SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room
San Joaquin Valley Rehabilitation Hospital – Room 213B
7173 n. Sharon Ave.
Fresno, CA 93720

AMENDED AGENDA
April 26, 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/Roll Call

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. 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 then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board. Items on the Consent Agenda are posted on the Hospital Website at least 72 hours prior to each meeting and can be viewed by the public at https://www.sierra-view.com/about-us/board-of-directors/board-of-directors-meetings/. A hard copy is also available for review at the Hospital Administrative Office at 465 W. Putnam Ave., Porterville, CA 93257.

III. Approval of Minutes

A. March 22, 2022 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove March 22, 2022 Minutes of the Regular Meeting of the Board of Directors

B. April 5, 2022 Minutes of the Special Meeting of the Board of Directors
Recommended Action: Approve/Disapprove April 5, 2022 Minutes of the Special Meeting of the Board of Directors

IV. 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

V. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – November 2022

D. 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 (1Item)

E. Pursuant to Gov. Code Section 54956.9, Exposure to Potential Litigation (d)(2): Conference with Legal Counsel. Pursuant to Evidence Code Sections 1156 and 1157, 1157.7; Health and Safety Code Section 32106(b) and Health and Safety Code Section 32155 (2 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.

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VI. Adjourn Closed Session and go into Open Session

OPEN SESSION

VII. 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: Vote to Approve/Disapprove

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

C. Discussion Regarding Trade Secret
Recommended Action: Approve/Disapprove

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

E. Conference with Legal Counsel (2 Items)
Recommended Action: Information only; no action taken
Recommended Action: Action taken at Board's discretion

VIII. 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.

IX. Hospital CEO Report

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X. Business Action Items

A. **Proposal to Initiate Adjustment of District Lines Based on the 2020 Census Data**
Recommended Action: Approve/Disapprove

B. **Porterville Academy of Health Sciences – Donation Request**
Recommended Action: Approve/Disapprove

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

D. **March 2022 Financials**
Recommended Action: Approve/Disapprove

E. **Board Self Evaluation**
Recommended Action: Approve/Disapprove

XI. Business Information Items

A. **Public Records Requests**
Recommended Action: Information only; no action taken

- **3/28/2022 Request** *from Richard Eckhoff for agendas, including minutes and other public package information for the Board Meetings*

XII. Announcements:

A. Regular Board of Directors Meeting – May 24, 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.

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PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Fuentes, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, 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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MEDICAL EXECUTIVE COMMITTEE	04/06/2022
BOARD OF DIRECTORS APPROVAL	
	04/26/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
April 26, 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
• Admission Guidelines for the Ambulatory Surgery Department	1-2	↓
• Chain of Command Regarding Patient Care	3-4	
• Contaminated Instrument Transportation	5-6	
• Drug/Nutrient Interactions and Enteral Tube Feeding Drug/Nutrient Interaction	7-9	
• Ebola Virus Disease	10-21	
• Formula Dating and Storage	22	
• Initiation of Hemodialysis Using Dual Lumen Catheter	23-24	
• Mechanical Ventilation	25-32	
• Medical Advice Via Telephone – SC	33	
• Medication Administration: Medical Assistant – SC	34-35	
• Medication Procurement, Storage, Distribution and Control	36-46	
• Mitomycin Intravesical Instillation	47-49	
• Patient's Own Medications	50-53	
• Point of Use: Instrument Cleaning and Transport	54-56	
• Procedural Sedation	57-78	
• Scope of Services and Equipment - SC	79-80	
• Sequential Ultrafiltration (SUF) – Acute Renal Services	81	
• Tube Feeding	82-84	

SUBJECT:	SECTION:
ADMISSION GUIDELINES FOR THE AMBULATORY SURGERY DEPARTMENT	**Page 1 of 2**

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

PURPOSE:

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

POLICY:

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

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

   Definitions:

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

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

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

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

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

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

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

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

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

9. Patients who receive procedural sedation or any type of ~~a general~~ anesthesia should identify a responsible adult to care for them in the first 24 hours after discharge.

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

~~10.~~11. Patients with a BMI greater than 50 must have their procedure completed at the hospital in the main operating room.

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AFFECTED AREAS/PERSONNEL:

AMBULATORY SURGERY DEPARTMENT PERSONNEL AND MEDICAL STAFF

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CROSS REFERENCES:

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

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

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SUBJECT: **CHAIN OF COMMAND REGARDING PATIENT CARE**	SECTION: *Leadership (LD)* **Page 1 of 2**

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

PURPOSE:

To provide a clearly delineated communication pathway utilized by the interprofessional disciplines within ~~our organization~~Sierra View Medical Center (SVMC). To ensure resolution of issues of nursing care, treatment, and services at the lowest possible level.

POLICY:

Every registered nurse (RN) is responsible for his/her actions in administering patient / resident care, and securing medical attention for the patient / resident when necessary. The RN acts upon the legal obligation as patient / resident advocates as described in the California Nurse Practice Act (~~2015~~2021).

AFFECTED AREAS/ PERSONNEL: *ALL Nurses and Physicians~~PERSONNEL~~*

PROCEDURE:

1. Chain of Command

   The nurse utilizes the following communication process when patients need medical attention and/or clarification of medical orders is necessary. The goal is to resolve the issue at the lowest level in the escalating chain of command. This chain of command stops once the issue has been satisfactorily resolved.

   a. Primary Care Nurse (PCN) contacts the attending physician **–or-**

   b. RN Clinical Manager or Charge Nurse contacts the attending physician.

   c. PCN / RN Clinical Manager or Charge Nurse- contacts Department Director and/or Shift House Supervisor.

   d. Department Director / House Supervisor or designee contacts attending physician.

   e. Any issue requiring Chief of Staff, Department Chair intervention must be reported to the Vice President of Patient Care Services / Chief Nurse Executive or the Administrator on Call if after hours, weekends and holidays.

      NOTE If at any time the Chief of Staff or Department Chair is not available, then the Vice Chief of Staff and/or Vice Chair of the Department is to be notified.

   f. The Vice President of Patient Care Services / Chief Nurse Executive, or designee, contacts the attending physician. (If attending physician does not respond or is involved in a patient safety concern move to the next level.)

   g. The Vice President of Patient Care Services / Chief Nurse Executive, or designee, contacts the Department Chair.

h. The Vice President of Patient Care Services / Chief Nurse Executive, or designee, contacts Chief of Staff.

i. The Vice President of Patient Care Services / Chief Nurse Executive notifies the CEO or Administrator on Call (AOC) of need to contact Department Chair or Chief of Staff.

2. Physician communication pathway for issue resolution (goal is to resolve at the lowest level in the escalating chain of command), i.e., concerns for patient care quality issues, process issues, and individual staff member issues, etc.

a. Physician communicates directly with the individual staff member involved with the issue.

b. Physician communicates with the Nursing Clinical Supervisor or Nursing House Supervisor to whom the individual reports.

c. Physician communicates with the Department Director to whom the staff member reports.

d. Physician communicates with the Vice President of Patient Care Services / Chief Nurse Executive (or Administrator on Call as appropriate) to whom the Department Director reports.

e. Physician communicates with the Chief Executive Officer to whom the Vice-President of Patient Care Services / Chief Nurse Executive reports.

Formal feedback may be utilized to ensure tracking and trending of issues, resolution and quality improvement efforts.

REFERENCES:

- *California Nursing Practice Act: With regulations and related statutes*. (~~2015~~2021). Charlottesville, VA: Lexis Nexis.

SUBJECT: **CONTAMINATED INSTRUMENT TRANSPORTATION**	SECTION: **Page 1 of 2**

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

PURPOSE:

Define the processes of decontamination and transport of surgical instruments between the point of use and Central Processing Department, to minimize the spread of potentially infectious microorganisms.

POLICY:

1. Instruments should be kept free of gross soil during surgical procedures.

2. All instruments, sterile or decontaminated, must be in solid closed containers for transport between buildings.

3. All decontaminated instruments must be transported as soon as possible from the point of use to the Central Processing Department.

4. Hospital vehicles may be used for transport.

AFFECTED AREAS/ PERSONNEL: *CPD, MAIN OR, OB-OR, ASD, WOUND CLINIC, UROLOGY CLINIC, ~~GENERAL & COLORECTAL~~ SURGERY CLINIC*

PROCEDURE:

1. Instruments will be wiped and soaked with sterile water during the procedure. Instruments with lumens should be irrigated with sterile water to remove obstructive organic material.

    a. (Corrosion, rusting or pitting may occur when saline, blood or debris are allowed to dry on surgical instruments. Subsequent decontamination and sterilization may not be achieved)

2. Immediately after use and prior to transport, instruments are pre-treated to ensure excess bio-burden is removed. This will occur in the decontamination or workroom area of each point-of-use location.

3. Instruments will be placed in a rigid, puncture resistant, covered transport container and kept moist by adding a towel dampened with sterile water, or an enzymatic foam product.

4. Never allow free fluid to remain in the tray/biohazard container as it may spill during transport. Clean items should be separated from dirty, and when possible instruments shall be returned together as sets. If the instruments are soaked in water from the back table or an enzymatic solution, the liquid should be discarded by properly attired personnel before transport.

5. If the external surfaces of the transport container are contaminated, the container will be placed in a red biohazard plastic bag for transport. Items will be labeled "biohazard" before being transported to the CPD.

6. Carts, reusable covers, bins and other transport containers should be decontaminated after every use with an EPA-registered intermediate level disinfectant.

7. The designated soiled lift between Surgery and Decontamination in CPD is considered to be a closed cart for transporting soiled instruments. The lift should be decontaminated once per month, and as needed with an EPA-registered intermediate level disinfectant.

8. Staff carrying containers with soiled instruments will enter the hospital through the loading dock and go immediately to the Decontamination area of CPD. Instruments will be logged in upon receipt. Containers should be maintained in a horizontal position during transport to prevent dislodging or potential damage during transport.

9. A log is maintained at the remote facilities and the CPD documenting instruments transported and received between the two locations. The log is to show the name of the person sending the instruments, the receipt of the instruments and that the (for sterile packages) sealing tape is intact.

10. Sterile items will also be placed in rigid, sealed containers for transport. Containers will be sealed with tape, to assure the integrity of sterility during transport, and marked with the initials of the person who is sending the instruments.

11. Sterile items must never be transported in the same cart or container as dirty items and are never in the soiled lift.

REFERENCES:

- ANSI/AAMI ST79, 2019.
- OSHA Blood Borne Pathogen regulation (29 CFR 1910.1030)
- Guideline for Cleaning and Care of Surgical Instruments. AORN Standards and Recommended Practices, 2019. Accessed 3/16/2019.

SUBJECT:	SECTION:
DRUG/NUTRIENT INTERACTIONS AND ENTERAL TUBE FEEDING DRUG/NUTRIENT INTERACTION	***Assessment of Patients (PE)*** **Page 1 of 3**

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

PURPOSE:

To discourage food and drug interaction when the patient is receiving enteral tube feedings. Section B seeks to define drug-nutrient interaction education process for patients on potential drug-nutrient interaction medications.

POLICY:

To provide guideline for nursing staff to hold tube feeding when appropriate. Enable the collaboration of Food and Nutrition service, nursing and pharmacy departments in providing patients with educational information about potential drug-nutrient interactions during hospitalization and prior to discharge from hospital.

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

PROCEDURE:

- All patients receiving medication via enteral feeding tube shall be monitored for potential drug food interactions by nursing staff. (Section A)
    - For medications that may have significant drug food interaction, tube feeding will be held for 1 hour before and after the administration of each dose.
- A diet aide will print a daily report from Meditech of patients on selected medications targeted for drug-nutrient interactions (Section B)

Section A
ORAL MEDICATIONS THAT SHOULD BE HELD INCLUDE:

- Phenytoin (Dilantin) (all ORAL formulations)
- Levothyroxine
- Warfarin (only when unable to obtain a therapeutic INR)
- Carafate (Sucralfate)
- Cipro and Levaquin
- Carbidopa/Levodopa (Sinemet)

- Tube feedings may be continued with the use of these medications if the Physician has adjusted the doses to compensate for reduced bioavailability and explicitly states that in his/her notes. Otherwise tube feeds should be held.

- Continuous enteral feedings may be changed to bolus feedings/per physician order when the listed medications are being used, if feasible to discourage potential drug and food interaction.

- In summary, unless the physician orders otherwise, Nursing will hold tube feedings for 1 hour before and after administration of one of the medications listed above.

- Nursing can request Dietitian consult as needed to address type of feeding modalities.

Section B

MEDICATIONS TARGETED FOR DRUG-NUTRIENT INTERACTIONS CONSULTATION:

A. Coumadin
B. Theophylline
C. MAOI's, Linezolid
D. Tetracycline, Doxycycline, Minocycline
E. Indinavir
F. Quinolones
    a. Ciprofloxacin, Levofloxacin, Moxifloxacin
G. Itraconazole
H. Carbidopa/Levodopa
I. Levothyroxine
J. Sucralfate
K. Statins
    a. Atorvastatin, Fluvastatin, Lovastatin, Pravastatin, Simvastatin, Rosuvastatin
L. Bisphosphonates
    a. Alendronate, Risedronate
M. Digoxin
N. Metronidazole
O. Ethambutol, Rifampin, Isoniazid
P. Divalproex
Q. Lithium
R. Lamotrigine
S. Carbamazepine

1. The dietitian will provide individualized counseling regarding the potential drug/nutrient interaction with the patient when consultation is ordered.

2. All drug-nutrient interaction consultation will be documented in the patient's medical record.

3. Discharge Education:

   a. a. Nursing will be responsible for dispensing drug-nutrient interaction information to patients who have not been counseled by the dietitian.

   b. Drug-nutrient interaction information will be available on all nursing units via Krames on demand located on the intranet. Upon discharge, nursing will provide the patient with a drug information handout that includes drug-nutrient information. Nursing will provide a brief explanation regarding drug-nutrient interaction.

   c. When members of the nursing staff give information and education to patient's regarding drug-nutrient interaction, this is to be documented in the patient's medical record.

REFERENCES:

- Guidelines for the Provision and Assessment of Nutrition Support Therapy in the Adult Critically Ill Patient:Society of Critical Care Medicine (SCCM) and American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)JPEN J Parenter Enteral Nutr February 2016 40: 159-211, doi:10.1177/0148607115621863

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; March 7th, 2022.

SUBJECT: **EBOLA VIRUS DISEASE**	SECTION: ***Infection Prevention*** **Page 1 of 12**

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

PURPOSE:

The purpose and intent of this document is to provide for the use of Sierra View Medical Center (SVMC) administration and planning personnel to identify and communicate key elements of this policy and procedure for screening, identification and initial management of a suspected Ebola patient. This policy is to be considered guidance and is intended to be used as a tool for hospital administration and planning personnel to assist in the effective preparation for, implementation and execution of facility Ebola response plans.

***As information related to recognizing, diagnosing, treating, and prevention of Ebola is updated at the federal, state and local levels, this response plan will be modified accordingly.**

DEFINITIONS:

The Ebola virus, previously known as Ebola hemorrhagic fever, is a rare and sometimes deadly disease. It is caused by infection with a virus of the family *Filoviridae* (http://www.cdc.gov/vhf/virus-families/filoviridae.html), genus *Ebolavirus.*

Many of the signs and symptoms of Ebola are non-specific and similar to those of many common infectious diseases, as well as other infectious diseases with high mortality rates. Symptoms may include: temperature >101.5, myalgia, severe headache, muscle pain, vomiting, diarrhea, abdominal pain, and bleeding.

POLICY:

A. The hospital keeps abreast of infectious diseases that are occurring locally, nationally, or worldwide that could potentially affect our local community. SVMC has developed an Ebola Preparedness Program that includes, but is not limited to, education and training in the following areas:

- Infectious Disease Screening Process
  - Inpatient and Outpatient
- Personal Protective Equipment (PPE)
  - Donning (placing on) and Doffing (removing)
- Equipment (Patient Care Cart)
- Education of Disease Process
- Patient Movement
- Environmental Safety

B. SVMC will utilize CDC's guidelines for screening and preparedness to handle an Ebola patient: http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html

C. The list of Ebola-affected countries is subject to change. For up-to-date information regarding the Ebola virus disease (EVD), refer to the CDC Ebola Virus Disease webpage at http://www.cdc.gov/vhf/ebola/index.html

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT, INTENSIVE CARE UNIT, NURSING, RESPIRATORY THERAPY, ENVIRONMENTAL SERVICES, INFECTION CONTROL / PREVENTION, FACILITIES, EMERGENCY MANAGEMENT, LABORATORY, RADIOLOGY, PHYSICIANS, SURGICAL SERVICES, CENTRAL PROCESSING SERVICES, ~~AND~~ LABOR & DELIVERY, AND SURGERY CLINIC.*

PROCEDURE:

INFECTIOUS DISEASE SCREENING

1. An "Infectious Disease Screening" tool will be utilized for all **Newly Admitted** patients and also for all **Outpatients** who have traveled to West Africa in in the last 3 weeks or have come into contact with anyone who has traveled outside the U.S in the last 3 weeks. (See **ADDENDUM A**)

PERSONAL PROTECTIVE EQUIPMENT (PPE)—Donning & Doffing

1. Ebola is spread through direct contact with blood or body fluids of a person who is sick with Ebola or with objects that have been contaminated with infectious blood or body fluids. PPE that fully covers skin and clothing and prevents any exposure of the eyes, nose, and mouth is recommended by CDC. The recommended PPE equipment and steps of applying (donning) and removing (doffing) are found in: (See **ADDENDUM B**)

EQUIPMENT: EBOLA PATIENT CARE CART (Stocked by Materials Management)

1. There will be 1 Ebola Patient Carts stocked with items needed to care for this type of patient. Materials Management will stock and have access to this cart. The cart will be stored in the SVMC basement and maintained by Materials Management.
(See **ADDENDUM C**)

EDUCATION

1. Competency Verification of Personal Protective Equipment (PPE)

   - All PPE Super Users will complete hands-on training for proper donning and doffing of PPE according to Center for Disease Control (CDC) recommendations. (Training to be done as needed)
   - A return demonstration is required for proper sequence of application and removal of PPE.
   - Advanced PPE (PAPR) will be provided to direct care providers in high risk areas (ED, ICU).

2. Identify, prompt isolation of patients and starting infection control measures to minimize the spread of infectious diseases to other patients or healthcare providers

3. There will be PPE training based on CDC's recommendations to healthcare workers involved in the care of hospitalized patients with known or suspected Ebola

PATIENT MOVEMENT AFTER PRESENTING TO THE EMERGENCY DEPARTMENT:

1. Ebola screening tool is used initially with the patient that presents to the Emergency Room and outpatient care departments. If patient presents with elevated temperature and one or more additional symptoms along with answering "Yes" to ANY of the questions under the section "Questions to Ask Patient or Family" patient must be isolated and masked immediately:
   - Outpatient departments:

//

1. Clinical Licensed staff: Immediately notify the provider in the department, Clinical Manager and Clinical Supervisor and the Infection Prevention Department (IP)
2. Patient must be kept in private room with door closed
3. Enhance Droplet and Contact Precautions
4. Call EMS and notify of Suspected Ebola Virus patient and location. Copy all records pertaining to work up of patient (vital signs, history provided, symptoms, etc) for the EMS to take in transport

- Emergency Department:
  1. The triage nurse, after applying proper PPE, will take patient via wheelchair outside of the ER and wheel patient to the 'Decontamination" room in the ER.
  2. The patient will be held here until one of the designated rooms in ER is set up and available. There are 3 designated rooms that would be set up for the Ebola patient with the use of a pre-fabricated "Containment Kit". All of the items to set up this kit are all included with the kit.
  3. The process would be for designated Engineering Supervisor to call COAST IAQ & Life Safety Services and request the need for the "Containment" to be set up.
  4. The Ebola patient would remain in the isolated ER Decontamination room until the "Containment" was set up and prepared for the patient. (See **ADDENDUM D** for floor plan of patient flow)

ENVIRONMENTAL CLEANING

1. SVMC will follow CDC's recommendations/guidelines for environmental cleaning of a room, equipment, or other surfaces that have been exposed to an Ebola patient. These recommendations can be found at: http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html.

2. Environmental services staff that perform cleaning after an Ebola patient will only be that staff that has been trained with donning/doffing personal protective equipment (PPE) specific for Ebola patients.

3. SVMC follows CDC's recommendation to use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces. EPA-registered hospital disinfectants with label claims against non-enveloped viruses are broadly antiviral and capable of inactivating both enveloped and non-enveloped viruses.

4. SVMC will handle and dispose of contaminated or suspected to be contaminated materials (e.g., any single-use PPE, cleaning cloths, wipes, single-use microfiber cloths, linens, food service) and linens, privacy curtains, and other textiles in the patient room per CDC recommendations: **https://www.cdc.gov/vhf/ebola/clinicians/cleaning/hospitals.html**

REFERENCES

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EBOLA CDC Update 2/2019. (2019, Feburary). Retrieved from The Society for Healthcare Epidemiology of America: https://shea-online.org/index.php/journal-news/website-highlights/643-ebola-cdc-update-2019

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Ebola: Transmission. (2021, January 14). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/vhf/ebola/transmission/index.html

Guidance on Personal Protective Equipment (PPE) To Be Used By Healthcare Workers during Management of Patients with Confirmed Ebola or Persons under Investigation (PUIs) for Ebola who are Clinically Unstable or Have Bleeding, Vomiting, or Diarrhea in U.S. (2018, August 30). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

Inerim Guidance for Environmental Infection Control in Hospitals for Ebola Virus. (2018, May 31). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/vhf/ebola/clinicians/cleaning/hospitals.html

Viral Hemorrhagic Fever (VHFs): Filoviridae. (2018, September 18). Retrieved from Centers for disease Control and Prevention: https://www.cdc.gov/vhf/virus-families/filoviridae.html

What is Ebola Virus Disease. (2020, December 1). Retrieved from Center for Disease Control and Prevention: https://www.cdc.gov/vhf/ebola/about.html

ADDENDUM A

Questions to ask Patient or Family-Ebola	
Ebola Risk: Travel/Contact With Anyone From Affected Area/s	○ Yes ○ No
	Does the patient have a potential exposure from travelling to a country with widespread Ebola transmission (Sierra Leone, Liberia, Guinea, Mali) or had contact with an Ebola patient in the 21 days before illness onset?
Text	
Questions to ask Patient or Family-Zika	
Zika Travel	○ Yes ○ No Comment: *South America, Carribean, Capa Verde, Central America, Mexico, Puerto Rico, El Salvador, Barbados, US Virgin Islands, Samoa
Been in w/Anyone who has been Dx'd w/Zika Virus	○ Yes ○ No
Been in Contact w/Anyone Sick During Travel Outside Country	○ Yes ○ No
Questions to ask Patient or Family-Zika	
Zika Travel	○ Yes ○ No Comment: *South America, Carribean, Capa Verde, Central America, Mexico, Puerto Rico, El Salvador, Barbados, US Virgin Islands, Samoa
Been in w/Anyone who has been Dx'd w/Zika Virus	○ Yes ○ No
Been in Contact w/Anyone Sick During Travel Outside Country	○ Yes ○ No
Questions to ask Patient or Family-Coronavirus	
Have you had fever AND any of the following S&S?	○ Yes ○ No Comment:
	Lower resp illness (cough, diff breathing) or chills, repeated shaking with chills, muscle pain, HA, sore throat, new loss of taste or smell, persistent pain or pressure in chest, new confusion or inability to arouse, bluish lips or face?
Have you traveled from China, Iran, Italy, Japan or South Korea or anywhere outside the immediate area in the last 14 days before	○ Yes ○ No Comment:

ADDENDUM A (Cont.)

symptom onset?	
Have you had close contact with any person, including health care workers, who had close contact with a lab-confirmed COVID-19 patient within 14 days of symptom onset?	○ Yes ○ No Comment:
Have you had a fever with severe acute lower resp illness (e.g., PNA, ARDS) requiring a previous hospitalization and without an identified source of exposure (e.g.Influenza)?	○ Yes ○ No Comment:
Temperature Upon Arrival (96.8 F-100.4 F)	
Symptoms Upon Arrival to Unit	☐ Temp > 100.4 ☐ Cough ☐ Difficulty Breathing ☐ Chills ☐ Repeated Shaking with Chills ☐ Muscle Pain ☐ Headache ☐ Sore Throat ☐ New Loss of Taste or Smell ☐ Bluish Lips or Face ☐ New Confusion or Unable to Arouse ☐ Persistent Chest Pain or Pressure

⊟ Implementation

Patient Isolated?	○ Yes ○ No *If patient answers "Yes" to any of the questions under the section "Questions to ask Patient or Family - Coronavirus", they must be isolated immediately.*
Charge Nurse Notified	○ Yes ○ No Comment: *Enter name of charge nurse notified in comment field
Comment:	

⊟ Note

Preadmission Comments	

SIERRA VIEW MEDICAL CENTER — INFECTIOUS DISEASE SCREENING

Questions to Ask Patient or Family

Have you encountered anyone who has been diagnosed with Ebola in the past 3 weeks?
❑ Yes ❑ No
Comment:

Have you traveled to West Africa (Sierra Leone, Liberia, Guinea, Mali) in the last 3 weeks?
❑ Yes ❑ No
Comment:

List countries traveled: _____

Have you had contact with anyone sick during travel outside of the country?
❑ Yes ❑ No
Comment:

Have you been with/near anyone who has been to West Africa (Sierra Leone, Liberia, Guinea, Mali) in the past 3 weeks?
❑ Yes ❑ No
Comment:

List known countries they visited: _____

Did they meet anyone who was sick?
❑ Yes ❑ No
Comment:

Symptoms patient presents with

Temperature upon arrival:_____
Symptoms upon arrival to unit:
❑ Temp > 101.5 (38.6 C) ❑ Abdominal Pain ❑ Diarrhea ❑ Severe Headache ❑ Vomiting
❑ Muscle Pain
Unit patient arrived to:
❑ ED ❑ Tele ❑ Flex ❑ OB ❑ MS ❑ CTC ❑ Dialysis ❑ Other _____

Implementation

Patient immediately isolated and masked:
❑ Yes ❑ No
Patient presenting with elevated temperature and one or more additional symptoms along with answering "Yes" to ANY of the questions under the section "Questions to Ask Patient or Family" must be isolated and masked immediately

Charge Nurse Notified:
❑ Yes ❑ No Name of Charge Nurse or Supervisor:

Signature: _____ Date: _____ Time: _____
(To be completed and signed by SVMC staff)

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
INFECTIOUS DISEASE SCREENING
Form # 015879 REV. 12/14 CVBF

Sierra View Medical Center is a service of the Sierra View Local Health Care District

PATIENT'S LABEL

ADDENDUM B

EQUIPMENT: Personal Protective Equipment (PPE)

- Impermeable garment:
  - Single-use (disposable) impermeable fluid-resistant gown extending to at least mid-calf
  - Single-use (disposable) impermeable fluid-resistant coveralls
- Authorized Undergarment (scrubs)
- Authorized Shoes
- Respiratory Protection:
  - N95 Mask
  - PAPR (full face shield, helmet or headpiece) covered with a single-use hood that extends the shoulders and fully covers the neck
- 2 pairs of Single-use (disposable) examination gloves with extended cuffs
- Face Shield/Goggles
- Single-use (disposable) boot covers that extend to at least mid-calf
- Single-use (disposable) apron
- EPA-registered disinfectant wipes

PROCEDURE: Donning (placing on) and Doffing (removing) PPE

Donning: (follow these steps in numerical order)

1. Partner (Buddy) and Donner engage.
2. Overall donner assessment (Psychological, Emotional, Physical (i.e. diabetic, open/broken areas on the skin), General fitness.
3. Remove all personal clothing and items (i.e. cell phone…).
4. Place hospital scrubs on.
5. Inspect PPE.
6. Put on Boot covers: This step can be omitted if wearing a coverall with integrated socks.
7. 1st pair of gloves.
8. Put on Gown or Coverall.
9. Put on Respirator: N95 mask or PAPR and put on surgical hood that covers hair, ears, neck, and extends to the Shoulder.
10. Goggles/Face shield (if no PAPRs are available).

ADDENDUM B (CONT.)

11. Put on Apron (if available).
12. 2nd pair of gloves: Ensure the cuffs are pulled over the sleeves of the gown or coverall.
13. Inspect 1st gloves, N95 mask/PAPR, or goggles/face shield.
14. Buddy and donner – Verify and confirm proper donning.

Doffing: (follow these steps in numerical order)

1. Buddy and doffer engage.
2. Assess gown/coverall and gloves (integrity, amount, and location of contaminant).
3. Disinfect Outer Gloves with EPA-registered disinfectant wipe and allow to dry.
4. Remove apron (if used).
5. Inspect the PPE ensemble for visible contamination or cuts/tears. Clean and disinfect affected areas with EPA-registered disinfectant wipe.
6. Disinfect and remove Outer Gloves.
7. Inspect and disinfect Inner Glove.
8. Inspect PAPR/N-95/goggles/face shield.
9. Remove PAPR/N-95/goggles/face shield.
   - Place all reusable PAPR components in an area or container designated for the collection of PAPR components for disinfection.
10. Disinfect inner gloves with either an *EPA-registered disinfectant wipe.
11. Remove gown/coverall.

    a. Depending on gown design and location of fasteners, the healthcare worker can either untie fasteners, have the doffing assistant or "buddy" unfasten the gown, or gently break fasteners. Avoid contact of scrubs or disposable garments with outer surface of gown during removal. Pull gown away from body, rolling inside out and touching only the inside of the gown.

    b. To remove coverall, tilt head back and reach zipper or fasteners. Use a mirror to avoid contaminating skin or inner garments. Unzip or unfasten coverall completely before

rolling down and turning inside out. Avoid contact of scrubs with outer surface of coverall during removal, touching only the inside of the coverall.

ADDENDUM B (CONT.)

12. Disinfect Inner Glove.

13. Remove Boot Cover.

14. Disinfect Washable Shoes: Use an *EPA-registered disinfectant wipe to wipe down every external surface of the washable shoes.

15. Disinfect and remove inner gloves.

16. Perform Hand Hygiene.

17. Inspect both the observer and healthcare worker for contamination of surgical scrubs. If contamination is identified, the garments should be carefully removed and the wearer should shower immediately. The trained observer should immediately inform the infection Preventionist or occupational safety and health coordinator or their designee for appropriate occupational health follow-up.

18. Healthcare worker can leave PPE removal area wearing dedicated washable footwear and surgical scrubs proceeding directly to showering area where these are removed.

*There will be some storage of PPE in designated areas in the Emergency Room

ADDENDUM C—Ebola Patient Cart

Drawer #1
MALE/FEMALE LUER LOCK, 014985 – 100 EACH
IV START KITS, 002323 – 12 EACH

Drawer #2
SMALL BORE TUBING, 014979 – 12 EACH
EXTENSION SET, 014997 – 12 EACH

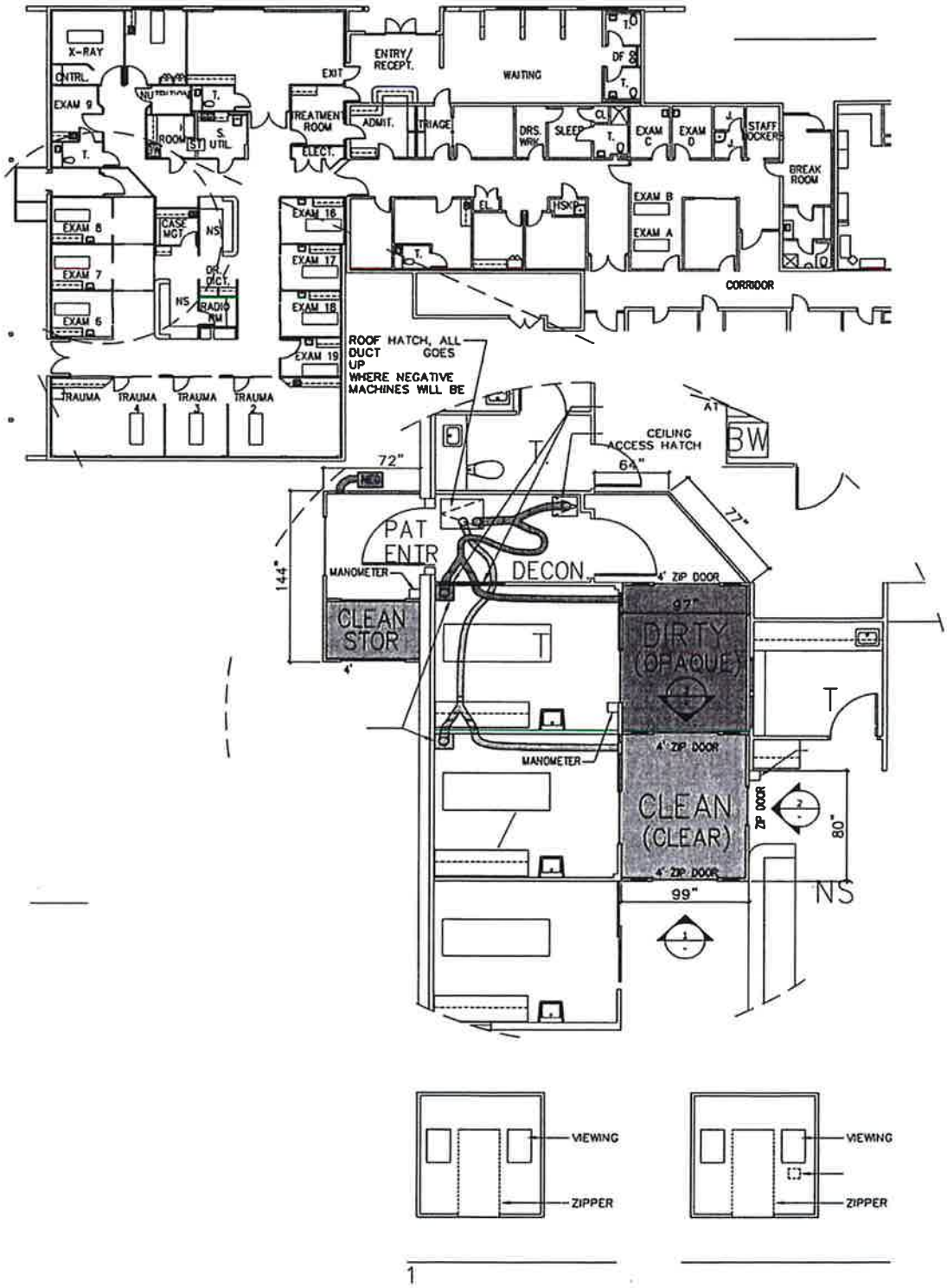
DRAWER #3
PRIMARY TUBING, 014976 – 8 EACH
SECONDARY TUBING, 014976- 4 EACH
2X2 STERILE GAUZE, 001918 – 2 PACKS

DRAWER #4
BLOOD TUBING, 014978 – 6 EACH
SUCTION CANISTER, 005079 – 3 EACH
16 FRENCH CATH KITS, 014557, - 2 EACH
SUCTION YANKERS, 008004 – 3 EACH
SUPER FLUFFS, 002852- 10 EACH

DRAWER #5
DIGI BILE BAGS, 015724 – 2 EACH
DIGI BILE KITS, 015723 – 2 EACH
EMESIS BAG, 019880 – 25 EACH

DRAWER #6
9% SODIUM CHLORIDE, 002638, - 10 EACH
LACTATED RINGERS, 002644 – 10 EACH

ADDENDUM D


X-RAY
CNTRL.
EXAM 9
EXAM 8
EXAM 7
EXAM 6
CASE MGT
NS
DR. DICT.
RADIO RM
ROOM
S. UTIL
ST
TREATMENT ROOM
ELECT.
EXIT
ENTRY/ RECEPT.
ADMIT.
TRIAGE
WAITING
DF
DRS. WRK
SLEEP
EXAM C
EXAM D
STAFF LOCKERS
BREAK ROOM
EXAM B
EXAM A
HSKP
CORRIDOR
EXAM 16
EXAM 17
EXAM 18
EXAM 19
TRAUMA 4
TRAUMA 3
TRAUMA 2
ROOF HATCH, ALL DUCT GOES UP WHERE NEGATIVE MACHINES WILL BE
CEILING ACCESS HATCH
64"
72"
77"
144"
PAT ENTR
MANOMETER
DECON
4' ZIP DOOR
CLEAN STOR
4'
97"
DIRTY (OPAQUE)
MANOMETER
4' ZIP DOOR
CLEAN (CLEAR)
4' ZIP DOOR
ZIP DOOR
80"
99"
NS
VIEWING
ZIPPER
VIEWING
ZIPPER

1

SUBJECT: **FORMULA DATING AND STORAGE**	SECTION: **Page 1 of 1**

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

PURPOSE:

To supply ready-to-feed formula to in-house pediatric patients.

POLICY:

All infant formulas, glucose water, sterile water and nipples should be stored in a clean storage area.

PROCEDURE:

1. Formula will be checked monthly for expiration dates and rotated for the most recent expiration date in front by materials management.
2. All formula should be labeled with expiration date visible.
3. All expired formula should be discarded immediately.
4. Expired formula is not to be used for any reason.
5. Formula should be ordered as needed to maintain adequate stock by the Distribution Department.
6. Ready to feed formula is always to be used unless otherwise ordered by the physician.

REFERENCE:

- Bowden, Vicky R., Smith-Greenberg, Cindy. 2015. Pediatric Nursing Procedures. Fourth edition. Lippincott Williams & Wilkins.

SUBJECT:	SECTION:
INITIATION OF HEMODIALYSIS USING DUAL LUMEN CATHETER	**Page 1 of 2**

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

PURPOSE:

To initiate the hemodialysis treatment with a dual lumen dialysis catheter.

POLICY:

- An informed consent must be signed prior to the first hemodialysis treatment.
- Current hepatitis B screening must be completed if this is not complete patient must be treated in isolation.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

CAUTIONS:

- Do not put any tension on the catheter.
- If catheter suture is loose or not intact, notify the Nephrologist prior to initiation of dialysis.

EQUIPMENT:

- Clean Gloves
- Gown, Mask, Goggles/face shield
- Barrier
- Six (6) alcohol prep pads
- Two (2) empty 10ml Syringes
- Two (2) 10ml Syringes with 10 ml of injectable normal saline in each
- One (1) 4 x 4 in. gauze pad
- Syringes and Blood Tubes for blood work, as necessary
- Tape

PROCEDURE:

- Assess the site for signs and symptoms of infection, swelling, redness, excessive warmth, drainage or tenderness. If infection is a concern, stop and contact the nephrologist for further instruction
- Put on the gown, face mask and goggles/face shield. Gather the supplies. Perform hand hygiene and put on clean gloves. Provide the patient with a face mask and ensure that it is properly worn.

- Place a barrier and a sterile 4 x 4 in. gauze pad under the catheter. Remove the existing gauze dressing and assess for visible clots in ports. Remove the gloves, perform hand hygiene and put on clean gloves.
- Cleanse the catheter connection sites and Y connection with alcohol prep pads and allow to dry.
- Be sure both limbs of the catheter are clamped. Remove the cap from the arterial (red) limb.
- Remove the arterial port cap and cleanse the port with an alcohol prep pad and allow it to dry. Using a 10 ml syringe, aspirate approximately 5 - 10 ml of blood from the arterial limb to remove the heparin dwell and evaluate the blood flow. Re-clamp the catheter.
- Remove the 10mL blood-filled syringe and cleanse the port with an alcohol prep pad and allow it to dry. Attach vacutainer to obtain blood, as needed for lab work.
- Remove vacutainer and cleanse the port with an alcohol prep pad and allow it to dry. Irrigate the arterial limb with a 10 ml syringe of normal saline. Assess the blood flow. Re-clamp the catheter.

  Repeat the above steps, excluding any lab draws, for the venous port.
- Remove syringes, cleanse catheter connections, and attach lines.
- Initiate the hemodialysis treatment.
- Remove the gloves and perform hand hygiene.
- Document the initiation of the dialysis treatment in the patient's medical record.

REFERENCES:

- ~~Centers for Disease Control. (September 2016). *Hemodialysis Central Venous Catheter Scrub-Hub-Protocol.* Retrieved on December 12, 2018 from https://www.cdc.gov/dialysis/prevention-tools/scrub-protocols.html.~~ Centers for Disease Control. (September 2016). *Hemodialysis Central Venous Catheter Scrub-Hub-Protocol.* Retrieved on January 25, 2022 from https://www.cdc.gov/dialysis/prevention-tools/scrub-protocols.html.

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SUBJECT: **MECHANICAL VENTILATION**	SECTION: **Page 1 of 8**

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

PURPOSE:

To ensure a consistent method of providing ventilator support.

POLICY:

- Respiratory Care Practitioners are responsible for the setup, maintenance and care of mechanical ventilators. Under physician order, Respiratory Care is responsible for management of the patient receiving mechanical ventilation.

Definitions

- VAP Ventilator associated pneumonia
- VAE Ventilator associated event
- VT Tidal Volume
- ABG Arterial Blood Gas
- FiO2 Fraction of inspired oxygen

AFFECTED AREAS/PERSONNEL: *RESPIRATORY CARE PRACTITIONER*

PROCEDURE:

1. Check to see if an operation verification of the ventilator has been performed.
2. Perform a system check prior to connecting patient to ventilator.
3. Connect oxygen supply tubing and compressed air supply tubing to wall outlets.
4. Connect electrical plug to properly grounded electrical emergency power outlet.
5. Push the ON/OFF switch to start the machine.
6. Set the tidal volume as prescribed by the physician.
7. Set the pressure limit to the maximum and occlude the patient connector to test the pressure alarm.
8. Set the respiratory rate as prescribed by the physician.
9. Set the FiO_2 as prescribed by the physician.
10. Set MODE prescribed by the physician.
11. The ventilator is now ready to be used on the patient.

12. Observe the peak pressure on the manometer required to deliver the set tidal volume. Set the pressure limit 10 – 15 cm H_2O higher than the peak inspiratory pressure. (DPSNF **excluded**)

13. Observe the peak pressure on the manometer required to deliver the set VT.

    a. Set the low inspiratory pressure alarm 5-10 cm lower than the peak pressure.

    (See Ventilator Alarm Guideline policy)

14. Allow the patient to stabilize the ventilator. Comfort and reassure the patient as necessary.

15. Document all appropriate data under Interventions: RCP Mechanical Ventilation.

16. Refer to patient ventilator system checks

17. Physician may order vent settings to keep ABGs within parameters.

ASSESSMENT:

Assessment of mechanical ventilation should include:

- Visual observation of adequate chest excursion
- Auscultation of breath sounds
- Arterial blood gases 30 minutes after starting mechanical ventilation
- Non-invasive monitoring of ventilation and oxygenation

HAZARDS:

- Accidental disconnection from the ventilator
- Accidental Extubation
- Loss of airway
- Oxygen toxicity
- Barotrauma
- Nosocomial pneumonia

- Over or under hydration from improperly operating humidification devices

EQUIPMENT:

- Mechanical Ventilator (with complete circuit) and disposable filters
- Closed Tracheal Suction Catheter (See attachment "A")
- Manual Resuscitation Device
- Suction Equipment
- Humidification System
- Additional Artificial Airway
- Cuff manometer

VENTILATOR CIRCUIT CHANGES:

1. Description: The ventilator circuit change will be done once per month and PRN and will consist of placing a clean ventilator circuit on an operating mechanical ventilator. Ventilator circuits will be disposable. The circuit will consist of large bore tubing, monitoring tubing, and humidifier or heat moisture exchangers (HME), thermal monitoring probes, water traps, and medication delivery devices.

2. Objectives:

   a. To limit the occurrence of nosocomial infections

   b. Assure the circuit maintains its physical integrity

3. Contraindications/Hazards/Complications:

   a. Pressure of conditions in the patient's cardiopulmonary status that might make tolerance of a ventilator circuit change hazardous to the patient

   b. Manipulation and disconnection of the ventilator's tubing can cause contaminated ventilator condensation to spill into the patient's airway, exposing the patient to further risk of infection.

   c. Failure to assure proper function prior to reinstituting mechanical Ventilation may endanger the patient.

4. Procedure:

Patient Ventilator System Checks: A patient ventilator system check is a documented evaluation of a mechanical ventilator and of the patient's response to mechanical ventilatory support. This procedure is often referred to as a ventilator check.

a. Evaluate and document that patient's response to mechanical ventilation at the time the check is performed.

b. Ensure and document the proper operation of the mechanical ventilator.

c. Verify and document that the ventilator is functioning and is properly connected to the patient.

d. All data relevant to the patient ventilator system check should be documented on the Interventions: RCP Mechanical Ventilation.

- Documentation that all alarms are functional and are properly set and audible alarms can be heard
- Documentation of measured inspired gas temperatures
- Endotracheal or tracheostomy tube size
- Documentation of any circuit changes
- Date and time of patient's ventilator system check

e. Documentation of a "vent check" must include:

- FIO2 setting
- Temperature setting (if applicable)
- Set ventilator frequency
- Peak pressures
- Plateau Pressures
- Compliance

- Intrensic PEEP (Positive End Expiratory Pressure)
- Set peak inspiratory limits and pressure support level (if applicable)
- Set tidal volume
- Exhaled tidal volume (Acute Care)
- Set high variables (if applicable)
- Set inspiratory time (if applicable)
- Set I:E ratio, percent inspiration, or inspiratory and expiratory times (if applicable)
- Set sensitivity threshold (if applicable)
- Documentation of all alarm settings and activation of appropriate alarms.
- A daily assessment of clinical observations indicative to the patients response to mechanical ventilation
- Documentation of the patient's oxygenation and ventilation status

f. A patient ventilator system check must be performed Q4 hours for ICU patients, acute patients Q4-6 hours for floor patients and Q6 hours for DPSNF patients. In addition, a check should be performed:

- Following any change in ventilatory settings
- As soon as possible following an acute deterioration of the patient's condition
- Any time that a ventilator performance is questionable

EQUIPMENT:

- Stethoscope
- Pulse oximeter

INFECTION CONTROL:

- Standard Precautions should be observed.

  VAP and VAE monitoring done following National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) surveillance algorithm. Head of bed should be elevated to 30 degrees or greater unless contraindicated.

DOCUMENTATION:

- Please see Respiratory Care Policy and Procedure: Documentation

SAFETY PRECAUTIONS:

- Use a properly grounded electrical (red) outlet only.
- Check all alarms every shift.
- Place nothing on top of the ventilator.
- NEVER turn alarms to off position.
- Exercise caution when handling liquids near electrical devices to avoid electrical shock or damage to the machine.
- Only properly licensed personnel are allowed to set-up, monitor or make any adjustments to a mechanical ventilator.

REFERENCES:

- Patient-Ventilator System Checks. (n.d.). Retrieved from http://www.rcjournal.com/cpgs/mvsccpg.html
- Ventilator-Associated Event (VAE) Surveillance Algorithm. Retrieved from http://www.cdc.gov/nhsn/pdfs/pscmanual/6pscvapcurrent.pdf

CROSS REFERENCE:

- Respiratory Care Services Policy & Procedure Manual: Ventilator Alarm Guideline

ATTACHMENT A

FORMAT	RATIONALE/PRECAUTIONS:
1. Select equipment • ETT/Trach care suction catheter • Suction regulator, tubing • Oxygen adjuncts • Oximeter • Normal saline for instillation	Ventilator, trach mist, etc. Provide 100% oxygen, if indicated. Monitor saturation during procedure.
2. Prepare equipment a. Wash hands	Prevention of transmission of infection.
3. Turn on suction a. Adjust suction regulator	120-150mm Hg for adults Pressures greater than 150mm Hg greatly increase the risk of trauma.
4. Prepare patient a. Introduce yourself to patient; explain procedure and purpose.	Professional courtesy reassures patient.
5. Begin procedure a. Attach ETT/Trach Care T-piece to ventilator circuit, using flex tube, if desired. b. Attach system to patient. c. Make sure all connectors are secure; i.e., T-piece to trach tube, suction tubing to control valve, wall connector to container. d. Lift and turn control valve to unlocked position. e. With patient's head in the 12 o'clock position, advance catheter into desired lung. f. Reassure patient.	Prevents inadvertent interruption of suctioning. Suctioning cannot be accomplished when valve is locked. Blue line on catheter indicates direction catheter tip will follow. One o'clock position will assist with access to left lung; eleven o'clock position will assist with access to right lung. Suctioning is a very traumatic procedure for some patients; provide reassurances and explanations throughout the procedure. Use intermittent suction only. Monitor saturation during procedure.

g. Depress suction control valve, gently withdrawing the catheter to its fully extended length.	Catheter is fully withdrawn when black mark is visible at back of T-piece.
6. Lavage a. Advance catheter approximately 4-5 inches into endotracheal or tracheostomy tube. b. Instill 3-5cc lavage solution into irrigation port. c. Suction as above.	Do not apply suction during lavage procedure. Close irrigation port.
7. Cleansing catheter. a. After suctioning, flush catheter by depressing control valve and slowly introducing 3-5cc flush solution into irrigation port.	Catheter must be in fully withdrawn position. Make sure irrigation port is closed when not in use.
8. Lift and turn control valve 180° to locked position.	Prevents inadvertent suction.
9. Chart procedure in patient progress notes and department records.	

SUBJECT:	SECTION:
MEDICAL ADVICE VIA TELEPHONE - SC	*Surgery Clinic* 1 **Page 1 of 2**

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

PURPOSE:

To ensure patient safety and staff compliance with legal scope of practice.

POLICY:

Medical advice will not be given over the telephone by the Surgery Clinic staff. Staff may provide patients with results of physician-ordered diagnostic testing only upon written direction from the provider.

AFFECTED PERSONNEL/AREAS: *ALL SURGERY CLINIC PERSONNEL AND MEDICAL STAFF*

PROCEDURE:

A. Patients seeking medical advice over the telephone will be courteously informed that it is the policy of the Clinic that medical advice is not given over the phone.

B. Staff will offer to take a message so that the physician may return the patient's call or offer to schedule an appointment for the patient with the physician.

C. Follow-up information or treatment due to physician-ordered diagnostic testing (lab, x-ray) may only be given by those personnel authorized to diagnose and prescribe (physicians, physician assistants, nurse practitioners).

D. Results of lab work are not to be given to patients by telephone unless approved in writing by the provider. A notation will be made in the medical record indicating the date, time, and name of person giving the information.

E. Confidential results (sexually transmitted diseases, pregnancy, etc.) will never to given over the telephone by Clinic personnel.

F. Under no circumstances will results of any kind (lab, x-ray, treatment) be left on answering machine or voice mail.

REFERENCES:

- "Is Your Medical Assistant Practicing Beyond His or Her Scope of Training?" Retrieved 3/11/15 from http://mbc.ca.gov.

SUBJECT:	SECTION:
MEDICATION ADMINISTRATION: MEDICAL ASSISTANT - SC	*Surgery Clinic* **Page 1 of 2**

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PURPOSE:

To ensure patient safety in the Surgery Clinic during the administration of medications.

POLICY:

Medical Assistants may administer medications (excluding anesthetics and chemotherapy) either by intradermal, subcutaneous, intramuscular injection or oral, sublingual, topical, vaginal or rectal routes or by providing a single dose to a patient for immediate self-administration. In all cases, prior to administration, the supervising practitioner must verify both the medication and dose and be on-site during the administration.

AFFECTED PERSONNEL/AREAS: *ALL SURGERY CLINIC PATIENT CARE PERSONNEL AND MEDICAL STAFF*

PROCEDURE:

A. Medications will be maintained and dispensed via an automated dispensing cabinet system (Pyxis).

B. Physician orders will be placed electronically and interfaced with the Pyxis.

C. Medications will be dispensed only as per written, signed order of licensed, qualified practitioner.

D. Patient allergies will be verified prior to administration.

E. Medical assistants will verify all dispensed medications with ordering practitioner prior to administration and document said verification.

F. Two patient identifiers will be used prior to patient's receipt of ordered medications.

G. Unit dose packaging/single dose vials are used when available.

H. Multiuse vials are initialed by first user and dated as per Pharmaceutical Services Policy & Procedure, Multidose Vial Expiration.

I. When medication or solution is transferred/removed from original packaging to another container, the container will be labeled as soon as it is prepared with the following:

1. Medication name
2. Strength
3. Quantity
4. Diluent and volume of diluent
5. Initial of person preparing medication
6. Preparation date
7. After the medication is mixed, it must be administered within one (1) hour.

J. Those containers with above said labels will have the labels verified verbally and visually by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

K. Enter date and time of administration of medication in patient's medical record, along with route of administration, and any reactions noted at the time the dose was given.

REFERENCES:

- California Business and Professions Code 2069-2071
- The Joint Commission (2019). Hospital National Patient Safety Goals (NPSG.03.04.01, page 3). Retrieved from https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2019.pdf.

CROSS REFERENCES:

- PROCESSING OF MEDICATION ORDERS AND DISPENSING OF MEDICATIONS
- MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL
- MEDICATION AND SOLUTIONS, MANAGEMENT IN THE OPERATING/PROCEDURE ROOM

SUBJECT:	SECTION:
MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL	***Medication Management (MM)*** **Page 1 of 11**

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

PURPOSE:

To ensure the safe and appropriate use of drug products and drug-related devices at Sierra View Medical Center.

POLICY:

The Pharmacy Department in collaboration and consultation with other professionals, departments and interdisciplinary committees, with approval by the medical staff, is directly responsible for the control and distribution of all stocks of drugs within the organization.

Under this policy, drugs and drug-related devices include, but are not limited to large and small volume injections, orally, topically or intravenous medications, radiopharmaceuticals, diagnostic agents including radiopaque contrast media, anesthetic gases, respiratory therapy drugs, biotechnologically produced drugs,, drugs brought into the hospital by patients or family, and other chemicals and biological substances administered to patients to evoke or enhance pharmacologic responses.

Control and distribution shall include procurement, recordkeeping, storage and inventory control, compounding, packaging, labeling and disposition.

AFFECTED AREAS/PERSONNEL:

PHARMACY, NURSING, RESPIRATORY THERAPY, DIAGNOSTIC IMAGING, MEDICAL STAFF

PROCEDURE:

I. Procurement

A. The Pharmacist in Charge ~~Director of Pharmacy~~ is responsible for maintaining standards to ensure the quality of all pharmaceuticals used at SVMC. The Pharmacy Department is responsible for the procurement of all pharmaceuticals with the following exceptions:

Large and small volume intravenous solutions without additives.

B. The pharmacist is responsible for specifications as to the quality, quantity and source of supply of all drugs used in the hospital. Special consideration is given to the current ASHP Guidelines for Drug Distribution and Control, as well as the USP-NF. The Pharmacist in Charge~~Director of Pharmacy~~ evaluates the acceptability of manufacturers and distributors. The pharmacist has the authority to reject a particular drug product or supplier if quality is an issue.

C. Procedure:

1. Requirements for medications and supplies are determined by a combined list of replacements from pharmacy stock and/or by evaluating minimum and maximum levels on high cost and/or fast moving items on a daily basis. Pharmaceuticals are ordered through the wholesaler's computer interface.

2. When the order is received, the contents of the order are verified against the invoice and/or stickers. All items are stickered and placed into stock. Special handling items i.e., refrigerated.

3. Hazardous drugs will be received and stored at the cancer center location.

4. Controlled substances are checked in and placed in the controlled substances safe in accordance with separate policy (see Controlled Substance Policy).

5. Invoices are matched with purchase orders and original forms and given to the pharmacy buyer for processing. Copies are retained in the pharmacy and originals are coded and forwarded to accounts payable for processing.

6. Items not ordered through the wholesaler, (i.e., IV solutions, blood fraction Products, other specialty items) are matched to the packing receipt and given to the pharmacy buyer for processing.

II. Storage and Control

A. All Pharmaceuticals are stored according to the manufacturer' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Also, all pharmaceuticals are stored under proper environmental conditions (i.e., proper temperature, light, humidity, conditions of sanitation and segregation). Storage areas must be secure, fixtures and equipment used to store drugs will be constructed to limit access only to designated and authorized personnel. Proper consideration is given to the safe storage of poisons and flammable compounds. Internal medications are stored separately from external medications. Non-medications and flammables are not to be stored in medication refrigerators.

1. Room Temperature – Room temperature, as it applies to medication storage shall be between 15°C (59°F) and 30°C (86°F). Medication rooms and drug storage area temperatures will be maintained within this range. Pharmacy will be notified by Plant Maintenance if the temperature in the storage area falls below or is above this specified range. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure proper relocation.

2. Refrigerator Temperature - Refrigerator temperature, as it applies to medication storage shall be between 2.2°C (36°F) and 7.7°C (46°F). Medication refrigerator temperatures will be maintained within this range. If the temperature is not within the specified range, both the Pharmacy and Plant Maintenance will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Refrigerator Temperature Log or in the temperature monitoring software system.

3. Freezer Temperature - Freezer temperature, as it applies to medication storage shall be below -1°F to -50° F) for all pharmaceuticals requiring freezer storage except Cervidil which shall be stored separately in a freezer with the temperature range of 14° F to -14° F. Medication freezer temperatures will be maintained within this range. . If the temperature is not within the specified range, both the Pharmacy and Plant Maintenance will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Freezer Temperature Log or in the temperature monitoring software system.

   Note: *Only freezers rated for cryogenic temperatures (below -20°C) are acceptable for medication storage. Freezer compartments of refrigerators are not acceptable for medication storage.*

   Each refrigerator/freezer will have a serviceable thermometer or other temperature recording device capable of monitoring temperatures within the range required.

   Wireless monitoring system that actively records temperatures every fifteen minutes, twenty four hours a day, seven days a week will alert engineering to any temperature excursions. Engineering will then in turn contact the pharmacy during normal business hours or the on-call pharmacist if excursions occur after normal business hours.
   4. All refrigerators and freezers in the pharmacy are connected to back up emergency power so that in the event of a power failure medication storage temperature will be maintained in an acceptable range.

4. Return to Storage

   a. Nursing

      i. Medications issued by the pharmacy (not obtained from Pyxis) that are discontinued by the physician or upon discharge will be returned

to pharmacy. These medications are to be placed in the designated box labeled "return to pharmacy".

ii. Medications obtained from Pyxis that are unopened and not used can be returned to the "return bin" in Pyxis.

b. Pharmacy

i. Medications returned to pharmacy will be removed from the designated pharmacy return boxes by the pharmacy staff during regularly scheduled rounds.

ii. Unused and unopened medications issued by the pharmacy will be credited to the proper patient's account regardless of the ability to re-issue that medication to another patient.

iii. Medications that are expired or close to expiration will be disposed of according to PHARMACEUTICAL WASTE policy.

iv. Medications removed from Pyxis during monthly floor inspections that are expired or close to expiration will be disposed of according to HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN.

III. Control and Security/Accountability

A. Pharmacy – The pharmacy is locked at all times. Only pharmacists will have keys to the pharmacy. During the hours which the pharmacy is open, pharmacy technical personnel have limited access to the pharmacy during normal pharmacy hours through a pass coded lock system, while under the supervision of a pharmacist.

B. Controlled Substances – All controlled substances of schedules C-II through C-V will be under a double lock system. A lockable door (i.e., outside door of a medication room or main pharmacy) qualifies as one lock. Within the main pharmacy, controlled substances of schedules C-II through C-IV will be under a double lock system. Procedures for documentation and recording can be found under ("Pharmacy – Controlled Substances Procedures and/or Nursing – Controlled Substances – Procurement, Administration and Documentation).

C. Medication Rooms – Medication rooms are to remain locked at all times. Only authorized personnel will have access to medication rooms. Authorized personnel will include, but are not limited to Registered Nurses, Licensed Vocational Nurses, Respiratory Therapists. Other hospital employees who access any medication room must be given authorization and must be observed by nursing or pharmacy staff.

D. Pyxis – Lockable medication cabinets are used to store unit-of-use medications in the patient medication dose system. These medication cabinets will be locked when not attended. Access to medication cabinets will be limited to licensed nursing and pharmacy personnel. The Pyxis cabinets maintain control and storage of medications for various nursing units and keeps specific documentation of all transactions in regards to distribution and dispensing.

E. Large and Small Volume IV Solutions – Certain plain IV solutions are purchased and distributed by the materials management department. These solutions are stored either in the materials management department (considered a limited access area) or in the medication rooms in specific patient care areas. Distribution and control of these solutions are under the guidelines of the pharmacy medication distribution system. These solutions are inspected monthly by pharmacy when completing unit/area inspections.

F. Radiopaque Contrast Media – Radiographic contrast media is purchased by pharmacy, stored and used by the diagnostic imaging department. These medications are controlled with limited access. These medications are inspected monthly by- pharmacy when completing unit/area inspections.

G. Radiopharmaceuticals – Radiopharmaceuticals are ordered from a certified/licensed distributor and delivered directly to the "hot lab" in Nuclear Medicine. Policies, procedures and protocols for handling, administration and disposition of radiopharmaceuticals are maintained by the Nuclear Medicine Department of Diagnostic Imaging Services. The Manager ~~Director of~~ Pharmacy confers with the Chief Nuclear Medicine Technologist annually to review these policies, procedures and protocols.

Drug Samples – Drug samples are not allowed at SVMC under any circumstances.

H. -Pharmaceutical Sales Representatives — -All representatives MUST sign-in with the pharmacy and are ONLY allowed in the pharmacy unless access to other areas in the hospital is approved.-

IV. Inspection and Disposition-

A. Inspections – All units and/or areas where medications are used or stored will be inspected by pharmacy staff under the direct supervision of a pharmacist no less frequently than every 30 days. The pharmacy staff during such inspections will ensure that at a minimum:

1. Individual patient medications, except those that have been left at the patient's bedside are returned to pharmacy for appropriate disposition.

2. All drug labels are legible and in compliance with state and federal regulation.

3. Test agents, germicides, disinfectants and other household substances are stored separately from drugs.

4. External use drugs are segregated from drugs for internal use.

5. Drugs are stored at appropriate temperatures.

6. Drugs are accessible only to responsible personnel designated by the hospital.

7. Drugs are not kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

Findings of unit/area inspections and corrective action(s) required, if any, are discussed with the unit/area supervisor. The unit/area supervisor will acknowledge this by signing the inspection form along with the pharmacist conducting the inspection. A report of findings is provided for the V.P. of Patient Care Services and/or the Chief Nursing Officer. Documentation of inspections is retained for 3 years.

B. Return and Disposal of Medications:

All expired or contaminated medications will be quarantined from Pharmacy stock and sent to a certified pharmaceutical recovery service that is under contract with the facility. The quarantined medications shall be logged into a record (drug return log) that contains at least but not limited to the following information: the date quarantined, name and strength of the medication, its NDC (national drug code) number, quantity, lot number, and the signature of the pharmacy staff that quarantined the medication. The contracted recovery service will conform to FDA and DEA guidelines. The recovery service will meet the following service guidelines:

1. Registered Pharmacist on staff.

2. Be a licensed DEA Registrant.

3. Be DEP/EPA registered large quantity hazardous waste generator.

4. Utilize a licensed hazardous waste transporter.

5. Utilize a licensed hazardous waste processing firm for incineration of disposable products.

6. Maintain general liability insurance.

7. Field Service Technicians are bonded and have Power of Attorney to handle narcotics.

8. Provide documentation or return and/or disposal in accordance with FDA and DEA guidelines.

Copies of the recovery service company's current Controlled Substances Registration Certificate, State Restricted Prescription Drug Distributor License and Department of Environmental Protection DEP/EPA ID Certificate will be maintained in the recovery services binder.

At least quarterly, or more frequently as required the recovery company will be notified to send a Field Service Technician to the Pharmacy to inventory and prepare returned items for shipping.

The recovery service Field Service Technician will segregate controlled substances (C-II through C-V) from non-controlled substances. Schedule II medications will be written up on a DEA Form 222. Schedule III, IV and V medications will be recorded on a Controlled Substances Inventory and Transfer. The original of the DEA Form 222 and the Controlled Substances Inventory and Transfer forms will be retained in the Pharmacy and Copies will be sealed with the separated medications and used as a packing list. Duplicate copies will be sent to the recovery service by the Field Service Technician. All non-controlled substances returned according to the drug return log shall be inventoried, signed, and dated by the recovery service field service technician.

The recovery service Field Service Technician will generate a shipping bill and seal all containers for shipping through a bonded transport service.

Upon receipt of the boxed medications, the recovery service will generate the following documentation:

- Credit Tracking Report – for all items being returned to manufacturers for credit by total Calculated Return Value.
- Manufacturer Return Report – details all items returned by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Disposal Report – details all items sent for destruction (incineration) by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Disposal Report (Hazardous) – details all hazardous items sent for destruction (incineration) by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Controlled Substance Inventory Schedule III – V Destruction Certificate - certifies incineration of schedule III – V medications.

- Copy of the Waste Manifest for Schedule C-II through C-V.
- Schedule Medication Incineration Certificate

The above documentation is maintained in the recovery services binder in the pharmacy and reconciled. Original copy of DEA form 222 is mailed to the DEA.

Waste Management and Accountability (On-site disposal)

Disposal of medication waste within the department shall be controlled and accountability held by the -Pharmacist in Charge~~Director of Pharmacy~~. Pharmacy Staff shall dispose of waste in a manner that is consistent and complies with state and federal regulations.

C. Wasting of Medications
(1) Controlled substances will be wasted as per SVMC's CONTROLLED SUBSTANCES policy.

(2) Non controlled medications will be wasted as per SVMC's PHARMACEUTICAL WASTE policy.

V. Distribution of Medications

The pharmacy will dispense all drugs in single unit of use (unit dose) packaging whenever practical and placed in automated dispensing machines.

A. Medications are contained in, and administered from, single unit or unit dose packages.

B. Medications are dispensed in ready-to-administer form to the extent possible.

C. For medications not available in an automated dispensing machine, not more than a 72 hours supply of doses is provided to or available at the patient-care area at any time.

D. A patient medication profile is concurrently maintained in the pharmacy for each patient.

VI. Blood Derivatives

Blood derivative products such as albumin, gamma globulin, immune globulin, etc., are procured and dispensed exclusively by the pharmacy department. Rh_o(D) Immune Globulin is procured by the pharmacy department and distributed to the Laboratory Blood Bank. The blood bank tracks the receipt and dispensing to patients by lot number, using the same procedure as tracking human blood.

VII. Guidelines For Product Dating

All medications at SVMC will be stored in accordance with the most recent guidelines as established by the United States Pharmacopeia (USP) and The National Formulary (NF), and recommendations form the Centers for Disease Control and Prevention (CDC). Consideration is given to the American Society of Health System Pharmacist (ASHP) practice standards.

General Guidelines:

All multi-dose *INJECTABLE* medication containers will be refrigerated after opening, unless specifically labeled "*Do Not Refrigerate*".

Form Specific Guidelines:

1. Injectable:
   a. Ampules – Discard immediately after use. Always use a filter straw.
   b. Single Dose Vials – Discard immediately after use.
   c. Multi-Dose Vials – Discard when empty, when suspected or visible contamination occurs, or if unopened when the manufacturer's expiration date is reached. If opened, use 28 days as expiration or as recommended by manufacturer's guidelines.
   d. Insulin products- 28 days after opening. Must label with expiration date.
2. IV Solutions – Admixed
   a. Mixed on the unit/patient care area – 24 hours after mixing.
   b. Mixed in the Pharmacy – As indicated on the IV labels by the pharmacist.
3. IV Solutions – Unmixed
   a. IVPB's and LVP's over 100ml– 30 days after removal of the moisture protective wrapping.
   b. IVPB under 100ml- 15 days after removal of the moisture protective wrapping.
4. Irrigation Solutions
   a. Sterile Saline & Water – 24 hours from opening.

5. EENT Solutions- 1 year after opening or manufacturer's expiration date whichever is first.
    a. Nasal solutions/sprays
    b. Ophthalmic
    c. Otic
6. Nitroglycerin
    a. Sublingual – 6 months after opening.
7. Oral Liquids & Solids
    a. Non-repackaged – manufacturer's expiration date.
    b. Re-packaged – 1 year from date of repackaging or manufacturer's expiration date, whichever is shortest.
8. Topicals- 1 year after opening or manufacturers expiration date, whichever is first.
    a. Solutions – manufacturer's expiration date if not repackaged or opened.
    b. Ointments, Creams
9. Non-sterile Compounded Medications
    a. Orals & Topicals – consult either, Remington's Pharmaceutical Sciences, U.S. Pharmacopeia or medical literature for sterility, stability data. May not be more than 1 year from date of compounding.

REFERENCES:

- "Best Practices for Health-System Pharmacy, Positions and Practice Standards of ASHP", American Society of Health System Pharmacists, 1999 – 2000, ASHP Technical Assistance Bulletin on Hospital Drug Distribution and Control, pp. 74 – 82.
- ~~FDA definition of drug recall classes~~FDA's role in Drug Recalls, from https://www.fda.gov/drugs/drug-recalls/fdas-role-drug-recalls, access on March 21st, 2022. ~~http://www.fda.gov/oc/po/firmrecalls/recall_defin.html - Accessed on May 20th, 2008.~~

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- "Guideline for Prevention of Intravascular Device-Related Infections", Public Health Service, U.S., Department of Health and Human Services, Centers for Disease Control and Prevention, Am J Infect Control 1996;24:262-93.
- The Joint Commission (2022~~19~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- The United States Pharmacopeia, 24th Rev., and The National Formulary, 19th Ed. (USP24/NF19) Supplement, 1999; 25:2589-90.
- "Revised USP Standards for Product Dating, Packaging, and Temperature Monitoring", Am J Health-Syst Pharm, Vol 57, Aug 1, 2000:1441-1445.
- State of California, Title 22, § 70263 – 70269
- "Self-Assessment Manual for Proper Management of Medical Waste", The Self-Assessment Project Partnership between the Ca. Dept. of Health Services and the California Healthcare Association. March 16, 1999, Second Ed. Revised, pp 13-14.

CROSS REFERENCES:

- Nursing Manual – "Controlled Substances – Procurement, Administration & Documentation."
- Pharmacy Manual – "Controlled Substances"
- Diagnostic Imaging Services – Nuclear Medicine Policy & Procedure Manual.

SUBJECT:	SECTION:
MITOMYCIN ~~AND BCG~~ INTRAVESICAL INSTILLATION	***Medication Management (MM)*** **Page 1 of 3**

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

PURPOSE:

To provide guidelines for the safe preparation, handling, and administration of chemotherapeutic agents and immunotherapy to be used intravesically.

DEFINITIONS:

1. Chemotherapeutic Agents - Are defined as medications that are used to treat or prevent the spread of cancer. Due to their mechanisms of action, they often possess properties that make them biochemically hazardous to store, prepare, administer and dispose.

~~2. BCG - Bacillus Calmette-Guerin~~

~~3.~~2. Intravesical instillation - Administration into the bladder

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that intravesical instillation of mitomycin and BCG will be administered according to the standards set forth in this policy. The hospital complies with all federal, state and local laws and regulations related to hazardous material and waste to provide an environment safe from hazardous material and exposure.

AFFECTED PERSONNEL/AREAS: *NURSING, PHARMACY*

EQUIPMENT:

- Personal protective equipment (PPE): impervious gown, doubled nitrile gloves, eye/face protection
- Plastic-backed absorbent pads
- Urinary catheter
- Catheter insertion tray
- Chemotherapeutic agent
- Sterile 4x4 gauze pads
- Blue luer lock catheter adapter
- Catheter clamps (2)
- Urinary drainage bag
- Closed male connector
- Chemotherapy/Hazardous Spill Kit
- Chemotherapy Drug Precautions labels
- Chemotherapy Sharps & Fluid Resistant Waste Container

PROCEDURE:

A. Intra-operative chemotherapy orders

The licensed practitioner will:

1. Before the procedure, write an on call order for mitomycin using the pre-printed order form and fax the order to the pharmacy. A call will then be placed to pharmacy to ensure the order is received and confirm stock available for compounding.

2. Upon physician request, Pharmacy will be notified by the physician or the OR staff when mitomycin will be needed.

B. Preparation of mitomycin:

Pharmacy will:

1. After receiving an order, Pharmacy will prepare the medication at the Cancer Treatment Center (CTC) and transport to Operating Room (OR).

C. Transport (Refer to policy STERILE HAZARDOUS DRUG HANDLING)

D. Intravesical Instillation:

The registered nurse assisting the medical doctor will:

1. Don personal protective equipment (PPE).

2. Ensure plastic-backed absorbent pads are placed beneath the patient where leaking may occur at catheter connection.

3. Connect the irrigation tubing to the irrigation port, if indicated.

4. Attach Chemotherapy Precautions label to the catheter drainage bag/tubing.

E. The physician or other allied health professional trained in intravesical instillation of chemotherapeutic agents will:

1. Don personal protective equipment (PPE).

2. Insert the appropriate urinary catheter into the bladder. If irrigation is required, irrigation tubing may be attached to the irrigation port of the 3-way catheter or the irrigation port will be clamped (Note: If the irrigation tubing is attached, the irrigation port must be clamped before the medication is instilled and remain clamped until the irrigation is to begin).

3. Attach the syringe and the blue luer lock catheter adapter to the drainage port of the catheter.

4. Instill the chemotherapy drug into the bladder via the drainage port.

F. Care of the patient who has received intravesical instillation of mitomycin~~/BCG~~:

1. Following insertion of intravesical chemotherapeutic agents, the patient should lie prone for 15 minutes and should then be allowed to move freely to ensure the drug has the opportunity to bathe all parts of the bladder mucosa. The drug needs to remain in the patient's bladder for at least 1 hour (to a maximum of 2 hours).

2. Following completion of treatment, the patient will void the bladder. The catheter drainage bag should be clearly labeled with a chemotherapy precautions label to ensure other staff members are aware of the potential contamination risk.

3. At the point of use, all waste used in administration of chemotherapeutic drugs will be placed in yellow plastic bags, which will be in yellow rigid containers marked "Chemotherapy Waste". Provide patient or family with education.

G. Disposal of hazardous waste (Refer to policy STERILE HAZARDOUS DRUG HANDLING)

H. Drug Spill or accidental exposure (Refer to policy STERILE HAZARDOUS DRUG HANDLING)

REFERENCES:

- Guideline for the Management of Nonmuscle Invasive Bladder Cancer: (Stages Ta, T1, and Tis): 2007 Update. American Urology Association. https://www.auanet.org/education/guidelines/bladder-cancer.cfm. Accessed December 18, 2020.
- Bladder cancer. National Comprehensive Cancer Network. http://www.nccn.org/professionals/physician_gls/f_guidelines.asp. Accessed ~~December 28, 2020~~March 14, 2022.
- Saskatoon Health Region Hospital Nursing Practice Committee. 2011. Chemotherapy Bladder Instillation (Intravesical)-Mitomycin: Assisting with & Care of Patient. 1-11.
- Washburn, D.J., August, 2007. Intravesical Antineoplastic Therapy Following Transurethral Resection of Bladder Tumours: Nursing Implications from the Operating Room to Discharge. Clinical Journal of Oncology Nursing, 11 (4):553-559.

CROSS REFERENCES:

- STERILE HAZARDOUS DRUG HANDLING Policy

SUBJECT: **PATIENT'S OWN MEDICATIONS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To define conditions under which patient's medications may be brought into the facility.

POLICY:

Patients are discouraged from bringing their own medications into Sierra View Medical Center (SVMC). Under limited and unusual circumstances, the patient may use their own medication (s) under the following circumstances:

1. Pharmacy cannot supply the medication.

2. When the patient insists.

Patient's own herbal remedies may not be used at Sierra View Medical Center due to the following reasons:

1. Herbal medications are categorized as a food (dietary supplement) under the Dietary Supplement Health and Education Act of 1994 by the Food and Drug Administration and are not held to the standards for the manufacturer of drugs.

2. These dietary supplements are not marked or identified with a stamp or number which does not satisfy the requirements for "positive identification" as stipulated in Title 22 § 70263 (m)(3).

Medications meeting the conditions above, may be brought into the hospital under the following conditions:

1. Drugs have been ordered by a person lawfully authorized to give such an order, and the order is entered in the patient medical record.

2. The medication container is clearly and properly labeled.

3. The contents of the containers have been examined and positively identified by the hospital's pharmacist.

    a. The pharmacist will log the medication into the "Patient Own Medication Log Sheet." For medications which the pharmacy cannot supply or when the patient insists, the pharmacist will take appropriate measures to ensure provided medications match the ordered medication. They will use a pill identifier via Clinical Pharmacology or other drug identifier database, at minimum, to confirm the contents of patient's bottles/bags, etc. Once confirmation is achieved, the pharmacist will enter the order for Patient's Own Medication. The patient's pill bottle will then be sent to the patient's unit with a label from Pharmacy for scanning/administration to patient. The pharmacist will initial this

label to show confirmation that the order was checked by pharmacy. Upon dispensing, the pharmacy will label the container stating "Return Patient's Own Medications To Patient Upon Discharge."

b. The pharmacist or pharmacy technician will then deliver Patient's Own Medications to the appropriate patient care area.

Drugs that are not to be used during the patient's stay at the hospital will be given to the patient's family to take home.

In the event that the medications cannot be sent home, the medications will be sent to the pharmacy. The pharmacist (or nursing supervisor, after normal pharmacy hours), will place the labeled bag of medications in a separate drawer/cabinet marked "patients own medications" away from all other pharmacy stock. Receipt of the medication will be documented on the "patient's medication log" to include the name of the patient, the date received and the disposition of the medications (i.e. date returned to the patient upon discharge or date destroyed as applicable).

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

A patient may utilize his/her medication on the written order of the attending physician when all of the following conditions are met:

1. Medications are ordered by the patient's physician and the order is entered on the patient's medication profile indicating:

   a. Patient's own medication may be used

   b. Name of the drug

   c. Strength of drug and route

   d. Dose schedule

2. Medications have been examined by the pharmacist for positive identification and correctly labeled.

3. In the event that a patient has an attached medication delivery device, (e.g., pump , etc.), the nurse will contact the pharmacist to come to the patient's bedside for a visual inspection of the device.

MEDICATION INFUSION DEVICES

1. The pharmacist will contact the pharmacy that provided the pump and determine concentration, original volume, expiration of the drug and any other pertinent information deemed necessary at the time and enter that information into the medical record.

2. The pharmacist will also contact the prescriber to validate dose and delivery rate of the medication being infused as well as any parameters under which the infusion should be slowed or stopped and enter that information into the medication profile.

3. Instructions on how to stop the pump or change the rate will be obtained from the original prescriber or manufacturer and kept at the nursing station.

STORAGE AND DESTRUCTION OF PATIENT'S OWN MEDICATION:

1. Patient's own medication should be returned to the patient's family upon admission.

2. If the medication is unable to be returned to the family, it is to be sent to the pharmacy for storage.

3. If the medications are not claimed 30 days after discharge, they will be destroyed in the following manner:

    a. Drugs listed in Schedule II, III, or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended, shall be destroyed in the presence of two pharmacists employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the required witnesses shall be recorded in a separate log. Such a log shall be retained for at least 3 years. Medications may be sent to DEA disposal unit as required by DEA office.

    b. Drugs not listed under Schedule II, III, IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of a pharmacist.

REFERENCES:

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

- Pharmacy Law: California Edition.(2019) San Clemente, California: Law Tech Publishing Group.

- Title 22 (n.d.).Retrieved on September 20, 2019, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SIERRA VIEW MEDICAL CENTER

Central Processing Policy & Procedure Manual

SUBJECT:	SECTION:
POINT OF USE: INSTRUMENT CLEANING AND TRANSPORT	**Page 1 of 3**

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

PURPOSE:

~~To ensure proper cleaning and transport of surgical instruments used for a procedure to the Central Processing Department (CPD), while decreasing the possibility of further contamination and prevention of the formation of biofilm on the instruments.~~ This document provides guidance for **cleaning** surgical instruments, including point-of-use treatment, transport, **decontamination**, inspection, and general care of reusable medical devices (eg. surgical instruments).

POLICY:

All instruments used in a procedure will be cleaned of gross soil, sprayed with instrument spray post procedure and returned to the CPD in a red puncture proof, locking container labeled as "Bio Hazardous."

AFFECTED PERSONNEL/AREAS: *ENDOSCOPY, SURGICAL SERVICES, AMBULATORY SURGERY, RADIOLOGY, UROLOGY CLINIC, WOUND CARE CLINIC, MEDICAL/SURGICAL UNIT, TELEMETRY UNIT, EMERGENCY DEPARTMENT, MATERNAL & CHILD HEALTH UNIT, INTENSIVE CARE UNIT, ENDO/FLEX CARE/PACU, CENTRAL PROCESSING DEPARTMENT, NICU, PHYSICAL THERAPY, CARDIAC CATH LAB, CDU, RENAL SERVICES, DP/SNF, ~~GENERAL & COLORECTAL~~ SURGERY CLINIC*

EQUIPMENT:

- Biohazard red containers
- Enzymatic instrument spray
- Closed transport carts

PROCEDURE:

1. Wear appropriate personal protective equipment (PPE), per task.
~~1.~~
~~2. Begin preparation for instrument decontamination at the point of use~~
2.

3. Pre-clean gross soil (to prevent the formulation of biofilm) ASAP at *point of use* (i.e., procedure room after patient leaves, operating room (OR), soiled utility room, etc.) per product recommendations and manufacturer's instructions for use (IFU).

4. After the procedure is complete, obtain instruments to be cleaned.

5. Sharp instruments must be separated from other instruments and confined in a puncture-resistant container before transport to the decontamination area.

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6. Protect delicate instruments (eg. fiberoptic cords, endoscopes, microsurgical instruments, robotic instruments) from damage during transport to a decontamination area by segregating them into different containers or by placing them on top of heavier instruments.

7. Keep instruments moist until they are cleaned by using either saturation with an enzymatic pretreatment product or a towel moistened with water placed over the instruments. Do not use saline.

5.8. Per the Association for the Advancement of Medical Instrumentation (AAMI) Guidelines, a disposable sponge or brush soaked in water could be used to wipe gross soil.

6.9. All items will be placed in CPD-provided leak proof red container labeled as biohazardous, without water added.

7.10. Prior to transport, spray item with CPD-provided instrument spray

a. Assure fully covered, especially around the hinges
b. Hinged instruments to remain open

8.11. Arrange for transport to CPD

a. Department with dirty instrumentation will ensure transport via CPD/courier to CPD in red biohazardous container for reprocessing.
b. Each department will be given an appropriate quantity of red biohazardous containers to allow for an exchange from dirty to clean containers (indicated by blue containers).

9.12. CPD will receive items in biohazardous containers. CPD is responsible to monitor the process and assure items are received in an appropriate manner. ~~If not, instruments are rejected.~~

10.13. When instruments have been reprocessed, they will be delivered back to department by CPD/courier ~~to the appropriate department.~~

REFERENCES:

- Association for the Advancement of Medical Instrumentation (AAMI) ST 79 (2017). *Comprehensive guide to steam sterilization and sterility assurance in healthcare facilities*. (pp.33-38).
- ~~CMS Standard, Reprocessing of Semi-Critical Equipment (2014, 3.A.4, p.20).~~

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- Association of Operating Room Nurses. Guidelines. Instrument Cleaning. October 12, 2020. Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173736661&view=book#173736661

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

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PURPOSE:

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

POLICY:

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

Exceptions:

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

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

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

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

4. Those patients requiring emergency tracheal intubation.

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

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

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

DEFINITIONS:

Levels of Sedation:

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

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

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

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

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

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

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

1. Minimal or Light Sedation

a. Ativan

b. Diazepam (Valium)

2. Moderate Procedural Sedation

a. Midazolam (Versed)

b. Fentanyl (Sublimaze)

c. Meperidine (Demerol)

d. Morphine Sulfate

3. Reversal Agents

a. Benzopdiazepines – Flumazenil (Romazicon)

b. Opiods – Naloxone (Narcan)

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

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

PATIENT ASSESSMENT AND CRITERIA FOR SELECTION:

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

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

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

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

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

   a. Patients who are to have deep sedation or analgesia

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

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

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

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

   c. Significant risk of aspiration

   d. Pregnancy

   e. Difficult airway

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

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

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

6. NPO Guidelines:

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

b. Solids > 6 hours is advisable

Fasting recommendation to reduce the risk of pulmonary aspiration:

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

NOTE: NPO status exempt in emergency situations.

PROCEDURE:

PRE-PROCEDURE PREPARATION:

1. Physician's responsibility

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

- Focused physical examination (performed within 30 days and 24 hour update), including pertinent medical history, auscultation of the heart and lungs, and evaluation of the airway.
- Indicated diagnostic test(s), including pregnancy test if female age 12-50 years unless sterilized;
- Informed consent of sedation risks, benefits and options as discussed with the patient and/or family prior to administration.
- Pre-procedure diagnosis
- Pre-sedation assessment and ASA category;
- Order for sedation medications

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

2. RN Responsibilities:

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

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~~a.~~b. Validate the following:

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

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

- To anticipate drowsiness/sleep lasting a short time
- That conscious awareness of activity will be limited
- That ability to hear will remain; nurse will communicate throughout procedure
- That BP cuff and pulse oximeter will remain on during the procedure
- To advise the nurse if pain, itching, or difficulty breathing occurs

- To advise nurse if pain is not tolerated
- That recovery period will remain relatively short
- Addressing any questions the patient may have at that time

~~c.~~d. Confirm patent IV access

~~d.~~e. Validate presence of emergency equipment:

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

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

IMMEDIATELY PRIOR TO DRUG ADMINISTRATION

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

   a. Respiratory rate;

   b. Oxygen saturation via pulse oximetry;

   c. Blood Pressure;

   d. Heart rate;

   e. Pain assessment

   f. Level of consciousness

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

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

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

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

   a. Oxygen saturation (pulse oximetry);

   b. End Tidal CO2;

   c. Blood pressure;

   d. Rate and quality of respirations;

   e. Level of consciousness;

   f. Response to verbal commands;

   g. ECG Monitoring;

   h. Vital signs.

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

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

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

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

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

   c. Dyspnea, apnea or hypoventilation

d. Chest pain or cardiac arrhythmia

e. Diaphoresis

f. Inability to arouse the patient

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

h. Any other untoward or unexpected patient responses.

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

IMMEDIATELY POST PROCEDURE:

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

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

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

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

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

a. Level of consciousness;

b. Oxygen saturation;

c. Movement of extremities;

d. Vital signs stable for 30 minutes;

e. Maintenance of airway; and

f. Pain assessment.

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

ALDRETE SCORE

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

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

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

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

   a. PACU

   b. ICU/CCU

   c. ER

   d. Radiology

   e. Endoscopy

   f. ASD

   g. Cardiac Catheterization Lab

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

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

Inpatients:

a. It has been at least 30 minutes since the last dose of sedation (or *1 hour if a reversal agent was used.*)
b. The patient has an Aldrete score within 2 points of pre-procedure baseline level.

EXCEPTION: Patient admitted to or currently in ICU.

c. Vomiting is absent or controlled with ordered medications.

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

Outpatients

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

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

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

d. Pain and nausea are controlled.

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

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

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

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

DOCUMENTATION:

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

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

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

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

   c. Type and amount of intravenous fluids administered;

   d. All assessment data;

   e. Unusual events during the procedure.

COMPETENCY REQUIREMENTS

NURSING STAFF

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

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

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

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

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

   e. Identify basic dysrhythmias

   f. Demonstrate ability to recognize and treat an obstructed airway

   g. Describe reportable conditions and appropriate nursing interventions.

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

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

PHYSICIAN TRAINING AND COMPETENCY

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

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

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

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

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

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

QUALITY ASSURANCE and RISK MANAGEMENT

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

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

   a. Cardiac or respiratory arrest

   b. Use of reversal agents

   c. Need for assisted ventilation (ambu)

   d. Sedatives or analgesic dosing outside of the dosing guidelines

   e. Transfer to a higher level of care after sedation

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- Intrafacility Transfers Policy- SVMC
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APPENDIX A: Procedural Sedation & Analgesia Guidelines (Adult & Pediatric)

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

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

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

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

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

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

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

SUBJECT: **SCOPE OF SERVICES AND EQUIPMENT- SC**	SECTION: *Surgery Clinic* **Page 1 of 2**

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

PURPOSE:

To define the scope of services provided in the Outpatient Surgery Clinic.

POLICY:

The Surgery Clinic is an outpatient department of Sierra View Medical Center (SVMC) and, as such, is found on the hospital's license issued by California Department of Public Health.

AFFECTED PERSONNEL/AREAS: *ALL OUTPATIENT CLINIC PERSONNEL, MEDICAL STAFF, AND SURGERY CLINIC PERSONNEL*

PROCEDURE:

A. The General and Colorectal Surgery Clinic will provide general and specialty urological care and treatment to include but not limited to:

1. New and established patient examinations
2. Pre-operative examinations
3. Post-operative follow-up examinations
4. Minor d~~D~~ressing changes ~~(including wound vac dressings and packing changes)~~
5. ~~Incision and drainage of skin abscesses~~
6. ~~Excision of skin lesions~~
7. ~~7.~~5. Anoscopy
8. ~~Proctosigmoidoscopy~~
9. ~~Adjustment of perianal seton~~
10. ~~10.~~6. Ostomy care

B. Emergency Medical Services

During business hours, emergency services will be provided as a first response until local 911 Emergency Medical Services arrive.

C. Equipment and Supplies

There shall be sufficient and appropriate equipment and supplies related to the scope and nature of the anticipated needs and services provided.

REFERENCES:

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

- California Code of Regulations (2022). Title 22. Outpatient Service Definition § 70525. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- California Code of Regulations (2022). Title 22. Outpatient Service General Requirements § 70527. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- California Code of Regulations (2022). Title 22. Outpatient Service Equipment and Supplies § 70531 Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SEQUENTIAL ULTRAFILTRATION (SUF)- ACUTE RENAL SERVICES**	SECTION: **Page 1 of 1**

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

PURPOSE:

Ultrafilration during dialysis is performed for the purpose of removing water accumulated by ingestion of fluid or by metabolism of food during the interdialytic period in which the dialysate is away from the dialyzer.

POLICY:

Sequential Ultrafiltration

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

PROCEDURE:

- Obtain the nephrologist order for Sequential Ultrafiltration and routine hemodialysis phase. Treatment shall be initiated as soon as possible after initiation of dialysis for optimal results (i.e., before osmotic shifts have time to occur).
- Select Sequential in Dialyis Flow Rate (DFR) options.
- Scissor clamp acid and bicarb lines.
- Maintain the blood pump speed per the nephrologist's orders.
- Document the initiation time.
- Check vital signs every 15-30 minutes.
- To discontinue sequential ultrafiltration, remove clamp from acid and bicarb lines. Discontinue Sequential Ultrafiltration (SEQ) option and selected ordered DFR. Continue hemodialysis treatment as ordered by the physician.

REFERENCES:

Fresenius Medical Care. (n.d) Ultrafiltration. retrieved on February 8, 2022 from https://fmcna.com/content/dam/fmcna/live/support/documents/operator's-manuals---hemodialysis-(hd)/2008k-operator's-manuals/490042_Rev_P.pdf

- ~~Kallenbach, J. (2016). Review of Hemodialysis for Nurses and Dialysis Personnel ninth edition. St. Louis, Missouri. Mosby Inc.~~

SUBJECT:	SECTION:
TUBE FEEDING	**Page 1 of 3**

PURPOSE:

To standardize enteral feeding administration and promote patient safety while receiving enteral feeding.

POLICY:

Enteral feeding products will be ordered, received, and stored in the Food and Nutrition Services Department. Any damaged products will be disposed and customer service will be notified.

1. Enteral feeding containers will be rotated using first in, first out (FIFO).

2. Tube Feedings (enteral feedings) are handled and administered using methods that minimize the risk of contamination of the feeding. Formulas are purchased from approved vendors and closed system feedings are used as part of Hazard Analysis Critical Control Point (HACCP) procedures per Enteral Formulary endorsed by Pharmacy and Therapeutics Committee. Modular nutrient components, food grade coloring, medications or water (formula dilution) are not added to enteral formula containers. Full strength formulas are used.

3. Modality:

    a. Continuous Feeding: Pump-assisted continuous drip infusion.

    b. Cyclic Feeding: Pump or gravity drip over a time period that is less than 24 hours. Nocturnal feeding is a form of cyclic feeding.

    c. Intermittent Feeding: Feeding by pump or gravity drip, administered in a timeframe ranging from 20-60 minutes, provided anywhere from 4-6 times per day.

    d. Bolus Feeding: Providing a set volume of formula at specified times over a very short period of time. A typical feeding regimen might provide 240 mL of formula over a 4 to 10 minute timeframe, with infusions 3-6 times per day. Bolus feedings typically mimic normal meal patterns.

4. Open vs Closed Systems:

    a. Closed System: Ready to hang sterile closed system formulas can hang up to 48 hours per manufacturer's guidelines. If more than one feeding set is used or if more than one RTH container is used with a single feeding set, the maximum safe hang time is 24 hours.

    b. Open System (sterile decanted formula) are limited to a hang time of (8) eight hours. Reconstituted powder formula is limited to a hang time of (4) four hours. Administration sets, and feeding bag, for open system enteral feedings should be changed at least every 24 hours.

5. Formulas reconstituted in advance should be immediately refrigerated and discarded within 24 hours of preparation if not used. Formulas should be exposed to room temperature for no longer than 4

hours after which they should be discarded. Use purified water or sterile water for irrigation supply and formula reconstitution.

6. Orders for non-formulary products are substituted per protocol as approved by Pharmacy and Therapeutics Committee. If there is no equivalent formulary product, or "no substitution" is indicated by the ordering physician, the product will be special ordered, if able. Expired formulas are not used.

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

PROCEDURE:

1. Food and Nutrition Services is notified of any patient/resident on enteral feeding via the electronic medical record as a Diet order, in the Dietary Special Needs category.

2. Nursing will order an enteral pump and tubing set from Distribution.

3. The enteral tube feeding order should specify the modality, feeding rate or amount per feeding, total number of feedings per (24) hours and water flushes. Food and Nutrition Services supplies the enteral products. The dietitian must be consulted for all enteral feeding orders.

4. Any pouring or mixing of a powdered product is done by Nursing or Nutrition Services according to the product label. Any mixed product is immediately placed in the delivery container in a quantity that would limit hang time to four hours. The formula should be labeled with the patient's/resident's name, room number, date, time, formula, #ml per hour, and strength.

5. All tube feedings are administered using clean technique.

6. Tube feedings should be started as per the physician's order. The rate should be increased to goal rate over the next 24 - 48 hours as tolerated.

7. DPSNF: The dietitian is responsible for completing a nutrition assessment on the patient/resident within (72) hours of the tube feeding initiation. Recommendations regarding the appropriateness of the product, volume, calories, protein, fluid needs, and percentage of the Dietary References Intake (DRI) for all vitamins and minerals will be addressed.

8. Drug-Nutrient Interactions: All patients shall be monitored for potential drug-food interactions. Dietitians will calculate accordingly and change to bolus feeds if necessary. *Refer to policy: "Drug Nutrient Interaction and Enteral Tube Feeding Interaction."*

9. Guidelines for gastric residuals:
   If residual is < 200ml, return to patient and continue infusion.
   If residual is >200ml, return to patient, hold feeding for 1 hour, then recheck.
   If residual remains >200, hold tube feeding and call physician.

10. Cranberry juice and/or soda should not be used to unclog a feeding tube. To unclog a tube, use warm water, or crushed sodium bicarbonate 325 mg tablets or crushed pancrease MT 10.

CROSS REFERENCES:

- DRUG/NUTRIENT INTERACTIONS AND ENTERAL TUBE FEEDING DRUG/NUTRIENT INTERACTION

REFERENCES:

- **Krames on Demand: https://www.kramesondemand.com/Search.aspx?SearchTerm=tube%20feeding**
- **CIHQ Acute care Accreditation, Nutrition Assessment and Care Plans file:///C:/Users/josec/Downloads/CIHQ%20Acute%20Care%20Accreditation%20Standards%20-%20Participating%20in%20Medicare%20Rev.1.21.pg 84 pdf**
- (2020) California Department of Public Health, Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2020). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- ~~The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.~~
- American Society of Enteral/Parenteral Nutrition (ASPEN) Copyright 2017.https://www.nutritioncare.org/uploadedFiles/01_Site_Directory/Guidelines_and_Clinical_Resources/EN_Pathway/EN%20Pathway%20PDF%206.pdf
- ~~American Society of Consultant Pharmacists (ASCP~~).
- 2019 Abbott Nutrition Best Practice for Managing Tube Feeding, A Nurse's Pocket Manual.https://static.abbottnutrition.com/cms-prod/abbottnutrition-2016.com/img/M4619.005%20Tube%20Feeding%20manual_tcm1411-57873.pdf
- The ASPEN Adult Nutrition Support Curriculum 3rd ed. 2017

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Senior Leadership Team	4/26/2022
Board of Director's Approval	
_____ Bindusagar Reddy, MD, Chairman	4/26/2022 Date

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
April 26, 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. American Express Credit Cards	1	
2. Cashless System	2-5	
3. Chart of Accounts	6	
4. Check Signing and Cash Disbursements	7	
5. Corrections to Payroll Checks	8	
6. Demand Checks	9	
7. Employee Termination Checks	10	
8. Financial Assistance Policy – Full Charity Care and Discount Partial	11-21	
9. Food Service Emergency Plan	22-33	
10. Food Supplies and Storage	34-38	
11. Garnishments	39-41	
12. Other Prepaid Expenses	42	
13. Safety Management Plan	43-53	
14. Vendor Credit Applications	54	
15. Vendor Dictionary	55	

SUBJECT: **AMERICAN EXPRESS CREDIT CARDS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the procedures for issuing and processing American Express credit cards.

POLICY:

As a convenience to Sierra View Medical Center (SVMC) employees, American Express credit cards will be issued to employees as requested for business related expenses only such as travel and expenses that cannot be handled through the use of a Check Payment Request or a Purchase Order.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS*

PROCEDURE:

Frequency: As needed

Responsibility: Accounts Payable Staff

1. Employees may obtain a credit card for business use by signing it out in General Accounting. A credit card is then issued to the employee, which must be returned to General Accounting within 24 hours after use or immediately upon return from an out of town conference

2. A Credit Card Expense Report must be filled out completely, with receipts attached and with proper authorized signatures, and then submitted electronically to General Accounting within 24 hours after credit card use.

3. Employees must not charge any personal items or alcoholic beverages on the credit card. If they do so, the employee is 100% responsible and must reimburse SVMC for the personal items and/or alcoholic beverages charged on the credit card.

4. Accounts Payable staff reviews Expense Reports and receipts for completeness and for proper authorized signatures. Accounts Payable staff reconciles online statement activity with Expense Reports on a monthly basis. American Express is paid with one check on a monthly basis.

SUBJECT: **CASHLESS SYSTEM**	SECTION: **Page 1 of 4**

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

PURPOSE:

To define the protocol for Sierra View Medical Center's Cashless System.

POLICY:

Sierra View Medical Center personnel may elect to utilize the Cashless System plans for purchases at the Café, the Coffee Corner, and the Gift Shop. Personnel may choose one or multiple plans available.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES, VOLUNTEERS AND EMERGENCY ROOM PHYSICIANS

PROCEDURE:

Available Plans:

1. A Cashless Payroll Deduction Authorization form must be completed and signed by staff members and submitted to Human Resources prior to use of the cashless system. If the staff member desires to terminate participation in the Cashless System program, he/she must complete a new "Cashless System Payroll Deduction Authorization Form" and check the declination box. This form must be submitted to Human Resources and will not take effect until the next pay period.

2. Cashless System plans available:

   a. Payroll Deduction (Employees only):

      - Purchases are deducted directly from an employee's payroll check. A maximum limit is permitted based on the employee's status as indicated below or to the extent permitted under state and federal wage and hour laws.

        – Full time – a maximum of $200.00 per pay period
        – Part time – a maximum of $100.00 per pay period
        – Per diem- not eligible for payroll deduction

      - Unused amounts will not roll over to the next pay period.

      - If the employee's earnings do not cover the charges incurred, the Cashless System privileges will be suspended until the balance is paid in full.

   b. Prepaid Declining Balance (Employees only):

- An amount may be prepaid at the Café or Coffee Corner registers. This amount declines with purchases. There are no maximum limits on this plan.

c. Gift Cards:

- A gift card is purchased at the Café or Coffee Corner registers. The staff member pays with cash or credit card, electing the amount desired. Upon depleting the card's balance, the card may be restored in the same process with the exception of a non-reloadable card.
- Non-reloadable cards will be collected by the cashier at the close of the transaction.
- Payroll Deduction or Prepaid Declining Balance cannot be utilized to purchase gift cards.

d. Credit Card:

- Visa, Master Card, Discover and American Express credit cards will be accepted at the registers with proper identification, which may include the staff member's identification badge.

Identification Badges:

1. Staff members must present their hospital identification badge to receive their discount and to utilize the Payroll Deduction and/or Prepaid Declining Balance plans.

2. It is against policy for an employee to allow another employee to use his/her badge for any reason, which includes making a Cashless System purchase.

3. Personnel who lose their badge will not be able to utilize Payroll Deduction or Prepaid Declining Balance plans until the next day after replacement of their badge.

   a. Replacement badges may be obtained from Human Resources.

Exceptions for Designated Staff:

1. Emergency Department (ED) Physicians, Hospitalists, Intensivists, the Volunteer League, and Adult Volunteers are not employees of the hospital and receive complimentary meals during their scheduled work shift. These designated staff will present hospital issued identification badges to receive their meals. Complimentary meals are limited to line items with the exception of milk and bottled water. Convenience food items such as chips, energy drinks, bottled beverages, etc. are excluded and must be paid using cash, credit card or a gift card.

2. Food & Nutrition Service (FNS) personnel are eligible for complimentary meals and limited to line items with the exception of milk and bottled water. Convenience food items such as chips,

energy drinks, bottled beverages, etc. are excluded and must be paid using one of the available plans or cash. The FNS personnel must be working a scheduled shift and present their hospital identification badge to receive their complimentary meal.

3. Employees returning from a leave will not be able to utilize the cashless system or payroll deduction for 24 hours upon their return to work.

Gift Cards Purchased with Hospital Funds:

1. Only management personnel may purchase departmental gift cards for their employees with Hospital funds as a form of employee recognition or appreciation.

   a. Gift Cards must be purchased at the Café or Coffee Corner registers with cash or credit cards. Hospital-issued American Express cards should not be used.

   b. Gift cards given to employees for amounts $25 or greater using SVMC funds are taxable to the employee, and therefore must be reported to Payroll. A Gift Card Receipts form must be completed with the employee's name and the amount received and submitted to Payroll.

   c. Payroll will include this amount as taxable wages to the employee and withhold appropriate taxes.

2. Gift cards cannot be redeemable for cash.

Discrepancies

1. Receipts will be required to substantiate any and all discrepancies, and must be addressed with the Food and Nutrition Director within the same meal period that the purchase was made. No refund credits will be made to an account without a receipt, and cash refunds will not be made for a credit purchase.

Termination of Employment:

1. If an employee provides notice to terminate employment, all privileges will be removed and they will not be eligible to continue in the Cashless System program.

2. Payroll Deduction (Employees only) – All charges are due and payable upon termination. The Hospital reserves the right to recover the balance of any outstanding charges owed by a terminated employee to the extent permitted under state and federal law.

3. Prepaid Declining Balance (Employees only) – Remaining balances will be reimbursed on the employee's final payroll check.

Abuse of the Cashless System program may lead to disciplinary action, up to and including termination.

Sierra View Medical Center (SVMC) reserves the right to change the requirements for participation in this program at any time.

SUBJECT: **CHART OF ACCOUNTS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To maintain a chart of accounts structure which will provide adequate information for financial and operational reporting across the organization in a uniform and consistent manner.

POLICY:

Sierra View Medical Center will utilize the California Department of Health Care Access and Information (HCAI) Chart of Accounts structure. All proposed changes to the Chart of Accounts will be forwarded to the Director of General Accounting who will verify compliance with regulatory reporting requirements. Upon approval, the Accounting and Financial Planning Departments will implement the change(s).

SUBJECT: **CHECK SIGNING AND CASH DISBURSEMENTS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To document Sierra View Medical Center's check signing and cash disbursement requirements.

POLICY:

1. Prior to the printing of any checks, the Director of General Accounting shall review the Scheduled Payments report to ensure that all proposed disbursements are reasonable and appropriate.

2. All disbursements must be approved by the appropriate Administrative Director, Director, or Manager. Without proper approval, no checks shall be written.

3. The Chief Executive Officer (CEO), Chief Financial Officer (CFO) shall have check signing authority for the Hospital.

4. Checks for amounts up to $10,000 shall require only one signature. A facsimile signature of the CEO or CFO may be used.

5. Checks for amounts greater than $10,000 shall require two signatures, one of which may be a facsimile.

6. Checks for amounts greater than $100,000 shall require CEO Check Review and electronic approval.

AFFECTED PERSONNEL/AREAS: *DEPARTMENTS OF FINANCE AND ADMINISTRATION*

SUBJECT: **CORRECTIONS TO PAYROLL CHECKS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish guidelines for payment of errors occurring on the payroll checks.

POLICY:

Errors causing an under or over payment occurring on the payroll checks will be made in an accurate and timely manner.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES IN ALL DEPARTMENTS*

PROCEDURE:

Frequency: Bi-weekly, as needed

Responsibility: Payroll Staff

CORRECTION BY SPECIAL PAYROLL CHECKS:

1. An adjustment for an under payment will be made by special payroll check for errors that have been made in the processing of a timecard by Payroll or Human Resources staff.

2. Adjustments will be processed only upon receipt of an approved "Payroll Adjustment Request" form.

CORRECTION BY ADJUSTMENT OF THE NEXT PAY PERIOD'S PAYROLL CHECK:

1. Adjustment for errors will be made on the next pay period's payroll check for errors that result from the failure of employees punching in and/or out using their Kronos badge.

2. Adjustment for errors will also be made when employees fail to record hours worked, by an approved alternative method, when notifying their supervisor of their failure to clock in and/or out via Kronos.

3. Adjustment for errors resulting from system or manual entry error resulting in overpayment will be adjusted on the next pay period's payroll check and can be extended to the maximum breakdown of only two pay periods.

4. Adjustments will be processed only upon receipt of an approved "Payroll Adjustment Request" form.

SUBJECT:	SECTION:
DEMAND CHECKS	**Page 1 of 1**

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

PURPOSE:

To define the procedure for processing an Accounts Payable Demand Check Request.

POLICY:

Demand Checks shall be done in accordance with all Accounts Payable signature and approval requirements, on an as needed basis. Demand Checks must be authorized by the Director of General Accounting, VP of Finance, or Chief Executive Officer.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS*

PROCEDURE:

Frequency: As needed

Responsibility: Accounts Payable Staff

1. A Demand Check Request is reviewed by Accounts Payable staff for proper authorized signatures and supporting documentation.

2. The Accounts Payable staff determines whether or not the invoice is already in Meditech. If not, the demand check may be processed.

3. The timeframe to process demand checks is within 24 hours after receipt of the request.

SUBJECT: **EMPLOYEE TERMINATION CHECKS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the procedures required to process employee termination checks.

POLICY:

Employee checks issued upon termination will include pay for all hours the employee worked during the last pay period and payment for all Vacation/Holiday benefit hours accrued. The pay for hours worked and hours accrued in the Vacation/Holiday bank will be calculated accurately and the payments will be processed in a timely manner, in accordance with the current Labor Code requirements.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Frequency: As Needed

Responsibility: Payroll Staff

1. Upon Receipt of the "Employee Change Notice" from Human Resources, Payroll staff will contact the employee's supervisor to verify and approve the hours worked, which are to be included in the computation of the final payroll check.

2. Payroll staff will determine if there are any voluntary deductions (e.g. medical, dental, vision, etc.), which must be withheld from the final payroll check.

3. Payroll staff will process the employee's final paycheck for final hours worked. If applicable, a second check will be processed for all hours accrued in the Vacation/Holiday bank that are due to the employee.

4. Payroll staff will complete the Employee Termination Checklist to verify that all necessary steps have been completed. Final payroll checks will be taken to Human Resources.

SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL	**Page 1 of 11**

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

PURPOSE:

Sierra View Medical Center (SVMC) is a non-profit organization, which provides hospital services to the community of Porterville and the greater area of Southeastern Tulare County. Sierra View Medical Center is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, SVMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify, in accordance with the requirements of this Financial Assistance Policy.

This Financial Assistance Policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), AB 72 (Balance billing), January 1, 2022 AB 1020 and AB 532 guidance, and United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") guidance regarding financial assistance to uninsured and underinsured patients, Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for charity care. The financial screening criteria in this policy are based primarily on the Federal Poverty Level ("FPL") guidelines updated periodically by HHS in the Federal Register.

AFFECTED AREAS/PERSONNEL: *FINANCIAL COUNSELORS, PATIENT ACCESS, PATIENT FINANCIAL SERVICES*

DEFINITIONS:

1. Charity Care: Full Charity Care is defined as a full charitable deduction (100% discount) for those with an income under 200% or less of the Federal Poverty Level
2. Partial Charity Care Payment: For those with an income of 201% - 400% of the Federal Poverty Level. A partial charitable deduction for all eligible amounts owed to Sierra View Medical Center.
3. High Medical Cost: Annual out-of-pocket costs at the hospital that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months.
4. Reasonable Payment Plan: A default plan required by SB 1276 for patients qualifying for partial charity when a negotiated plan cannot be reached. SB 1276 defines the plan as monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.
5. Good Faith Estimate (GFE): A cost estimation for the items and services furnished by SVMC and convening providers
6. Independent Dispute Resolution (IDR): a process in which providers, emergency facilities and health plans can use to resolve payment disputes for certain out-of-network items and services.
7. Provider Dispute Resolution (PDR): a process a patient can initiate if a patient receives a bill that is substantially in excess of the GFE (defined as bill is >$400 in excess of the GFE) and is done within one hundred and twenty calendar days (120) of receiving a bill.

POLICY:

Sierra View Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. The Financial Assistance Policy will apply to all patients who receive

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services at SVMC. SVMC provides all patients a written notice about the availability of our discount payment and charity care policy, including information about eligibility and contact information to the financial counseling department. This notice also includes how to find our shoppable services and the contact information to the Consumer Alliance; an organization that helps patients understand the billing and payment process, as well as provides information regarding Covered California and Medi-Cal presumptive eligibility. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

In accordance with Sierra View Medical Center's mission and values, all patients will receive medically necessary healthcare in compliance with federal law, regardless of the patient's ability to pay for services. The hospital will also provide qualified patients with financial assistance to help cover the costs of services and reduce patients' personal financial responsibilities

Full Charity Care Defined

Full Charity Care is defined as a full charitable deduction (100% discount) for all eligible amounts owed to Sierra View Medical Center. The applicants must have a qualifying income of 200% or less of the Federal Poverty Level. Any necessary[1] inpatient or outpatient hospital service provided to a patient who is either unable to pay for care and who has established qualification in accordance with requirements contained in the SVMC Financial Assistance Policy and by requesting assistance in a timely-manner, defined as request being made for financial assistance one year from date of service or date of denial or payment from insurance company.

Partial Charity Care Defined

Partial Charity Care is defined as a partial charitable deduction for all eligible amounts owed to Sierra View Medical Center. The applicants must have 1) qualifying income between 201% to 400% (or not to exceed 400%) of the Federal Poverty Level, 2) applicant with a high medical cost to include any necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured.

Depending upon individual patient eligibility, financial assistance may be granted for full charity care or discount partial charity care. SVMC may exclude patients who would be eligible to apply but who do not apply or otherwise comply with the hospital's reasonable process for qualifying for Full Charity Care and Discount Partial Charity Care. SVMC definition of reasonable process for qualifying for Full Charity Care and Discount Partial Charity Care is to complete the charity application and submit all financial documents and supporting documentation within one year from the date of service or one year from the insurance payment or denial.

Full and Discount Partial Eligibility: General Process and Responsibilities

The SVMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, SVMC will use a financial assistance application. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial

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assistance application. Uninsured and underinsured patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-Cal and the Healthy Families program) for which they may be eligible. Patients with a qualifying income of 400% or less of the current Federal Poverty Level who experience high medical costs, including patients with a third-party insurance coverage may also be eligible for financial assistance. In addition, SVMC will provide contact information to a local consumer assistance center, Central California Legal Services, located within Tulare County, and for patients residing outside Tulare County, we will provide the Health Consumer Alliance contact information. Patients presenting with these types of situations will be required to follow the same application process and approval will be reviewed on a case-by-case basis. A patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for charity care or discount payment program. Any patient who requests financial assistance will be asked to complete a financial assistance application.
The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

Eligibility is defined for any patient whose family[2] income is 400% or less of the current Federal Poverty Level. Request for Financial Assistance Program can't be for services related to an injury compensable for the purpose of workers' compensation, automobile insurance or other insurance as determined and documented by the hospital and/or unable to pay for their care, based upon determination of financial need in accordance with this policy.

Patients' income and other financial criteria are the basis for determining the amount of the hospital-sponsored financial assistance patients receive. While both uninsured and insured patients are eligible for financial assistance from Sierra View Medical Center, patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-Cal and the Healthy Families program) for which they may be eligible. Patients will be given the opportunity to explore these resources before receiving charity care.

Patients at Sierra View Medical Center who are unable to pay their balances and are in need of financial assistance will be screened without bias toward their gender, ethnicity and religion or employment status. Patients will be objectively assessed by a qualified hospital staff member through the review and assessment of pertinent patients' information. For the purposes of this objective screening process, patients will be required to submit relevant documentation such as the following:

- Applications are located on the SVMC website, the patient portal or by contacting the financial counseling department
- All W-2 earnings or previous tax returns or most recent previous 2 months pay stubs and withholding statements
- Pension or Social Security income statements
- All statements of financial obligation
- Government-sponsored program denial or approval letter with effective date

- Hardship letter, if applicable

Financial assistance will be provided to eligible uninsured and insured patients in the form of discounts of patients' personal financial responsibilities. The following framework, based upon the federal poverty guidelines that consider patients' income and number of dependents, will be utilized to objectively and consistently determine the percentage discount that eligible patients receive:

Financial Assistance Guidelines

Percent of Federal Poverty Guidelines	Charity Care Discount Percentage
200% or below	100%
Percent of Federal Poverty Level	**Partial Charity Care Discount Percentage**
201 – 266%	75%
267 – 332%	50%
333 – 400%	25%
401% or above	0%

- Partial Charity Care Discount Percentage will be applied to the Medicare rate in effect at the time of service.

For example, an individual with two other family members and an annual income of $18,000 is at less than 200% of the federal poverty guidelines and would receive a 100% discount on their bill.

For example, an individual with two other family members and an annual income of $43,000 is between 251 – 300% % of the federal poverty guidelines they would only pay 50% of the Medicare rate in effect at the time of service.

All financial assistance provided to patients, whether covering all or part of their balances, will be documented by SVMC in order to ensure objectivity in the charity care dispersed, and to provide records able to meet all internal and external requirements for providing assistance to patients in need.

In order to communicate its charity care policy to all patients, SVMC billing statements will include the phone number(s) of SVMC Financial Counselors that patients may call for financial assistance information. In addition, a copy of the application will be sent to every patient before assigning to collections. Contact information along with phone numbers with information on how to receive Charity Care and Financial Assistance will also be prominentlydisplayed in all hospital registration areas including observations units if applicable. A notice of the hospital's policy will also be available on the hospital internet website.

Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Financial Counselors.

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SVMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:

Patient Financial Services Manager: Accounts less than $10,000
Administrative Director of Revenue Cycle: Accounts less than $25,000
Chief Financial Officer: Accounts greater than $25,000

Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:

- No insurance or a valid denial under any government coverage program or other third party insurer;
- Limited insurance benefits paid by third party payer
- Family income based upon tax returns or recent pay stubs (2 month)
- Family size, per tax returns
- Monetary assets as provided for under law
- Hardship letter, if applicable

Financial Assistance Program qualification may be granted for full charity care (100% free services) or discount partial charity care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.

When Financial Assistance is granted, the patient and dependents will remain eligible for 6 months from the month of service. Accounts within the 6 month span can automatically be applied to charity, but on the 7th month and forward, the guarantor/patient will need to complete another Financial Assistance application. Medi-Cal/Medicaid share of cost (SOC) amounts are not eligible for financial assistance. The SOC amounts are set by the State, the State require patients to pay the SOC as a condition of receiving Medi-cal/Medicaid.

Patients at or below 400% of the Federal Poverty Guidelines who do not qualify for 100% discount will pay a percentage of the Medicare rate in effect at the time of service.. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided by SVMC.

Financial Assistance Exclusions/Disqualification

The following are circumstances in which Financial Assistance is not available under this policy:

a) Uninsured or Self-Pay patient seeks Complex/Specialized Services: Generally, Uninsured Patients who seek Complex/Specialized services (e.g. experimental or investigational procedures), and seek to

receive Financial Assistance for such services must receive administrative approval from the individual responsible for finance at the Hospital (or designee) prior to the provision of such services in order to be eligible for Financial Assistance. The uninsured or self-pay patient and/or ordering doctor will need to provide diagnosis and procedure code(s) and SVMC will provide the uninsured or self-pay patient a good faith estimate (GFE). If the patient elects to continue services we will initiate financial clearance which must have administrative approval. Elective services that are normally exclusions from coverage under health plan coverage agreements (e.g., cosmetic procedures) are not eligible for Financial Assistance.

b) Patient declines covered services: An Insured Patient who elects to seek services that are not covered under the patient's benefit agreement (such as an HMO patient who seeks out-of-network services.)

c) Insured Patient does not cooperate with third-party payer: An Insured Patient who is insured by a third-party payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability is not eligible for Financial Assistance.

d) Payer pays patient directly: If a patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the patient is not eligible for Financial Assistance for the services.

e) Information falsification: Hospitals may refuse to award Financial Assistance to patients who falsify information regarding Family Income, household size or other information in their eligibility application.

f) Third party recoveries: If the patient receives a financial settlement or judgment from a third-party tortfeasor that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any patient account balances, and is not eligible for Financial Assistance.

Payment Plans

When a determination of discount partial charity has been made by the hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled reasonable payment plan.

The hospital and patient will work together to negotiate the terms of a payment plan. In the event the hospital and the patient cannot agree on a payment plan, SVMC will abide by the payment plan formula, defined in AB1276. SVMC will take into consideration the patient's family income and essential living expenses when determining a payment plan. The patient is responsible for providing SVMC copies of their essential living expenses. If an agreement cannot be reached with the patient, SVMC must institute a reasonable payment plan, with monthly payments not to exceed 10% of a patient's family income for a month after deductions of essential living expenses. "Essential living expenses" are defined as expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses. If the reasonable payment formula results in a payment of less than $10 a month, the subsequent extended payment plan shall be $10 per month.

Patients who wish to renegotiate the terms of a defaulted extended payment plan are able to enter into another extended payment plan with payments in the amount of either the reasonable payment formula or

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$10 per month and if the patient fails to make all consecutive payments due during a 90-day period, that extended payment plan is considered inoperative.

No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Special Circumstances

In extenuating circumstances, SVMC may at its discretion approve financial assistance outside of the scope of this policy.

Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, and when collection agency assignment would not result in resolution of the account. The accounts eligible for charity due to homelessness are identified by the current ICD-10 per CMS guidelines. No application will be required for these circumstances.

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program.

Other Eligible Circumstances

SVMC deems those patients that are eligible for government sponsored low-income assistance program (e.g., Medi-Cal/Medicaid, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g., CHDP, and CCS) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under the hospital's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care. All Service Authorization Request (SAR) denied due to attending physician is not CCS paneled under the California Children Services (CCS) program will qualify for charity care.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

1. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient whose income exceeds 400% of the Federal Poverty Guidelines and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high

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incomes, do not qualify for routine full charity care or discount partial charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.

- The California law, AB 72, which took effect in July 2017 and the No Surprise Act effective January 2022 protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services and non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. In addition, the No Surprise Act provides uninsured or self pay patients with protections as well.

- SVMC utilizes the services of contracted physicians. These physicians are not employed by the district but provide services to the SVMC patient population. These physicians may not be an in-network provider. The No Surprise Act prevents the hospital and convening providers from balance billing.

SVMC will make every reasonable, cost-effective effort to communicate payment options and programs with each patient who receives services at the hospital. In the event that a patient or guarantor does not respond or communicate with SVMC to resolve an open account, SVMC may forward the account to its collection agency after 180 days has elapsed and after providing the patient a financial assistance application.

Collection Guidelines

SVMC will make reasonable attempts to obtain insurance information. If no insurance was provided at the time of service, patient will receive statements, which includes language telling the patient that he or she may be eligible for coverage offered through the California Health Benefit Exchange and other state- or county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services, and the phone number to the Financial Counseling Department.

Calls to obtain insurance information or set up a payment plan with patients may be made. If a patient indicates they are unable to pay, the patient will be referred to a Financial Counselor to assist them with applying for health coverage, to include the California Health Benefit Exchange and other state-or county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services along with the SVMC Financial Assistance program.

SVMC will assign unresolved financial obligations to a debt collection agency after: 180 days if the patient has failed to comply with an established payment plan or non-payment on an account where the

patient guarantor is not in process of completing an eligibility application for a government-sponsored insurance program or applying for charity care and/or financial assistance. A final notice with a charity care and financial assistance application, the name of the collection agency whom the account will be referred to, along with information on how to receive help will also be included in the final bill. Patients with pending appeal for coverage of services will not be forwarded to a third party collection agency until a final determination of that appeal is made. If the appeal is unfavorable and the patient is responsible for the outstanding obligation, the patient will be afforded the opportunity to qualify for charity care or discount payment arrangements as prescribed above. Patient guarantors must keep SVMC Financial Counselors updated on the coverage appeal.

Certain account categories returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care, provided that the patient cooperates with the Charity Care/Financial Assistance Guidelines outlined in this policy. The following types of claims categories will be reviewed for possible charity:

1) Self-Pay or Underinsuredaccounts
2) Any account where the guarantor expressed the inability to pay the accounts

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

Collection Agencies will return all accounts that meet the following guidelines; 1) Deemed patient is unable to pay, 2) Patient provides 3rd party coverage, 3) Patient requests Financial Assistance, 4) Not able to reach a reasonable payment plan.

Collection agencies have the responsibility to be familiar with SVMC's policy for Financial Assistance and Charity Care and as such will be responsible for ensuring patients who meet guidelines are returned to SVMC.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital within thirty days of notification of denial. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all-additional relevant documentation to support the patient's claim should be attached to the written appeal.

Any or all appeals will be reviewed by the hospital's Administrative Director of Revenue Cycle. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the patient will be notified of findings and determination within thirty days of appeal notification.

In the event that the patient believes a dispute remains after consideration of the appeal by the Administrative Director of Revenue Cycle, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and

documentation, as well as the findings of the Administrative Director of Revenue Cycle. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient within thirty days of appeal notification. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

Public Notice

SVMC shall post notices informing the public of the Charity Care and Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas, observation units, or other common outpatient areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. The information notice is also available onthe Sierra View Medical Center website. Patients can access the Charity Care and Financial Assistance Policy and download the application and return via email, in person, or by mail.

These notices shall be posted in English and Spanish and any other primary languages that are representative of 5% or greater of patients in the hospital's service area.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

Good Faith Requirements

SVMC arranges for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, SVMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for the Sierra View Medical Center financial assistance.

REFERENCES:

- Assembly Bill 774. Health Facilities, Reporting (2019). Retrieved from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB774.
- Assembly Bill 72 (2019). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB72.

- Assembly Bill 1503 (2019). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1503.
- Senate Bill 1276 (2020). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB1276.
- No Surprise Billing (CMS) Title XXVII of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021
- Assembly Bill 532 (2022). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB532
- Assembly Bill 1020 (2022). Retrieved from **https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1020**

SUBJECT: **FOOD SERVICE EMERGENCY PLAN**	SECTION: ***Emergency Management Plan*** **1 of 12**

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

PURPOSE:

Sierra View Medical Center (SVMC) will have the means to provide nutritional assistance to staff and patients for ninety six (96) hours in the event of a disaster or emergency situation.

DEFINITIONS:

Emergency: An 'unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services.'

POLICY:

The facility maintains at least a seven days staple and two days perishable foods in inventory. In addition the facility maintains four days (96 hour) emergency meals, potable water and disposable supplies in the facility's secured, temperature-controlled warehouse.

A Nutrition Service disaster and emergency plan is prominently posted in the food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences an emergency/disaster. It is possible that any one or all of these services may be interrupted.

The Food & Nutrition Service Director or Dietitian or Food Service staff member in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration.

If needed, all or part of this emergency meal plan will be implemented to ensure provision of nutritious meals to patients despite the limitations of the disaster. The ***Meals for All*** Emergency Solution menu may be used during an emergency/disaster at the discretion of the Food & Nutrition Service Department, House Supervisor or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the Registered Dietitian will be notified.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS*

EQUIPMENT:

Food preparation tool box

PROCEDURE:

At least once a year, the Food & Nutrition Department conducts an in-service session on disaster plans and emergency procedures in regards to the nutritional assistance that will be provided to patients. The *Quick Guide to Emergency Feeding* guidelines will be posted in food service and the house supervisor office. A copy of the disaster and emergency procedures will be stored with the *Meals for All* emergency food and supplies ready reference. *(See attachment I - Quick Guide to Emergency Feeding Guidelines)*

HEATING SOURCE FOR WATER:

If no heating source is available, *Meals for All* may be reconstituted using unheated potable water. All food items are fully cooked and safe to serve at room temperature.

Do not attempt to cook or boil water over an open flame whenever gas leaks are possible.

FOOD TEMPERATURES / FOOD SAFETY:

For best palatability, hot foods are best served at 135°F or more, cold foods are best served at 41° or colder.

However, all foods on this menu may be safely served at room temperature between 41° - 135° if opened, prepared and served within two hours.

HANDWASHING FOR FOOD PREPARERS:

Proper hand washing when water is scarce requires the use of two basins, one with an approved sanitizing agent, and one with clear rinsing water. Approved hand sanitizer may also be utilized.

FOOD PREPARATION:

Follow instructions on the *Meals for All* containers for proper preparation. *See attachment II*

EMERGENCY FOOD ITEMS STORAGE:

The *Meals for All* emergency meals and other emergency supplies will be secured in the facility storage warehouse and easily accessible during an emergency or disaster situation. All food items are dated by the manufacturer and have a ten year shelf life. During the final year of the expected shelf-life, SVMC will determine if the facility will donate the *Meals for All* to a charitable organization or utilize for a facility disaster exercise.

EQUIPMENT FOR FOOD PREPARATION:

The equipment needed for food preparation is secured and stored in the facility storage warehouse. The equipment is in its own marked container and located next to the *Meals for All* pallets. The equipment toolbox includes but not limited to:

- 4 gray scoops (4oz), 4 green scoops (3oz), 4 spoodles (4oz), 2 serving spoons, 2 slotted serving spoons, 4 ladles (3oz), 2 rubber spatulas, 4 tongs, 2 sets measuring spoons, 2 measuring cups, 4 mixing bowls, 2 containers (12 quart), disposable aluminum pans, 2 spot lights, 6 headlamps; 3 lanterns, 10 flashlights, 72 (D) batteries, disposable gloves, 2 can openers, 4 thermometers, 2 boxes storage bags, 2 boxes hairnets, 2 box cutters & extra blades, black markers, 2 scissors, 2 lighters,

masking tape 72 (D) batteries, 2 boxes storage bags, 2 cases disinfectant wipes, 2 boxes alcohol wipes, 4 bottles hand sanitizer, black markers, 2 scissors, 2 lighters, masking tape , garbage bags.

INVENTORY AND VERIFICATION:

The *Meals for All* Emergency Menu Inventory and Supply list will be maintained in the Food & Nutrition Service Director's Office, and a copy will be placed in the Emergency Operations Procedures manual. The inventory and supply list will be inspected on a semi-annual basis to determine all items are present in the quantities specified. The Emergency Supply Inventory Verification form (attached) will be utilized for documenting the inventory, which will include;

- Date of inventory check.
- Results of the inventory.
- Corrective action if needed.
- Signature of person performing the supply inventory.

The Emergency Supply Inventory Verification form will be kept in the Director of Food & Nutrition office and available upon request. (*See attachment IV: Inventory Verification form.*)

DECENTRALIZED FOOD PREPARATION:

The Food & Nutrition Service Director or designee in charge may designate some or all of the emergency food preparation to be conducted at a decentralized location or on each nursing unit or at a remote locations from the facility. The *Meals for All* are packaged to be easily transportable in the event of an evacuation and can be set up in any decentralized location.

MEAL SERVING HOURS:

The meal serving hours for the *Meals for All* will be modified or staggered depending on the emergent situation and will be determined by the Incident Commander, Food & Nutrition Service Director, or designee. The necessary amount of batch cooking to prepare in order to serve in large quantities to the patients and staff members will be taken into consideration. The meals may be served tableside to facilitate having a limited staff to efficiently prepare and serve during an emergency situation. If emergency circumstances warrant, the meals may be served directly from the cooking container directly to the patient / staff.

USE OF EMERGENCY MENUS:

Depending on the time of day and expected duration of the emergency, the Food & Nutrition Service Director or designee may implement the *Meals for All* emergency menus and may be used for a single meal or for several days. (*See attachment III - 4 Day Emergency Menu.)*

MENUS AND THERAPEUTIC DIETS:

The *Meals for All* menus have been planned to provide basic nutrients and meet the needs of most therapeutic healthcare diets. The *Meals for All* menu and products have been specially prepared to allow their use for most healthcare therapeutic diets. The therapeutic menu is appropriate for *Regular, Mechanical Soft, Cardiac, Sodium Restricted, Diabetic and Renal diets.* Specific Therapeutic Diet modifications are as follows:

- Consistent Carbohydrate, Diabetic Gestational Diabetes and Low/No concentrated Sweets Diets may be served all menu items except the pudding. Offer sugar substitute and diet jelly, if available.
- Low Cholesterol/ Low Fat Diets may be served on all menu items.
- No Added Salt/Low Salt Diets may be served on all menu items, but the salt packets are omitted.
- 2 Gram Sodium Diets may be served on all menu items, but the salt packets are omitted.
- Calorie Controlled diets, 1500 Calorie or less, and Consistent Carbohydrate or Diabetic Diets may be served on all menu items except portions of milk, cracker-biscuits and snacks are reduced and the puddings are omitted. Offer sugar substitute and diet jelly if available.
- Renal and Hepatic Diets may be served on all menu items except the milk, pudding and salt packets are omitted. Limit beverages if fluid restriction is prescribed.
- Resident's allergies will be accommodated by knowledgeable staff by offering suitable foods from the *Meals for All* Emergency menu. Diets may be deficient in one or more nutrients.
- Powdered milk is included in the *Meals for All* to meet nutritional needs.

Clear Liquid Diets shall receive broth, gelatin, and clear soda stocked on the nursing units. Nutritional supplements may be ordered to increase calories and nutrient values.

BEVERAGES / CONDIMENTS:

Beverages will be provided as requested or available during an emergency situation. Patients needing thickened liquids will be served beverages thickened to the appropriate level. Substitute dehydrated milk mixed with water for fluid milk if needed. Condiments such as salt, pepper and sugar are made available when possible and not contraindicated by the prescribed diet order. Consistent Carbohydrate or Diabetics shall receive sugar substitute. Sodium-Restricted, Hepatic and Renal diets will not receive salt packets.

WATER STORAGE GUIDELINES:

The facility will maintain designated emergency water in SVMC's secured, temperature controlled warehouse. The water will be stored in a cool, dry area, away from heat sources, and staff will be instructed not to utilize it for any other purpose except an emergency situation. One gallon of water per person per day for proper hydration will be stored. This allows two quarts for drinking water and two quarts for food preparation. However, *Meals for All* dehydrated emergency foods require approximately one quart of water per person per day for reconstitution. *Refer to Water Requirements Appendix in 4-*

Day Meal Plan Guide for water requirements table for exact amounts of water per can. Storing one gallon of water per person per day is adequate to meet emergency water needs.

Although the bottled water packaging may indicate an expiration date, the United States Food and Drug Administration (FDA), which regulates bottled water as a packaged food, has determined that there is no limit to the shelf life of bottled water.

MEAL / WATER ALLOCATION

DAY 1		DAY 2		DAY 3		DAY 4	
Patients	165	Patients	165	Patients	165	Patients	165
Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400
EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85
Water (gallons)	650	Water gallons)	650	Water gallons)	650	Water (gallons)	650

A MINIMUM OF 1 GALLON PER PERSON PER DAY ON SITE.

A MINIMUM OF 2600 GALLONS STORED ON SITE.

Meals for All

Day 1	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 2	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 3	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 4	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)

Emergency Tool Box

Disposables / Dry Supplies

ATTACHMENTS:

- *Attachment I: Quick Guide to Emergency Feeding*
- *Attachment II: Meal Preparation*
- *Attachment III: Four Day Emergency Meal Menu*
- *Attachment IV: Inventory Verification Form*

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission. (2022). Accreditation Participation Requirements (APR) Manual.
- Nutricopia, *Meals for All* Emergency Solutions (2022). Retrieved from https://www.nutricopiaonline.com.
- International Bottled Water Association (2021). Retrieved from https://www.bottledwater.org/education/bottled-water-storage.

ATTACHMENT I

QUICK GUIDE TO EMERGENCY FEEDING

1. Notify Food & Nutrition Service Director or Clinical Nutritional Manager using the emergency call back list or appoint an alternate to be in charge.

2. Determine nature of emergency or interruption:

   - ELECTRICITY - Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NATURAL GAS - Use alternate heating source if safe. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - WATER SUPPLY - Affects ware washing and cooking, so conserve water and liquids. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NO POWER OR WATER - Use alternate heating source if safe. Affects ware washing and cooking, so conserve water and liquids. Substitute *Meals for All* as needed.

3. SELECT MENU PLAN TO FOLLOW:

   - Usual menu with needed adaptations (uses perishable supplies first)
   - Meals for All emergency solution.

4. DIET MODIFICATIONS: Refer to usual menu, if using.

   - Follow "Emergency Menu Serving Instructions" when using *Meals for All.*
   - Be aware of those with food allergies.
   - Modify texture for chewing/swallow needs (e.g. mince or mash foods, serve thickened liquids.)

5. LOCATE NEEDED ITEMS:

   - Emergency procedures and menus are posted in Nutrition/Food/Dietary Department, Emergency food storage area, and House Supervisor's office.
   - Emergency food supplies are located at the SVMC warehouse.
   - Emergency disposable supplies are located at the SVMC warehouse.
   - Preparation supplies are located in emergency toolbox at the SVMC warehouse.
   - Water supply is located at the SVMC warehouse.

ATTACHMENT II

MEAL PREPARATION

Refer to the label on each product for specific instructions.

General Instructions for Hot Foods:

1. Open can and discard oxygen absorber* packet.
2. Boil water amount as directed, OR mix with room temperature water if there is no heating source.
3. Stir dry contents of can or cans into boiling water.
4. Cover and remove from heat.
5. Allow to stand for 15 minutes for boiling water, 1 hour if room temperature water utilized.
6. Stir and serve 1 1/3 cup (2 x No. 6 Scoop) or as directed

Instructions for Ready to Eat Items (Fruit, Vegetables, Crackers):

1. Remove oxygen absorber* packet.
2. Ready to eat from packaging.
3. If desired, rehydrate as above using cold water for fruit.

Instructions for Pudding Preparation:

1. Open can and discard oxygen absorber* packet.
2. Stir dry contents of one can into cold water, amount as directed.
3. Whisk thoroughly to mix. Allow to stand for 15 minutes.
4. Stir and serve #8 scoop for ½ cup or as directed.

Non-Fat Milk, to prepare:

1. Add water as directed on label, allow to stand 15 minutes, stir and serve 8 ounces or as directed.

Notes:

- Food Safety Note: Food should be consumed within 2 hours of preparation unless maintained at 135° or higher or below 41° for cold foods.
- No heating methods: Allow 1 hour to rehydrate when using cold or room temperature water.
- Product shelf life is ten years when properly stored in a cool, dry environment.

*Contains a non-toxic oxygen

ATTACHMENT III

MEALS FOR ALL EMERGENCY MENU FOUR DAY				
DAY ONE	**DAY TWO**	**DAY THREE**	**DAY FOUR**	**VEGETARIAN**
BREAKFAST				
Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
MID-MEAL				
Beef & Mushrooms with Noodles	Turkey & Potatoes with Cranberry	Southwestern Chicken & Rice	Chicken Curry with Rice	Spaghetti with Mushrooms
Green Peas	Corn Niblets	Green Beans	Garden Mixed Vegetables	Green Peas
Apples Diced	Peaches Diced	Applesauce	Peaches Diced	Applesauce
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
DINNER				
Chicken Curry with Rice	Spaghetti with Mushrooms	Beef Stew with Potatoes	Macaroni & Cheese	Macaroni & Cheese
Carrots	Garden Mixed Vegetables	Broccoli	Green Peas	Green Beans
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Chocolate Pudding	Banana Pudding	Vanilla Pudding	Banana Pudding	Vanilla Pudding
Beverage	Beverage	Beverage	Beverage	Beverage
SNACK				
Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers

ATTACHMENT IV

25 Person Serving Unit

Inventory List (Four Day Emergency Menu)

Case Number	Day	Meal	4-Day Emergency Menu items	Servings Per Can	Number of Cases in Inventory
1-A	1	Breakfast	Apple Cereal, Fortified	25	
	1	Breakfast	Cracker-Biscuits	25	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Green Peas	25	
	1	Mid-meal	Apples, Diced	25	26
1-B	1	Mid-meal	Cracker-Biscuits	25	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Carrots	25	
	1	Evening	Cracker-Biscuits	25	
	1	Evening	Chocolate Pudding	25	26
2-A	2	Breakfast	Apple Cereal, Fortified	25	
	2	Breakfast	Cracker-Biscuits	25	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Corn	25	26

	2	Mid-meal	Peaches, Diced	25	
2-B	2	Mid-meal	Cracker-Biscuits	25	26
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Garden Mixed Vegetables	25	
	2	Evening	Cracker-Biscuits	25	
	2	Evening	Banana Pudding	25	
3-A	3	Breakfast	Apple Cereal, Fortified	25	26
	3	Breakfast	Cracker-Biscuits	25	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Green Beans	25	
	3	Mid-meal	Applesauce	25	
3-B	3	Mid-meal	Cracker-Biscuits	25	26
	3	Evening	Beef Stew	12.5	
	3	Evening	Beef Stew	12.5	
	3	Evening	Broccoli	25	
	3	Evening	Cracker-Biscuits	25	
	3	Evening	Vanilla Pudding	25	
4-A	4	Breakfast	Apple Cereal, Fortified	25	26
	4	Breakfast	Cracker-Biscuits	25	
	4	Mid-meal	Curry Chicken and Rice	12.5	

	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Garden Mixed Vegetables	25	
	4	Mid-meal	Peaches, Diced	25	
4-B	4	Mid-meal	Cracker-Biscuits	25	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Green Peas	25	
	4	Evening	Cracker-Biscuits	25	
	4	Evening	Banana Pudding	25	26
Milk	1	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 1A/1B
	2	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 2A/2B
	3	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 3A/3B
	4	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 4A/4B
Snack	1	Snack	Peanut Butter	25	
	1	Snack	Cracker-Biscuits	25	incl 1A/1B
	2	Snack	Peanut Butter	25	
	2	Snack	Cracker-Biscuits	25	incl 2A/2B
	3	Snack	Peanut Butter	25	
	3	Snack	Cracker-Biscuits	25	incl 3A/3B
Snack	4	Snack	Peanut Butter	25	
	4	Snack	Cracker-Biscuits	25	incl 4A/4B
				EXPIRATION DATE:	2024

SUBJECT: **FOOD SUPPLIES AND STORAGE**	SECTION:

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

PURPOSE:

Food and supplies will be stored within regulatory guidelines to maintain optimal nutritional composition and prevent all sources of contamination.

POLICY:

The Food and Nutrition Service (FNS) Department shall ensure that all foods, non-foods and supplies shall be stored in a manner to prevent physical, chemical and bacterial contamination. All food shall be of good quality and procured from sources approved or considered satisfactory by federal, state, and local regulatory agencies.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. At least one week's supply of staple foods and at least two (2) days' supply of perishable foods shall be maintained on the premises.

2. Emergency food for 96 hours shall be stored separate *(Please refer to FOOD SERVICE EMERGENCY PLAN Link).*

3. The storage areas are well ventilated and clean.

4. Food storage refrigerators, walk-ins, and freezers are provided with reliable thermometers. Temperatures are inspected/recorded daily to ensure proper temperature control. Temperature records are retained for reference for one (1) year.

5. Perishables are stored at 41°F or below after delivery.

6. Frozen foods are stored at 0°F or below after delivery.

7. Dry or staple items are stored a minimum of 12 inches above the floor and 18 inches from the ceiling.

8. Food overages held in storage areas are clearly identified, dated, and appropriately covered. Food items will be labeled with the expiration date and will not be re-used more than once.

9. Chemical materials used for cleaning purposes and pesticides are clearly labeled and stored separately, away from food and supplies.

10. All cans that are dented, bulging or leaking shall be considered a possible health risk and should be placed in a designated area for return or discarded.

11. The store room stock is rotated using the FIFO (first in first out) method.

12. Milk is served in individual containers. All liquid beverages are served capped.

13. Foods refrigerated or in other storage areas shall be stored appropriately, clearly labeled if not easily identifiable, and dated.

14. Hermetically sealed foods or beverages shall have been processed in compliance with applicable federal, state and local codes. No home canned foods will be used.

15. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. It is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodents and insects. The storeroom is maintained at a comfortable temperature.

16. Only Food & Nutrition Service (FNS) employees are authorized to enter the storeroom. Any person(s) needing to access or survey the storeroom will be escorted by an authorized hospital employee.

17. The storeroom shelves are cleaned and checked weekly. The floor is swept and mopped daily.

18. The outside storage area is organized and cleaned monthly. All paper products used for eating purposes shall be well-wrapped and stored in boxes. Any uncovered containers shall be discarded to avoid possible contamination.

19. All refrigerators in the FNS department are constructed to maintain a temperature at or below 41°F. Freezers will be at 0°F or colder. The temperatures are recorded for all freezers and refrigerators daily.

20. Each refrigeration unit will house an internal thermometer. The inside thermometer is the primary method of recording temperatures and will be used when documenting temperatures. The outside temperature gauges are not utilized to verify temperatures.

21. Shelving will be constructed to allow for adequate air circulation.

22. All refrigerators and freezers are cleaned weekly.

23. All raw food is stored below cooked foods.

24. All foods in process will be covered, labeled when not clearly identifiable, and dated with expiration date.

25. All foods are dated when received to ensure proper rotation.

26. All frozen foods removed from original packaging will be clearly identified with date received. *Example: An eighty (80) pound case of ground beef may contain eight (8) 10 pound tubes. If six (6) tubes were pulled for production, the remaining two (2) may be removed from the original*

box and placed on the freezer shelf if they are each labeled (ground beef) and with the date received.

27. All meat and egg products are thawed in the refrigerator. In an emergency, frozen meat may be thawed under continuous running potable water.

28. Open cans are not stored in the refrigerator.

29. Items that have been thawed are not refrozen.

30. Foods predated with an expiration date such as milk, sour cream, etc. will be dated the day the container was opened. The pre-dated product will be disposed on the manufacturer expiration date on the container.

31. Prepared items such as mayonnaise, pickles, dressings, etc. will be dated with a 30 day expiration date.

32. Canned or perishable items such as peaches, olives, luncheon meat, etc. will be dated with a three (3) day expiration date after opened.

33. Food will be discarded when it exceeds the established standards based on the date listed on the label, or as stated on the preprinted expiration date on the food item.

Non-definitive Food Dating Labels such as "Best By" and "Enjoy by":

Food labels other than "Use by" may be used on food products received, printed by the manufacturer.

- Per FDA, "Consumers should examine foods for signs of spoilage that are past their "Best if used by" date. If the products have changed noticeably in color, consistency or texture, consumers may want to avoid eating them."- https://www.fda.gov/media/101389/download
- Per USDA, "A "Best if Used By/Before" date indicates when a product will be of best flavor or quality. It is not a purchase or safety date."-: https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

At SVMC, freshness labels will be treated as an expiration date for dry stock items. However for perishable items, such as produce, foods may be used past the "best by" date, if they are inspected for freshness and no signs of spoilage are present, per USDA and FDA guidelines.
No items may be used past an expiration, or "use by" date.

FOOD STORAGE

FROZEN FOOD

Meats

Uncooked beef, lamb, veal, chicken..... 6 - 12 months
Ground meats, sausage, turkey, pork..... 1 – 3 months
Cooked ..... 1 month
Meat casserole ..... 2 – 6 months

Baked goods
Baked..... 3 – 6 months
Unbaked rolls ..... 2 months
Unbaked cookies ..... 6 months

Ice Cream Products ..... 6 months

Vegetables ..... 8 – 12 months
Potatoes ..... 2 – 6 months

Fruit juices ..... 8 months

REFRIGERATOR FOODS

Eggs
Whole raw in shell..... 30 days
Cooked whole..... expiration date

Milk ..... not after date on carton

Cheese..... 45 – 60 days
Hard..... not after date on carton
Cottage ..... not after date on carton

Juice (thawed) ..... 2 weeks

Canned fruits..... 3 days

Margarine and butter..... 30 days

Desserts
Gelatin (Jell-O)..... 3 days
Pudding and custards..... 3 days

Produce ..... 1 – 2 weeks

REFERENCES:

- California Department of Public Health (2021). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2021). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- FDA, Food Facts - How to Cut Food Waste and Maintain Food Safety, Retrieved on 01.24.2022 https://www.fda.gov/media/101389/download
- USDA, Food Product Dating, , Retrieved on 01.24.2022 https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

CROSS REFERENCES:

- FOOD SERVICE EMERGENCY PLAN Link

SUBJECT: **GARNISHMENTS**	SECTION:
	Page 1 of 3

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

PURPOSE:

To provide guidelines for the processing of payroll garnishments, support orders and tax levies in a manner that is consistent with relevant state and federal statutes including those related to the rights of the employee.

POLICY:

It is the policy of the District to comply fully with Title III of the Consumer Credit Protection Act as well as with any other state and federal laws related to the attachment of wages for the purpose of debt repayment.

Definitions

Garnishment: Any legal procedure through which the earnings of an individual is required to be withheld for the payment of a debt.

Support Order: A legal notification from a federal or state agency, normally a Child Support Enforcement Agency (CSE), directing an employer to withhold a portion of an employee's wages for the payment of alimony or for the financial support of a dependent child. A support order is generally ongoing until stopped through proper legal process.

Tax Levy: A legal notification from a federal, state or local tax collection entity, (e.g. IRS), directing an employer to withhold a portion of an employee's wages for the payment of a tax liability. A tax levy is generally ongoing until stopped through proper legal process.

Earnings: Legally defined as "wages, salaries, commissions, bonuses, periodic payments made pursuant to a pension or retirement plan, tips that pass through an employer, sick pay, and value of meals and lodging furnished by the employer".

Disposable Earnings: The net amount of employee wages remaining after legally required deductions have been withheld.

- Amounts required by state or federal law that must be deducted before determining an employee's disposable earnings include: Federal income tax; State or city income tax; Social Security and Medicare taxes; Unemployment taxes; and Court costs and attorney's fees for garnishment proceedings when the employee is liable for such costs under state law.

- Deductions that are "not legally required" include: Deductions for insurance benefits that are not pre tax reductions in a qualified Section 125 Plan, and voluntary contributions to a retirement saving plan; Deductions pursuant to the

voluntary assignment of earnings; and deductions to repay loans or payroll advances made by the District/employer.

Single Indebtedness: A single debt, regardless of the number of proceedings brought to collect it: or the "joint amount" (total) when several creditors combine their debts in a single garnishment action; or a second indebtedness, when considerable time (such as a year) has elapsed between garnishments, will be considered a "single" indebtedness.

Multiple Garnishments: To be considered a "multiple garnishment", two or more separate garnishment actions must be processed on the same individual within a reasonably brief time interval and without violation of legal restrictions. A garnishment order that violates California and Federal restrictions cannot be processed and will not be counted as a garnishment action.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

1. EMPLOYEE NOTIFICATION

Upon receipt of a garnishment order, support order or tax levy, the payroll department will immediately notify the affected employee to verify that the employee has also received notice and that the amount in question is accurate. If there appears to be a problem, the employee will be advised to return to the creditor or agency involved and try to resolve the problem. By law, however, the District must honor the court order, support order or tax levy, including time frames, unless such order is voided through proper legal process.

2. FEDERAL AND STATE GARNISHMENT EXEMPTIONS (LIMITS)

Restrictions or limitations on the amount of an employee's wages that may be subjected to garnishment are mandated by federal law and by the State law in which the garnishment was issued.

3. GARNISHMENTS ISSUED OUTSIDE OF CALIFORNIA

Garnishments that are issued outside of the State of California may be subject to different garnishment restrictions than those imposed locally. The rules for each issuing state should be reviewed prior to determining garnishment amounts.

4. CHILD SUPPORT AND ALIMONY SUPPORT ORDERS

As a general rule, the law requires support orders to be processed ahead of general garnishments. General garnishments are prioritized by date of issuance.

5. PAYCHECK DEDUCTIONS

Garnishments will be taken out of each paycheck of the identified employee and will continue until the District and employee are notified otherwise in writing.

REFERENCES:

- United States Department of Labor, Wage and Hour Division. 1977, The Federal Wage Garnishment Law, Title IIIof the Consumer Credit Protection Act. Retrieved January 30, 2018, from https://www.dol.gov/whd/garnishment/, The Law (PDF) - 15 U.S.C. 1671, *et seq.*

SUBJECT: **OTHER PREPAID EXPENSES**	SECTION:

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

PURPOSE:

The Hospital occasionally incurs costs that benefit future periods. In order to match these costs, through amortization, against revenues generated, the following policy is established. This policy does not apply to deferred costs.

POLICY:

Prepayments may be recorded for such items as insurance, maintenance agreements, rents and membership dues. The payment must be made in advance of the receipt of a service or expiration of the time period covered by the expenditure.

The only items that should be considered as a prepaid expense are those items that have a substantive benefit to future periods. For example, items which are properly included as inventory should not be considered as prepaid.

To qualify as a prepaid expense, the expenditure must be in excess of $20,000. All items under this amount should be expensed. The prepaid account should only include the unexpired period to which the item relates.

AFFECTED PERSONNEL/AREAS:

GENERAL ACCOUNTING – ACCOUNTANTS, ACCOUNTS PAYABLE STAFF

PROCEDURE:

Frequency: Monthly

Responsibility: Accountant, Accounts Payable Staff

1. Accountant will prepare summary schedules of the various prepaid balances on a monthly basis. Schedules will be updated for any additions and the monthly amortization of these expenses will be recorded by a monthly general ledger journal entry.

SUBJECT:	SECTION:
SAFETY MANAGEMENT PLAN	***Safety Management***

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

I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Management Plan for Environmental Safety and associated polices extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. The identification of specific risks faced by patients, employees, and others is essential for designing safe work areas and work practices.

B. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.

C. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

III. OBJECTIVES

A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.

B. Perform additional risk assessments when changes involving these issues occur.

C. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.

D. Make changes in the procedures and controls to address identified root causes of incidents.

E. Conduct environmental rounds in all areas of the hospital and affiliated medical practices. Staff making rounds will evaluate the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.

F. Present quarterly reports of EC management activities to the Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.

G. Assure that all departments have current organization wide and department specific procedures and controls designed to manage identified risks.

H. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.

I. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.

J. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.

K. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer, Administrative Director of Quality and Care, and Manager of Infection Control work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk-related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Performance Improvement/Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.

B. The Environmental Safety Leadership Team coordinates the development of reports to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.

C. The Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Safety Committee are appointed by the Committee Chair. The Safety Committee meets a minimum of four (4) times per year. During each meeting, one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes, and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

The Committee assigns individual's or group's responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.

Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality and Patient Safety, Human Resources, Senior Administration, Education, Medical Staff, Physician representation, Infection Control, and others as deemed appropriate.

D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the environmental safety program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the environmental safety program.

E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Environmental Safety Program. The Chief Executive Officer collaborates with the ESLT and other appropriate staff to address environmental safety

issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Environment of Care Safety Program.

F. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.

G. The Human Resources Department, with the assistance from the Education Department and other leadership staff, are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.

H. Department Directors are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work-related activities in a manner consistent with their training. Department Directors also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.

I. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM

EC.01.01.01 EP1 – Appointment of Environmental Safety Leadership

The Chief Executive Officer appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The Environmental Safety Leadership Team (ESLT) includes the Safety Officer, Administrative Director of Quality and Care and the Manager of Infection Control.

The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with patient safety, infection control, risk management, and other programs as appropriate.

The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, and assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

EC.01.01.01 EP4 – Environmental Safety Management Plan

The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of Sierra View Medical Center.

EC.02.01.01 EP1 – The hospital identifies safety risks associated with the environment of care

The ESLT of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts and FDA product recall notices.

The ESLT coordinates the risk assessment process with the Facilities Manager and Department Directors and others as appropriate.

EC.02.01.01 EP3 – The hospital takes action to minimize or eliminate identified safety risks in the physical environment

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of

equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.

EC.02.01.01 EP14 & EP16 – The hospital manages safety risks in the MRI environment

The Radiation Safety Officer (RSO) follows the MRI Safety Policy to ensure the safety of all patients, visitors, and staff who enter the MRI Suite. Staff is trained to eliminate or reduce identified risks. MRI staff are familiar with proper screening procedures for all patients and staff (*i.e. ferrous objects, metallic implants and devices)* and trained to recognize when patients display signs of claustrophobia, anxiety, or emotional distress.

LD.04.01.07 EP1 – Development and Management of Policies and Procedures

The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job-specific environmental safety procedures and controls.

The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job-related procedures and controls. Department Directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.

The Safety Officer coordinates the reviews of policies and procedures with department heads and other appropriate staff.

EC.02.01.01 EP5 – The hospital maintains all grounds and equipment

The Facilities Manager is responsible for managing the appearance and safety of the hospital grounds. In addition, the Facilities Manager is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.

The grounds include but are not limited to lawns, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes but is not limited to mobile docking facilities, the oxygen storage facility, electrical service entrances and transformers,