adequately protected with overlying fascia, tissue, or other protective barrier.

4. **Documentation:**

The following will be documented in the medical record **in the EMR :**

- Measurement and documentation of the wound's length, width and depth along with undermining/tunneling must preclude V.A.C placement and must occur weekly.
- Initiation of V.A.C, including therapy mode, negative pressure setting and type of foam used (Black, Silver or White)
- Dressing changes (M-W-F or Tu-Th-Sat)

- Number of foam pieces used inside the wound
- Drainage amount, if applicable
- Resident tolerance (pain), daily
- Appearance of dressing (raisin-like) on days when dressing change is not due
- Discontinuance of V.A.C.

GUIDELINES FOR SPECIFIC WOUNDS AND MACHINE SETTINGS (To be determined by RN Wound Nurse or MD):

1. Acute Wounds and Pressure Injuries: Cycle: Continuous
   Target Negative Pressure: 125 mmHg
   - Consider Intermittent Cycle mode when drainage decreases and minimal change in wound dimension occurs.
2. Surgically Created and Wound Dehiscence: Cycle- Continuous
   Target Negative Pressure- 125 mmHg
   - Consider Intermittent Cycle mode when drainage decreases and minimal changes in wound dimensions occur.
3. Meshed Grafts: Cycle: Continuous
   Target Negative Pressure: 75-125 mmHg
   - Initial dressing change is performed 4-5 days and drainage is minimal.
   - Place a single layer of non-adherent, Adaptic dressing between the skin graft and black foam.
   - White foam may be indicated.
4. Compromised Flaps: Cycle: Continuous
   Target Negative Pressure: 125 mmHg
   - Check for flap/base adhesion and edema reduction
   - White foam may be used with pressures 125-175 mmHg
5. Chronic Ulcers: Venous Stasis, Arterial Insufficiency and Neuropathic Ulcers
   Cycle: Continuous
   Target Negative Pressure: 50-125 mmHg

- White foam may be used with Target Pressures 125-175 mmHg

6. Wound Undermining:

   - Fill undermined areas with foam. DO NOT over pack such that capillaries may compress.
   - Irrigation and aggressive wound cleansing with each dressing change is recommended.

7. Tunneling:

   - White foam is moist and dense, therefore recommended when placing in narrow areas.
   - Insert foam until it reaches approximately 1 cm from distal end of tunnel.
   - Be sure to extend foam outside of tunnel to allow for easy removal.

Note: V.A.C. dressing should never be used in conjunction with wall or other suction devices.

DRESSING CARE AND MANAGEMENT (Aseptic Technique):

Supplies needed:

- V.A.C. Pump
- V.A.C. Dressing Kit of choice that includes foam dressing, transparent/occlusive drape and TRAC pad
- Wound Cleanser
- Scissors
- Towels and/or gauze to maintain a dry peri-wound area
- Skin Prep
- Gloves
- Optional- clippers to clip hair, Y-connector to connect multiple wounds

Dressing Application Using Aseptic Technique:

- Aggressively clean and irrigate wound with wound cleanser

- Achieve hemostasis
- Clip hair around border if needed
- Dry peri-wound area. Skin prep to be applied to secure occlusive drape
- Cut foam dressing to shape and size of wound, if necessary
- Gently place the foam into the wound. DO NOT PACK the wound tightly.
- Multiple pieces of foam dressing may be used when faced with a large or odd shaped wound as long as foam touches foam. This will ensure collapse of the foam when negative pressure is applied
- When cutting foam, make sure to remove excess foam fragments that may become embedded into granulation tissue
- Cover the foam and surrounding healthy tissue with the occlusive drape
- Cut a portion of the occlusive drape where the TRAC pad is to be placed. The cut should measure the size of a nickel or quarter. Take care in positioning tubing near areas of bony prominence.
- Position clamps away from patient to avoid additional source of pressure

Undermining Wounds

- DO NOT over pack the dead space created by undermining. Gently fill it. Over packing can cause capillary compression which prohibits adequate wound perfusion.
- Fill the distal portion of the undermined area first, remembering to stop about a centimeter from the wound wall to allow granulation tissue to form.

Tunneling Wounds

Tunneling can result in abscess formation when the main body of the wound heals and closes the entrance to the tunnel. To avoid this from happening, the white foam should be inserted into the tunneled area approximately a centimeter from the distal end of the tunnel. Leave a portion of the foam extending beyond the surface to allow for easy removal. Record the number of individual foam pieces to ensure the total number gets removed during the next dressing change. The white foam is soft, moist and dense which allows for easier insertion and removal from tunneled areas.

Wounds Small in Diameter

Frame outer wound edge with skin prep and V.A.C. drape. Place foam dressing inside wound and lay a large piece of foam directly on top making sure that foam touches foam. Cover foam with V.A.C. drape and apply TRAC pad after creating a nickel or quarter size opening in drape.

Multiple Wounds (Contact wound nurse for assistance):

When treating multiple wounds, a "Y" connector can be inserted into the system as along as the surface area of total wounds does not exceed the V.A.C. pump's ability to achieve an adequate negative pressure seal.

Wounds that are in close proximity to one another may be dressed using the "bridging" technique. The advantage to this technique is that multiple wounds can receive therapy with the use of only one TRAC pad.

- It is critical to protect intact skin between the wounds with skin prep and the clear V.A.C drape to prevent breakdown of healthy tissue from constant negative pressure and moisture applied through the porous dressing.
- Cover each wound with the VAC foam dressing of choice. Attach an additional piece of foam between wound(s), acting as the "Bridge." Remember to place foam on top of the V.A.C. drape and ensure that foam touches foam in order to achieve proper collapse of the foam when negative pressure is initiated.
- Apply the TRAC pad to only one of the foam dressings. When negative pressure is applied, evaluate the entire area to ensure that collapsing of all foam is achieved.

Maintaining an airtight sealed dressing:

To assure optimal outcomes in utilizing the V.A.C., an airtight dressing seal is critical. The following techniques will be helpful in achieving a tight dressing seal.

- Dry the peri-wound area thoroughly. Use skin prep to prepare the area before applying the clear occlusive drape.
- Frame the wound with the skin prep when the skin around the wound is delicate or convoluted.
- Reduce the height of the foam dressing by cutting or beveling the edges when treating shallow wounds or wounds near the perineal area.

Fecal Incontinence:

When a tight seal is difficult to achieve on a resident who has fecal incontinence and the wound is in the sacral, coccyx or perineal region, the following techniques may be helpful in achieving a tight dressing seal.

- Utilize a fecal collection bag or a rectal tube with a collection device.
- Frame the wound with skin prep and V.A.C drape. May frame the wound with Stoma adhesive as well.
- RN Wound Specialist to consult the physician about the possibility of a temporary ostomy until the wound heals or improves.

Dressing changes:

Dressing changes are performed every forty-eight to seventy two hours by competent and qualified personnel. Deviations from the 48-72 hour dressing are as follows:

- Infected Wounds-(bacterial count > 10 to the 5th power) Dressing changes are to be performed every 12 hours. When the bacterial count decreases to < 10 to the 5th power, or clinical signs of wound improvement are present, resume dressing changes every 48 hours.
- Status Post Graft- Perform dressing change every 4-5 days

Dressing Removal:

- Raise tubing above V.A.C. pump to allow the pump to pull exudate remaining in the tubing into the canister.
- Press the Therapy ON/OFF button to deactivate pump.
- Clamp both dressing and canister clamps.
- Gently remove occlusive drape. The drape may be stretched horizontally to release the adhesive which allows for gentle removal when sensitive skin is present.
- If dressing adheres to the base of the wound:
  - Consider a single layer of Adaptic or White foam between the wound base and foam dressing.
  - Turn V.A.C. pump off. Inject foam with wound cleanser or normal saline. Allow the foam to become completely saturated. Wait 5-15 minutes prior to removal of dressing.
- If pain is present during dressing changes, turn the V.A.C. pump off. Inject the foam with 1-2% Lidocaine. Wait 5-15 minutes prior to removal of dressing.

Canister Changes:

The canister is to be changed every five days or prn when full. The canister is self-contained and cannot be emptied.

- Close both dressing and canister clamps.
- Disconnect canister tubing at the male/female connector.
- Push the canister release button on the pump. This releases the canister, which can now be removed from the pump.
- Dispose of the canister in the appropriate receptacle per hospital policy.

CARE AND SAFETY RECOMMENDATIONS:

- Keep NPWT ON- V.A.C. therapy must be applied to the wound at least twenty-two hours a day. Should therapy be interrupted for more than two consecutive hours, the entire dressing must be changed to avoid bacterial colonization in the foam dressing.
- Dressing Changes- Always use sterile unopened foam disposables when performing dressing changes. Do not "save" foam after package is opened. It is acceptable to use excessive occlusive drape.
- Daily Wound Care- Inspect wound frequently. Visually observe the VAC dressing to assure that it has the collapsed appearance of a raisin. Review the pump screen to verify proper negative pressure setting and mode of therapy. Watch for signs/symptoms of infection (fever, redness, increased warmth to wound area and purulent discharge or strong odor.
- Discomfort- Consider lowering the V.A.C target pressure. A physician order is required.
- Wound Appearance- A steady decrease in wound volume should be noted. Initially the wound may appear larger due to the wound edges softening and the reduction of edema. The wound may appear paler as the amount of collagen in the wound increases.
- V.A.C. Pump Operation

Buttonology:

- Power Switch- Provides electricity to the V.A.C. pump.
- Main Screen: Shows the operator Utility button, Therapy button, battery status, whether or not AC power is in use, current negative pressure being measured at the wound site, Therapy mode, Lock Out status and (?) Help option.

- Lock out button is activated or deactivated by pressing and holding the Lock symbol on the display screen for three seconds.

- Therapy Screen: Shows the operator

  - On/Off button- Turns the negative pressure on and off

  - Target pressure display

  - Arrow buttons- Adjusts the negative pressure, changes intermittent therapy intervals and controls the intensity of the initial collapse of foam.

  - Intensity button- Sets the rate of negative pressure change at the wound bed, after initiating therapy. The lower the intensity, the more comfortable it is for the patient as the dressing draws down.

  - Continuous and Intermittent mode buttons.

- Utilities Screen:

  - Gives the operator five different options

  - About

  - Cleaning

  - Hour Log

  - Service

  - Options

ALARMS:

There are a total of five alarms. Each alarm will be displayed on the LED screen when it is activated and there will be a prompt to troubleshoot the alarm condition.

1. Leak- The screen message will display- Tubing and/or dressing has leaks

Action: Check that the canister is securely connected to the dressing. If that does not resolve the alarm condition, apply pressure with your fingers around the dressing and clear occlusive drape. When the leak is located and sealed, the dressing will collapse. It may be necessary to cut away the drape and reapply drape to area to achieve an effective seal.

- If the alarm condition is not corrected in two minutes, the audible alarm will sound.
- If the alarm condition is not corrected, the pump will shut down five minutes after the audible alarm is activated.

2. Tubing blocked- The screen will display - Tubing is blocked

Action: Ensure tubing clamps are open and check that the tubing is not kinked or pinched.

3. Canister Full- The screen will display- Canister full. The canister has reached the maximum capacity of 500ml

Action: Turn pump off. Clamp and disconnect the canister from the dressing tubing. Remove the canister and dispose of it per hospital policy. Insert a new canister and reconnect it to the dressing tubing. Open the clamps. Activate the pump. Observe the dressing for proper compression. The dressing should appear "raisin-like."

4. Therapy is not activated - The screen will display - Therapy not activated

Action: Turn therapy on.

5. Low Battery- The screen will display - Battery is low

Action: Plug the AC cord into a red electrical outlet. Be sure that the plug to the pump unit is also firmly attached.

6. Back Up Battery Operation:

The backup battery will be automatically activated when the pump is disconnected from the AC source. The plug symbol will disappear from the screen. Once the V.A.C. is plugged into the AC source, the unit will begin recharging.

- Average battery life is approximately four hours.
- Average time to recharge the battery is four hours to reach 85% charge capacity and approximately ten hours to achieve full charge.
- The battery life is represented by the battery symbol on the display screen. The lines inside the battery symbol represent the battery time remaining. Each line has a value of one hour.
- Automatic pump shutdown will occur when the battery has reached a critical level. The pump will remain off even when AC power is restored. The operator must flip the green power button to regain pump function.

7. Mute button- silences the alarm for two minutes

REFERENCE:

- Thomson Reuters (2019) Barclay's California Code of Regulations, §72315 (7), San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- KCI The Clinical Advantage, San Antonio, Texas, 78219. Retrieved from www.kci1.com.

- Negative Pressure Wound Therapy with Instillation: International consensus guidelines update. Kim PJ, et al. Int Wound J. 2020. PMID 31667978.

SUBJECT: **WATER PASS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To provide fresh cold water to residents daily and as needed to maintain hydration.

POLICY:

It is the policy of this facility to provide residents with a clean water pitcher and cover, glass and fresh cold water on a daily basis and as needed, unless the resident is NPO, or on restricted fluids.

AFFECTED PERSONNEL/AREAS:

LICENSED NURSES, CNAs

PROCEDURE:

1. Establish a schedule to provide nursing with clean, disposable pitchers, covers and plastic cups.
2. Nursing will ensure that the clean pitcher liners are changed and filled with fresh water according to the schedule established.
3. Each resident (unless they are NPO) will be provided with a covered pitcher of fresh water and a clean cup daily. Pitchers and cups will be made available on resident's bedside stands or over bed tables.
4. All Nursing Assistants will offer water or fluids every 2 hours and assist those residents capable of PO intake to drink as needed (unless NPO). Then, the CNA will document in the appropriate area on PCS.
5. Nursing Assistants will replenish water throughout their shift as needed.

REFERENCES:

- Thomson Reuters (Revised April 1, 1990). Barclay's California Code of Regulations, §72315, San Francisco, California, Title 22
- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 (j) United States of America, Med Pass Inc.

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