A. An intern pharmacist, pharmacist or a pharmacy technician will obtain/verify the home medication list and reconcile, as necessary, for this high risk group prior to their discharge from the hospital.

3. When obtaining the medication list, there are a variety of appropriate sources that may be used. . sources of information may include, but are not exclusive to:

A. Patient (via interview)
B. External Medication History available within the EMR
C. Patient-owned medication lists
D. Family members and other caregivers
E. Pill bottles
F. Pharmacy(ies) where patient fills prescriptions
G. Medication lists and/or notes from outpatient providers and Skilled Nursing Facilities.
H. Transfer orders from other facilities

4. Medication lists in the electronic medical record from previous visits must be reviewed and confirmed with each patient visit to ensure the list is kept accurate.

Physician Orders for Admission

1. The provider will also conduct a medication review as part of the medication reconciliation process to ensure the list is accurate prior to ordering medications. Before any medication is prescribed and/or administered or if treatment is affected by any medications that the patient is currently taking, the provider shall review the medication list to identify any potential adverse drug reactions.

2. Once the patient's current medications are listed, the physician indicates which medications to continue or discontinue during admission.

Medication Reconciliation for Patients in the Outpatient Setting

1. Licensed personnel will obtain a list of current medication to include, at minimum, dose, route and frequency for all patients entering an outpatient service for treatment/procedure when there is a potential a patient may receive medication.

2. The patient's current medication list will be available to the ordering physician for review.

3. The medication reconciliation process will be considered complete as long as the ordering physician has been notified of the patient's current medication list. However, if licensed personnel have any concerns, the issues will be discussed with the physician.

Medication Reconciliation at Discharge:

Outpatient Settings

1. When discharged from an outpatient setting, and the only additional medications prescribed are for a short duration, the medication information provided to the patient may include only those short term medications.

2. Where medication is administered and there is no change to the patient's continuing medication regimen and no new medications were prescribed and the patient has a current list of their medications, no list needs to be provided.

3. If the patient does not have a current list of their medication, then they will be provided a copy of the updated list upon discharge.

Inpatient Setting

1. Upon discharge from the inpatient setting, the patient will be provided with a current/updated list of medications from their nurse.

2. Patients are informed to provide this list to their primary care physician and to read and follow the instructions on their medication bottles.

REFERENCES:

- Agency for Healthcare Research and Quality (AHRQ) 2014, Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS) Toolkit, innovations.ahrq.gov
- California Senate Bill No.1254, Stone. Hospital Pharmacies: Medication profiles or lists for high-risk patients. Business and Profession Code 4118.5, Chapter 697. (2018)
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **MEDICATIONS RESTRICTED TO AREAS OR PERSONNEL**	SECTION: ***Pharmaceutical Services*** **Page 1 of 6**

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

PURPOSE:

To provide guidelines for the safe administration of specific medications restricted to approved nursing units and patient care areas.

DEFINITIONS:

1. Approved areas: Areas as indicated in policy where medications may be administered.

2. Non-approved areas: Any unit where identified medications are not approved for administration.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that identified medications by nature of their pharmacology and indications require specific monitoring.

AFFECTED PERSONNEL/AREAS: *ALL NURSING AREAS AND PHARMACY*

PROCEDURE:

A. Administration of medications in approved nursing units

1. Restricted medications will be administered only in the approved units and with the requirements indicated in Addendum A of this policy and more specifically described in medication-specific policies, which may be referenced.

B. Administration of medications in non-approved nursing units

2. If the physician orders a medication listed in Addendum A for a patient located in an non-approved unit, and/or the requirements listed in Addendum A or medication specific policy, as referenced, cannot be met, the physician will:

a) Consider an alternative therapy.

b) Order the patient transferred to an appropriate unit.

c) Order the medication to be given using the criteria listed below:

i. The patient must have bedside monitoring to include continuous cardiac monitoring, pulse oximetry, and monitoring at least every 15 minutes or more frequently as indicated in Addendum A or in referenced medication specific policies. These vital signs will be documented as obtained.

ii. The medication must be administered under the direct supervision of the ordering physician.

iii. The ordering physician, nurse, or allied health professional administering the medication must have the appropriate credentials and meet the requirements listed in Addendum A or in medication-specific referenced policies.

iv. Pharmacy must be notified by telephone that the criteria listed above have been met before they will send the needed medication(s).

v. Staff involved in the care of the patient must complete appropriate competencies to manage the patient's care. It will be the responsibility of the unit manager to ensure their staff have the appropriate competencies and training before assigning them to a unit/or patient that requires use of these orders.

RASS Goal drips: Must complete Rass competencies

TOF Goal drips: Must have completed TOF competencies

Addendum A

Generic Name	Trade Name	Approved Unit	Additional Requirements
Adenosine	Adenocard®	OR, L&D-OR, ED, PACU, ICU	Every 5 min vitals and transfer to Critical Care
		ICU & Cath Lab Imaging (Stress tests) NICU	Physician administered only and patients must be on a cardiac monitor For NICU, RN can administer but Physician must be at bedside
Alteplase	Activase®	ICU, ED, Cath.Lab	For stroke, MI patients only
Amiodarone IV	Cordarone®	ICU, OR, ED, PACU, Cath.Lab, Tele	
Cisatracurium	Nimbex®	ICU, ED, OR, PACU L&D- OR, Cath Lab	.
Desflurane	Suprane®	L&D-OR, OR only	Anesthesia staff only
Diltiazem IV	Cardizem®	ICU, OR, ED, PACU, Cath.Lab, Tele	
Dobutamine	Dobutrex®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab,	Vital signs every 15 min while on drip
Dopamine	Intropin®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, TELE	Vital signs every 15 min while on drip, TELE ok for non-titratable low dose renal perfusion.
Epinephrine Drip		ICU, ED, Cath Lab, OR, PACU, NICU	
Eptifibatide	Integrelin®	ICU, Tele, ED, Cath Lab	

Generic Name	Trade Name	Approved Unit	Additional Requirements
Esmolol	Brevibloc®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab	
Etomidate	Amidate®	All units see additional requirements	Anesthesia staff, physicians credentialed in Rapid Sequence Intubation, or RNs who have completed the RSI Learning Module, Vital signs every 5 min.
Fentanyl IV Push Fentanyl IV Drip		All Inpatient Units ED/ICU/Cath Lab *Tele/3rd floor	Pain or sedation for a procedure *must be a fixed dose and comfort care
Factor VII	NovoSeven®	ICU,ED, OR	.
Glycopyrrolate	Robinul®	L&D-OR, OR only	Anesthesia staff only
Haloperidol IV	Haldol®	All units	All IV administration at any dose amount must have cardiac monitoring.
Heparin IV		All Inpatient Units Clinics	
Hydralazine IV	Apresoline®	ICU, DOU, ED, OR, L&D-OR, L&D,NICU, MS, TELE, CDU, Cath Lab	
Insulin IV Drip (Regular Insulin only)		ICU, ED, Cath Lab	
Isofluorane	Forane®	L&D, OR only	Anesthesia staff only
Ketamine	Ketalar®	Bolus	Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation, and RNs who have completed RSI and Procedural Sedation Learning Modules, vital signs every 5 min during Deep Sedation
		Infusion: ICU/ED/Cath Lab	
Labetalol IV	Normodyne®, Trandate®	ICU, OR, L&D, ED, PACU, Cath.Lab,TELE, CDU	*Cardiac Monitoring

Generic Name	Trade Name	Approved Unit	Additional Requirements
Lidocaine IV	Xylocaine®	ICU, OR, L&D, OR, ED, PACU, Cath Lab	Required vital signs every 15min.
Lorazepam IV Drip	Ativan®	ICU, ED, PACU	
Magnesium-Sulfate IV Drip (40 gram)		L&D, ICU, PACU	PACU or OB patients only.
Metoprolol IV	Lopressor®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, TELE	*Cardiac Monitoring: ECG, HR, BP
Midazolam IV Drip	Versed®	ICU, ED, PACU, Cath Lab	
Midazolam	Versed®	All Inpatient Units	
Nitroglycerin IV		ICU, OR, ED, PACU, Cath Lab	Vital signs every 15 min while on drip.
Nitroprusside	Nipride®	ICU, OR, ED, PACU, Cath.Lab	
Norepinephrine	Levophed®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab	
Octreotide	Sandostatin®	ED, ICU, OR, PACU, MS, TELE, Cath Lab	
Phenylephrine	Neosynephrine ®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab	
Physostigmine	Antilirium®	OR, L&D-OR, PACU	
Propofol	Diprivan®	ICU, ED, OR, L&D-OR, PACU, Cath Lab	If intended for Deep Procedural Sedation, vital signs every 5 min.
Propranolol IV	Inderal®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab,	
Rocuronium	Zemuron	L&D-OR, OR Only, ED, ICU, Cath Lab	

Sevoflurane	Ultane	L and D OR, OR only	Anesthesia only.
Succinylcholine	Anectine®		Anesthesia staff, physicians credentialed in Rapid Sequence Intubation, or RNs who have completed the RSI Learning Module.
Tenecteplase	TNKase	ICU, ED, Cath lab	
Vasopressin	Pitressin®	ICU, OR, ED, PACU, Cath.Lab	
Vecuronium	Norcuron®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, NICU	Drips only for ICU & recommend preparation by pharmacy for NMBA drip.
Verapamil IV	Calan®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, TELE	*Cardiac Monitoring: BP, HR, ECG

SUBJECT: **MENU PLANNING**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide nutritionally-balanced meals for patients/residents, hospital staff, and visitors.

POLICY:

1. The Food and Nutrition Service (FNS) Director will plan all menus for patient/resident food service, cafe, and special food service functions with assistance from the dietitian. CBORD software is used as a guide for menu planning, recipe modification, nutrition analysis, and food ordering. Principles of good menu planning are considered to include taste, texture, color, flavor, seasonal variations, and cultural, religious, and regional preferences. The Clinical Nutrition Manager (CNM) will approve all patient/resident menus.

2. Menus written for patient/resident food service, unless prevented by therapeutic modification, shall meet the nutritional standards of the Recommended Dietary Allowances as set by the Food and Nutritional Board of the National Research Council and National Academy of Sciences. Those that do not will be noted in the Diet Manual. Determination of nutritional adequacy is based on a weekly average of each nutrient.

AFFECTED PERSONNEL/AREAS:

FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS, HOSPITAL STAFF, VISITORS

PROCEDURE:

1. Menus for both the regular and therapeutic diets shall be planned to comply with the Diet Manual, which has been approved by the Medical Staff and the CNM.

2. A minimum of a three-week cycle menu shall be for Distinct Part Skilled Nursing Facility (DP/SNF). A minimum of a seven-day cycle menu shall be for the acute care facility. Patient/resident food preferences shall be respected as much as possible and substitutes shall be offered through use of a selective menu or substitutes from appropriate food groups.

3. The cycle menu is available in an electronic version. A copy of the three-week cycle is posted on the DP/SNF unit and is available upon request. If any meal served varies from the planned menu, the change shall be noted in writing on the posted menu in the kitchen.

4. Diets shall be in accordance with the approved diet manual.

5. The regular diet house menu is written with the goal of at least 1800 calories per day. The following menu pattern is used as a guide for menu development.

    - Bread group: 6 oz- equivalents per day, ½ being whole grain

- Vegetable group: 2 ½ cup equivalents (raw) per day. (1 cup raw = ½ cup cooked)
- Fruit group: 1 ½ cup equivalents per day
- Dairy group: 3 cup equivalents per day
- Protein group: 5 ounce equivalents per day

Servings are defined as:

a. Breads:

- 1 oz slice bread
- ½ cup cooked rice or pasta
- ½ cup cooked cereal
- 1 ounce of ready cooked cereal
- 2 x 2 inch piece of cake or ¾ to 1 ounce of cookie

b. Vegetables:

- ½ cup chopped raw or cooked
- 1 cup leafy raw vegetables

c. Fruit:

- 1 piece of fruit or ½ cup canned; usually juice packed
- 1 cup 100% fruit juice
- ½ cup dried fruits

d. Milk:

- 8 ounces of milk, fortified soy milk
- 8 ounces of yogurt
- 1 ½ ounces of natural cheese

- 2 ounces of processed cheese

e. Protein:

- 1 oz cooked lean meat, fish, or poultry
- 1 egg
- ¼ cup cooked legumes, 1 tbsp. peanut butter, ½ oz nuts/seeds

6. Nutritional considerations in meal planning:

a. A good source of Vitamin C is included in the daily menu.

b. A good source of Vitamin A is included at least 3 to 4 times during the seven-day cycle to ensure the daily average meets the Recommended Daily Allowance of the vitamin. (5000 IU or 4000 RE).

c. Vitamin D fortified milk or milk substitute is used to ensure Vitamin D adequacy.

d. Enriched breads are routinely included at once or more a day on the modified diet when permitted.

e. Raw fruit or vegetables are routinely included once or more a day and on modified diets when permitted.

Sample Menu pattern:

BREAKFAST
Fruit/juice
Cereal
Egg or substitute as ordered
Breakfast meat as ordered
Toast
Milk
Margarine
Jelly

LUNCH & DINNER
Meat or substitute
Starch or starchy vegetable
Salad
Dessert or fruit
Bread/margarine

Milk

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance
- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Dietary Guidelines for Americans 2020-2025 pg 96.

SUBJECT: **NAMING CONVENTIONS FOR THE MASTER PATIENT INDEX (MPI)**	SECTION:

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

PURPOSE:

To ensure consistency and accuracy of the Master Patient Index (MPI).

POLICY:

All registration locations and processes will utilize the approved naming conventions.

AFFECTED AREAS/PERSONNEL: *ALL REGISTRATION/HIM PERSONNEL*

PROCEDURES:

- Patient names should be entered with surname first, then given name followed by middle name or initial, i.e. JAMISON JOHN JACOB
- We will be maintaining an "alias" file in the new system. Patients having other names that are in the system can be attached to one medical record number without destroying the system, i.e. JAMISON JAKE AND JAMISON JJ can all be traced back to #1 above under the same medical record number so long as birthdates and social security numbers also match.
- If more than one person has the same surname and given name and no middle initial can be obtained, patient will be #1, #2, etc., according to admission date.
- Names with prefixes of D, de, Des, Di, du, La, Mc, Mac, Van, Von, etc., will be entered as DARMAND, VONBUELOW, DELAVEGA, MACBETH, and so on. No apostrophes or separations will be recognized.
- Names beginning with St., as St. John will be entered as STJOHN.
- Compound or hyphenated names are filed as one word; thus Tyler-Evans would be TYLEREVANS, following through letter by letter.
- Names and religious titles, such as Brother Conrad, Mother Teresa, or Sister Mary are entered under the surnames, the titles being disregarded. See #2 above if a cross-reference might be useful. MURPHY TERESA MARIAS OR JACKSON CONRAD.
- Many names have multiple spellings (35 or Baer, 10+ for Burke) so a name search if that is the only identification may have to be done for several spellings. The telephone directory is a good resource if you can't always imagine the ways a name can be spelled. It is also why the new system has deeper searches than just the name, like phonetic listings, DOB, SSA, etc. Check the patient's driver's license, insurance card, or social security card to ensure the correct spelling of patient name.
- Name modifications such as Jr, Sr, III, will be entered in this system.

REFERENCES:

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

SUBJECT: **NEONATAL HYPOGLYCEMIA**	SECTION: **Page 1 of 7**

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

PURPOSE:

To provide standardized procedure and guidelines to assess, screen and manage risk factors and symptoms associated with hypoglycemia in the newborn.

DEFINITIONS: N/A

POLICY:

A.

1. Newborns who are at risk for hypoglycemia, or newborns showing symptoms of hypoglycemia will have Point of Care (POC) bedside Glucose Screening and Neonatal Hypoglycemia Standardized Procedure initiated per physician orders.

2. The following conditions place infants at risk for hypoglycemia:
    - Birth weight < than 2500 grams or >4000 grams.
    - Symptoms suggestive of hypoglycemia: Jitteriness, cyanosis, tachypnea, hypotonia, poor feeding, apnea, weak or high-pitched cry, temperature instability, seizures, lethargy, irritability or pallor.
    - Prolonged/complicated labor and delivery.
    - Meconium stained amniotic fluid associated with fetal distress.
    - Infants of diabetic mother (IDM).
    - Prematurity (< 37 weeks gestation) or post term (>42 weeks).
    - Small for Gestational Age (SGA<10%) or Large for Gestational Age (LGA > 90 %).
    - Discordant twins.
    - Stressed or compromised infants (i.e., 5 minute Apgar score of 6 or less)
    - Unexplained lethargy/flaccidity.
    - Current history of maternal sepsis and premature rupture of membranes (PROM) greater than 18 hours.
    - Signs and symptoms of respiratory distress.
    - Infants whose mother received betamethasone for fetal lung maturity within 7 days of delivery.

SUPERVISION:

- RN will perform under the indirect supervision of a physician.

AFFECTED PERSONNEL/AREAS: *MATERNAL AND CHILD HEALTH SERVICES; REGISTERED NURSES (RN), PHYSICIAN PROVIDERS*

SUPPLIES

- Glucometer machine
- 40% glucose gel pre-filled oral syringe from pharmacy

- Clean gloves

PROCEDURE:

A. Obtain point of care (POC) blood glucose screening in infants who are at risk or who have clinical manifestations of hypoglycemia after 24 hours of birth.

B. Initiate breastfeeding as soon as possible within the first hour of age. (See Breastfeeding Policy)

C. Feed all infants at risk for hypoglycemia, who are symptomatic by 30 minutes of age and recheck after 30 minutes by heel stick after feeding. Feed infants every 2-3 hours and screen before each feeding.

D. Feed babies before or after glucose gel, include breastfeeding, feeding mother's colostrum, donor breastmilk or formula.

E. Feed at risk asymptomatic infants by 1 hour of age then every 2-3 hours and screen before each feeding. Consider alternative supplemental feeding methods in infants who are not sucking well.

F. Glucose screening should continue until:

I. 12 hours of age for infants born to diabetic mothers, infants large for gestational age (LGA) and infants whose mother received betamethasone for fetal lung maturity within 7 days of delivery if POC blood glucose screens remains >45mg/dl.
II. 24 hours of age for late preterm 34-36 6/7 and small for gestational age (SGA) infants.
III. Physician orders to discontinue glucose screening as appropriate.

G. To minimize risk of neuronal injury in asymptomatic infants with persistent hypoglycemia, target plasma glucose concentrations are:

1. >45 mg/dl at less than 24 hours of age
2. >50 mg/dl when greater than 24 hours of age

H. Obtain STAT serum glucose on any infant with a bedside glucose screen of <30 mg/dl and initiate Newborn Hypoglycemia Algorithm.

I. Newborn admission orders will include a PRN order for 40% glucose gel 0.5ml/kg. Round off patient's weight to the nearest kilogram to calculate dose to be given.

1. Obtain supplies
2. Squeeze excess gel out of oral syringe
3. Use gloved finger, to administer 0.5 milliliters (ml) of gel into buccal mucosa at infant's cheek.

4. Repeat administering 0.5 gel in other cheek and continue alternating sites until dose is given,
5. Do not squirt gel straight into the infant's mouth to avoid aspiration of the gel.

J. Hypoglycemic babies who will bottle feed can be offered 5ml/kg of mother's breastmilk, donor breastmilk or formula.

K. Infants at risk for hypoglycemia who are SYMPTOMATIC:

1. With a POC blood glucose screen <30 mg/dl, administer glucose gel 0.5 ml/kg and transfer to Neonatal Intensive Care Unit (NICU).

2. With a POC glucose screen 30-44mg/dl, administer glucose gel 0.5mg/kg and feed; repeat glucose screen 30 minutes after completion of feeding.

    a. If POC blood glucose screen <45mg/dl, administer glucose gel 0.5 ml/kg feed and transfer to NICU.

L. Infants at risk for hypoglycemia who are ASYMPTOMATIC:

1. Birth to 4 hours of age:
    a. POC blood glucose screen < 44mg/dl:
        1. Administer oral glucose gel 0.5 ml/kg and feed. Repeat blood glucose screen after completion of feeding.
            a. If repeat POC screen < 25mg/dl, repeat oral glucose gel 0.5ml/kg and transfer baby to NICU.
            b. If repeat glucose screen is 25-44mg/dl, repeat oral glucose gel 0.5 ml/kg and feed; repeat glucose screen 30 minutes after feeding.
            c. If repeat POC glucose screen is <45mg/dl, transfer baby to the NICU.

2. Infants 4-24 hours of age:
    a. With POC blood glucose screen of <45mg/dl:
        1. Administer oral glucose gel 0.5ml/kg and feed; repeat POC screen 30 minutes after completion of feeding.
            a. With POC blood glucose screen of 35-44mg/dl:
                1. Administer oral glucose 0.5ml/kg and feed; repeat screen 30 minutes after feeding.
                2. If POC screen <45mg/dl, transfer baby to NICU.

3. Infants >24 hours of age:
    a. Blood glucose level of <50mg/dl:
        1. Notify physician

M. The nurse may also perform a bedside glucose screen at any time during length of stay on an infant demonstrating any of the above signs and symptoms.

N. If Labor and Delivery (L&D) RN or Mom & Baby RN feels uncomfortable with baby's glucose level, baby can be brought to the NICU for observation. (Make sure physician is aware).

O. Newborns with intravenous (IV) infusion will have a bedside glucose screen performed:
1. One hour following initiation of dextrose, and increasing or decreasing dextrose concentration and/or flow rate unless glucose testing previously unstable, then test within 30 minutes following change or as ordered by physician.
2. One hour following interruption of an IV with an inability to restart glucose infusion.
3. One hour after hanging new dextrose solution or Total Parenteral Infusion (TPN) fluid.

P. MANAGEMENT OF HYPOGLYCEMIC INFANT IN THE NICU:
1. Infants who are brought to the NICU for observation due to hypoglycemia remain under the care of the assigned pediatric hospitalist until the infant requires IV fluids.
2. Infants at risk for hypoglycemia who are SYMPTOMATIC:
    a) With a POC blood glucose screen <45mg/dl after 1 dose of glucose gel 0.5ml/kg:
        1) Attempt to feed.
            a. If unable to feed infant or if able to feed infant and 30 minutes after completion of feeding repeat POC screen is <45mg/dl:
                i. Notify physician.
                ii. Start PIV if infant does not have IV access then give 2ml/kg of 10% Dextrose Water (D10W) as bolus.
                iii. Begin continuous infusion of D10W at 80ml/kg/day.
3. Infants at risk for hypoglycemia who are ASYMTOMATIC:
    a) Birth to 4 hours of age:
        1. If repeat POC screen is <25mg/dl, has received one dose of glucose gel 0.5ml/kg or repeat blood glucose screen is <45mg/dl after 2 doses of glucose gel 0.5ml/kg:
            a. Administer another dose of glucose gel 0.5ml/kg
                a. Notify physician
                b. Bolus with 2 ml/kg of D10W
                c. Begin continuous infusion of D10W at 80ml/kg/day.
            b. POC blood glucose screen >44mg/dl:
                a. Continue POC screen as per protocol and allow baby to be transferred to the mother's room in mother-baby unit.
                b. If during follow up screens, the POC blood glucose screens decrease to <45mg/dl, the infant will be transferred back to NICU for admission.
                    i. Notify physician
                    ii. Bolus 2ml/kg of D10W
                    iii. Begin continuous infusion of D10Wml/kg/day
    b) Infants 4-24 hours of age:

1. POC blood glucose screen of<35mg/dl after one dose of 0.5ml/kg or<than 45mg/dl after 2 doses of glucose gel 0.5ml/kg:
    a. Administer another dose of glucose gel 0.5ml/kg
    b. Notify physician
    c. Begin continuous infusion of D10W at 80ml/kg/day
2. If POC blood glucose screen>45mg/dl:
    a. Continue POC blood glucose screens as per protocol and transfer baby to the mother's room when blood glucose screens stable.
    b. If during follow up screens, the POC screens decrease to <45mg/dl and infants is less than 24 hours of age, the infant will transfer back to the NICU.
        i. Administer oral glucose gel 0.5ml/kg and attempt to feed. Obtain POC blood glucose screens 30 minutes after completion of feeding.
        ii. If glucose level <than 45mg, give 3rd dose of glucose gel 0.5ml/kg and attempt to feed. Obtain POC screen 30 minutes after completion of feeding.
        iii. Notify physician if POC screen<45mg/dl.
        iv. Bolus 2ml/kg of D10W
        v. Begin infusion of D10W at 80ml/kg/day

c) Infants > 24 hours of age:
    i. If POC screen <50mg/dl, notify physician.

Q. Education to Patient/Family:

1. Discuss with parent(s) the need for glucose monitoring for the baby.
2. Describe the heel stick procedure and the need for subsequent sticks.
3. Discuss options for feeding and family preferences.
4. Describe the physician contact and orders received.
5. Heel stick procedure (Refer to Capillary Blood Sample- Heel Stick Policy NICU)

Documentation

1. Document in patient's EMR:
    a. Blood glucose levels.
    b. Interventions performed in response to low blood glucose levels and effectiveness of interventions.
    c. Newborn assessment of hypoglycemic signs and symptoms.
    d. Communication with physician.

R. Reportable Conditions

1. Notify Physician

S. Experience/Training/Education Requirements

1. Initial competency validation
2. Ongoing yearly competency validation

3. Competency validation tools/method

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- Gardner, S., Carter, B., Hines, M., Hernandez, J. (2016). Merenstein & Gardners handbook of neonatal intensive care (8th ed.). St. Louis, MO: Mosby Elsevier.

- Wight, N., Marinelli, K.A., and the Academy of Breastfeeding Medicine Protocol Committee. (2006). ABM Clinical Protocol #1: Guidelines for Glucose Monitoring and Treatment of Hypoglycemia in Breastfed Neonates. Breastfeeding Medicine 1(3). P. 178-184.

SUBJECT: NOURISHMENTS	SECTION: Page 1 of 2

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

PURPOSE:

To meet the nutritional needs of identified residents.

POLICY:

It is the policy of this facility that residents may be given nourishments without obtaining a physician's order, following appropriate diet as recommended by the registered dietitian or licensed nurse.

AFFECTED PERSONNEL/AREAS: *RN, LVN, CNA, NUTRITION SERVICES, DIETITIAN*

SCOPE:

Provision of nourishments is the responsibility of the Nutrition Services Department. The Dietitian will initiate nourishment service whenever it has been determined that a resident requires additional nutritional support. Nourishments are not a replacement for routine meals.

PROCEDURE:

1. ORDERING AND DISCONTINUING – The Dietitian will coordinate with nursing regarding residents who require nourishments. If initiated by nursing, the Charge Nurse will order and/or discontinue via Meditech.

2. IMPLEMENTATION – The food service staff and Dietitian will maintain a current "Nourishment List- Dietary Special Needs."

3. MONITORING – The Dietitian will review the need for the nourishment with Charge Nurse monthly for continuance. The Registered Dietitian will review the list of residents routinely.

4. NOURISHMENT COST – Nourishments will be included in the food cost and will not be charged to residents.

5. NOURISHMENT TIME AND DISTRIBUTION

    a. Routine Nourishments (Snacks)

    - Routine nourishments will be offered at bedtime (H.S.) unless contraindicated by diet or condition. Items available for H.S. nourishments will be recommended by the Registered Dietitian.

      Schedule is as follows:

      a. 0800 – 1000 (coordinated with activities)
      b. 1400
      c. 1900

- Bedtime (H.S.) nourishments will be provided by Nutrition Services and will be delivered by the staff to each nursing station before closing the kitchen each night.

b. Recommended Nourishments

- Recommended nourishments will be served at the designated times and frequency. They will be labeled with the resident's name and room number and delivered by dietary to the nursing station.

- The Nursing Staff will be responsible for nourishment distribution each time and will document intake in the appropriate notes.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72335 (2), 72351, San Francisco, California, Title 22.

SUBJECT: **NURSING CARE, RESTORATIVE AND SUPPORTIVE**	SECTION:

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

PURPOSE:

To provide residents with restorative and supportive nursing care to enhance the resident's physical, mental and social well-being and independence.

POLICY:

It is the policy of this facility that each resident will be provided with an individualized restorative and supportive plan of care to allow the resident the highest degree of independence possible within their physical and mental capabilities and to provide early detection and intervention when independence declines in order to prevent complications and maintain the resident at their highest level of functioning.

AFFECTED PERSONNEL/AREAS: *RN, LVN, RNA, CNA*

PROCEDURE:

1. Each resident shall be assessed upon admission for levels of functional abilities utilizing the Nursing Assessment and the interdisciplinary Minimum Data Set.

2. An interdisciplinary plan of care will be established identifying short-term and long-term resident goals.

3. The resident and family will be involved in establishing the plan of care whenever possible.

4. Restorative and supportive care shall include:

    a. Maintaining good body alignment and proper positioning of bedfast and dependent residents.

    b. Encouraging and assisting residents at least every two hours.

    c. Making every effort to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physician order.

    d. Encouraging resident to achieve the highest degree of independence in activities of daily living by teaching self-care, transfer and ambulation techniques and providing assisting devices.

    e. Assessing bowel and bladder function, providing toileting assistance and retraining programs based on the individual resident need and abilities.

f. Providing range of motion to maintain joint mobility, prevent contractures or prevent further deterioration and complications of limited range of motion.

g. Assessing self-feeding skills and providing adaptive devices and retraining programs based on resident needs and capabilities, including weaning from feeding tubes.

h. Assessing skin integrity and nutritional status to ensure prevention or early detection of pressure ulcers.

i. Assessing social activity preferences/needs and implementing social service and activity plans of care to enhance the residents' emotional and social well-being.

j. Referring therapy programs (P.T., O.T., and S.T.) as indicated by resident assessment and need.

5. Restorative and Supportive Nursing Care Services when provided to the resident will be documented on the CNA / RNA in the EMR as indicated.

REFERENCE:

- California Code of Regulations (2019). Title 22. §70557. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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

SUBJECT: **NUTRITIONAL SCREENING AND ASSESSMENT/REASSESSMENT**	SECTION: **Page 1 of 5**

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

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing a comprehensive nutrition care program including food and nutrition therapy in a timely, effective and efficient manner. The nutrition care program is integrated with nursing and other appropriate disciplines as needed.

The nutritional assessment is utilized to evaluate the patient's nutritional status, develop a plan of nutritional care and evaluate the efficiency of nutritional support. The need for a nutritional assessment is determined by following a nutritional screening process completed by nursing during the initial patient assessment.

POLICY:

The nutritional assessment is utilized to evaluate the patient's nutritional status, develop a plan of nutritional care and evaluate the efficiency of nutritional support. The need for a nutritional assessment is determined following a nutritional screening process completed by nursing during the initial patient assessment.

AFFECTED PERSONNEL/AREAS:

FOOD AND NUTRITION SERVICE, PHYSICIAN, NURSING, OTHER DISCIPLINES AS REQUIRED

Food and Nutrition Service: The Registered Dietitian (RD) will prioritize the nutritional risk level of patients. The RD assesses the patient for medical nutrition therapy, develops, implements and evaluates the effectiveness of the nutrition therapy plan, identifies sub optimal responses and potential adverse effects to the nutrition care. A diet aide will visit each patient for food allergies, menu/religious food preferences, and refers the patient to the dietitian if needed.

Physician: The physician assumes the responsibility for the overall nutrition management of the patient.

Nursing: Nursing identifies patients at high nutritional risk through the admission assessment. They monitor and report the effect of nutrition care on an ongoing basis. They monitor nutrition and fluid intake.

Other Disciplines: As required. *Example: Speech Therapy will perform swallow evaluations.*

PROCEDURE:

A. NUTRITIONAL SCREENING:

All patients *(see labor & delivery for exceptions)* will be screened for nutritional risk by nursing staff using criteria established by a Registered Dietitian.

1. Nursing:

a. Completes nutritional screening on the Initial Patient Assessment form within 24 hours of patient admission.

b. Included in the "Nutritional Screening" form is the presence of the following, which triggers a referral to the dietitian for the general patient population:

- Vomiting/Diarrhea ≥ 3 days prior to admit
- Unintentional weight gain or loss
- Difficulties in chewing/swallowing/feeding self
- Enteral/parenteral feeding/total parenteral nutrition (TPN)
- Pregnant or Lactating and ≤ 17 years old
- Pressure ulcer ≥ stage II
- NPO (nothing by mouth), > 3 days
- New onset diabetes
- Age >80 with planned surgery
- Recent change in diet
- New start Warfarin

c. Included in the "Pediatric Nutritional Screening" form is the presence of the following, which triggers a referral to the dietitian:

- Failure to thrive/malnutrition
- Enteral/ feeding
- Food allergies/intolerances
- New onset diabetes
- Vomiting/diarrhea >3 days prior to admit
- Difficulties in chewing/swallowing/feeding self/delayed feeding skills
- Weight loss in last 3 months
- Chronic GI problems/reflux
- Cancer
- Metabolic disorder
- Chronic kidney disease
- Eating disorder

d. Labor and Delivery patients will not automatically be assessed by dietitians or visited by diet aides for menu selections upon admission to respect the patient's privacy during her labor. The patient will be referred to the dietitian if any of the following triggers are present:

- Gestational DM
- ≤17 years of age
- Hyperemesis gravidarum
- Nutrition education needed/requested

2. Nutrition Services:

a. The diet aide will refer patients to the dietitian if the patient requests medical nutrition therapy.

b. Dietitians will screen each patient for nutritional risk level based on nutrition assessment guidelines within 72 hours of admit.

c. Dietitian will monitor patients on an ongoing basis who are or who may become at nutritional risk during hospitalization.

B. NUTRITIONAL ASSESSMENT:

1. Registered Dietitian:

a. Physician-ordered nutritional consults are completed within 24 hours of order.

b. Nursing referrals identified from the nutritional screening on nursing initial assessment form will be prioritized for nutritional risk by 48 hours.

c. All patients identified to be at high/moderate nutritional risk receive nutritional assessment by a dietitian.

d. Ongoing monitoring of patients occurs daily for indications of nutritional status changes. This is accomplished through monitoring the enteral/parenteral nutrition support census and daily census, as well as physician, nurse or diet aide referrals.

2. Risk levels for nutritional assessment are as follows:

a. Patients at high nutritional risk are assessed within 48 hours of admission and may include the following: require enteral/parenteral nutrition support, malnutrition/failure to thrive, ulcerative colitis/Crohn's disease, cerebrovascular accident (CVA) with dysphasia, intubation, pregnancy/lactation < 17 years old,

hyperemesis gravidarum, decubitus ulcer ≥ stage II, dysphasia, ileus, hepatic encephalopathy, multi-system organ failure, NPO/clear liquid >/ 72 hours.

b. Patients not identified from nursing screen and/or increased risk diagnosis may be at moderate nutritional risk and will be assessed within 72 hours of admission and may include the following: diabetic ketoacidosis (DKA), acute respiratory failure without ventilator support, bowel surgery, liver disease including cirrhosis, body mass index (BMI) <18.5 (underweight), cancer with recent chemo/radiation/cachexia, 80 years old with planned surgery, pancreatitis, renal failure, gestational diabetes mellitus (GDM), peritonitis.

c. Patients at low nutritional risk are evaluated within 72 hours of admission and re-evaluated within seven days. This may include the following: multiple food allergies, eating >50% of meals, dental difficulties, substance abuse, pneumonia, COPD, TB, coronary artery disease (CAD), congestive heart failure (CHF), hyperlipidemia, colostomy, gastritis/peptic ulcer, gall bladder disease, hypothyroidism, obesity, musculoskeletal disorder, anemia, amputation of limb, total hip arthroplasty, comfort measures and assessments per RD discretion.

3. The Registered Dietitian may include information collected from medical, social and dietary histories, anthropometric data, biochemical data, and review of prescribed drugs.

4. The Nutritional Assessment and Plan of Care will define:

a. Nutrition risk level- high, moderate or low

b. Central goal or desired outcome, where appropriate.

c. Nutrition plan to meet the desired outcome.

d. Roles of other disciplines as appropriate.

e. Evaluation of appropriateness of diet.

f. Where applicable, a summary of what the current nutrition support provides and if it is appropriate.

g. A breakdown of the nutrient composition of any recommendations for parenteral/enteral feedings.

C. REGISTERED DIETITIAN & NUTRITIONAL REASSESSMENT/RE-EVALUATION:

1. Nutritional reassessment will be conducted using the following general guidelines, as indicated by assigned risk level by the Registered Dietitian:

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

   b. Moderate risk patients, 4-5 days

   c. Low risk re-evaluated every 7 days or as deemed appropriate at the last evaluation

   d. When ordered by a physician

   e. Or more often as deemed necessary by the Registered Dietitian

2. The reassessment will document the patient's response to care. At the time of reassessment, the dietitian may determine that the patient is no longer at a certain nutritional risk level. This change of nutritional risk will be documented in the medical record.

3. All patient reassessment/re-screen is documented in the patient's medical record.

REFERENCES:

- California Department of Public Health (~~2022~~2023). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (~~2022~~2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (~~2022~~2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PATIENT EDUCATION FOR MODIFIED DIET**	SECTION:

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

PURPOSE:

To establish a protocol for patient diet education.

POLICY:

Sierra View Medical Center (SVMC) gives diet education with discharge instructions to the patient/resident or family or individuals who are responsible for their care.

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

PROCEDURE:

1. Diet instruction is provided when ordered by nursing or the physician or when it is determined that it is needed during patient nutritional screening or assessment.

2. The dietitian is responsible for patient/resident nutrition/diet instruction including, but not limited to, therapeutic diets, drug-food interaction and complex clinical nutrition.

3. Nursing may provide written and/or verbal diet instruction upon discharge for those patients/residents being discharged on a mechanically altered or therapeutic diet.

4. Approved reference materials, instructional tools, etc., are kept in the dietitian's office, and on the computer using the Nutrition Care Manual and Krames on Demand. Verbal and written instructions are provided to facilitate the patient's/resident's understanding and ability to follow through with the diet at home. Written instructions for diet after discharge are also given to the representative responsible for the patient's/resident's health care needs.

5. Instructions may include the following:

    a. Brief explanation of the need for the diet with their present condition.

    b. Review of the foods allowed, portion size, and foods to be discouraged/avoided.

    c. Discussion of appropriate food items that can be bought to replace regularly used items (i.e., low sodium versions).

    d. Suggestions for food preparation, recipes, etc.

    e. Hospital telephone number with the dietitian's phone number to call with questions as needed after discharge.

6. Patients/residents may be encouraged to watch AllenTek videos on their hospital TV on varying health conditions

7. Documentation of the diet instruction provided, information covered, patient's/resident's understanding and expected compliance will be included in the dietitian assessment and in Interdisciplinary Education Record section.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/regulations-and-guidance/regulations-and-guidance.html
- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PHYSICIAN ORDERED CONSULTATION**	SECTION:

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PURPOSE:

To establish protocol for a physician-requested nutritional consult.

POLICY:

Nutrition consultations ordered by the physician will be completed by a Registered Dietitian (RD).

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

PROCEDURE:

1. A physician may order a nutritional consultation utilizing the electronic medical record (EMR). The RD will be notified of the nutritional consultation through the EMR.

2. A thorough nutrition assessment will be completed for all patients with a physician-ordered nutritional consultation. The RD will complete the nutrition assessment with recommendations within 24 hours of notification.

3. A nutritional assessment and recommendations will be communicated to the physician in the EMR and may include diet order changes, enteral or parenteral nutrition changes, dietary supplements, and/or vitamin and mineral supplementation.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/regulations-and-guidance/regulations-and-guidance.html
- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PHYSICIAN'S SERVICES**	SECTION: **Page 1 of 4**

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

PURPOSE:

To ensure physician services to the residents on the DP/SNF Unit in order to achieve for each resident the highest optimal health possible in his/her circumstances by obtaining prompt and adequate medical attention.

POLICY:

A. The Medical Director is a physician who is currently licensed to practice in the State of California, and has experience and knowledge in the care of DP/SNF residents.

B. The Medical Director is appointed by the Administrator and shall be designated by the Medical Staff of the Hospital with the approval of the Board of Directors.

C. The duties and responsibilities of the Medical Director include, but are not limited to, the following:

1. Directing and coordinating medical care in the unit, including providing orientation to other attending physicians on the unit. Orientation shall include Title 22 and OBRA Regulations.

2. Assisting in arranging for continuous physician coverage to handle medical emergencies.

3. Assisting in developing procedures for emergency treatment of unit residents.

4. Participating in establishing policies, procedures and guidelines designed to assure the provision of adequate comprehensive services.

5. Participating in the resident care management system (i.e., attending weekly team conference).

6. Serving as a member of the Medical Staff, attending its meetings, and helping to assure adherence to the Medical Staff bylaws and Rules and Regulations.

7. Participating with other health care professionals in establishing policies designed to assure the governing board that all health care professionals act within the scope of their practice and license and within the scope of California's laws.

8. Providing consultation in the development and maintenance of an adequate medical record system.

9. Participating in the in-service training program.

10. Monitoring the health status of employees and advising the administration on employee health policies.

11. Providing consultation to the Unit's Clinical Director and the individual responsible for Social Services concerning the evaluation of the unit's ability to meet the psychosocial, medical and physical needs of the residents.

12. Advising the Clinical Director about the adequacy and appropriateness of the unit's scope of services for the residents, its medical equipment and its professional and support staff, the use and availability of ancillary services such as lab, radiology, etc..

13. Assisting in assuring a safe and sanitary environment for residents and personnel by:

    a. Reviewing and evaluating summaries of occurrence reports

    b. Identifying hazards to health and safety

    c. Making relevant recommendations to the Administrator

    d. Being knowledgeable about the policies and programs of public health agencies that may affect the resident care programs

    e. Acting as the unit's medical representative in the hospital and the community

    f. Monitoring the quality and appropriateness of medical services as an integral part of the overall Quality Assurance Performance Improvement (QAPI) program of the unit and the hospital

14. The Medical Director will be involved in the physicians credentialing process for the DP/SNF unit (as more particularly described in the following paragraph).

    a. The Medical Director recognizes that all physicians caring for residents in the DP/SNF unit must be a member in good standing, of the hospital's medical staff. As such, following processing of a physician's application by the hospital's Medical Staff Coordinator (who will already have validated the physician's credentials and professional information), the application for a physician wishing to care for residents on the DP/SNF unit will be forwarded to the Medical Director to assess the application/credentials and other professional information. His/Her recommendations will be forwarded to the hospital's Credentials Committee who will review and forward, together with its recommendations, to the hospital's Medical Executive Committee or Governing Board, as the case may be, who will make the determination as to whether or not privileges should be granted to the applying physician for the provision of DP/SNF care services.

b. The Medical Director will be knowledgeable about quality indicators for all DP/SNF services provided and will ensure that care provided to residents is adequate, comprehensive and appropriate.

c. The Medical Director will be available to and responsive to all unit residents, families and/or unit staff, either physically or by telephone, and in his/her absence will make arrangements to provide adequate coverage during those periods in which he/she may be away from the facility.

d. The Medical Director recognizes that there may be instances when expertise in the areas of neurology, pulmonology, podiatry, cardiology, dentistry, and oncology, may be required. As such, if the Medical Director does not have expertise in the specialty required, the Medical Director will seek adequate consultation.

15. The Medical Director agrees to the foregoing and to any additional requirements of the DP/SNF Care Certification Manual, and as required by Title XXII of the laws of the State of California.

D. Upon admission, the resident's physician will see the resident within48 hours to evaluate the resident's needs and complete a history and physical, as necessary, and to initiate via appropriate orders a care plan to achieve those needs.

1. The physician will be credentialed and privileged by the facility, per Medical Staff Bylaws.

2. Physician's visits for residents of the DP/SNF unit are medically required at least twice weekly during the first month, a minimum of at least once every seven days thereafter and as necessary for acute problems.

3. The physician is required to attend each resident's team conference weekly for DP/SNF residents.

4. Federal and State regulations and professional ethics mandate that the physician complete the resident's medical record in a timely manner that conforms to the regulations mentioned.

5. All orders for treatment and medication must be in writing and signed/dated/timed by the physician.

6. Admission orders must include the following: date/time of order, diagnosis, activity level/functional status, medications/treatments, and diet.

7. The admission diagnosis and orders must be written on admit and signed/dated/timed by the physician within 48 hours of admission for DP/SNF.

8. All telephone orders must be signed/dated/timed by the physician within 48 hours.

9. Progress notes reflecting review of the residents overall condition and program of care must be written into the resident's medical record and signed/dated following each visit to the facility by the physician.

10. History and Physicals for all residents will be reviewed and rewritten annually.

AFFECTED PERSONNEL/AREAS: *MEDICAL DIRECTOR AND/OR ATTENDING PHYSICIAN*

REFERENCES:

- Med Pass, Inc. (updated February 6, 2015) Facility Guide to OBRA Regulations, 73303 United States of America, Med Pass Inc.

SUBJECT: **PROPOFOL (DIPRIVAN)**	SECTION: ***Drug Protocols*** **Page 1 of 3**

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

PURPOSE:

For induction and maintenance of sedation in critically ill ventilated adult patients.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

DILUTION:

- No dilution needed.
- Premixed bottles 10 mg/mL in 20 mL and 100 mL bottles. Run with fat emulsion tubing. Do not administer in same IV catheter w/blood or plasma products.

INFUSION (10 mg/mL):

- **Initial therapy:** Start at 5 mcg/kg/min and increase by 5 mcg/kg/min every 5 minutes to a maximum rate of 50 mcg/kg/min (may exceed at Physician's discretion, WITH A CHANGE TO ORDER PARAMETERS) to maintain desired Richmond Agitation Assessment Scale (RASS) level of sedation. TARGET RASS ENDPOINT MUST BE SPECIFIED IN ORDER. The default Target RASS will be -2, but can be changed at physician discretion when ordering.
- **Titrations**: With every 5mcg/kg/min change in rate the RN is to document the patient's pre-titration RASS score.
- **Ventilation Weaning:** Discontinue opioids and paralytic agents first, and then after patient has been fully weaned, discontinue Propofol infusion approximately 10 minutes prior to extubation.
- **WAKE-UP Daily Protocol ("Sedation Vacation/Sedation Holiday"):** Per physician's orders.
- For patients maintained at a RASS score of -5 to 0, Wean infusion as specified by physician.

Richmond Agitation Assessment Scale (RASS)

+4	Combative	Overtly combative or violent, immediate danger to staff
+3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
+2	Agitated	Frequent nonpurposeful movement or patient ventilator dysynchrony
+1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact/eye opening to voice
-2	Light sedation	Briefly (less than 10 seconds) awakens with eye contact to voice

-3	Moderate sedation	Any movement (but no eye contact) to voice
-4	Deep sedation	No response to voice, but any movement to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

CONTRAINDICATIONS:

- Hypersensitivity to propofol or any component of the formulation; hypersensitivity to eggs, egg products, soybeans, or soy products; when general anesthesia or sedation is contraindicated.
- **Note:** Fresenius Propoven is also contraindicated in patients who are hypersensitive to peanuts.

PRECAUTIONS:

1. Must be administered via the Alaris IV smart pump , through a dedicated peripheral or central line (using fat emulsion tubing).
2. Vented tubing and infusion must be changed every 12 hours (vented tubing must be used).
3. Be careful with boluses, may cause hypotension; if significant hypotension occurs, discontinue infusion.
4. Use cautiously in patients with hyperlipidemia, hypotension or hypovolemia.

ADVERSE EFFECTS:

- Hypotension
- Bradycardia
- Asystole
- Nausea/Vomiting
- Hives
- Apnea

MONITORING PARAMETERS:

- Cardiac monitor, blood pressure, oxygen saturation (during monitored anesthesia care sedation), arterial blood gas (with prolonged infusions). With prolonged infusions (eg, ICU sedation), monitor for metabolic acidosis, hyperkalemia, rhabdomyolysis or elevated CPK, hepatomegaly, and progression of cardiac and renal failure.

- Sedation: Assess and adjust sedation according to scoring system (Richmond Agitation-Sedation Scale [RASS] or Sedation-Agitation Scale [SAS]) (Barr, 2013); assess CNS function daily. Serum triglyceride levels should be obtained prior to initiation of therapy and every 3-7 days thereafter, especially if receiving for >48 hours with doses exceeding 50 mcg/kg/minute (Devlin, 2005); use intravenous port opposite propofol infusion or temporarily suspend infusion and flush port prior to blood draw.

- Diprivan®: Monitor zinc levels in patients predisposed to deficiency (burns, diarrhea, major sepsis) or after 5 days of treatment

REFERENCES:

- Propofol. Lexicomp Online. Lexi-Drugs. Retrieved May 4, 2023.

- Frank, Robert L. Procedural Sedation in Adults Outside the Operating Room. Retrieved August 12th, 2017. https://www.uptodate.com/contents/procedural-sedation-in-adults-outside-the-operating-room

- Tietze, Karen; Fuchs, Barry. Sedative-analgesic medications in critically ill adults: Properties, dosage regimens, and adverse effects. Retrieved August 12th, 2017. https://www.uptodate.com/contents/sedative-analgesic-medications-in-critically-ill-adults-properties-dosage-regimens-and-adverse-effects

SUBJECT: **RECALL OF STERILIZED ITEMS/PRODUCTS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish the procedure to follow in the event of the need to recall instrumentation sterilized in the Central Processing Department (CPD).

POLICY:

To ensure patient safety and compliance with the Safe Medical Devices Act, this procedure will be followed, in the event that any sterile items processed at SVMC are suspected to be non-sterile due to sterilizer failure or malfunction.

AFFECTED AREAS/PERSONNEL:

ALL PATIENT CARE AREAS USING STERILE INSTRUMENTS/ ALL STAFF IN THE PATIENT CARE AREAS.

PROCEDURE:

A. When it is indicated that the criteria for sterilization may not have been met, a Sterile Processing Product Recall is to be initiated. The Manager or Director of Surgical Services/CPD will be responsible to issue the recall order. Indications for recall may include any or all of the following:

   1. Bacterial growth in a Biological Monitoring Test.
   2. Unacceptable Bowie-Dick Test.
   3. Chemical indicators which do not show appropriate changes.
   4. Wet packs from a load of instruments.

B. Any of the above circumstances shall be reported immediately to the Central Processing Manager.

C. Recall must include all items processed back to the last negative biological indicator.

D. CPD staff will be responsible for execution of the recall order, using the following list of instructions

   1. Pull the load cards for the date or dates in question.
   2. List items in question on recall form and item location.
   3. Contact by phone all affected areas and request that items labeled for the loads

in question be pulled from use. Send affected areas a copy of the recall form to check items off the list as accounted for. Items should be bagged and returned to Central Processing.

4. If items have already been used, the area should ascertain when and on whom if possible and complete an occurrence report for each.

5. Risk Management and Infection Prevention is notified that a recall is being initiated.

6. Engineering is notified by the Central Processing Manager.

7. Do not use the sterilizer for sterilization until approval by Engineering.

8. Central Processing Manager: Notify areas served of the delay.

   Note: If it is possible, utilize another sterilizer to minimize interruption of necessary service.

9. Sterilizer cannot be used until it has been recertified according to the Autoclave Qualification Testing policy

10. Initiate Recall Report form and send to:

    a. Surgical Services Director

    b. Engineering Manager

    c. Managers of departments involved

    d. Risk Management Manager

    e. Infection Control Manager

11. Notification of Central Processing Product Recall.

    a. Affected areas are contacted by phone to explain process.

    b. Recall form is instituted by CPD staff to document and report results of recall

E. Recall of product manufactured or processed outside the facility

1. Notification of manufacturer's recall may come directly to Central Processing Department in the mail or it may be forwarded to Central Processing through hospital channels.

2. Central Processing will assist in a product recall by:

   a. Assist with retrieving items and returning them to the Materials Management Department.

   b. Ascertaining if and where the items may be in the Department.

REFERENCES:

- AAMI *ST79*. Comprehensive guide to steam sterilization. *2017*
- AAMI ST 98. Cleaning Validation of Healthcare Products. 2022
- Central Service Technical Manual ~~Eighth Edition. 2016~~ Ninth Edition. January 2023
- CDC. Sterilization Monitoring. 2018. https://www.cdc.gov/oralhealth/infectioncontrol/faqs/monitoring.html

SUBJECT: **REFERRALS TO SOCIAL SERVICE DEPARTMENT**	SECTION: ***Social Services*** **Page 1 of 1**

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

PURPOSE:

To define the process by which social services are requested in the Distinct Part Skilled Nursing Facility (DPSNF).

POLICY:

Requests for social services may be made at any time by any staff member, physician, resident, or family member. Social Services Designee will respond to such requests within 24 hours on weekdays or within 72 hours on weekends.

AFFECTED PERSONNEL/AREAS: *NURSING, MEDICAL STAFF, ANCILLARY STAFF*

PROCEDURE:

1. During business hours, referrals may be called directly to the Social Service office or made verbally to the Social Service Designee.

2. After hours, or on weekends or holidays, a written request may be placed in the mailbox on the door of the Social Service Designee.

3. At any time, a voice mail message may be left on the office phone of the Social Services Designee.

4. If the matter is extremely urgent, the Unit Director or Manager may be contacted by the Charge Nurse.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72445, San Francisco, California, Title 22.

SUBJECT: **RESIDENTS' FUND POLICY**	SECTION: **Page 1 of 3**

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

POLICY:

Sierra View Medical Center (SVMC) will handle Distinct Part/Skilled Nursing Facility (DP/SNF) residents' funds, for the benefit of the residents, conforming to Title 22 regulations, with reasonable business practices and generally accepted accounting standards in maintaining their accounts.

Sierra View Medical Center will only handle DP/SNF residents' funds when asked to by the resident, their responsible party or other authorized agent or agency.

Sierra View Medical Center shall inform residents upon admission that this service is available.

A resident's fund bank account shall be established separate from the facility's accounts and clearly designated as a resident demand trust account. Any resident funds in excess of $50 must be deposited into the trust account, (see Social Services P & P Trust Account). This account shall be interest bearing. At no time will the balance in this account be less than zero. (However, should a credit balance occur, the patient or responsible party will be notified immediately.) This bank account will be reconciled monthly.

A record showing an individual resident's account activity shall be given to SSD quarterly by Patient Accounting for DPSNF.

A resident's funds shall be returned within thirty days, upon death of the resident, using state regulations and guidelines.

A surety bond shall be secured in an amount sufficient to comply with state regulations.

A separate list shall be maintained for all checks from residents' funds which are, or have been, outstanding for 45 days or more as reflected on the most recent bank statement. Bank statements shall be reconciled monthly with copies of the reconciliation maintained by the facility. Any checks' on such accounts written off or uncashed shall result in an addition to the appropriate resident's account.

The Business Office Manager has been assigned by the Administrator; the responsibility to handle all patient monies, under the Administrator's coordination and direction.

The DP/SNF Patient Account Specialist shall have access to the Organization's safe, located at the Cashier, where some residents' cash (as applicable) will be kept for regular use per the latter's requests for minimal purchases. The specified fund will be available Mondays through Fridays from 0800-1630.

AFFECTED PERSONNEL/AREAS:

RN, SOCIAL SERVICES, PATIENT ACCOUNTING

PROCEDURE:

1. Sierra View Medical Center does not mingle resident's monies with any other monies.

2. When resident/responsible party asks the facility to handle his/her funds, a "Resident Trust Fund Authorization" form is completed and kept with the resident's ledger.

3. The individual resident ledger will then be established for the resident.

4. Each resident ledger will reflect all transactions, including deposits and withdrawals, as well as balance in chronological order.

5. Withdrawal will be recorded on resident's ledger will be given quarterly. One copy will be kept with the resident's ledger.

6. A monthly "Cash Receipts Journal" will be kept for listing all cash received in chronological order.

7. Withdrawals will be recorded on resident's ledger with appropriate receipt and description of the expenditure kept with the ledger. Signature of authorized person is required on the ledger.

8. Trust fund bank statements will be reconciled monthly with residents' ledgers.

9. Interest will be posted monthly on each resident ledger as a deposit.

10. All records of resident monies, including banking records, deposit slips, checks, cancelled checks, statements, and check registers are maintained for three (3) years from the date of the transaction.

11. For residents who choose to keep money at their bedside, the Social Services Designee will offer to have such funds be kept at the designated safe in the cashier's office, which will be handled by the Patient Account Specialist. If the resident refuses, a care plan shall be immediately initiated to reflect this preference. A limit of $50 will be suggested if the resident chooses to keep money at the bedside. Note that once the resident decides to keep any amount of money at the bedside and refuses offered safe-keeping, that the resident claims full responsibility of whatever happens with the money. This means that the department will not be expected to replace any amount missing or be held accountable for any noted discrepancy.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72529, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (c) United States of America, Med Pass Inc.

CROSS REFERENCES:

- Social Services Policy and Procedure: TRUST ACCOUNT-SOCIAL SERVICE POLICY

SUBJECT: **RESTRAINTS, CHEMICAL**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To establish set guidelines for the proper use of chemical restraints in the DP/SNF

POLICY:

When psychoactive medications are ordered, the assessment process will be utilized to ensure:

1. Environmental causes of resident's distress or behavior have been ruled out.
2. Alternative behavioral management programs have been attempted prior to the use of psychoactive medication.
3. Early identification and reporting of drug side effects are documented.
4. Physician is provided with summaries of resident's behavioral manifestation, frequency, response to behavioral programs and medications, as well as recommendations for changes in medication.
5. Psychoactive medications are used in the lowest possible dose, and are discontinued when no longer required to treat a mood or behavior problem, unless the medication is used to maintain a resident with a psychotic diagnosis, or organic mental disorder.
6. Psychoactive medications are given only after the physician has obtained informed consent from the resident/surrogate decision maker.
7. Facility staff has verified that informed consent has been obtained.
8. Residents with dementia on antipsychotic/psychotropic medications will be reviewed by Pharmacy for any issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

POLICY:

1. Residents will be enabled to achieve the highest level of functioning, and will receive psychoactive medications only when they are necessary to treat medical, mood, behavioral, or psychiatric symptoms. These medications will not be used for the convenience of staff. Informed consent will be obtained by the physician from the resident, unless the resident lacks decisional capacity, in which case, consent will be obtained from the surrogate. In the absence of surrogate, the Interdisciplinary Team will make the recommendation regarding the use of the medication. Consent will also be obtained for any change of dosage.
2. Antipsychotic Medications

a. Anti-psychotic medications will not be initiated for residents who have not used them previously, unless the clinical record documents the medication is necessary to treat a "specific condition".

b. Non-pharmacological interventions will be initiated and documented prior to the use of antipsychotic medications.

c. Psychologist consults as per MD order.

d. In the event that non-pharmacological interventions are ineffective, and a pharmacological intervention has been initiated secondary to consult, licensed nursing staff will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anti-psychotic medications.

e. Continued aggravation or deterioration in status will be reported to the physician.

f. Anti-psychotics will be given in the lowest effective dose to start, and increased as needed by physician order.

g. Use of a one-time only dose of anti-psychotics more than two times in seven days will be assessed by the Interdisciplinary Team for side effects and continued use.

h. Gradual dose reductions will be attempted twice in a year unless the physician documents that it is clinically contraindicated.

i. The medication's effectiveness will be reevaluated by the physician on a weekly basis during the Interdisciplinary Team Meeting.

3. Anti-anxiety Medications

a. Nursing will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anxiolytics.

b. Anti-anxiety medications will be administered only when the appropriate indications/diagnoses are present:

- Generalized anxiety disorder
- Organic mental syndrome associated with agitated states
- Panic disorder
- Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder).

c. Long acting benzodiazepines will not be used unless the short acting benzodiazepines have failed.

d. Daily use will be reevaluated every 6 months unless a dose reduction is attempted and is unsuccessful.

4. Antidepressant Medications

a. Residents with symptoms of depression (e.g., withdrawn behavior, refusal to speak, poor appetite, and/or loss of interest) will be provided appropriate non-pharmacological interventions such as altered lighting, distractions with activities, relaxation techniques, calming music, repositioning, sit and conversing with resident, etc. These non-pharmacological interventions will be attempted prior to the initiation of any drug therapy.

b. Any use of an antidepressant medication outside the Diagnostic and Statistical Manual of Mental Disorders (DSM V) guidelines will be justified by a physician's note explaining why the medication is clinically appropriate, and this should be supported by a psychiatrist/psychologist consultation.

c. Behavioral monitoring charts via MAR will be used for residents receiving antidepressant medications.

5. Sedative/Hypnotic Medications

a. All environmental factors for insomnia will be ruled out before pharmacological interventions will be initiated to assist a resident to sleep.

b. Daily use of drugs for sleep induction will be less than ten consecutive days or as the physician deems necessary, unless an attempt at a gradual dose reduction has been unsuccessful.

c. Barbiturates will not be used except as a single dose for dental or medical procedures, and phenobarbital will be used only for seizure disorder.

d. When resident is admitted with barbiturates, or miscellaneous hypnotic, sedative, or anxiolytic drugs, there will be a gradual dose reduction at least two times in one year before dose reduction is determined to be "clinically contraindicated".

e. Neither barbiturates, nor miscellaneous sedative, hypnotic, anxiolytic drugs will be initiated in the facility as part of an initial therapeutic treatment program.

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

PROCEDURE:

1. Residents who are admitted with a psychoactive medication will have an assessment of the continued need, dosage, and indications for the medication.

   a. The physician's admitting order for psychoactive medication will state the behavior or mood problem being treated.

   b. The physician is to obtain the informed consent.

   c. The behavior or mood problem will be entered on the care plan with the side effects of the drug and non-drug interventions.

   d. The Interdisciplinary Team will complete the "Psychoactive Medication Assessment" at the first Team Conference Meeting following admission, review the treatment progress in the monthly Team Conference Meeting, and reevaluate in a quarterly assessment the appropriateness of continued treatment with psychoactive medications.

   e. Nursing and Social Service Designee will document in their progress notes the interventions provided, and resident's response to treatment.

   f. Nursing will stop the medication and notify the physician if medication side effects are suspected.

2. When psychoactive medications are initiated on the unit, the resident's medical record will contain completed assessments, documented interventions, and appropriate consents, before the drug is administered.

   a. The physician's order for psychoactive medication will identify the mood or behavior problem being treated and order behavioral monitoring when behaviors are targeted.

   b. The physician will then complete the appropriate consent form for the medication with the resident.

   c. If the resident is not capable of giving informed consent, consent will be obtained from the resident's surrogate.

   d. Nursing will have documentation in regards to the non-drug interventions that have been unsuccessfully implemented.

   e. A care plan will be completed noting the behavior or mood problem being treated, non-drug interventions, and drug side effects.

3. Informed consent, assessment, and response to psychoactive medications will be documented in the medical record.

a. Prior to the administration of any psychoactive medications initiated on the unit, the consent for the specific medication will be documented in the medical record.

b. When a resident, or the resident's surrogate refuses a psychoactive medication that has been ordered, the Refusal of Medication will be documented in the medical record. Documentation will state that the resident was informed, inclusive of details, regarding the risk and benefits of the medications ordered.

c. The Interdisciplinary Team will review the use of psychoactive medications in the Interdisciplinary Team Conference meeting, and will document in the Team Conference notes a re-evaluation of the medication's effectiveness, with recommendations for the continued usage, dose reduction, or discontinuance of the medication.

d. When resident is receiving a psychoactive medication and dosage reduction is "clinically contraindicated," the physician will document the reason as to why the medication is necessary on a Risk vs. Benefits form.

e. When medications are ordered outside the "Unnecessary Drug Guidelines," the physician will document the reason for the medication and the psychiatric condition necessitating the medication. The physician's documentation should be supported by a psychiatric/ psychologist consultation.

f. Nursing will document frequency of incidents of the behavior on each shift, when a resident is receiving any psychotropic medication for a disorder, which is manifested by inappropriate behaviors.

g. Nursing will document responses to dosage reduction attempts.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) *Barclays California Code of Regulations,* 72319 (j) San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Stones, MJ (2019). *Psychotropic Medication Use and Mortality in Long Term Care Residents.* Retrieved from https://www.intechopen.com/books/aging-life-span-and-life-expectancy/psychotropic-medication-use-and-mortality-in-long-term-care-residents.

- Medicare State Operations Manual for Long Term Care Facilities, Department of Health and Human Services, September 2000 , Tag F221, F222, Appendix PP.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT .

SUBJECT: **SCOPE OF SERVICES- DPSNF**	SECTION:

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

PURPOSE:

To describe the purpose and scope of the social services program provided to residents of the DP/SNF.

POLICY:

It is the policy of the DP/SNF that all residents are provided the medically related social services that will enable them to achieve and maintain their highest practicable level of physical, mental, and psychosocial wellbeing.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES*

PROCEDURE:

Social Services staff is responsible for the following:

1. Consultation with allied health professionals regarding provisions for the social and emotional needs of the resident and family.
2. Comprehensive documentation of social service assessment and intervention for each resident.
3. Obtaining pertinent information regarding personal and family problems related to the Resident's illness and care needs.
4. Maintaining regular progress and follow-up notes indicating the resident's response to the Care Plan and interventions.
5. Assisting residents/families with financial, insurance, and benefit programs, and maintaining required logs and records.
6. Maintaining current information regarding community health and service agencies.
7. Maintaining contact with the Resident's family members, significant others or responsible party, and involving them in the Resident's plan of care.
8. Providing or arranging supportive counseling to Residents and/or families.
9. Informing the Resident or responsible party of the Resident's personal property rights to assure that complaints and/or grievances are promptly resolved.
10. Participation in interdisciplinary staff meetings, providing social service information to ensure appropriate intervention and/or treatment of the social and emotional needs of the Resident as a part of the total Personalized Care Plan.

11. Assisting members of the interdisciplinary team and residents, family or responsible party in developing alternative therapeutic strategies for residents with behavior problems and/or who are prescribed psychotropic medications.

12. Coordinating the discharge planning process with resident, responsible party, and facility staff.

13. Providing financial and legal assistance through referral to appropriate resources.

14. Developing and participating in in-service training programs and classes.

15. Making arrangements for obtaining needed adaptive equipment, clothing, and personal items.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (6), 483.15 (g) United States of America, Med Pass Inc.

SUBJECT: **SIDERAILS**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to provide a device to assist residents in independent bed mobility, to provide a safety device for preventing residents from falling from bed, or as a restraint to prevent injuries for those residents who have been screened for the use of restraints and for whom the use of siderails has been determined to be the appropriate, least restrictive type of restraint. An Informed Consent from the family/responsible party and a physician's order has also been obtained for their use and must be obtained before they are used.

POLICY:

It is the policy of this facility to assess all residents for the appropriate use of siderails.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

PROCEDURE:

1. Upon admission, all residents will be assessed for functional and cognitive levels.
2. The appropriate use of siderails will be determined by the resident Bed/Siderail Assessment.
3. Residents for whom siderails are determined appropriate for assistive or safety reasons will have care plan entries identifying the reason for use.
4. Residents for whom siderails are determined appropriate will have an appropriate personalized care plan completed and informed consent signed by the resident, family, significant other or guardian.

REFERENCES:

- Thomson Reuters (2019). Barclay's California Code of Regulations, 72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25(n), (2) (3) (4) United States of America, Med Pass Inc.

SUBJECT: **SMOKING CESSATION**	SECTION:
	Page 1 of 3

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

PURPOSE:

To reduce the overall incidence of tobacco use by providing tobacco dependence treatment to SVMC patients who smoke, thereby, promoting better health and decreasing the likelihood of tobacco-related illnesses and conditions.

STANDARD OF CARE:

- Health care providers should assess and document tobacco use status for every patient who has been identified as a primary smoker, or is exposed to second hand smoke.
- For users, readiness to quit should be assessed and documented on each admit.
- Patients indicating a readiness to quit should be given choices of methods at every opportunity.

GOAL:

- All patients admitted to SVMC will be screened for tobacco use and dependency. Patients identified as current smokers will be advised to stop and will be offered education and counseling on smoking cessation.
- To provide the evidence based guidelines to assist clinicians for evaluation and treatment of patients with tobacco dependency.
- To ask tobacco use status at every hospital visit and provide advice to quit for all identified tobacco users.

DESCRIPTION:

Smoking Cessation Education will be done by a licensed Respiratory Care Practitioner (RCP) to include:

1. Assessment of tobacco use and reinforcement of non-use in patients that have quit within the past 12 months.
2. Advise smokers of the benefit of stopping in a personalized and appropriate manner (this may include linking the advice to their clinical condition).
3. Evaluate indications for pharmacological support and provide patient with information on pharmacologic therapy choices.
4. Discuss with the physician and document the suggested personalized patient smoking cessation plan.

5. Bedside spirometry will be performed per clinical practice guideline and/or bronchodilator protocol when appropriate.

6. All educational materials and handouts will be provided/available in English or Spanish.

7. Inform and offer information related to programs available such as Freedom From Smoking prior to discharge.

SETTING:

Inpatient admissions per nursing / MD referral**

- Intensive Care and Telemetry Unit
- Medical Surgical Unit
- Pediatric Unit
- OBGYN Unit

** Automatic referral when patient answers "yes" to smoking questions on Nursing Admission Assessment.

PROCEDURE:

1. Nursing will provide patients that answer "Yes" on "Currently smoking" or "Have you quit in last 12 months" on Nursing Admission Assessment, care notes on smoking cessation.

2. If patient is interested in quitting, nursing will contact the RCP covering that floor and place order in computer under Respiratory Therapy for Smoking Cessation education.

3. RCP will provide counseling and materials with educational information to resources such as the quitline and Freedom From Smoking program.

4. RCP will document under interventions in the Interdisciplinary Education Record.

REFERENCES:

https://www.thoracic.org/statements/resources/pfet/PFT2.pdf

- Centers for Disease Control and Prevention (CDC). Smoking Cessation- The Role of Healthcare Professionals and Health Systems. (February, 2020). Retrieved from https://www.cdc.gov/tobacco/sgr/2020-smoking-cessation/fact-sheets/healthcare-professionals-health-systems/index.html

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- Stop Smoking. (n.d.). Retrieved from http://www.lung.org/stop-smoking/.

SUBJECT: **SOCIAL SERVICE ROLE IN THE ADMISSION OF RESIDENTS**	SECTION: Social Services 3 **Page 1 of 6**

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

PURPOSE:

To assure that residents are informed of their rights and the responsibilities governing resident conduct during their stay in the facility.

POLICY:

The facility's skilled nursing admission agreement will be used to communicate rights and services information to the resident or his representative prior to or upon admission, during resident's stay as changes may occur, and when the facility's rules change. This information will be given both orally and in writing according to applicable regulations.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, NURSING*

PROCEDURE:

1. Upon receipt of notice of the resident's admission, the Social Service Designee (SSD)/Admitting Representative will schedule a meeting with resident and/or responsible party within 24 hours of admission. Within 24-48 hours of the initial appointment, the SSD will complete the admission agreement and initial consents, unless they are mailed out of the area.

2. The admission agreement will be reviewed with the resident unless she/he lacks decisional capacity, has been adjudicate incompetent, or wishes to delegate decision making to a responsible party. (Should any of these circumstances change, the Social Service Designee/Admitting Representative will review the information with the resident to complete a new admission agreement.)

3. The Social Services Designee will document, in Meditech and on the admission agreement, the resident's decision to delegate responsibility, and any portions of the agreement that were reviewed with the resident. (i.e., resident informed of rights but preferred to have information reviewed and signed by responsible party)

4. In the absence of a responsible party, the Social Services Designee/Admitting Representative will document in Meditech and on the admit checklist the reasons for an unsigned admission agreement, and will include in Notes all efforts made to seek a surrogate on the resident's behalf.

    a) Under the judgment of the Epple Bill, facilities serving current residents who lack capacity and have no surrogate decision will need to take immediate steps to do the following:

        a. First, facilities must provide verbal and written notice to those residents of: (1) the determination made by their physician that they lack capacity to make medical decisions; (2) the determination that they have no surrogate decision maker; (3) the current treatment ordered by their physician and approved by the interdisciplinary team (IDT); and (4) that the treatment will continue without interruption.

b) The notice also needs to inform the resident that they have the right to a representative and that the resident can seek judicial review of the determinations made by their physician as well as the intervention being provided by the facility, approved by the IDT.

c) A copy of the written notice also needs to be sent to the resident's representative if there is one. If there is no representative, a copy of the written notice needs to be sent to the local office of the long-term care ombudsman's office for the county or counties served by that office.

d) Second, if facilities are serving new residents who are determined by their physician to lack capacity and have no surrogate decision makers, facilities will need to likewise provide verbal and written notice to the resident as to those determinations as well as the fact that medical decisions will be made by the IDT based upon the recommendations made by their physician, that the resident has the right to have a representative present at the IDT where the proposed treatment and the right to seek judicial review.

e) A copy of the written notice needs to also be provided to the resident's representative and if there is no such representative, the notice needs to be provided to the local office of the long-term care ombudsman.

5. When the resident lacks capacity and the responsible party is out of area and/or unable to come in to review admission agreement, it should be mailed (by certified mail, to verify receipt of the information). The Social Services Designee shall review the information orally with them by phone if possible to assure understanding prior to their signing and returning the packet. The Social Services Designee shall document ongoing efforts to complete this task in the electronic medical record.

6. When the resident is physically unable or refuses to review admission agreement, the following steps should be taken:

   a. Document reasons, and ongoing efforts to obtain cooperation and compliance.

   b. Assure that at least the following documents are completed with the resident within the first 24-48 hours: Resident Rights, Advance Directive Acknowledgement, Preferred Intensity of Care Form, facility's conditions of admission or the consent for treatment portion of the admission agreement.

   c. Give resident the admission agreement and request signature on the admission page to acknowledge receipt. Social Services Designee shall document all efforts to complete process.

   d. Provide information to surrogate/responsible party on resident's behalf, and document efforts.

7. When a resident is unable to comprehend English, a translator/interpreter will be utilized. For foreign languages commonly used in the facility (i.e., Spanish), written translations of the Resident Rights, Resident Responsibilities, and other forms will be utilized as available, along with an interpreter. For less commonly encountered languages, a representative of the resident may serve as interpreter, and sign that s/he has explained the statement of rights to the resident prior to acknowledgement of receipt.

8. When a resident is admitted, the Social Services Designee/Admitting Representative will make all efforts to review the admission agreement in its entirety with the resident or responsible party. If unable to complete due to resident's condition, refusal to cooperate, etc., the Social Services Designee will follow steps outlined in #6, above.

9. As an interim measure to expedite the admission consents for treatment, Social Services Designee or charge nurse should obtain consents by phone with a witness present, and should document this on the forms as in #6(b), above. Alternatively, documents can be faxed to the responsible party to be reviewed and immediately returned by fax. These measures should only be undertaken when the resident lacks capacity and the responsible party is unable to be present at the time of admission.

REFERENCES:

- CAHF, California Association of Health Facilities, California Court of Appeals (July 23, 2019) EPPLE Bill, Health and Safety Code 1418.8.

SUBJECT:	SECTION:
STERILE PRODUCTS:EDUCATION AND COMPETENCY	**Page 1 of 7**

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

PURPOSE:

To provide the necessary training and education of pharmacy personnel to promote preparation of pharmacy-prepared sterile products.

DEFINITIONS:

Validation: Documented evidence providing a high degree of assurance that a specific process will consistently produce a product meeting its predetermined specifications and quality attributes.

USP 797- United States Pharmacopeia (USP) is a quality organization that publishes acceptable standards for sterile preparations and "797" refers to the chapter that deals with sterile product quality benchmarking.

Category 1 CSP- A compounded sterile preparation (CSP) assigned a beyond use date (BUD) of 12 hours or less at controlled room temperature or 24 hours or less refrigerated. All sterile products compounded in the hospital pharmacy ~~and at Cancer Treatment Center (CTC) Suite A~~ will not exceed a BUD of 12 hours as they are prepared in a segregated compounding areas.

Category 2 CSP- A CSP assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated that is compounded in accordance with all applicable standards found in USP 797.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the Pharmacist in Charge shall ensure that all personnel engaging in preparation and handling of sterile products will have training and demonstrated competence in the safe handling and compounding of sterile drug preparations. All sterile products will be prepared according to USP 797 standards by appropriately trained pharmacy personnel.

AFFECTED PERSONNEL/AREAS: *PHARMACY*

PROCEDURE:

A. Initial and Annual Education Shall Include at the Minimum:

1. Aseptic technique: Pharmacy personnel preparing or dispensing sterile products will receive didactic and experiential training in aseptic technique. Personnel shall read and/or watch a USP 797 video and take a test based on the contents. A passing score will be 90%. Technique will be evaluated by the pharmacist or designee staff. A checklist of score results will be maintained on file in the pharmacy. This competency will be repeated annually or upon a new hire or as deemed necessary.

2. Calculations and terminology: A written test on calculations and terminology will be required annually and maintained in personnel files. A passing score is 90%.

3. Education shall include a review of:

   a. Contamination of critical area/ Environmental monitoring

   b. Equipment and supplies

   c. Compounding and documentation

   d. Quality assurance procedures as outlined in COMPOUNDED STERILE PREPARATION:QUALITY ASSURANCE PROGRAM

   e. Non-pharmacy and pharmacy personnel cleaning

   f. Observations of technique

   g. Process validation

   h. USP Chapter 797 review and USP 800 as needed

   i. Aseptic preparation technique via media fill

   j. Proper hand hygiene, gowning, gloving and garbing technique

   k. General conduct

   l. Decontamination (where applicable), cleaning, disinfecting, and maintaining of the equipment and controlled area.

   m. Principles of High Efficiency Particulate Air (HEPA) filtered air

B. Competency

1. Initial competency evaluation will be done immediately following initial hand hygiene and garbing procedure, each individual shall complete a gloved fingertip (all fingers both hands) sampling procedure (zero CFU's both hands) at least three times before being initially allowed to compound sterile drugs.

   In addition to the written testing process, validation confirming sterile technique shall also be performed annually. This process evaluates practical skills of personnel's sterile technique by utilizing a culture from multiple aseptic procedures upon a sterile broth medium, i.e., media fill test.

2. Recertification competency including testing glove fingertip, media fill, garbing and hand hygiene, aseptic technique shall be done annually after initial competency and completed with no more than a total of 3 CFU's.

   - This testing will be done with a gloved fingertip testing method.
   - A media fill challenge will also be done
   - In addition, a visual observation will be conducted and documented.
   - All records will be maintained on file in the pharmacy for at least three years.
   - The quarterly fingertip testing must be performed on the sterile gloves inside of the compounding aseptic isolator (CA~~C~~I) that are placed over the gauntlet gloves. The gloved fingertip testing of these sterile gloves that cover the gauntlet gloves shall be done AFTER completing the media fill preparation WITHOUT applying alcohol.

3. Personnel who fail written tests regarding~~:~~ hand hygiene, garbing, and aseptic technique; gloved fingertip sampling; or media-fill test;

   a. Must undergo immediate requalification and pass with 90% before they can resume compounding.

4. Personnel who fail any visual observation of hand hygiene, garbing, and aseptic technique; gloved fingertip sampling; or media-fill test;

   a. Must repeat and pass ~~three successive~~the evaluation~~s~~ in the deficient area(s) before they can resume compounding.

5. Timing of Reevaluation and Requalification

   a. Visual Observation of Compounding- Initially and then at least quarterly.
   b. Gloved Tip Fingertip Sampling-~~Three~~ One times initially and then quarterly.
      ~~b.~~i. If conducting initial evaluation, three times initially, then one time upon subsequent evaluations.
   c. Media-Fill testing- Quarterly
   d. Cleaning and Disinfecting-After a change in cleaning or disinfecting procedures
   e. After a Pause in Compounding related activities (including but not limited to compounding & quality assurance monitoring)- Personnel who have not compounded in 3 months must be requalified. If the pause exceeds 6 months, that person will be treated as a new employee.

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6. Annual competency can be completed in approximately 8 weeks from previous year's completion date.

7. Routine performance checks shall occur to ensure adherence to aseptic policies and procedures.

8. All policies and procedures pertaining to sterile compounding shall be reviewed by all staff annually or when there are changes to any of the policies. All staff shall sign off on education of these policies and acknowledge that any material failure to follow the policies and procedures shall constitute a basis for disciplinary action by SVMC and/or the Board of Pharmacy.

C. Personnel Cleansing and Garbing

1. Personnel experiencing rashes, sunburns, weeping sores, oozing tattoos, conjunctivitis, or active respiratory infections or other communicable diseases shall not compound sterile products until their conditions have resolved.

2. Compounding personnel shall not wear cosmetics, hand, wrist, or other visible jewelry, artificial nails, or extenders. Cover any jewelry that cannot be removed. Natural nails shall be kept neat and trimmed. Remove head phones, ear buds, cell phones, bandanas, coats, hats, jackets, scarves, sweaters, and vests while compounding.

3. In preparation for entering the ante room, personnel shall first don shoe covers, head and facial covers.

4. Hand Hygiene

   a. Remove debris from under fingernails, if present. Use a nail cleaner (pick) under warm water.
   b. Hands and forearms shall be washed vigorously with soap (chlorhexidine) and water for at least 30 seconds.
   c. Dry hands and forearms up to the elbows with low-lint disposable towels.
   d. Immediately before donning sterile gloves, apply a suitable alcohol-based hand rub, Sterillium©. Allow a sufficient time and amount of product to keep hands wet for manufacturer specified application time, at least 3 minutes.
   e. Allow hands to dry thoroughly before donning sterile gloves.
   f. After donning sterile gloves, apply sterile alcohol 70% to outside of gloves and allow alcohol to dry.

5. For Category 2 with a CACI/Hood: A clean non-shedding (low-lint) gown dedicated to use in the compounding area shall be next donned.

6. For a Category 1: A sterile gown or low-lint gown with sterile sleeves shall be donned after hand cleansing.

7. Visibly soiled gowns must be changed immediately. Gowns and garbing items must be segregated and stored before use in an enclosure to prevent contamination (away from sinks to avoid splashing).

8. Sterile gowns may~~must not~~ be reused within the same shift by the same person if they are maintained in a manner that prevents contamination. This privilege does not apply to hazardous drugs.

9. Garbing and de-garbing shall not occur in the ante-area at the same time.

10. After hand cleansing, sterile gloves shall be donned before sterile gowns are donned. If sterile sleeves are used then they are donned after sterile gloves.

11. Once inside the compounding area, hands will be disinfected with an alcohol-based hand scrub.

12. Gloves will be alcohol disinfected prior to entering the glovebox and anytime hands are removed and placed back into the glovebox.

13. Gloves that become contaminated by contact will be disinfected with 70% isopropyl alcohol and applied to all surfaces.

D. Doffing Procedure when Exiting Hazardous Drug Compounding Area

i. Remove outer pair of HD gloves and place in HD waste container.
ii. Remove outer pair of booties and place in yellow HD waste container.
iii. While in the HD buffer area, remove the HD gown and place in yellow HD waste container.
iv. Remove inner pair of HD gloves
v. Exit HD Buffer and enter clean side of ante room and go to the sink.
vi. Remove bouffant/mask and place in yellow HD waste container found under sink.
vii. Wash hands as stated above.
viii. Remove booties and step across LOD
ix. Use Sterillium© gel

E. Conduct

1. Food and drink and cardboard will not be permitted in the IV room.

2. Actions such as talking and coughing should be directed OUT of the IV room.

3. Any unnecessary motion in the IV room should be minimized to avoid turbulence of air flow.

4. Activities in the IV room should only be related to procedures for the parenteral preparations.

F. Pharmacy Personnel will be trained on:

1. Using the appropriately labeled container for the type of surface to be cleaned (floor, wall, etc.)

2. Documenting cleaning activity.

3. Following garbing procedures when performing activity in the segregated compounding area.

4. Mopping floors with a pharmacy specific mop used ONLY for floors. The mopping should start at the wall opposite the entry room door. Mop the floor with even strokes toward the operator. The applied agent (Ecolab- hospital grade germicidal) shall remain visibly wet for 10 minutes, i.e., dwell time.

5. Cleaning the sink and all contact surfaces.

6. Cleaning of walls top to bottom, ceilings left to right toward the operator.

7. Cleaning of shelves, bins, buffer area chair, exterior of trash bins.

8. Documenting all cleaning.

G. Pharmacy Personnel will be trained on cleaning the CA~~C~~I/Hood

1. When properly garbed, the pharmacy technician, at a minimum twice a day, when there is a spill or prior to preparing a new sterile product:

   a. Wipe down the entire CA~~C~~I/Hood chamber with sterile water.

      - Using long strokes left to right on the bottom and top surfaces and long strokes top to bottom progressing towards the operator on the vertical sides of the CA~~C~~I/Hood.

      - This process will be repeated with 70% sterile alcohol and Peridox ©

   b. This procedure will be used for application of monthly sporicidal (Peridox ©, with a dwell time of at least 3 minutes) and germicidal agents. The daily, weekly and monthly cleanings shall NOT overlap and will be performed separately.

2. Competency will be assessed with a written test and a visual observation annually. Records will be kept for three years.

H. Record Keeping

Records of training and demonstrated competency shall be maintained for each individual for three years beyond employment.

I. Whenever a change in a policy or procedure occurs, the pharmacist in charge will notify the staff via a meeting or email. Staff shall sign off on changes, acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2022) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved May 12, 2020 , from http://www.usp.org/compounding/general-chapter-797.
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CROSS REFERENCES:

- COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM

SUBJECT: **THERAPEUTIC DRUG SUBSTITUTION PROTOCOL**	SECTION: ***Clinical Pharmacy Drug Protocols*** **Page 1 of 11**

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

PURPOSE:

To promote cost effective, rational drug therapy by controlling the number of similar medications within a given therapeutic class that will be available on formulary.

POLICY:

A therapeutically equivalent drug may be dispensed following the development of objective interchange guidelines by the medical and pharmacy staff through the Pharmacy and Therapeutic Committee.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF, PHARMACY, NURSING*

PROCEDURE:

The Pharmacy and Therapeutics Committee will identify potential therapeutic classes of medications, which may provide an opportunity for therapeutic interchange. Upon identification, experts in the area of therapeutic classification will be changed with selecting an appropriate therapeutic class representative drug. In making this selection, the following factors should be considered: mechanism of action, adverse effect profile, dosing schedule, monitoring parameters, potential drug interactions, and cost. Following the agent selection, objective interchange guidelines will be established and will be reviewed with other members of the medical staff.

The P&T Committee will review these guidelines. Following approval by P&T, the Medical Executive Committee of the institution will review and approve. Once approved the medications within "Non-Form" section will become non-formulary.

Medications with a DAW or dispense as written designation will be reviewed through the non-formulary process.

DEFINITIONS:

1. Therapeutic Substitutions- Is the replacement of the originally prescribed drug with an alternative molecule with assumed equivalent therapeutic effect. The alternative drug may be within the same class or from another class with assumed therapeutic equivalence.

2. Biosimilar- FDA approved medication that is highly similar to the reference product. For approval, the structure and function of an approved biosimilar were compared to reference product and shown to have no clinically meaningful differences in safety, purity, or potency (safety and effectiveness) compared to the reference product.

Appendix A: Proton Pump Inhibitor

Pantoprazole (Protonix®) will be the preferred (medication substituted to) proton pump inhibitor at Sierra View Medical Center. Lansoprazole (Prevacid®) 30mg Solutabs may be used if PPI needed to be delivered via G-tube. Orders written for oral dexlansoprazole (Dexilant®), esomeprazole (Nexium®), lansoprazole (Prevacid®), omeprazole (Prilosec®) or rabeprazole (Aciphex®) are autosubstituetd by Pharmacy per the table below.

Preferred Agent					
Pantoprazole (Protonix®)	**Omeprazole (Prilosec®)**	**Esomeprazole (Nexium®**	**Rabeprazole (Aciphex®)**	**Lansoprazole (Prevacid®**	**Dexlansoprazole (Dexilant®)**
20mg daily	10mg daily	20mg daily	20mg daily	15mg daily	30mg daily
40mg daily	20mg daily	20mg daily	20mg daily	30mg daily	60mg daily
40mg BID	20mg bid or 40mg daily	40mg daily	20mg BID	30mg BID	30mg BID
80mg BID	40mg bid	80mg daily	40mg BID	60mg BID	60mg BID

Note: In the event of a drug shortage for Pantoprazole; Esomeprazole will be the substitute agent.

Appendix B: Nasal Corticosteroid Products

Substitutive Agent-Therapeutic Interchange	Non-Form
Fluticasone Nasal 1 spray each nostril daily	Beclomethasone Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Budesonide Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Flunisolide Nasal, 2 sprays each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Mometasone Nasal, 2 sprays each nostril daily
Fluticasone Nasal 2 spray each nostril daily	Triamcinolone Nasal, 2 sprays each nostril daily

Note: In the event of a drug shortage for Fluticasone nasal, Triamcinolone Nasal will be the substitute agent.

Appendix C: Inhaled Combination Medication Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Budesonide/Formoterol (Symbicort) 80/4.5 mcg 2 puffs BID 160/4.5 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID 500/50 mcg 1 puff BID	Fluticasone/Salmeterol(Advair HFA) 45/21 mcg 2 puffs BID 115/21 mcg 2 puffs BID 230/21 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Fluticasone/Vilanterol (Breo) 100/25 mcg daily 200/25 mcg daily
Albuterol MDI same dose and frequency plus Tiotropium (Spiriva Respimat) 2 INH daily	Ipratropium/Albuterol (Combivent)
Fluticasone/Salmeterol (Advair) 250/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Mometasone/Formoterol (Dulera) 100/5 mcg 2 puffs BID 200/5 mcg 2 puffs BID
Tiotropium (Spiriva Respimat) 2 inhalations (2.5mcg) daily	Tiotropoium (Spiriva Handihaler) Inhale contents of one capsule daily

Appendix D: Insulin Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Insulin Lispro (Humalog) 1:1 conversion	Insulin Aspart (Novolog)
Insulin glargine 1:1 conversion	Insulin degludec (Tresiba)
Insulin glargine 1:1 conversion	Insulin detemir (Levemir)

Note biosimilar's for substitutive therapeutic interchange may be used.

Appendix E: Antihistamine agents

Substitutive Agent- Therapeutic Interchange	Non-Form
Loratadine (Claritin) 10mg daily	Cetirizine (Zyrtec) Oral 5mg or 10mg daily
Loratadine (Claritin) 10mg daily plus Equivalent Pseudoephedrine up to 60mg po QID	Cetirizine/Pseudoephedrine (Zyrtec-D) All doses
Loratadine (Claritin) 10mg daily	Desloratidine (Clarinex) Oral 5mg daily
Loratadine (Claritin) 10mg daily	Fexofenadine (Allegra) Oral all doses
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Fexofenadine/Pseudoephedrine (Allegra-D) All doses
Loratadine (Claritin) 10mg daily	Levocetirizine (Xyxal) Oral 2.5 to 5mg daily
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Loratidine/Pseduoephedrine (Claritin D)

Appendix F: HMG CoA Reductase Inhibitors

Substitutive Agent- Therapeutic Interchange	Non-Form
Atorvastatin (Lipitor) 5mg daily 10mg daily	Fluvastatin (Lescol) 40mg daily 80mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Lovastatin (Mevacor) 20mg daily 40mg daily 80mg daily
Atorvastatin (Lipitor) 20mg daily 40mg daily 80mg daily 80mg daily	Rosuvastatin (Crestor) 5mg daily 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Simvastatin (Zocor) 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Pitavastatin 1mg daily 2mg daily 4 mg daily

Note: In the event of a drug shortage for Atorvastatin, Simvastatin will be the substitute agent.

Appendix G: Angiotensin II Receptor Blocker

Substitutive Agent- Therapeutic Interchange	Non-Form
Losartan 25mg 50mg 100mg 150mg	Telmisartan (Micardis) 20mg 40mg 80mg >80mg
Losartan 25mg 50mg 100mg 150mg	Olmesartan (Benicar) 5-10mg ----- 20mg 40mg
Losartan 25mg 50mg 100mg 150mg	Irbesartan (Avapro) 75mg 150mg 300mg ---
Losartan 25mg 50mg 100mg 150mg	Candesartan (Atacand) 4-8mg --- 16mg 32mg
Losartan 25mg 50mg 100mg 150mg	Azilsartan (Edarbi) 40mg 80mg --- ---
Losartan 25mg 50mg 100mg 150mg	Eprosartan (tevetan) 400mg 600mg 800mg ---

Appendix H: Biosimilar Medications

Note- Preferred agents should be utilized for inpatient and outpatient use. If a patient's payer requires use of a non-preferred agent, the non-preferred biosimilar may be used.

Therapeutic Interchange (Preferred agent)	Reference Product	Comments
Alymsys (Bevacizumab- maly) Mvasi (Bevacizumab- awwb)	Avastin (Bevacizumab)	As required by payor
Kanjinti (Trastuzumab-anns)	Herceptin (Trastuzumab)	As required by payor
Ziextenzo (pegfilgrastim-bmez)	Pegfilgrastim (Neulasta)	As insurance allows Pegfilgrastim biosimilar and products is NON-FORMULARY for inpatients. Filgrastim should be used for inpatients
Releuko (Filgrastim-ayow)- preferred Zarxio (Filgrastim-sndz)	Neupogen (Filgrastim)	As required by payor
Renflexis (infliximab-abda)- preferred Inflectra (infliximab-dyyb)	Remicade (Infliximab)	As required by payor
Retacrit- epoetin alpa-epbx	Procrit/Epogen- epoetin alpha	
Truxima (rituximab-abbs)- preferred Riabni (rituximan-arrx)	Rituxan-rituximab	As required by payor

Cancer Treatment Center Procedure:

If it is discovered that a patient's insurance rejects said biosimilar as part of the patient's treatment, the patient's care plan will be adjusted by the CTC pharmacist to reflect the approved agent. Example: Mvasi is rejected but insurance will cover Avastin→Pharmacist will be allowed by physician to make the adjustment in the patient's care plan.

1. Upon receipt of new care plan, CTC pharmacist will confirm with said list and if necessary, adjust the medication within the care plan to reflect the current approved medication from Addendum A if necessary to conform to insurance authorized and physician requested care plan.

2. After pharmacist adjustment in care plan, they will forward to insurance authorizer for approval. Once approved, Pharmacy will order as needed.

Dose Rounding for Continuous Infusion of Oncology Medications

1. Upon receipt of new orders for chemotherapy or biotherapy, the pharmacist will verify all calculations for dosage of agents ordered by the MD.
2. The pharmacist will evaluate the availability of the medications ordered. If the medication is available as a single use vial, the pharmacist shall calculate the difference in the dose ordered and the dose rounded to vial size.
3. For all single use vials of chemotherapy the pharmacist shall round the dose to a vial size within a 10% range of the dose ordered.
4. For all single use vials of monoclonal agents, the pharmacist shall round the dose to vial size within a 10% range of the dose ordered.
5. The provider will not be notified for dose changes of up to 5% for either chemotherapy or monoclonal agents.
6. The provider will be notified for dose changes greater than 5% and up to 10% for either chemotherapy or monoclonal agents.
7. Patients enrolled in clinical trials are excluded from the policy (unless dose rounding is specifically allowed in the investigational protocol)
8. If the physician does not wish to have the rounding policy applied, they will document on the order "no dose rounding" within the treatment plan within the administration instructions section.

Duplicate Orders

- Pharmacists may delete duplicate orders of the same medication, dose, and route with varying schedules. It will be assumed the new order with updated schedule is intended to replace the previous order (update frequency, dose, etc). E.g. Acetaminophen 650mg PO Q4HRS prn pain and Acetaminophen 650mg po Q6hrs prn pain. Pharmacist can authorize to delete the old order, and verify the new order while adding additional comments not to exceed 4gm/day as they see necessary.

Interchange between liquid and solid dosage forms

Pharmacists may automatically interchange between liquid and solid forms and route. EG patient is receiving medication and/or feedings via NG,OG,PEG; Pharmacist after discussion with patient's nurse will switch from oral to liquid form if available. Exception-Phenytoin with consult to patient practioner.

Therapeutic Duplications

Duplicate orders for the same indication are only appropriate if clear instructions around the circumstances each order applies to are indicated by the ordering practitioner. Any duplicative order without clear distinction will be assessed and addressed by the reviewing pharmacist.

Any parenteral (IV, IM, SQ) or rectal (PR) medication ordered as needed (PRN), will have direction added by pharmacist to "use when unable to tolerate oral" if another order for an oral alternative is ordered for the same as needed indication.

Example: Order written for Ondansetron 4mg IV q8h prn Nausea/vomiting with an existing Ondansetron 4mg PO q8h prn Nausea/vomiting. Pharmacist to clarify in the comment field of the IV order: Ondansetron 4mg IV q8h prn Nausea/vomiting, use when unable to tolerate oral

Example: Order written for Oxycodone 5mg PO q4h prn pain scale 4-7 with an existing Hydromorphone 0.4mg IV q4h prn pain scale 4-7. Pharmacist to clarify in the comment field: Hydromorphone 0.4mg IV q4h prn pain scale 4-7, use when unable to tolerate oral

Any order for a parenteral (IV, IM, SQ) as needed (i.e., PRN) opioid will be discontinued when a subsequent order for a parenteral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. breakthrough pain).

Example: Order written for HYDROmorphone (Dilaudid®) 0.5 mg IV q4h PRN pain 8-10 ordered on a patient with an existing order for Morphine 2 mg IV q4h PRN pain 8-10. Pharmacist will discontinue the existing Morphine order and validated the new HYDROmorphone (Dilaudid®) order.

Any order for a short-acting PRN oral opioid will be discontinued when a subsequent order for a short-acting oral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. Breakthrough pain).

Example: Order written for Oxycodone Immediate Release (IR) 5 mg PO q4h prn pain 8-10 ordered on a patient with an existing order for Tramadol (Ultram) 50 mg PO q4h prn pain 8-10. Pharmacist will discontinue the existing Tramadol order and validate the new Oxycodone order.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will discontinued when a subsequent order for a PCA or epidural is placed unless a clear indication that both can be administered concurrently via an order clarified with the provider.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will be left unvalidated if ordered at the same time as a PCA or epidural unless a clear indication that both can be administered concurrently via an order clarified with the provider. Upon PCA or epidural discontinuation, parenteral or oral as needed opioids will be validated.

Any orders with overlapping pain scales ordered at the same time will be clarified that the higher dose of medication is clarified to the higher pain scale as long as no medication is indicated for that pain scale.

Example: Orders written for Oxycodone Immediate Release 2.5mg PO q4h prn pain 4-7 and Oxycodone Immediate Release 5mg PO q4h prn pain 4-7. Pharmacist will adjust the Oxycodone Immediate Release 5mg PO q4hr prn pain 4-7 to a pain scale of 8-10 upon validation.

Any orders with pain scales of 1-3 or 4-7 and no order or information that include the higher pain scales will be clarified to include the higher pain scale as long as no medication is indicated for that pain scale.

Example: Order written for Tramadol 50mg PO q4hr prn pain 4-7. Pharmacist will adjust the Tramadol 50mg PO q4hr prn pain 4-7 to a pain scale of 4-10 upon validation.

Appendix: IV to PO Subsection

PURPOSE: To provide a process for changing parenteral medications to the oral/enteral route when medically appropriate. The advantages of this program are to provide an oral/enteral dosage form with comparable bioavailability to the intravenous form, which has been shown to decrease length of hospitalization.

To reduce the added risks associated with continued intravenous therapy.
To lower overall medication and associated costs to the patient and the hospital.

Additional benefits include greater patient comfort, decreased nursing needs, & easier ambulation. Orders for approved intravenous (IV) medications are automatically changed to PO (by mouth) administration form when medical staff approved conditions and guidelines are met, and the switch is appropriate.

PROCEDURE: Patients must meet the following criteria in order to be considered for automatic IV to PO conversion of the selected medications. If the patient does not meet all criteria listed below, they will not be considered for automatic IV to PO conversion.

Inclusion Criteria

- The patient must be on IV therapy for at least 24 hours before IV to PO conversion consideration.
- The patient is tolerating scheduled medications and diet (orally, or via NG or G tube).
- The patient is not on a pre-operative or -procedure or post-operative or -procedure fast.
- The patient has not experienced any recurrent nausea, vomiting or diarrhea for at least 24 hours.
- The patient does not have documented esophophageal sphincter incompetence.
- The patient does not have an active gastrointestinal bleed.
- The patient does not have documented problems with oral absorption (i.e., ileus, short bowel syndrome, celiac sprue, and inflammatory bowel disease or malabsorption syndrome).
- The patient is not at risk for aspiration (e.g., decreased consciousness, seizures, etc.).

Additional criteria for antibiotic/antifungal agents

- The patient is afebrile for at least 24 hours (temp < 100.4° F).
- The patient is clinically improving (white blood cell count decreasing, bands decreasing, improved signs and symptoms as documented in prescriber progress notes).

- The infection is at a site where an oral agent will achieve an adequate level (not endocarditis, meningitis, brain abscess, orbital cellulitis, other CNS infections, osteomyelitis, and endophthalmitis).
- The patient is not septic, and is hemodynamically stable (heart rate ≤ 100 beats/minute, respiratory rate ≤ 24 breaths/minute, and systolic blood pressure > 90 mm Hg without vasopressor support).
- For documented fungemia, fluconazole will continue IV for 7 days before PO switch.

The pharmacist may automatically switch the following medications to the oral dosage form, if the conditions under section 1 of this policy are met:

Antimicrobials

Medication	Intravenous Dose	Oral Equivalent
Azithromycin	250 mg IV daily 500 mg IV daily	250 mg PO daily 500 mg PO daily
Ciprofloxacin	200 mg IV every 12 hours 400 mg IV every 12 hours 400 mg IV every 8 hours	250 mg PO every 12 hours 500 mg PO every 12 hour 750 mg PO every 12 hours
Clindamycin	600mg-900mg IV every 8 hours	300mg-450 mg PO every 8 hours
Doxycycline	100 mg IV every 12 hours	100 mg PO every 12 hours
Levofloxacin	250 mg IV daily 500 mg IV daily 750 mg IV daily	250 mg PO daily 500 mg PO daily 750 mg PO daily
Fluconazole	100 mg IV daily 200 mg IV daily 400 mg IV daily	100 mg PO daily 200 mg PO daily 400 mg PO daily
Linezolid	600 mg IV every 12 hour	600 mg PO every 12 hours
Metronidazole	500 mg IV every 8 hours	500 mg PO every 8 hours
Rifampin	600 mg IV daily	600 mg PO daily
Trimethoprim / Sulfamethoxazole (TMP/SMX)	5-20 mg TMP/kg/day in 3-4 divided doses IV	As close to 1:1 conversion of TMP as possible: 1 double strength = 160 mg TMP 1 single strength = 80 mg TMP
Voriconazole	3-4 mg/kg IV every 12 hours (maintenance dose)	<40 kg: 100 mg PO every 12 hours ≥40 kg: 200 mg PO every 12 hours

Others

Medication	Intravenous Dose	Oral Equivalent
Acetaminophen IV (Ofirmev) (restricted only for those with strict NPO)	IV to PO is equivalent	Same dose regimen and frequency. May need to adjust in multiples of 325mg. IV acetaminophen doses limited to 2 doses for PRN orders and 4 doses for scheduled orders.
Famotidine	20 mg IV every 12 hrs.	20 mg PO every 12 hours
Ranitidine	50 mg IV every 6 or 8 hrs.	150 mg PO every 12 hours
Pantoprazole	40 mg IV daily	40 mg PO daily (lansoprazole 30mg NG daily)
Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

The pharmacist will review the criteria and effect the change when appropriate. He/She will enter an order in the patient's chart under "Physician Orders" as "Change I.V. (*insert drug name*) to P.O. per protocol". The notation "Per SVMC Policy" will be entered or written adjacent to the pharmacist's signature.

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SUBJECT: **TRANSFER WITHIN FACILITY- CHANGE OF ROOM/ROOMMATE**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the process of notification of change of room or roommate.

POLICY:

The resident and/or representative will be provided a written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES DESIGNEE*

PROCEDURE:

Administrative:

1. Changes in resident's room or roommate will be based on nursing/medical care needs and/or resident request. The resident's cultural, spiritual, and age related needs will be considered whenever a room or roommate change is necessary.

2. No resident will be involuntarily transferred within the facility without reasonable notice in writing (as required by law), except in an emergency, which necessitates transfer to acute level for health reasons, or safety and regulatory compliance reasons.

3. The resident's right to refuse certain transfers (per regulatory standards) and his/her wishes regarding transfer will be considered and complied with when they do not interfere with the resident's care and safety needs, and/or the rights and needs of other residents.

4. If the resident lacks the capacity to make decisions or to participate in his/her care, the responsible party will be contacted for notification of room or roommate changes. Written notice will be sent via one of the following options: certified mail, e-mail, fax. Acknowledgement of receipt of notification will be confirmed via phone call and will be documented as appropriate.

5. Documentation of verbal and written notice of changes in the resident's room or roommate will be maintained in the resident's record.

6. The Ombudsman's Office will be contacted to serve as advocate and liaison as needed to assure the resident's rights, when refusal of certain transfers occur, and to assist the resident/responsible party and facility to resolve concerns regarding room or roommate changes.

Preparation for Transfer:

1. The Social Services Designee will discuss the room change with the resident, responsible party and affected roommates, and complete charting needs related to the notification for transfer.

2. The licensed nurse will assemble current health records and all medication and treatment supplies.

3. The nursing assistant will assemble all resident's belongings, verify belongings against the personal inventory form, and date and initial upon completion; complete current charting needs; and, assemble all resident information forms located in the resident's room.

Transfer:

1. The licensed nurse and nursing assistant will transfer the resident with all belongings, records, medications and treatment supplies, after verification of the new room assignment.

2. The nursing assistant will assist resident adjustment through introductions to the new nursing assistant and review of the resident's ADL needs. The new assistant will introduce the resident to his/her new roommate(s) and orient the resident to the new room.

3. The licensed nurse will give verbal report to the receiving nurse (medication and care orders, resident care plan information, general condition and vital signs, medications administered and treatments done), will transfer all medications and treatment supplies, and will document that the transfer of the resident and all belongings has occurred and include the new room and bed number.

Post-Transfer:

1. The nursing assistant receiving the resident will complete admission to the room, safely store resident belongings and appliances for use, and will implement appropriate records maintained in the resident's room.

2. The licensed nurse receiving the resident will introduce self, document the admission in the Electronic Health Record, and notify the Dietary Department of the change in room.

3. The nursing assistant transferring the resident will check the resident's old room for any overlooked belongings (ensure that the bedside stand, closet and drawers are empty), and will remove all linen from the resident's old bed to prepare for cleaning.

4. The licensed nurse transferring the resident will document completion and assignment change in the Electronic Health Record, and will notify Housekeeping of the need to terminally disinfect the resident's old room.

5. Social Services and Nursing will monitor and assist in the adjustment of the resident and roommate(s) to the change, as well as the responsible parties.

GUIDANCE 483.10(e)(4)-(6)

Residents have the right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.

There are some limitations to these rights. Residents do not have the right to demand that a current roommate is displaced in order to accommodate the couple that wishes to room together. In addition, residents on DP/SNF are not able to share a room if one of the residents elects to pay privately for his or her care, or one of the individuals is not eligible to reside in a nursing home.

Moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of the facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.

A resident receiving a new roommate should be given as much advance notice as possible. The resident should be supported when a roommate passes away by providing time to adjust before moving another person into the room. The length of time needed to adjust may differ depending upon the resident. Facility staff should provide necessary social services for a resident who is grieving over the death of a roommate.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10(e)(4)-(6) United States of America, Med Pass Inc., Rev 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17.

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

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

PURPOSE:

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

POLICY:

Enteral feeding products will be ordered, received, and stored by 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.

7. ICU Standard of Care order set: Please see electronic orders for TF regimen

8. Critical Care Area Guidelines for gastric residuals:
   Gastric residual volume (GRV) will be checked once per shift
   If < 500ml with **no** evidence of intolerance, continue infusion
   If > 500ml with symptoms of intolerance, replace 250ml of aspirate, continue infusion, and consult physician for prokinetic agent
   If > 500ml or evidence of intolerance, hold tube feeding, return 250ml GRV and discard remaining volume, consult physician and recheck GRV after 2 hrs, if < 500ml restart feeds. Consult physician to consider post pyloric feeding tube.

9. Non-Critical Care Area Guidelines for gastric residuals:
   Gastric residual volume (GRV) will be checked once per shift
   If <250ml, then return residual, continue infusion
   If >250ml **and** symptoms of intolerance are present (abdabdominal distention, nausea, vomiting, diarrhea) hold feeding and notify MD. Return up to 250ml GRV
   If >250ml **without symptoms** of intolerance, return up to 250ml GRV, continue feeding and recheck in 2 hrs. If still greater than 250ml, hold feeding and notify MD

~~6.~~

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.

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7. DPSNF: The dietitian is responsible for completing a nutrition assessment on the patient/resident ~~7.~~ 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.~~8. Cranberry juice and/or soda ~~should~~ shall 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.

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CROSS REFERENCES:

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

REFERENCES:

- **Krames on Demand: Gastroenterology ->Tube Feeding**
- CIHQ Acute care Accreditation, Nutrition Assessment and Care Plans ~~file:///C:/Users/josee/Downloads/CIHQ%20Acute%20Care%20Accreditation%20Standards%20-%20Participating%20in%20Medicare%20Rev.1.21.pg-84.pdf~~ (2023) California Department of Public Health, Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- American Society of Enteral/Parenteral Nutrition (ASPEN) Guidelines for the Provision and Assessment of Nutrition 2016~~https://www.nutritioncare.org/uploadedFiles/01_Site_Directory/Guidelines_and_Clinical_Resources/EN_Pathway/EN%20Pathway%20PDF%206.pdf~~
- ~~).~~
- ~~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~~2019 Abbott Nutrition Best Practice for Managing Tube Feeding, A Nurse's Pocket Manual
- American Society of Enteral and Parenteral Nutrition (ASPEN) Critical Care Guidelines 2021
- The ASPEN Adult Nutrition Support Curriculum 3rd ed. 2017
- ASPEN 2014 Gastric Residual Volume in Critically Ill Patients: A Dead Marker or Still Alive?

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SIERRA VIEW MEDICAL CENTER **ANESTHESIA PRE-OPERATIVE ORDERS**

TREATMENT

ALL ORDERS MUST BE DATED, TIMED AND SIGNED BY THE PRESCRIBING PHYSICIAN

Physicians: Please indicate your orders by checking the boxes or filling in the blank spaces below

	All labs will be within 1 week of surgery and EKG within 6 months unless approved by Anesthesia. Weigh pt on admit (actual, not stated). Do not repeat any order by the admitting physician. All labs within 1 week of surgery PLUS: a. Glucose on arrival: for diabetic patients b. Potassium on arrival: for dialysis/ESRD patients or if recent K < 3 or > 5.2 c. PT/INR on arrival: for patients taking Warfarin if last INR > 1.5 within last 3 days
1.	**CBC:** H/o anemia, thrombocytopenia, or bleeding disorder; major surgery or anticipated significant blood loss.
2.	**Pregnancy test:** Test all female patients between the onset of menses and post-menopause (12 consecutive months without a menses); typically between the ages of 10-55 years, unless sterilized. a. Test over the age of 12 years unless sterilized or h/o hysterectomy or menopausal (12 consecutive months without a menses) b. Must obtain patient or guardian/parent consent before testing. Discuss with anesthesia provider if patient declines or if result positive.
3.	**EKG:** Age over 60, or Any age AND h/o cardiac disease (CAD/MI, CHF, HTN, DM, Chronic Kidney Disease, A fib or arrhythmia).
4.	**Complete Metabolic Panel:** Age over 60, or any age and history of cardiac disease (CAD/MI, CHF, HTN, Chronic Kidney Disease, A-fib, or arrhythmia) or any patient taking a diuretic or lithium.
5.	**Chest x-ray:** Recent acute/new onset cardiopulmonary symptoms (within the last month), worsening symptoms in patients with asthma or COPD, patients with history of heart failure or on dialysis AND experiencing shortness of breath or leg swelling, patients with history of lung surgery or cancer. a. Recent h/o persistent or worsening pulmonary symptoms (such as shortness of breath, chest pain, persistent cough, chest congestion, hemoptysis) within last one month. b. Worsening symptoms in patients with asthma or COPD within last one month. c. Worsening shortness of breath in patients with h/o CHF or on dialysis within last one month. d. Patients with h/o lung resection surgery or lung cancer AND no CXR available within last 2 years.
6.	**Fingerstick glucose:** Day of surgery for Diabetic patients
7.	**Coags** (PT/INR, PTT)**:** patients with history of chronic hepatitis, cirrhosis, bleeding disorder or taking Warfarin.
8.	Patients with Renal disease use 500ml NS with minidrip.
9.	Children over 5 yrs & under 50kg, start IV LR, 20-22g catheter with minidrip after topical use of EMLA cream. Consult anesthesia provider if IV needed on children under age of 8 years.
10.	**Respiratory:** Give Small Volume Nebulizer 2.5mg Albuterol in 3ml NS in pre-op to patients who are wheezing.
11.	**Cardiac History:** Contact patient's cardiologist to obtain most recent cardiac notes: cardiology notes, echo report, stress test report, cardiac cath report, carotid doppler report, pulmonary function tests.
12.	**Pacemakers or implanted defibrillators** – Obtain copy of the last time device checked for proper functioning, type of device (pacemaker or Implantable cardiac defibrillator), setting (mode and response to magnet), and pacemaker dependant or not. Must deactivate defibrillator immediately prior to the procedure, if applicable, and reactivate once procedure is completed.
13.	**Medications:** Hold oral hypoglycemic meds and MAOI inhibitors. Okay to take any regularly scheduled meds including cardiac, hypertensive, respiratory, seizure, antidepressant, antipsychotic, antibiotic, antiviral medications with sip of water on am of surgery. Consult Anesthesiologist for Insulin dosage on day of surgery. Also okay to take any regularly scheduled chronic pain medications.

PATIENT'S LABEL

14.	Screen patient for BETA BLOCKER use and document last dose on Procedural Patient Assessment form.
15.	Initiate warming therapy in FlexCare.
16.	Rapid COVID swab unless proof of prior positive test within 90 days
	Physician Signature: _____ **Date:** _____ **Time:** _____

PATIENT'S LABEL

Human milk is best for your baby. It is easy to digest and lowers the risk of illness. Breastfeeding is good for mom's health as well. Doctors prefer giving mom's milk first and heat-treated donor milk as a second choice. Donor milk protects and nourishes your baby in ways that formula cannot. Formula can be hard on baby's stomach early in life.

Our donor milk comes from milk centers that follow strict rules. The milk is heat-treated to kill germs. There are no known risks to donor milk, but risks that are not tested for at this time may exist. Since the start of the new milk centers (1980), no babies have gotten sick from donor milk.

Donor milk process:

- Health screening
- Blood test
- Milk tested
- Milk heat-treated (sterile)
- Milk tested again

Recommended by:

- American Academy of Pediatrics (MP)
- American Academy of Family Physicians (MFP)
- Academy of Nutrition and Dietetics (AND)
- Academy of Breastfeeding Medicine (ABM)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- World Health Organization (WHO)

❑ I consent for my baby to be fed donor breast milk.

I have read the above information and discussed it with _____, a member of my baby's health care team. My questions have been answered.

Signature _____ Relationship to Baby _____ Date/Time _____

Witness _____ Date/Time _____

2nd Witness (if phone consent) _____ Date/Time _____

Interpreter (if needed) _____ Date/Time _____

PATIENT'S LABEL

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La leche humana es lo mejor para su bebé. Es fácil de digerir y reduce el riesgo de enfermedades. El amamantamiento también es bueno para la salud de la mama. Los médicos prefieren dar leche materna primero y leche de donante tratada térmicamente como segunda opción. La leche de donante protege y nutre a su bebé de maneras que la fórmula no puede. La fórmula puede ser pesada para el estómago del bebé, especialmente en los primeros años de vida.

Nuestra leche de donante proviene de centros de leche que siguen reglas bastante estrictas. La leche se trata con calor para eliminar los gérmenes. Actualmente no se conocen riesgos para la leche de donante, pero pueden existir riesgos que no se han analizado en este momento. Desde el inicio de los nuevos centros de leche (1980), ningún bebé se ha enfermado por la leche de donante.

Proceso para Donantes de Leche:
- Exámenes de salud
- Análisis de sangre
- Leche probada
- Leche tratada térmicamente (estéril)
- Leche analizada nuevamente

Recomendado por:
- Academia Estadounidense de Pediatría (MP)
- Academia Estadounidense de Médicos de Familia (MFP)
- Academia de Nutrición y Dietética (AND)
- Academia de Medicina de Lactancia Materna (ABM)
- Asociación de Salud de la Mujer, Obstetricia y Enfermeras Neonatales AWHONN)
- Organización Mundial de la Salud (OMS)

❑ Doy mi consentimiento para que mi bebé sea alimentado con leche materna de donante.

He leído la información anterior y la he discutido con_____,

un miembro del equipo de atención médica de mi bebé. Mis preguntas han sido respondidas.

Firma_____ Relación con el bebé_____ Fecha/Hora_____

Testigo_____ Fecha/Hora_____

2do Testigo (si el consentimiento es por teléfono) _____ Fecha/Hora_____

Intérprete (si es necesario) _____ Fecha/Hora_____

PATIENT'S LABEL

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MINUTES OF A REGULAR MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **June 27, 2023 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:06 p.m.

Directors Present: REDDY, MARTINEZ, PANDYA, KASHYAP

Directors Absent: LOMELI

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Tracy, VP of Human Resources, Gomez, Cindy, Director of Compliance, Dickson, Doug, Chief Financial Officer, Espinoza, Alexis, Porterville Recorder, Hefner, Donna, President/Chief Executive Officer, Hirte, Todd, Contracts Administration, Franer, Julie, Admin Director Revenue Cycle, Jimenez, Alejandra, Project Manager, Mandujano-Roberts, Silvia, Manager of Care Integration for Social Services and Case Management, Mitchell, Melissa, VP Quality and Regulatory Affairs, Parsons, Malynda, Marketing, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Stringham, Zaelin, Director Food and Nutrition, Wallace, Marcella, Director of Communications, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director MARTINEZ, seconded by Director PANDYA, and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:06 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

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

G. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Strategic Planning (1 Item). Estimated Date of Disclosure – February 2026

Closed Session Items C, D, F, and H were deferred to the conclusion of Open Session as there was not time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:45 p.m., reconvening in Open Session at 5:45 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

Following review and discussion, it was moved by Director MARTINEZ, seconded by Director KASHYAP, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

Following review and discussion, it was moved by Director MARTINEZ, seconded by Director PANDYA, and carried to approve the Quality Division Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent

MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Conference with Legal Counsel

Information only; no action taken

G. Discussion Regarding Trade Secret

Information only; no action taken.

IV. Public Comments

A public comment, Chairman Response was made by Bindusagar Reddy, MD and Chairman of the Board. The Public Comment is attached to the file copy of these minutes.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Director MARTINEZ, seconded by Director PANDYA, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director MARTINEZ and seconded by Director PANDYA to approve the May 23, 2023 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

Following review and discussion, it was moved by Director MARTINEZ and seconded by Director PANDYA to approve the June 5, 2023 Special Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. Business Items

A. SVLHCD Fiscal Year 2024 Operating Budget

Presented by Doug Dickson, CFO

Following review and discussion, it was moved by Director PANDYA and seconded by Director KASHYAP to approve the Equity Adjustments and Merit Increase as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

Following review and discussion, it was moved by Director PANDYA and seconded by Director MARTINEZ to approve the Capital Budget of $3,865,895 as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

Following review and discussion, it was moved by Director MARTINEZ and seconded by Director PANDYA to approve the Operating Budget of $158,155,212 as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

B. Capital Budget – Quarter 3

Alejandra Jimenez presented the Capital Budget for Quarter 3

Following review and discussion, it was moved by Director PANDYA and seconded by Director MARTINEZ to approve the Capital Budget Report for Quarter 3 as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. May 2023 Financials

Doug Dickson, CFO presented the Financials for May 2023. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $13,255,002. Supplemental Funds were $1,278,678. Total Operating Expenses were $14, 244,939. Loss from operations of $969,937.

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve the May 2023 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Guidelines for Public Comment

Following review and discussion, it was moved by Director MARTINEZ, seconded by Director PANDYA and carried to approve the Guidelines for Public Comment as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View:

In the District:

- The Roger S. Good Cancer Treatment Center and the Sierra View Ambulatory Surgery Center won silver in the Best of Central California.
- SVMC welcomed 13 new residents to the SVMC Graduate Medical Education program! We are excited to expand our program and train the next physicians who will provide exceptional care to our patients, achieve optimal clinical outcomes, and be part of the future of healthcare!

- Sierra View is now the only healthcare facility in Tulare County to hold a Tissue Bank License, which will allow for Sierra View to begin a Human Donor Milk Program! Soon MCH will be working with a company to supply Sierra View with donor breastmilk to give to mothers having trouble breastfeeding.

- Sierra View Medical Center has been notified of a potential scam call regarding Patient Accounting. We have verified that these calls are not scams. These are valid calls from the Self-Pay Department that Sierra View Medical Center partners with. As required by HIPAA regulations, Sierra View does ask for 2-3 patient identifiers such as the last four of SSN, birthdate, and address at the start of the call. These calls will never ask for your full SSN. If you have a concern or question about a Patient Accounting call from Sierra View Medical Center, call the hospital's main line at (559)784-1110 and ask to be transferred to Patient Accounting.

- California State Board of Pharmacy – inspection completed and passed. Dr. Schmidt passed her CAP Survey.

IX. Closed Session: Board adjourned Open Session at 6:18 p.m. and went into Closed Session at 6:28 p.m. to discuss the following items:

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

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

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

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

X. Open Session: Board adjourned Closed Session at 7:48 p.m. and went into Open Session at 7:48 p.m. to discuss the following items:

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

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

C. Discussion Regarding Trade Secret. Information only; no action taken.

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

XII. Announcements:

A. Regular Board of Directors Meeting – July 25, 2023 at 5:00 p.m.

The meeting was adjourned 7:52 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww