SIERRA VIEW
MEDICAL CENTER

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

AGENDA
October 25, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

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

Call to Order/Roll Call

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION

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

III. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

C. Conference with Legal Counsel pursuant to Gov. Code Section 54956.9(d), Ongoing Litigation in Tulare County Superior Court Case VCU291990; Exposure to Potential Litigation (d)(2): Pursuant to Evidence Code Sections 1156 and 1157, 1157.7; Health and Safety Code Section 32106(b) and Health and Safety Code Section 32155 (1 Item)(Time Limit – 20 min)

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Items). Estimated Date of Disclosure – February 2023 (Time Limit – 10 minutes)

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (2 Items). Estimated Date of Disclosure – February 2023 (Time Limit – 10 minutes)

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

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

D. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken (it will be approved after the report is given in open)

E. Discussion Regarding Trade Secret
Recommended Action: Approve/Disapprove as to Item 1

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

VI. Public Comments

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

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If

discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. September 27, 2022 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove September 27, 2022 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **FY2022 Audited Financials Report – To be taken up after all Closed Session Items have been addressed**
Recommended Action: Approve/Disapprove

B. **September 2022 Financials**
Recommended Action: Approve/Disapprove

B. **President/CEO Contract**
Recommended Action: Approve/Disapprove

C. **Zone 3 – To be taken up after all Closed Session Items have been addressed**
Recommended Action: Approve/Disapprove marketing plan to encourage applications in the event of no write-in candidate.

XI. Announcements:

A. Regular Board of Directors Meeting – November 22, 2022 at 4:30pm

B. Ethics Training

C. Anti-Harassment Training

XII. Adjournment

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
October 25, 2022

SPECIAL NOTICE

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

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

Senior Leadership Team	10/25/2022
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	10/25/2022 Date

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
October 25, 2022
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	**Action**
Policies:		Approve ↓
1. Employee Right to not Participate in Care	1-2	
2. Nourishment Room Floor Stock	3-4	
3. Patient Food From Home DPSNF	5	

SUBJECT: **PATIENT FOOD FROM HOME - ACUTE**	SECTION: **Page 1 of 1**

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

PURPOSE:

Sierra View Medical Center (SVMC) may permit family members to bring food to patients. This policy defines the procedure for patient food brought from home.

POLICY:

Food that may be brought into the hospital for patients will be for that specified meal. All leftover food will be disposed or removed from the hospital. Patient food will not be stored in nourishment room refrigerators.

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

PROCEDURE:

1. Visitors are not permitted to bring food to the hospital for patients on a mechanically altered diet unless approved by their physician, dietitian, nurse or speech therapist.

2. Visitors may bring food for patients that are on a regular textured diet (not a pureed, ground, chopped or thickened liquid diet).

3. The physician, dietitian, nurse, or social service may recommend the need for food from home.

4. Food brought into the hospital for patients will be for one meal at a time. All leftover food will be disposed or removed from the hospital. Patient food will not be stored in nourishment room refrigerators.

REFERENCES:

- California Department of Public Health (2021). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2021). Retrieved from https://www.cms.gov/Regulations-and-Guidance
- The Joint Commission. (2021). Accreditation Participation Requirements (APR) Manual. PC 02.02.03

SUBJECT: **EMPLOYEE RIGHT TO NOT PARTICIPATE IN CARE**	SECTION: **Page 1 of 2**

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

PURPOSE:

Sierra View Medical Center (SVMC) understands the impact that Staff's personal values and beliefs have on patient care. Sierra View Medical Center also recognizes the rights of staff to request not to participate in aspects of care or treatment that are in conflict with the employee's cultural values or religious beliefs.

POLICY:

Department Managers shall discuss staff requests not to participate in aspects of patient care when cultural values or religious beliefs conflict. When accommodations are not available, the staff member is expected to provide patient care.

The Manager will restructure staffing pursuant to appropriate licensure, training, experience and cultural beliefs, values and religious beliefs, of available staff to provide coverage for the requesting staff member's vacancy. These issues related to replacement of staff will be carefully considered to provide a smooth continuum of patient care and services.

Human Resources shall review this policy with applicants as part of the initial employment/orientation process and complete an acknowledgement form. See Addendum A Acknowledgement Form.

Requests for accommodation shall be stated and discussed during the staff member's initial period of employment. Requests shall be assessed on an individual basis to determine appropriateness without disrupting patient care. Following their employment, employees may amend their previous initial declaration and initiate a new Acknowledgement Form.

Refusal to perform assigned tasks shall result in the employee's disciplinary action, up to and including termination of employment.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

REFERENCES:

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

ADDENDUM A.

Employee Right Not To Participate In Care

ACKNOWLEDGMENT

I have read the Employee Right To Not Participate In Care policy and understand the requirements set forth therein.. I am aware that when accommodations are not available, staff members are expected to provide patient care.

I have identified requested accommodation based on my personal values and beliefs. I am not willing to assist with:

☐ Abortions

☐ Blood Transfers

☐ Other _____.

☐ I decline to request an accommodation and can fully participate in all aspects of patient care.

Date: _____ _____
Signature

Date: _____ _____
Signature of Official

SUBJECT: **NOURISHMENT ROOM FLOOR STOCK**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish protocol for stocking patient nourishment rooms.

POLICY:

Adequate quantities of nourishments and condiments will be delivered to the patient nourishment rooms on the nursing units according to par levels developed for each area.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICES, ENVIRONMENTAL SERVICES, NURSING, PATIENT CARE AREAS*

PROCEDURE:

1. Food & Nutrition Service (FNS) will inventory and stock nourishment rooms daily.

2. The designated FNS employee will deliver floor stock daily.

3. All items placed in the refrigerators will have an expiration date, be labeled, and appropriately sealed. The stock will be rotated to ensure FIFO (first in first out).

4. All items found to be outdated will be discarded. Any items found to be open or not clearly labeled and dated will be discarded.

5. All employee items will be stored in an area other than the patient nourishment rooms. All employee items found in patient nourishment rooms will be discarded immediately. FNS employees will not be responsible for discarding employee items found in the patient nourishment room.

6. Patient nourishments will be stored and maintained under sanitary conditions.

7. FNS employees will be responsible for cleaning the inside of refrigerators, counters, and inside of floor stock drawers daily.

8. Environmental Services will be responsible for cleaning the general area of the nourishment rooms. The outside of the refrigerator, counters, floors, ice machine, and microwave will be cleaned daily.

9. Opened items, e.g. cans, milk cartons are NOT to be placed in the refrigerator. All partially used items will be discarded immediately.

10. Any person who spills food is responsible for cleaning it up.

11. All food items will be handled under sanitary conditions and using clean hands.

12. All patient items stored in the nourishment room areas will be identified with patient's name, room number, and will be properly covered, labeled, and dated. No items that have been in a patient room may enter the patient nourishment areas. No partially consumed items may be stored in patient nourishment areas.

13. Perishable items should not be left on the counters.

14. Nutritional supplements will be routinely checked by nursing and FNS employees for expired dates. Expired items will be discarded.

15. FNS employees are responsible for monitoring the temperature of refrigerators in the patient care units, maintaining a thermometer, and storing the recorded data.

16. At no time will medications, lab specimens or items other than patient designated food items be stored in patient nourishment areas.

REFERENCES:

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

MEDICAL EXECUTIVE COMMITTEE	10/05/2022
BOARD OF DIRECTORS APPROVAL	
	10/25/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
October 25, 2022 BOARD APPROVAL

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

	Pages	Action
I. Policies:		APPROVE
• Arterial Puncture	1-5	↓
• Clean Catch Urine Collection for Urinalysis	6	
• Compounded Sterile Preparation: Quality Assurance Program	7-11	
• Controlled Substances	12-21	
• Criteria for Collection of Stool for Culture	22-23	
• Criteria for Rejection of Lab Specimens	24-27	
• Guidelines for Waste Handling – Waste Management Program	28-31	
• Guidelines for Single Use Devices (Disposables), Reuse and Reprocessing of Patient Care Equipment	32-34	
• Hospital-Approved Handwashing, Cleaning and Disinfectant Products	35-38	
• Infiltrate Management	39-48	
• Oral Nutrition Supplement	49-52	
• Patient Discharge to Post-Acute Care Setting	53-55	
• Recognizing and Reporting Elder Abuse/Neglect	56-59	
• Seasonal Influenza Plan	60-63	
• Seeing/Hearing/Companion Dog (Service Animals)	64-66	
• Sign-Out Protocol for Blood Components	67-68	
• Sterile Products: Education and Competency	69-75	
• Sterile Products: Sterile Product Quality Assurance	76-88	
• Storage of Blood Components in the Event of the Loss of Monitored Refrigeration	89	
• Urinary Catheter Discontinuation Protocol	90-92	
• Venous Blood Collection	93-94	
II. Forms:		
• Anesthesia Pre-Operative Orders	95	
• Procedural Sedation Flow Sheet	96-97	

SUBJECT: **ARTERIAL PUNCTURE #9014**	SECTION: **Page 1 of 5**

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

PURPOSE:

To instruct staff on the proper procedure for collecting a specimen by arterial puncture.

POLICY:

It is the policy of Respiratory Care Services or Laboratory to obtain accurate arterial blood samples so that pH, pCO_2, pO_2, $\%O_2$, HCO3 and BE values can be measured and calculated

AFFECTED AREAS/PERSONNEL: *ALL LABORATORY, RESPIRATORY EMPLOYEES, PHYSICIANS*

Important Point:

If patient is less than 5 years old, notify the physician.

a. The physician may decide to attempt the arterial puncture him/herself
b. The physician may decide to cancel the order
c. The physician may decide to order pulse oximetry instead

PROCEDURE:

1. Wash your hands. Put on fresh gloves.

2. Introduce yourself to the patient.

3. Verify the patient's identity using two identifiers by checking his/her ID bracelet.

4. Explain to the patient what you are about to do. Reassure the patient as necessary.

5. Perform the Allen's test to verify collateral circulation to the hand via the ulnar artery (see procedure for Allen's test).

    a. If the collateral circulation is adequate, continue with the procedure.

    b. If the collateral circulation is not adequate, test the patient's other hand. If collateral circulation to both hands is inadequate, notify the physician.

        - The physician may request that an alternate site be used for the puncture.
        - The physician may decide to attempt the radial arterial puncture himself/herself.
        - The physician may decide to cancel the order.
        - The physician may decide to order pulse oximetry instead.

6. Gather and prepare the blood gas kit.

7. Position yourself and the patient's arm so that both you and the patient are comfortable.

8. Carefully feel the pulse, taking as much time as necessary.

9. Cleanse the site thoroughly with the alcohol prep.

10. With the needle bevel pointing up and the pulse isolated, enter the patient's skin with a quick steady motion as parallel to the arm as possible.

11. Once the skin has been punctured, slowly insert the needle in a straight line until the artery is entered (blood will spurt into the needle hub and start to fill the syringe). If the artery is missed, withdraw the needle until the tip is just beneath the skin. Adjust the needle angle and proceed as before until the sample is obtained.

12. Obtain at least 1cc of blood.

13. When the sample is obtained, using a quick steady motion, remove the needle from the patient's arm, putting pressure over the puncture site using a clean gauze pad. Hold pressure over the puncture site for a minimum of five minutes or longer if necessary.

14. Expel any air bubbles from sample.

15. Quickly seal the needle and syringe to maintain anaerobic conditions.

a) If using the Radiometer brand safePICO sampler, holding the sampler in one hand slide the needle shield device over the needle until a click is heard. Remove the needle and discard into a sharps container. Holding onto the syringe barrel, firmly press down and twist the safeTIPCAP one-quarter turn onto the syringe luer tip. Hold the syringe vertically so the safeTIPCAP is at the top and gently flick the syringe barrel so that any air bubbles will rise to the top of the syringe. Press the plunger slowly to expel the air through the vented safeTIPCAP. A red band will form in the cap and there will be resistance in the plunger indicating that the air has been removed.

Mix the sample thoroughly to ensure a homogenous sample.

16. Transport the sample to the blood gas machine within 20 minutes.

17. Once bleeding has stopped, feel for a pulse distal to the puncture site to ensure that the patient's circulation has not been interrupted.

18. Place Band-Aid over site.

19. Wash your hands.

Indications:

- Dyspnea
- Tachypneic
- Impairment of lung function that has been documented
- Ventilatory support or being weaned from ventilatory support
- Pre-operative assessment of high risk patients receiving general anesthesia
- Suspicion of respiratory failure (patients with pneumonia, bronchospasm, acute heart failure, etc.)
- Smoke inhalation or suspicion of carbon monoxide poisoning

Contraindications:

Negative results of a modified Allen test (collateral Circulation test) are indicative of inadequate blood supply to the hand and suggest the need to select another extremity as the site for puncture.

Arterial puncture should not be performed through a lesion or through or distal to a surgical shunt (e.g., as in a dialysis patient). If there is evidence of infection or peripheral vascular disease involving the selected limb, an alternate site should be selected.

- Agreement is lacking regarding the puncture sites associated with a lesser likelihood of complications; however, because of the need for monitoring the femoral puncture site for an extended period, femoral punctures should not be performed without an order from a physician.
- A coagulopathy or medium dose anticoagulation therapy (e.g., heparin or coumadin, streptokinase, and tissue plasminogen activator, but not necessarily aspirin) may be a relative contraindication for arterial puncture.

Hazards & Complications:

Hematoma

- Arteriospasm
- Air or clotted blood emboli
- Anaphylaxis from local anesthetic
- Introduction of contagion at sampling site and consequent infection in patient;
- Introduction of contagion to sampler by inadvertent needle "stick"

Hemorrhage

Trauma to the vessel

Arterial occlusion

Vasovagal response

Pain Assessment of Need:

The following findings may assist the clinician in deciding whether arterial blood sampling is indicated:

- History and physical indicators (e.g., positive smoking history, and recent onset of difficulty in breathing independent of activity level, trauma).
- Presence of other abnormal diagnostic tests or indices (abnormal pulse oximetry reading, chest x-ray).
- Initiation of, administration of, or change in therapeutic modalities (e.g., initiation, of, changes in, or discontinuance of supplemental oxygen or initial of, changes in, or discontinuance of mechanical ventilation).
- Projected surgical interventions for patients at risk.
- Projected enrollment in a pulmonary rehabilitation program.

Equipment:

- Blood Gas Kit
- Gloves
- Label

Documentation:

- Enter all pertinent data into the computer for the blood gas report.
- Blood gas report will automatically be generated when resulted and verified by the Clinical Lab Scientist in the Clinical Laboratory.

Infection Control:

- Wash your hands before and after this procedure.
- Wear gloves during this procedure.

- Use only sterile needles and syringes.
- Use a new sterile needle each time skin is punctured.
- Cleanse site thoroughly prior to the puncture.
- Any materials containing blood samples must be disposed of as infectious waste, according to hospital procedures.
- Environmental Services Department removes waste and replaces liners in trashcans.
- The container for infectious waste is clearly marked with an identifiable label.

Safety Precautions:

1. Only personnel approved by the Respiratory Care Services Medical Director are allowed to attempt this procedure.
2. Wear gloves during this procedure.
3. Exercise caution when handling needle to avoid injury to patient or yourself.
4. Choose puncture site in the following order:
   a. Radial
   b. Brachial
   c. Femoral (only when absolutely necessary and with a doctor's order) (Respiratory Care Practitioners only)

REFERENCES:

- Radiometer America Inc., Training Poster Arterial puncture for ABG using safePICO sampler.
- Radiometer America Inc. (2021). "How to perform an Arterial Puncture", Retrieved from www.radiometeramerica.com/en-us/knowledgecenter/guide-to-blood-gas-analysis.

SUBJECT:	SECTION:
CLEAN CATCH URINE COLLECTION FOR URINALYSIS	**Page 1 of 1**

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

POLICY:

All patients will be instructed how to correctly cleanse and collect a urine specimen for urinalysis.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ***Collection of Clean-Catch Midstream Urine - Male***

    a. Wash hands thoroughly with soap and water and wipe dry with a paper towel.

    b. Pull back the foreskin (if uncircumcised) and thoroughly cleanse the glans penis with the provided antiseptic towelette.

    c. Begin to urinate. Allow the first stream of urine to flow into the toilet, then place the container under the stream and fill the container 1/4 full.

    d. Do not touch the rim or the inside of the specimen container.

2. ***Collection - Females***

    a. Wash hands thoroughly with soap and water, wipe dry with a paper towel.

    b. Cleanse each side of the urinary meatus, then cleanse meatus with the provided antiseptic towelette, wiping from front to back.

    c. Begin to urinate. Allow the first stream of urine to flow into the toilet, then place the container under the stream and fill the container 1/4 full.

    d. Do not touch the rim or inside of the specimen container.

REFERENCE:

- Turgeon, Mary Louise, Linne & Ringstrud's Clinical Laboratory Science, 8th Edition, 2020.

SUBJECT:	SECTION:
COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM	***Medication Management (MM)*** **Page 1 of 5**

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

PURPOSE:

To provide guidelines for the pharmacy quality assurance practices related to the preparation of compounded sterile drug products.

DEFINITION:

Quality Assurance – For purposes of these guidelines, quality assurance is the set of activities used to ensure that the processes used in the preparation of sterile drug products lead to products that meet predetermined standards of quality.

CACI - Compounding Aseptic Containment Isolator - is a Unidirectional HEPA-filtered airflow isolator designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations, also known as sterile intravenous preparation hood.

CSP- Compounded Sterile Preparation

POLICY STATEMENT:

It is the policy of Sierra View Medical Center (SVMC) that all pharmacy preparations of compounded sterile products will follow accepted standards of practice by conducting regular quality assurance activities and testing.

PROCEDURE:

A. Quality Assurance indicators will be implemented to evaluate the following:

1) Personnel Qualifications
   - See Sterile Products: Education and Competency

2) Personnel performance. The total number of errors will be reported in the following categories:
   - Wrong Drug or solution
   - Wrong Strength
   - Wrong Label
   - Wrong Expiration Date

3) Equipment and facilities

- Record of daily anteroom countertop sanitizations
- Record of daily IV room floor cleaning and sanitizations
- Record of daily cleanings for each hood
- Record of weekly anteroom cleaning
- Record of weekly wall and ceiling cleaning
- Record of weekly shelf cleaning environment
- Record daily CACI/hood pressures and room pressures
- Record of monthly sporicidal cleaning

4) Environment

- Daily record of room temperature and humidity
- Daily record of refrigerator temperature
- Record airflow pressure differentials daily, where they are available, on a daily basis when open for patient care. During non-operational days, continuous monitoring will alarm for an out of range result and Engineering will alert the pharmacist on call or the pharmacist in charge (PIC).
- In the event of an out of range, personnel will follow the procedure outlined in: MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL

4) Pharmacy personnel will be trained annually on:

- Proper garbing (donning and doffing of personal protective equipment (PPE) while in the compounding areas)
- Proper cleaning/disinfecting/decontamination of compounding areas
- USP 797 Appendix V, "Sample Form for Assessing Cleaning and Disinfection Procedures" will be used as an education and competency training tool.
- Competency will be validated by written and visual observation and training records shall be retained.

5) End product sampling

- End product sampling will be performed once per month. If six months of continuous negative cultures are reported, preparations will be sampled quarterly.
- In the event of a positive culture, the following shall occur:
    - The pharmacy member that compounded the product will not be allowed to compound sterile IV products until:
        - Aseptic Technique Written Quiz is passed (considered passing score is 100%)
        - Broth Dilution testing of aseptic technique yields absence of microbiological contamination.
    - Infection Control and Quality will be notified

6) Compounded sterile product analysis

- Randomly selected compounded sterile products will be subjected to qualitative and quantitative analysis at least on a quarterly basis. Testing shall include:
    - Potency Testing
    - Comparison of sampled concentration to labeled concentration
    - Endotoxin Testing
    - Any products failing to meet minimum standards will be reviewed by the Pharmacist in Charge and the following corrective actions will be taken:
    - Failed Potency and/or Concentration Test:
        - Review procedure with personnel
        - Review master formula
        - Repeat procedure with Pharmacist in Charge Supervision
        - Resubmit for potency analysis
    - Failed Endotoxin Test:

- The pharmacy member that compounded the product will not be allowed to compound sterile IV products until:
    - Aseptic Technique Written Quiz is passed
    - Broth Dilution testing of Aseptic Technique yields absence of microbiological contamination.
- Infection Control and Quality will be notified

7) Recall procedures

- Recalls will be handled as per SVMC policy DRUG RECALL PROCEDURE

8) Adverse Events and complaints

- Adverse events related to CSPs will be reported into the hospital's data base for review
    - Serious or unexpected adverse events with CSP will be reported to the Food and Drug Administration (FDA) through the Medwatch program for human drugs.
- The PIC will review all complaints related to CSP and determine if the complaint indicates a quality problem with CSP.
    - If a quality problem is discovered:
        - A corrective action plan will be initiated immediately which may include:
        - a recall of all CSP's that may have been affected.
        - A suspension of compounding
    - A written record of the complaint must be kept and contain:
        - The name of the complainant
        - Date received
        - Nature of complaint
        - Response to the complaint
        - Name and strength of the CSP, prescription number
        - Findings of investigation
        - Record of complaint must be kept so it is readily retrievable
        - A CSP returned with a complaint must be quarantined until it is destroyed AFTER the investigation

9) Validation of expiration dates used

- Chart listing expiration dates will be reviewed periodically with a complete update of current manufacturers and/or peer reviewed literature.

- Any changes identified in the interim time period will result in the immediate updating of the table found in GUIDELINES FOR PRODUCT DATING

DOCUMENTATION:

A. Training record retention shall be maintained in employee files. Re-training will be performed annually.

B. All logs and chart recorders shall be retained for three years.

C. CACI shall be tested by a qualified person every six months, whenever it is moved, or if filter damage is suspected. Specific tests are used to certify airflow velocity and HEPA filter integrity. Records of certification shall be retained for three years.

D. Compounding records shall be filed alphabetically by generic name, documenting technician and pharmacist for three years.

EDUCATION:

SVMC Staff: All pharmacists and pharmacy technicians will receive education regarding the indicators used to track quality assurance of pharmacy prepared sterile drug products. All pharmacy staff will sign an acknowledgement form indicating that they understand the policy and will comply with the policy.

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 March 20 6, 2020 from http://www.usp.org/compounding/general-chapter-797.

CROSS REFERENCES:

- Drug Recall Procedure – SVMC Policy and Procedures
- Medication Procurement, Storage, Distribution and Control – SVMC Policy and Procedures
- Guidelines for Product Dating – SVMC Policy and Procedures

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SUBJECT:	SECTION:
CONTROLLED SUBSTANCES	***Medication Management (MM)***

PURPOSE:

To ensure that medications defined as controlled substances under Division 10 of the Uniform Controlled Substances Act are procured, distributed and accounted for in accordance with all Federal and State laws and regulations.

DEFINITIONS:

Cactus Sink – Designated pharmaceutical waste container for all controlled substances.

POLICY:

The Department of Pharmaceutical Services shall be responsible for the organizational compliance of all laws and regulations governing the procurement, distribution and accountability of controlled substances of Schedule II, III, IV and V at Sierra View Medical Center. The Pharmacy under definition of Drug Enforcement Agency registration will not procure, retain or dispense medications that fall under definition of schedule I under the Uniform Controlled Substances Act. Systems (procedures) will be developed and maintained by the Department of Pharmaceutical services to ensure accountability, with valid audit trails and record retention.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, ANESTHESIA*

PROCEDURE:

A. GENERAL INFORMATION

1. All controlled substances at SVMC are stored, managed, secured, and reviewed through the Pyxis C-II Safe and by the Pyxis Med Station dispensing cabinets.

B. ORDERING

Controlled substances are procured through the wholesaler by the initiation of:

1. Schedule II – Pharmacists who have been granted power of attorney shall order through the wholesaler's ordering system via CSOS (Controlled Substance Ordering System). When there are technical problems with CSOS software or internet access, then DEA 222 paper forms will be utilized.

2. Schedule III-V's are ordered through the wholesalers ordering system.

C. RECEIPT AND STORAGE

1. Controlled Substances received from vendors/other pharmacies:

   a. Vendor invoices are compared with order form, confirmed with physical count, and then signed and dated by a Pharmacist.

b. Any discrepancies are handled immediately.

2. Received inventory placed in C-II Safe by a licensed pharmacist

a. Quantity received, invoice number, date ordered, and User ID of who received them is recorded on the Vendor/Pharmacies Report. (DEA 222 number also required if Schedule II's are received).

b. These reports are filed and retained on-site for 3 years and in readily retrievable storage for no less than 7 years prior to destruction.

c. The DEA222 order form, delivery receipt from the wholesaler and CII safe report "medications received from vendors" that shows drug and quantity added to CII safe are all reviewed and signed by pharmacist checking in the medication and then reviewed and signed by the pharmacist in charge.

D. DISPENSING

1. Physician orders for medications including controlled substances are entered by the Physician via CPOE (Computer Physician Order Entry) or faxed to the Inpatient Pharmacy.

2. A Pharmacist evaluates the medication order for safety, efficacy, and appropriateness, and then verifies the approved order into the patient's profile as found in the hospital's information system.

3. Controlled substances are removed from the C-II Safe and placed into the various units Pyxis MedStations throughout the facility by the Narcotic Technician.

a. A Pharmacist checks all medications, including controlled substances, that are dispensed to Pyxis prior to the medications leaving the pharmacy.

b. The Narcotic Technician is required to run Pyxis vs. C-II Safe Compare reports prior to the end of their shift to verify that the exact quantity of each controlled substance dispensed was received by the Pyxis MedStation and that there are no discrepancies. These reports are to be given to the Technician Supervisor for review. Any open discrepancy is immediately reported to the pharmacist in charge.

4. Controlled substances removed from the units' Pyxis MedStations by Pharmacy personnel must be returned to the C-II Safe. If not, a discrepancy will show in the Compare Report until documentation is provided to clear the variance. Documentation must be provided within 24 hours to clear the variance. At the end of each shift, an "Open Discrepancy Report" is run to confirm inventory and identify any open discrepancies. All discrepancy reports are reviewed and signed and dated by the pharmacist in charge.

5. If a controlled substance is lost or is missing after an exhaustive search, a Lost Medication Report must be filed with the DEA immediately upon discovery and with the Board of Pharmacy within thirty days.

6. After the medication order is processed by the Pharmacist, the medication becomes available to the nurse for administration via the unit's Pyxis Med Station.

E. WASTING AND ADMINISTRATION

1. When a physician ordered dose is less than the unit dose stocked medication in Pyxis:

   a. The Pyxis will require a witness upon removal of all controlled medication prior to removal.

   b. The nurse and the witness will waste the excess medication in the proximally located Cactus Sink.

   c. The administering nurse will scan the patient's wrist band and the medication.

   d. Scanning of the medication will create documentation of the administered dose.

   e. The nurse will administer the medication.

2. Controlled substances removed from Pyxis without authorization or review by the pharmacist via override requires a witness.

3. Override medication removals are reported and evaluated on the Pyxis override report generated daily by the inpatient pharmacy.

Unapproved removals are reported into the hospital's occurrence reporting system and the pharmacy director is notified immediately.

4. Wasting of controlled medication in the Pharmacy must be done by two pharmacists:

   a. Upon discovery or creation of a controlled medication requiring it to be wasted, i.e., broken vial, damaged package, creation of a unit dose medication from a bulk package, the following will occur:

      - Pyxis CII Safe is accessed and the Expiration Function is selected
      - Uncheck option for placing into "destruction bin"

         1. A description for reason for wasting of medication is typed in the field provided.

2. Pharmacist will login to Pyxis and witness transaction

3. Remaining or residual drug is physically wasted in pharmacy designated Cactus Sink with witness.

4. A daily Undocumented Discrepancy Waste Report is run in the pharmacy to identify any absent documentation. Any open discrepancies are immediately reported to the pharmacist in charge.

F. MONITORING

1. The Narcotic Technician is required to perform regular patient chart audits, comparing controlled substance removal records with patient eMAR documentation.

2. Pharmacy runs a monthly Proactive Diversion Report that looks at controlled substance utilization using standard deviation determinations. Unusual usage by any nursing staff is reported to the Nursing Manager of that unit and a full comparison check of targeted controlled substance removals from Pyxis with patient eMAR documentation is required to be completed within 72 hours. Based on the results of that investigation, the following will happen:

   - Nothing – the investigation reveals no problems and all documentation is confirmed

   - Progressive Discipline – The Nursing Manager finds that poor documentation issues are revealed but no evidence of diversion exists. This will result in disciplinary action that may be as basic as verbal warning but could result in termination based on that employee's past history. Progressive Discipline is coordinated in conjunction with HR (Human Resources). All errors are documented in the hospital's incident reporting system.

   - Diversion Investigation – The Nursing Manager's investigation reveals substantial deficits in documentation. At that point, Pharmacy is contacted to assist with expansion of the employee's history via Pyxis reports. See Diversion below.

G. DIVERSION OF CONTROLLED SUBSTANCES

1. The Clinical Director of the unit where the suspected employee works will conduct a full investigation with the expanded Pyxis report from Pharmacy. Pharmacy and HR may be called to assist with this investigation.

2. Human Resources will be notified that a suspected diversion has occurred. If a diversion is validated by the investigator, HR in conjunction with Nursing Administration, will inform the CEO (Chief Executive Officer) of the hospital

and file the police report. If applicable, a report will also be filed with the licensing board of the suspected diverter (Board of Registered Nurses, or the Department of Consumer Affairs for Pharmacists, and Physicians).

3. Based on the results of the investigation, any suspected diversion of controlled substances is to be reported immediately upon discovery to the DEA (Drug Enforcement Agency).

H. PYXIS ANESTHESIA SYSTEMS

All controlled substances are pulled by the Narcotic Technician according to par levels set in the Anesthesia Carts. A MedStation auto restock report is run and the meds are pulled from C-II Safe to replenish and make sure that the Anesthesia Carts are at maximum level daily. A Pharmacist will verify that all medications and quantities are correct before they are taken to the stations.

I. REMOVING OUTDATES FROM INVENTORY

When Schedule II-V medications are outdated, they are removed from inventory and placed in the drawer segregated in the C-II Safe designated specifically for controlled substance outdates and held until processed through the recover service (See "Disposition" below).

J. DISPOSITION

1. Return for manufacturer credit/destruction.

2. At regular intervals (quarterly, or more frequently as required), a Pharmaceutical Reverse Distributor that is under contract to process expired medications. Controlled substances are processed in the following manner.

   a. Expired Schedule II medications contained in the outdate drawer in the C-II Safe are inventoried by the reverse distributor personnel. The inventory is then verified against the "dispensed" with the transaction date and the DEA Form 222 number.

   b. The recovery service issues a DEA Form 222 as a registered distributor to the Hospital (supplier) for each line item medication that is being returned by NDC number, up to 10 line items per form.

   c. The top copy "Supplier's Copy 1" is retained by the Pharmacy. A copy is made and placed in the "Expired C-II Safe Inventory" folder, until a "Manufacturer Return Report – Schedule Drugs" is received. Once received, it is reconciled against the DEA 222 and the original forwarded to the DEA in accordance with regulation.

d. Schedule III, IV and V

Expired Schedule III, IV and V medications contained in the outdate drawer in the C-II Safe are inventoried by the reverse distributor personnel. A "Controlled Substances Inventory and Transfer" document is generated by the recovery service and a copy retained in the "Expired C-II Safe Inventory" folder and reconciled when a "Manufacturer Return Report – Schedule Drugs" and/or a "Disposal Report – Schedule Drugs" is received and reconciled.

K. DOCUMENTATION AND RECORD RETENTION AND INVENTORY

1. All documentation regarding procurement, distribution and/or disposal of controlled substances shall be kept on-site for at least 3 years and in readily retrievable storage off-site for no less than 7 years prior to destruction.

2. A physical inventory will be conducted no less than twice a month for all Scheduled medications. All discrepancies will be reconciled and brought to the attention of the Director of Pharmacy.

3. A biennial ~~bi-annual~~ inventory will be completed in accordance with DEA regulations and retained ON SITE for no less than 7 years.

4. Physical inventory audits are performed in all areas where controlled substances are maintained and are performed during required monthly unit/area inspections. Results of inventory audits will be monitored and reported as a performance improvement indicator to identify and trend any problems. Subsequent action and control will be implemented as deemed necessary and appropriate.

5. At least every three months, the pharmacist in charge will compile an inventory reconciliation report of all Federally Scheduled CII Drugs stored in the pharmacy. The compilation shall require:

   a. A physical count of all controlled substances.

   b. A review of the acquisitions and dispositions of all controlled substances since the last inventory reconciliation report.

   c. A comparison of the physical count with the acquisitions and dispositions to determine if there are any variances.

   d. All records used to compile each inventory reconciliation will be maintained in the pharmacy for at least three years in a readily retrievable form.

e. Possible causes of overages shall be identified in writing and incorporated into the inventory reconciliation report.

f. The inventory reconciliation report shall be dated and signed by the individual (s) performing the inventory, and countersigned by the pharmacist-in-charge and readily retrievable in the pharmacy for three years. A counter signature is not required if the inventory was personally completed by the pharmacist-in- charge.

6. The pharmacist-in-charge shall ensure that the Pyxis Med Stations located outside of the pharmacy:

g. All controlled substances added to the Pyxis stations are accounted for (not just CII);

h. Access to the Pyxis machines is limited to authorized personnel

i. Ongoing evaluations of discrepancies or unusual access associated with controlled substances is performed;

j. Confirmed losses of controlled substances are reported to the Board of Pharmacy.

L. REPORT OF THEFT, LOSS OR SHIPPING DISCREPANCY

1. Pursuant to Division 10, Chapter 3, Article 1, Section 11103 of the State Health and Safety Code "The theft or loss of any substance regulated Pursuant to Section 11100 discovered by any licensee or any person regulated by the provisions of this chapter, shall be reported to the Department of Justice within THREE (3) days after such discovery. "Any difference between the quantity of any substance regulated pursuant to Section 11100 received and the quantity shipped shall be reported to the Department of Justice within THREE (3) days of the receipt of actual knowledge of the discrepancy.

2. Pharmacy shall submit to the Board a report containing information according to California Code of Regulations Title 16, Division 17, Article 2, Section 1715.6 no later than thirty (30) days after the date of discovery of the following:

Any loss of a controlled substance ein one of the following categories that causes an aggregate amount of unreported losses discovered in that category, on or after the same day of the previous year to equal or exceed:

a. For tablets, capsules, or other oral medication, 99 dosage units.
b. For single-dose injectable medications, lozenges, fild, such as oral, buccal and sublingual, suppositories, or patches, 10 dosage unites.

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c. For injectable multi-dose medications, medications administered by continuous infusion, or any other multi-dose unit not described in subparagraph (A), two or more multi dose vials, infusion bags, or other containers.

Any loss of a controlled substance regardless of the amount, attributed to employee theft, in addition to the reporting requirements and time frames mandated by Business and Professions Code section 4104.

Any other significant loss as determined by the pharmacist-in-charge, including but not limited to losses deemed significant relative to the dispensing volume of the pharmacy.

All reports under section 1715.6 Reporting Drug Loss of California Code of Regulations shall specify the identity, amount and strength of each controlled substance lost, and date of discovery of the loss, for all losses that have made the report necessary.

~~2. Pharmacy shall report identified losses and known causes to the Board within 30 days of discovery unless the cause is theft, diversion, or self-use, in which case the report shall be made in 14 days of discovery. If the cause is unable to be identified, further investigation shall be undertaken to identify the cause and actions necessary to prevent additional losses of controlled substances.~~

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M. SUSPICIOUS ORDER REPORTING SYSTEM

1. Orders for controlled substances may be considered suspicious if it is an unusual size, unusual pattern or frequency.

2. The pharmacist in charge will report any suspicious orders to the DEA's Suspicious Orders Report System (SORS) online

N. LICENSED EMPLOYEE, IMPAIRMENT, THEFT AND DIVERSION: PHARMACY PROCEDURES

1. The Department of Pharmacy shall report to the Board, within 14 days of the receipt or development thereof, the following information with regard to any licensed individual employed in or working with the pharmacy.

   a. Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice.

   b. Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.

c. Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs.

d. Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

e. Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects their ability to practice.

f. Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

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~~f.~~g. If the cause is unable to be identified, further investigation shall be to taken to identify the cause and actions necessary to prevent additional losses of controlled substances.

2. The report required to be submitted to the Board of Pharmacy shall include sufficient detail to inform the Board of facts upon which the report is based, including the estimate of the type and quantity of all dangerous drugs involved, the time frame of the losses, and the date of the last controlled substance inventory. All reports to the Board are immune from civil or criminal liability.

FORMS:

Form Name	*Obtained From*	*Process*
DEA Form 222	Drug Enforcement Administration	Complete and send in request form to DEA (allow 2 weeks for processing). If request forms are needed, the DEA may be contacted and additional request forms will be mailed (allow 2 weeks for processing).
Expired C-II Safe Inventory Forms	Printed Locally	Form is printed from the C-II Safe
Pyxis vs. C-II Safe Compare Reports	Printed Locally	Form is printed from the C-II Safe
MedStation Auto Restock Forms	Printed Locally	Form is printed from the C-II Safe

REFERENCES:

- California Board of Pharmacy. Retrieved -June 21, 2022, from https://www.pharmacy.ca.gov/about/news_release/board_update_may_22.pdf

- Department of Justice. Drug Enforcement Administration Diversion Control Division. Retrieved October 26, 2021, from https://www.deadiversion.usdoj.gov/21cfr/cfr/index.html.
- Nursing Practice Act. (n.d.). Retrieved October 23, 2017, from http://www.rn.ca.gov/practice/npa.shtml.
- Marquardt, K.A., Tharratt, R.S., Musallam, N.A. Fentanyl remaining in a transdermal system following three days of continuous use. *Ann Pharmacother.* 1995; 29: 969-971.

CROSS REFERENCE:

- Wasting or Returning Controlled Substances Policy

SUBJECT: **CRITERIA FOR COLLECTION OF STOOL FOR CULTURE**	SECTION: **Page 1 of 2**

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

POLICY:

SPECIMEN CONTAINER:

A stool preservative such as Cary Blair stool transport medium (preferred) or a clean, leak-proof container with a tight fitting lid.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

- A bedpan is an ideal initial collection container provided it has been thoroughly cleaned, and the patient is cautioned against contaminating the specimen with urine. A clean, wide mouthed container or a plastic bag or plastic wrap placed over the toilet seat is also acceptable. Note: do not use toilet paper to collect stool, because it may be impregnated with barium salts, which are inhibitory to some fecal pathogens.
- An appropriate (i.e. bloody, slimy, watery) area of stool should be selected and sampled with the collection spoon provided in the cap of the transport medium container. Add sufficient specimen to bring the liquid level up to the "Add Specimen to this Line" mark. This will result in approximately 5 ml of sample.
- Tighten the cap and agitate the vial to ensure that the specimen is adequately mixed. The specimen should appear homogenous.
- Label the specimen, and transport the specimen to the laboratory.
- If submitting specimen in a clean, leak proof container, submit at least 5 ml of diarrheal stool or a walnut-sized portion of formed stool.

PROCEDURE NOTES:

- Specimens collected after antibiotic therapy has been initiated may be contraindicated for successful recovery of organisms.
- Fecal cultures should not be performed for patients being treated with broad-spectrum antimicrobial agents, because it is likely that the antimicrobial therapy is responsible for the diarrhea.
- Stools from inpatients who have been in the hospital for >3 days are of limited value unless the patient is known to be human immunodeficiency virus positive or in cases of a cluster epidemic within the hospital. Consider C. difficile testing as an alternative to routine microbiologic studies.

CRITERIA FOR SPECIMEN REJECTION:

When a specimen is rejected for any of the reasons listed below, the nursing unit will be notified by phone, giving the reason for the rejection, and a new specimen will be requested.

- Specimen not in transport medium received >2 hours after collection. Changes occur that are detrimental to most Shigella spp.
- Specimens in transport medium received >24 hours after collection. Recovery of pathogens may be compromised.
- If the transport vial indicator has turned yellow. Shigella organisms are killed at low pH.
- Hard, solid stools that cannot be sampled for inoculation.
- Stools containing barium. Wait one week after barium before collecting specimen.
- Specimens contaminated with urine or water from the toilet.

REFERENCES:

- Forbes, Betty A., Sahm, Daniel F. and Weissfeld, Alice S., Bailey and Scott's Diagnostic Microbiology, C.V. Mosby Co., St. Louis, Missouri, 14th edition, 2017.
- Isenberg, Henry D., Clinical Microbiology Procedures Handbook, American Society for Microbiology, 4th Edition, 2016.
- Murray, Patrick R., Manual of Clinical Microbiology, American Society for Microbiology, 12th edition, 2019.
- Remel, Inc. Cary Blair Transport Medium package insert, IFU 21610, Revision 10/25/12.

SUBJECT: **CRITERIA FOR REJECTION OF LAB SPECIMENS**	SECTION: **Page 1 of 4**

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PURPOSE:

To ensure the integrity of patient specimens and the achievement of accurate results.

POLICY:

A. The lab will reject a specimen for any of the reasons below.

B. When the physician, nurse, or patient is responsible for the collection and the specimen is rejected, the nursing unit or physician's office will be notified by phone and a new specimen will be requested.

C. In the event a physician insists a procedure be run on a specimen where results might be compromised, the condition of the specimen must be noted on the patient's lab report.

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

SPECIMEN CRITERIA:

A. All specimens must be properly labeled and submitted in conjunction with a suitable electronic or paper request.

1. Outpatient Referrals:

   a. Patient name and date of birth
   b. Date of collection
   c. Time of collection (if applicable)
   d. Source (if applicable)

2. Inpatients:

   a. Patient name and date of birth
   b. Patient account number or other suitable identifier
   c. BBK# and two (2) sets of initials (if applicable)
   d. Date and time of collection
   e. Meditech mnemonic of collecting person
   f. Patient location (if applicable)
   g. Pertinent clinical data (if applicable)

B. Within the hospital institution, all specimens not collected by lab personnel shall be transported to the laboratory in sealed plastic biohazard bags.

C. All specimens must be adequate for the testing requested.

Rejection Criteria for Blood Bank Specimens: (Antibody Screen, ABO typing, Crossmatch, Rh)

- Hemolyzed specimen
- Specimen > 48 hours old
- Improper labeling such as missing BBK#, lacking two sets of initials and/or time of collection
- Any sample suspected of contamination with IV fluid

Rejection Criteria for Serology Specimens:

- ASO – plasma, contaminated serum; hemolysis; or lipemia
- HIV – whole blood >5 days old
- Mono – contaminated serum or plasma
- RA – contaminated serum or plasma; gross hemolysis; lipemia
- RPR – contaminated serum or plasma; gross hemolysis
- Any sample suspected of contamination with IV fluid

Rejection Criteria for Chemistry Specimens:

- Acid phosphatase – hemolysis; serum or plasma in contact with cells >90 minutes
- ABG – clotted specimen; inhomogeneous specimen; venous blood
- Amylase – gross hemolysis
- Alcohol – specimen drawn using alcohol prep; received in Lab >20 minutes
- Alkaline Phosphatase – gross hemolysis; serum or plasma in contact with cells >3 hours
- ALT – gross hemolysis; serum or plasma in contact with cells >2 hours
- Ammonia – specimen received in Lab >20 min
- AST – gross hemolysis; serum or plasma in contact with cells >2 hours
- Bilirubin – gross hemolysis; specimens exposed to light >2 hours
- CPK (CK) – gross hemolysis; lipemia; serum in contact with cells >2 hours
- CRP – contaminated serum or plasma; specimen >8 hours old
- Glucose – serum or plasma in contact with cells >2 hours
- HCG – contaminated specimen; specimen >48 hours old
- Iron – hemolysis; serum or plasma >2 hours old
- Lactate – specimen >20 minutes old
- LDH – hemolysis; serum or plasma in contact with cells >2 hours
- Sodium and Potassium – hemolysis, serum or plasma in contact with cells >2 hours; specimen drawn in sodium heparin or EDTA
- Any sample suspected of contamination with IV fluid

Rejection Criteria for Hematology/Coagulation Specimens:

- Blood Counts – clotted specimens; specimens >24 hours old; specimens drawn in other than EDTA
- Smears – no ridges, lines, or holes; leukocytes not evenly distributed; cells broken; too small or too long

- Platelet Count – drawn in other than EDTA; clotted specimen; specimen not mixed; specimen >24 hours old
- Reticulocyte Count – specimen >24 hours old
- PT or PTT – tube not filled to the line; clotted specimen
- Semen – specimen >2 hours old
- Body fluids for cell counts – clotted specimen
- Any sample suspected of being contaminated with IV fluid

Rejection Criteria for Microbiology Specimens:

- Any dry swab
- Labeling on specimen and requisition label do not correlate
- Specimen in improper collection device, container, or transport media
- Specimen not in sterile container
- Collection device outdated
- Insufficient quantity and/or dried specimen
- Specimens exhibiting gross external contamination of the container (spillage)
- Sputum – saliva, mouthwash, or food contamination; specimen doesn't meet gram stain criteria for number of epithelial cells
- Stool – not fresh or not transferred into Cary Blair medium; collected on swab
- Urine – unpreserved specimen >20 minutes after void; specimen in preservative tube >48 hours old

Rejection Criteria for Molecular Diagnostics Specimens:

- Abbott ID NOW COVID-19 RNA – NP swab held at room temperature greater than 1 hour
- Abbott ID NOW Influenza A/B 2 – NP swab held at room temperature greater than 2 hours
- Abbott ID NOW RSV – NP swab held at room temperature greater than 2 hours
- Abbott ID NOW Strep A 2 Rapid Test – Throat swab held at room temperature greater than 3 days
- Abbott COVID-19 Antigen – Nasal swabs held at room temperature greater than 1 hour
- BD Max SARS-CoV-2 PCR – NP swab not put into UTM (universal transport media) and/or held unrefrigerated (2-8 degrees C); specimens greater than 3 days old
- BD Max *Cdiff* – formed stool specimen and/or specimens held at room temperature greater than 48 hours, only loose or liquid stools are acceptable
- BD Max CT/GC/TV Panel – unpreserved urine (not transferred into UVE special collector) >4 hours at room temperature or >24 hours at 2-8 degrees C; endocervical swab not in UVE special collection kit within 2 hours of collection
- BD Max Vaginitis Panel – specimen not in UVE special collection kit within 2 hours of colletion

Rejection Criteria for Urinalysis:

- >2 hours without preservative

REFERENCES:

- Garcia, Lynne S (2016). Clinical Microbiology Procedures Handbook, Fourth Edition, Washington, D.C.: American Society for Microbiology.

- Turgeon, Mary Louise (2020). Clinical Laboratory Science, Eighth Edition, Maryland Heights, MO: Elsevier Mosby.
- BD C&S urine collection tube package insert (2016)
- Abbott ID NOW package inserts (2020)
- BD Max package inserts (2021)

CROSS REFERENCE:

- The Joint Commission (2020). Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing. NPSG 01.01.01, DC 01.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **GUIDELINES FOR WASTE HANDLING – WASTE MANAGEMENT PROGRAM**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide an effective waste management program in accordance with local, state, and federal requirements.

POLICY:

Sierra View Medical Center (SVMC) waste management program describes the procedure for identification, packaging, storage, collection and disposal of all waste generated. State and local regulations will be observed in the handling and disposal of SVMC waste.

PROCEDURE:

A. **Definitions and Classifications of Wastes:**

1. **Solid Waste** includes, but is not limited to, empty specimen containers, bandages, dressings containing non-liquid blood, paper towels, trash, and surgical gloves. Solid wastes shall be stored and eliminated in a manner to preclude the transmission of communicable disease.
2. **Medical Waste** is defined by the State of California Department of Health Services, 2017 which meets both of the following requirements:
   a. The waste is composed of waste which is generated or produces as a result of any of the following actions:
      - Diagnosis, treatment, or immunization of human beings.
      - Research pertaining to the activities specified in the 2017 regulation.
      - The production or testing of biologicals.
      - The accumulation of properly contained home-generated sharps waste that is brought by a patient, a member of the patient's family, or by a person authorized by the enforcement agency.
   b. The waste is either of the following:
      - Biohazardous waste.
      - Sharps waste.

3. **Biohazardous Waste** requires special disposal treatments such as autoclave, sewer disposal or incineration. Biohazardous waste includes all of the following:
   a. Laboratory waste includes, but is not limited to, all of the following:
      - Human specimen cultures from medical and pathological laboratories,

- Cultures and stocks of infectious agents from research and industrial laboratories,
- Wastes from the production of bacteria, viruses, or the use of spores, discarded live and attenuated vaccines used in human health care or research, discarded animal vaccines, including Brucellosis and Contagious Ecthyma, and culture dishes and devices used to transfer, inoculate, and mix cultures.

b. Human surgery specimens or tissues removed during surgery or at autopsy which are suspected by the attending physician and surgeon or dentist of being contaminated with infectious agents known to be contagious to humans.

c. Waste which at the point of transport from the generator's site, at the point of disposal, or thereafter, contains recognizable fluid blood, fluid blood products, containers, or equipment containing blood that is fluid.

d. Waste containing discarded materials contaminated with excretion, exudates or secretions from humans who are required to be isolated by infection prevention staff, the attending surgeon, or the local health officer to protect others from highly communicable diseases.

4. **Sharps Waste** means any devices having acute rigid corners, edges, or protuberances capable of cutting or piercing, including but not limited to, all of the following:

a. Hypodermic needles, hypodermic needles with syringes, blades, and needles attached to tubing, syringes contaminated with biohazardous waste, acupuncture needles, and root canal files.

b. Broken glass items such as Pasteur pipettes and blood vials contaminated with biohazardous waste.

c. Any item capable of cutting or piercing that is contaminated with trauma scene waste.

B. Waste Disposal:

1. Personal Protective Equipment (PPE), including impervious gloves, shall be worn when handling biohazardous waste materials.

2. Containers filled with blood or body fluids:

a. Empty contents of containers designated "safe to empty" (low risk for splash potential) carefully into the sewer system. Then dispose of container in solid waste.

b. Containers filled with body fluids that have not been designated "safe to empty" are to be secured to prevent leakage and placed in a red bag labeled "biohazard waste." Place red bag in biohazard container to be picked up by Environmental Services for transport to secured area until waste handler takes for final disposal.

3. Segregate waste at the point of origin:
   a. Solid waste (general trash) shall be placed in an appropriately-colored plastic lined trash receptacle. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either. Solid waste containers shall be stored and located in a manner that will protect against odors.
   b. Biohazardous (infectious) waste, as defined above, shall be placed in a red-lined trash receptacle and then taken to the soiled utility room for disposal into a closeable, leak-proof, biohazard labeled container.
   c. Sharps as defined above, shall be placed in a closeable, leak-proof, rigid, puncture-resistant container which, when sealed, cannot be reopened without great difficulty. Sharps containers shall be closed tightly and replaced when they are ¾ full. Sealed "full" containers are to be placed in the soiled utility room. Sharps containers shall be locked in areas where personnel are not present consistently. Safe handling of sharps:
      - Needles should not be recapped, bent, broken or otherwise manipulated by hand.
      - If a sharps safety device is available, activate the device immediately after needle use.
      - Dispose of sharps in a sharps container immediately after use.
      - Needles should always be secured by hospital personnel. (Never leave needles unattended).
      - Sharps used in the operating suite should be placed in a "safe zone" in the sterile field.
      - Report any sharps injuries immediately.
   d. Glass items- regular trash.
   e. Chemotherapy wastes are to be stored separately in rigid, leak-proof containers marked with "Chemotherapy" warning label.
   f. Recognizable human anatomical remains shall be placed in a sealed container and transported to the locked facility in the back of the hospital.
   g. Pharmaceutical Waste: Refer to pharmaceutical services policy, "Pharmaceutical Waste"

C. **Final Disposal:**

1. Environmental Services shall conduct rounds at least daily to empty and reline all waste receptacles. Movable bins, when used for transporting solid wastes from the premises, shall meet the following requirements:

a. Have tight-fitting covers.

b. Be in good repair.

c. Be leak-proof.

d. Be rodent-proof unless stored in a room or screened enclosure. Waste is stored in locked facility behind the hospital grounds.

e. Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners.

2. Environmental Services shall remove biohazard waste from utility rooms at least daily.

3. A licensed hauler removes the solid/biohazardous waste in accordance with all local and state regulations.

REFERENCES:

- California Department of Public Health (2019). Medical Waste Management Program. Page update June 22, 2022. Retrieved on November 1, 2019 from https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx.
- California Health and Safety Code, Sections 117600-118360 (2017). Medical Waste Management Act. Retrieved on August, 29, 2022 from https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/MedicalWasteManagementAct.pdf.

SUBJECT:	SECTION:
GUIDELINES FOR SINGLE USE DEVICES (DISPOSABLES), REUSE AND REPROCESSING OF PATIENT CARE EQUIPMENT	**Page 1 of 3**

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

PURPOSE:

To ensure safe, clean, sterile ~~(when appropriate)~~ equipment for use in patient care ~~activities~~.

POLICY:

1. Single-use (disposable) supplies, equipment and devices are for one-time use in accordance with ~~the~~ each manufacturer's recommendations and shall be disposed of after the one-time use.

2. Reuse of supplies, equipment or devices not intended for multi-use *shall not* be practiced by ~~the facility~~SVMC.

DEFINITIONS:

1. ***OPIM*** – Other potentially infectious material.

~~1.~~2. ***Reprocessing:*** The packaging and sterilization of a device that has been opened but not used on a patient.

3. ***Reuse:*** The cleaning, packaging and sterilization of a single-use medical device after use on a patient for the intended purpose of using it on another patient.

~~2.~~4. ***SCD*** – Sequential compression device.

PROCEDURE:

Single-use (disposable) supplies and equipment:

1. Dispose of any sharp object immediately after use by placing it into a labeled sharps container.

2. Dispose of any non-sharp item in a regular trash receptacle (unless dripping with blood or other potentially infectious materials (OPIM).

3. Dispose of any non-sharp item dripping with blood or OPIM in a red/biohazardous bag.

Reuse supplies/equipment not intended for multi-use:

1. This practice is expressly prohibited.

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Reprocessing supplies/equipment:

1. Identify the item(/s) for reprocessing.
2. Evaluate the feasibility of reprocessing the identified item(s).
3. ~~Identify~~ Locate and review the manufacturer's recommendations for reprocessing (i.e. disposable pulse oximeter, sequential compression device (SCD) and pick-up, if applicable.)
4. Identify the current standards of care for reprocessing of item(/s).
5. Identify the legal responsibilities of SVMC as an FDA-defined 'manufacturer' and the implications of reprocessing.

REFERENCES:

- Disinfection and Sterilization: Guideline for Disinfection and Sterilization in Healthcare Facilities (2008, Updated May 2019) Centers for Disease Control & Prevention (CDC) Accessed August 22, 2022. Print Version https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf Downloaded from the following CDC website along with the HICPAC Summary of Recommendations: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html
- CPG Sec. 300.500 *Reprocessing of Single Use* Devices. (1987, Rerelease 2005). Content current as of: April 22, 2022. From FDA Manual of Compliance Policy Guides. Accessed August 23, 2022. https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/compliance-manuals/manual-compliance-policy-guides and https://www.fda.gov/media/71769/download
- California Code of Regulations, Title 22, Section 70831. Central Sterile Supply. Retrieved on 08/02/19 from http://www.nursealliancecca.org/files/2012/06/Title-22-Chapter-5.pdf
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- ~~Centers for Disease Control & Prevention (CDC). (2018). Infection Control and Prevention Guidelines, Resources, and Toolkits. Retrieved on 08/01/19 from www.health.pa.gov/topics/Documents/Programs/HAIP~~

CROSS REFERENCES:

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- California Code of Regulations, Title 22, Section 70739. *Infection Control Program*. Retrieved on 08/02/19 from http://www.nursealliancecca.org/files/2012/06/Title-22-Chapter-5.pdf

SUBJECT:	SECTION:
HOSPITAL-APPROVED HANDWASHING, CLEANING AND DISINFECTANT PRODUCTS	**Page 1 of 4**

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

PURPOSE:

To establish Infection Prevention-based standards for the review and approval of potential changes to established cleaning and disinfecting products and routines.

POLICY:

All products, reagents and schedules shall be approved by the Infection Prevention Manager and the Infection Prevention Council.

PROCEDURE:

ANTISEPTIC HAND HYGIENE PRODUCTS

1. Hand washing is considered the single most important procedure for preventing healthcare-associated infections. Handwashing removes transient microbial contamination acquired through microscopic holes in gloves, from contact with infected or colonized patients and other environmental sources.
2. Alcohol-based hand sanitizers are effective products for reducing the number of germs on the hands of healthcare providers (Table 1). Alcohol-based hand sanitizers that contain at least 60% alcohol are the preferred product for performing hand hygiene in most, but not all, clinical situations.
3. All hand hygiene products used at SVMC shall be approved by the Infection Prevention Council.
4. Factors influencing the effectiveness of hand hygiene products include:
    a. The antibacterial agent and its concentration/strength
    b. The harshness on skin
    c. Possible interactions with lotions and gloves
    d. The ability to be easily dispensed
5. Submission process for proposed product change
    a. All proposed items will be reviewed for their effectiveness, safety, appropriateness and feasibility (including cost) of application.
    b. Any proposed change of products, equipment, techniques, etc., used in cleaning and/or disinfecting shall be submitted to Materials Managements for consideration by the Value Analysis Committee, the Infection Prevention Manager, and the Pharmaceutical & Therapeutic Infection Prevention Committee.
    c. The department requesting the change in products, etc., shall be informed of the outcome (approval or disapproval) from the above stated vetting process. At this point, a representative from the department requesting the change must be prepared to present the product information to the Infection Prevention Council.

d. The final evaluation and approval will be done by the Infection Prevention Council and then codified through the Policy Approval Process.

GENERAL CHEMICAL DISINFECTANT PRODUCTS

There are many factors to consider that influence the effectiveness of disinfectants. For this reason, it is necessary to fully understand disinfection principles and apply this knowledge during the selection process.

1. During the selection process, the level of disinfection based on the Spaulding classification scheme, must be taken into consideration. For instance, does the proposed disinfectant need to function as a high level disinfectant for critical items, etc.?
2. In any disinfection process, the item must first be free of dirt, blood, grime, bodily secretions and other extraneous materials that would inhibit the action of the disinfectant. Therefore, the first step in any disinfection process is the meticulous cleaning of medical instruments.
3. The efficiency of any disinfectant is dependent on product concentration and contact time, both of which are clearly described in the manufacturer's instruction for use (IFUs).
4. Disinfectants require an optimal environmental pH for effectiveness, which is described in the IFUs, and must be followed. Failure to do so could reduce disinfecting properties of the disinfectant and/or cause harm to the surgical instrument.
5. Most disinfectants function within an optimal temperature range therefore it is essential to take temperature into consideration when selecting a new product.
6. Cleaning and disinfecting agents must be used in accordance with the IFUs to ensure effectiveness.

Table 1 from Guideline for Hand Hygiene in Health-Care Settings

Antimicrobial Spectrum and Characteristics of Hand-Hygiene Antiseptic Agents*

Group	Gram-positive bacteria	Gram-negative bacteria	Mycobacteria	Fungi	Viruses	Speed of action	Comments
Alcohols	+++	+++	+++	+++	+++	Fast	Optimum concentration 60%–95%; no persistent activity
Chlorhexidine (2% and 4% aqueous)	+++	++	+	+	+++	Intermediate	Persistent activity; rare allergic reactions
Iodine compounds	+++	+++	+++	++	+++	Intermediate	Causes skin burns; usually too irritating for hand hygiene
Iodophors	+++	+++	+	++	++	Intermediate	Less irritating than iodine; acceptance varies
Phenol derivatives	+++	+	+	+	+	Intermediate	Activity neutralized by nonionic surfactants
Triclosan	+++	++	+	—	+++	Intermediate	Acceptability on hands varies
Quaternary ammonium compounds	+	++	—	—	+	Slow	Used only in combination with alcohols; ecologic concerns

Note: +++ = excellent; ++ = good, but does not include the entire bacterial spectrum; + = fair; — = no activity or not sufficient.
* Hexachlorophene is not included because it is no longer an accepted ingredient of hand disinfectants.

NOTE: In the state of California, the use of Triclosan has been banned in some products.

SELECTION OF DISINFECTANT PRODUCTS

Although there is no 'universal' disinfectant, it is economically infeasible to purchase several products for similar disinfecting tasks. Limiting the numbers of products within an institutions provides for better and more consistent use of available disinfectants. The following criteria and/or standards should be considered when evaluating disinfectants:

1. Formulation – especially the active ingredients and the product concentration.
2. Disinfectant activity on specific pathogens – for instance, does the product kill microbes at the expected level of disinfection?
3. The contact time or time of action should be less than 15 minutes.
4. Corrosiveness – at what concentration will the disinfectant cause harm to metallic surfaces?
5. Possible side effects such as skin irritation, staining or discoloration of materials, levels of toxicity and possible allergic reactions.
6. Cost – consider comparing cost per gallon of disinfectant at the recommended dilution.
7. Effects of pH on product effectiveness – is disinfectant activity changes in the presence of an acidic or basic environment?
8. Product incompatibility with conditions such as hard water, or the presence of specific detergents or other chemicals commonly used during cleaning and disinfecting.
9. Considerations should include:
    a. Purchasing disinfectants and cleaning agents from reputable and well-established companies.
    b. Disinfectants and cleaning agents shall have an EPA registry number, easily understood Manufacturer's Instructions for Use (IFU) and a product Safety Data Sheet (SDS) that will be kept on file and consulted as needed.

A LIST OF SOME TYPICAL DISINFECTANTS

1. Omega (quaternary ammonium compound)
2. Bleach (sodium hypochlorite)
3. Sani-Cloth Plus (germicidal disposable wipes)
4. Moni-Chlor Wipes (sodium hypochlorite cloths)

REFERENCES

Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002; 51. Page last reviewed: January 8, 2021, document retrieved August 25, 2022. From https://www.cdc.gov/handhygiene/providers/guideline.html

Title 22 California Code of Regulations Division 5, Title 22 Social Security. §70005. General Acute Care Hospital, §70015. Cleaning, §70025. Disinfection, §70063. Sterilization, §70739. Infection Control Program, §70827. Housekeeping, §70831. Central Sterile Supply, and §70835. Disinfecting. From: https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IE55EDC305B6011EC9451000D3A7C4BC3&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default) Retrieved August 26, 2022 from https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Regulations.aspx

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Triclosan Fact Sheet, Triclosan: Biomonitoring California. Published 2013, updated 2018, Accessed August 27, 2022. From: https://biomonitoring.ca.gov/chemicals/triclosan

SUBJECT: **INFILTRATE MANAGEMENT**	SECTION: **Page 1 of 10**

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

PURPOSE:

This document directs the registered nurse (RN) in the management of peripheral IV infiltrations, outlining administration as ordered by the physician, of hyaluronidase for severe (Stage III and IV) infiltrations and phentolamine for infiltration of vasoactive medications.

POLICY:

The stage of infiltration, the nature of the infiltrated fluids and the availability of specific antidotes determine the degree of intervention. IV infiltration or extravasations of known vesicants are managed according to the guidelines as written.

Extravasation Treatment

Antidote and compress treatment of IV infiltrates and extravasations vary according to the medication extravasated. The RN should follow the Appendix below or the most recent version from Lexicomp online, search of "extravasation". Additional information may be obtained by consulting with the Pharmacist. Measures will be taken to mitigate pain associated with injection procedures.

Definitions

Infiltration: When a non-vesicant fluid leaks from a vein.

Extravasation: The inadvertent leakage or escape of a vesicant drug or solution into healthy tissue.

Vesicant: When the fluid/medication is toxic to the tissue causing blistering and/or necrosis.

AFFECTED AREAS/ PERSONNEL: *NURSING AND PHARMACY*

PROCEDURE:

A. **Assessment**

1. At the very first sign or symptom of infiltration or extravasation, immediately stop the infusion or injection.
2. Estimate the volume of infiltrated fluid and/or medications.
3. Assess motion, sensation, and capillary refill distal to the injury.
4. Consider transferring the patient to a higher level of care based on the severity of the infiltration and frequency of monitoring.

B. **Management**

1. Disconnect the administration set from the catheter hub/IV device. Do not flush the line, and avoid applying pressure to the site.

2. Attach an empty 3- or 5-mL syringe and attempt aspiration of the residual solution/drug from the IV device.

3. For a short peripheral catheter:

   a. For peripheral sites (Peripheral cannula, midline) and peripherally inserted central catheters, elevate the affected extremity.

   ~~a.~~b. Remove the dressing and withdraw the catheter.

   ~~b.~~c. Use a dry gauze pad to control bleeding.

   ~~c~~d. Apply a dry dressing to the puncture site, but avoid applying excessive pressure on the area.

   ~~d~~e. Do not insert a new peripheral IV catheter distal to a site of infiltration or extravasation.

4. For a central venous catheter:

   a. Clamp the catheter. Consult the physician about the need for a radiographic study of the catheter to determine the cause of the infiltration or extravasation.

   b. Assess the need for continuing IV therapy and plans for another central venous catheter.

5. Evaluation ~~Elevation~~ of the need for continuing IV therapy and plans for another central venous catheter.

6. Local thermal treatments are used to decrease the site reaction and absorption of the infiltrate.

   a. Local cooling aids in vasoconstriction to limit drug dispersion.

   b. Local warming (dry heat), aids in vasodilation to enhance dispersion of the vesicant agent and decrease drug accumulation in local tissue.

   c. Refer to Appendix A for guidelines on the use of heat and cold for specific vesicant agents.

   d. Reapply compresses for 15 to 30 minutes every 4-6 hours for 24 to 48 hours.

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Note: Heat and cold applications are not well supported in neonates and young infants.

7. Administer the antidote, as ordered by a physician. See procedures below for specific antidote administration.

C. **Procedure for Hyaluronidase (Vitrase) Administration**
Equipment

1. Hyaluronidase ~~200~~ 150 units/1 ml vial
2. TB syringe
3. Four to ten ½ inch 30 G needles to minimize pain with injections
4. Appropriate sized blood pressure cuff

a. Process

i. Obtain a physician order for hyaluronidase and order from Pharmacy **STAT**. **Hyaluronidase requires refrigeration until use.**

Key Point: Recommended dose is 1mL (150 units) infiltrated subcutaneously, as five separate injections of 0.2 mL each, into the extravasated site along the leading edge of erythema using a 25 gauge or smaller needle. ~~Obtain the physician order in specific units not to exceed 30 units. Recommended total dosage = 15 units, divided into 5 aliquots of 3 units/ 0.15 ml. Large infiltrates spread over a wide area may require up to a total of 30 units.~~

ii. Check the physician order prior to the use of the medication.

~~iii.~~ Local administration: Using a 150 units/mL concentration, mix 0.1 mL (of 150 units/mL) with 0.9 mL NS in 1 mL syringe to make final concentration of 15 units/mL; administer a total of 1 to 1.7 mL (15 units/mL) as 5 separate 0.2 to 0.3 mL (15 units/mL) into area of extravasation~~The concentration of hyaluronidase is 200 units per ml. Obtain a 200 units/ml vial from pharmacy. Using a tuberculin syringe, withdraw 0.1 ml of this solution and add 0.9 ml Normal Saline. The resultant concentration is 20 units per ml. * A maximum of 30 units may be used (1.5ml).~~

Key Point: Over dosage may cause hypotension.

~~iv.~~ iii. Cleanse the site with alcohol if skin is intact; if skin is broken or blistered, cleanse with normal saline.

Key Point: Use gentle cleansing, avoiding pressure at site.

~~v.~~iv. Begin subcutaneous injections of hyaluronidase using 0.2~~0.15~~ ml aliquots. Inject around the infiltrate on the margin of the infiltrate.

Key Point: Change needle after each injection; a maximum of 10 injection sites may be used.

~~vi.~~v. Observe the site carefully every fifteen (15) minutes for two (2) hours for improvement in color, capillary refill, skin temperature, and/or edema/swelling.

Key Point: Usually there is a marked decrease in swelling within 15-30 minutes after administration of the enzyme.

~~vii.~~vi. **Safety Point: Monitor heart rate and blood pressure carefully and document every 30 minutes times two.** Allergic (urticara) and anaphylactic like reactions may occur. This drug MAY cause hypotension.

~~viii.~~vii. Continue to monitor the site for 48 hours after treatment/catheter removal for additional complications.

~~ix.~~viii. Implement topical wound care and/or obtain wound care consult per physician orders.

D. **Safety**

1. Verify with a second RN/LVN.
   a. Correct dilution
   b. Reconstitution dosage
2. Overdose / Symptoms of Toxicity
   a. Local edema or urticaria
   b. Erythema
   c. Chills
   d. Nausea/vomiting
   e. Tachycardia
   f. Hypotension
   g. Dizziness

E. **Procedure for Phentolamine (Regitine) Administration**
Equipment

1. 5 mg vial of phentolamine
2. 10 mL syringe
3. Filter needle
4. TB syringe
5. Four to ten ½ inch 30G needles
6. Appropriate-sized blood pressure cuff

a. **Process**

~~i.~~ Obtain a physician order for phentolamine of 5 to 10mg. ~~0.1 mg/kg or no more than 2.5 mg.~~

~~i.~~

ii. Obtain phentolamine from Pharmacy and double check the order.

iii. Mix 10 mL of 0.9% sodium chloride (normal saline) with ~~a~~each 5 mg vial of phentolamine powder (0.5 mg/ml).

iv. Draw up 1 ml of phentolamine solution (in a TB syringe with a filter needle), remove filter needle and attach a 30 gauge needle for drug administration.

v. Ensure baseline vital signs have been obtained, and then provide continuous blood pressure monitoring (non-invasive blood pressure (NIBP) or arterial blood pressure to repeat every 3 - 5 minutes) throughout administration procedure. If possible, use the extremity that is unaffected by the infiltration for the NIBP.

Note: Phentolamine administration can cause hypotension.

vi. Cleanse site with alcohol if skin is intact; if skin is broken or blistered, cleanse with sterile normal saline.

Key Point: Use gentle cleansing, avoiding pressure at site.

vii. Begin subcutaneous (SQ) injections of phentolamine using 0.1 ml aliquots. Begin at the center of the affected area and work outward, infiltrating the area in a circular pattern. Aspirate syringes frequently to check for blood.

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Safety Point: Do not administer phentolamine if blood is aspirated.

Key Point: Obtain a new syringe if blood is aspirated.

Key Point: Change the needle after each injection.

viii. Continue administering the diluted solution as long as the patient's vital signs are stable, until the entire area is re-perfused, or up to the maximum dose of 2.5 mg of diluted phentolamine is given.

Key Point: Take care not to cause so much swelling that a compartment syndrome occurs.

ix. Observe the site carefully every fifteen (15) minutes for two hours for improvement in color, capillary refill, skin temperature, and/or edema/swelling.

x. Monitor heart rate (for tachycardia and/or arrhythmias) **and blood pressure carefully and document every 30 minutes times two.**

Safety Point: This drug MAY cause hypotension.

xi. Continue to monitor site for 48 hours after treatment/catheter removal for additional complications.

F. **Reportable Conditions**

If any of the following conditions are noted, discontinue the treatment, notify the physician, and initiate supportive measures immediately per physician orders:

1. Development of hypotension.
2. Development of tachycardia or arrhythmias.
3. Reperfusion of extravasation site does not occur within 30 minutes of completion of administration.

G. **Education**

Teaching is provided regarding indications for antidote administration and potential complications from treatment.

H. **Documentation**

1. Call to physician and orders received.
2. Location of infiltrate/extravasation and type of fluid infiltrated.
3. Appearance of infiltrate/extravasation before intervention – size and color; grade/severity of infiltration/extravasation.
4. Appearance of infiltrate after intervention –size and color.
5. The type, size and length of the catheter involved.
6. Initial interventions e.g. aspiration, catheter removal, application of heat or cold.
7. Total amount of antidote administered.
8. Patient tolerance of procedure.
9. Patient response to interventions.
10. Patient/parent education regarding the event and follow-up care.
11. Vital signs.
12. Complete online event reporting.

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APPENDIX A

Medication Extravasated	**Cold/Warm Pack**	**Antidote**
For additional information, search George Page *Policies and documents for Extravasation* or call Pharmacy.		
Chemotherapeutic agents		
Anthracyclines Daunorubincin Doxorubincin Mitomycin ~~Vinca alkaloids~~	Cold	~~None~~DMSO
Vinblastine Vincristine Vindesine Alkylating agents	Warm	Hyaluronidase (Vitrase)
Mechlorethamine (Nitrogen mustard) –Bendamustine Carboplatin Cisplatin Dacarbazine	Cold	Sodium thiosulfate 1/6 molar solution: ~~Mix 4 mL of 10% sodium thiosulfate with 6 mL of sterile water.~~Inject 2 mL of the 1/6 Molar solution for each mg suspected to have extravasated.
~~Other vesicant Chemotherapeutic agents~~	~~Cold~~	~~None~~
Vasopressors Dopamine Epinephrine Norepinephrine Phenylephrine	None	Phentolamine (Regitine®)
I.V. fluids and other medications ~~Antibiotics~~ Other agents	Cold	~~Hyaluronidase (Vitrase)~~

~~Calcium~~

SUBJECT: **ORAL NUTRITION SUPPLEMENT**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish protocol for oral nutrition supplement (ONS).

DEFINITIONS:

ONS includes high calorie protein drinks and protein powders/liquids that are considered by the manufacturer to be medical foods.

POLICY:

ONS and oral modular supplements are available to patients as ordered by the physician and/or registered dietitian (RD).

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

PROCEDURE:

A. The RD may order or discontinue any ONS for patients on a modified diet using the ONS and Diet Type chart. The RD may modify the frequency, delivery time, and flavor of the existing ONS orders entered by the physician or other ~~RD's~~. RDs may only discontinue ONS ordered by other RDs. *See attached addendum.*

B. The RD may add protein modular (amino acid powders/protein powders/liquids).

C. The RD may adjust the diet downwards for calories, protein and textures.

REFERENCES:

- California Code, Business and Professions Code - BPC § 2585. (n.d.). Retrieved from https://codes.findlaw.com/ca/business-and-professions-code/bpc-sect-2585.html.
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ADDENDUM

Food and Nutrition Services Dept. Diet Manual
Diet Types & Oral Nutrition Supplements (ONS)

Oral Nutrition Supplements by Diet

A crosswalk illustrating the ONS that fits the macronutrient composition and pattern of the diets listed. These may be selected by the Clinical Dietitian or Nurse, to be offered to patients based on assessed need. Only a physician may order alternate supplements.

Diet	Supplement
• High Iron • **Regular** • **Vegetarian** • **Kosher** • **High Calorie/High Protein** ~~Fortified~~ • **Pregnancy/Lactation** • **Low Microbial/Neutropenic** • **Full Liquid** • **Low Fiber/Low Residue** • **Dysphagia I,II, III** • **Blenderized Puree** • **Cardiac** • Low Sodium**2 gm** ~~Sodium~~ • **No Added Salt (4 gm)** • **Low Fat/**~~Low Cholesterol~~ • **Gluten Free** • **PUD/GERD** • 6 Small Meals • Hyperemesis Gravidarum	• Boost Plus • Ensure Clear • Ensure ~~Enlive~~Plus High Protein • ~~Ensure Pudding~~ • Ensure Plant Based Protein • Ensure Max Protein • Glucerna Therapeutic Nutrition Shake • TwoCal HN • Nepro • SF Mighty Shake, regular Mighty Shake • Suplena • Pediasure • Propass ~~P~~powder • SF Prostat • Banatrol Plus • Juven
• **Thickened liquids**	All ONS thickened to appropriate consistency
• Clear Liquid w/Supplement • **Clear Liquid**~~Pediatric Clear Liqd~~ • Diabetic Full Liquid • Diabetic Clear Liquid	• Ensure Clear (Not on Diabetic Clear/Diabetic Full Liquid) • Juven • SF ProStat • Diabetic FL: Glucerna, SF Mighty ~~s~~Shake, Ensure

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	Max Protein, Banatrol Plus, Ensure Plant Based
• **Consistent Carbohydrate** • **Consistent Carbohydrate Low** • **Gestational DM**	• Glucerna Therapeutic Nutrition Shake • Ensure Plant Based • Ensure Max Protein • Banatrol Plus • Nepro • Suplena • Propass powder • SF Prostat • SF Mighty Shake
• **Renal - ~~Dialysis~~** • **Renal – ~~Not Dialysis~~ High Protein**	• Nepro, Glucerna (dialysis) • Suplena (Low Protein Diet, no dialysis) • Ensure Clear • Propass Ppowder, SF ProStat • Juven
• **Calorie Restriction: 1200,1500,1800,2000,2400**	• All ONS • Propass • SF Prostat • Consult RD if needed
• **Hepatic 2gm Na+, 50gm protein** • **Low protein (50gm)** • **Renal Low Protein (60g)**	• Suplena, consult RD if needed
Combination Diets • **Consistent Carb/Renal** • **Consistent Carb Cardiac** • **Cardiac Low Potassium**	• Glucerna, no chocolate • Nepro • Suplena • Propass Ppowder • SF Prostat
• **Toddler 1-2** • **Pediatric 2-12**	• PediaSure • Ensure Enlive

• **Gastro Pediatric** • **BRAT**	No supplement
• **NPO Except Supplements**	Any liquid oral supplement (No TRAY)

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SUBJECT: PATIENT DISCHARGE TO POST-ACUTE CARE SETTING	SECTION: CARE MANAGEMENT Page 1 of 3

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

PURPOSE:

- To ensure continuity of nursing and medical care to a patient being discharged from Sierra View Medical Center (SVMC) to a post-acute care setting. This may include, but is not limited to:

  a) Skilled nursing facilities
  b) Long term acute care facilities
  c) Acute rehabilitation
  d) Hospice
  e) Home health

- Members of the patient's health care team assist in evaluating and identifying his/her needs and help him/her to understand and prepare for his/her care after discharge.

- Members of the patient's healthcare team may recognize a need for a referral to a post-acute care service, and indicate it to Care Integration, the Patient Care Unit Nurse Manager or team leader, who discusses this with the attending or consulting physician.

- The referral is planned with the patient, his/her family, to the extent possible based on patient's cognitive ability and family availability, and the healthcare team. Ultimately, discharge plans are an agreement between the treating physician and the patient or their representative.

- See also, "Discharge Planning Assessment and Reassessment" policy.

POLICY:

1. A physician's discharge order specifying the type of post-acute care facility/service is required for discharge of a patient.

   a. A discharge packet is to be completed by Care Integration or nursing staff.

   b. The discharge packet includes a photocopy of the history and physical, discharge summary, progress notes, medication reconciliation and diagnostic test results.

   c. Any other forms requested by the post-acute facility/service are to be approved by the discharging physician.

   d. Do not send the entire medical record or Nurses' Notes.

   e. Care Integration staff shall arrange for ambulance transport during 0800-1630. After hours, nursing staff will make arrangements as needed.

PROCEDURE:

1. After receiving the discharge order for the patient, Care Integration or nursing staff is to call the receiving facility and confirm specific arrangements (time that the patient is expected, area to be received, etc.).

2. Notify the patient, patient's family and/or guardian of the pending discharge.

3. Arrange transportation for the patient.

4. Complete the interfacility transfer report in duplicate (PCS/EMS transfer form).

5. Place interfacility transfer report and any other approved documents in an envelope with the patient's name, hospital's name and address, and name and address of the facility where the patient is being transferred.

6. Nursing staff to ready the patient's belongings by having the patient review and sign off on their patient belonging sheet.

7. Give the documents in a sealed envelope to the person/EMS staff taking the patient to the new facility.

8. The following patient information shall be documented and communicated to the receiving facility:

    a. Patient's physical status
    b. Current code status
    c. Patient's psychosocial status
    d. Patient's cognitive status
    e. Patient's care plan, as to be continued at the receiving care facility, if applicable
    f. A summary of care, treatment and services that the patient received
    g. Patient's progress towards established goals
    h. A list of additional referrals provided/made to the patient

DOCUMENTATION:

1. Nursing documentation:

    a. The date and time of discharge

    b. Method transferred

    c. Name of individuals transferring patient, i.e., ambulance company, relatives

    d. Information sent with patient

e. Discharge education provided, method, and signature documenting such

f. Signature and classification

REFERENCES:

- (2021). Comprehensive Accreditation Manual. Oakbrook Terrace, IL: The Joint Commission.
- (2021). The CMS Hospital Conditions of Participation and Interpretive Guidelines. Brentwood, TN: HcPro.

CROSS REFERENCES:

- DISCHARGE PLANNING: ASSESSMENT AND REASSESSMENT

SUBJECT: **RECOGNIZING AND REPORTING ELDER ABUSE/NEGLECT**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide hospital staff with criteria for recognition of suspected elder abuse and/or neglect, delineate responsibility for reporting, and provide the reporting methods and forms.

All licensed hospital personnel are mandated reporters, and responsible for recognition and reporting.

POLICY:

Sierra View Medical Center provides for the protection of the elderly and/or dependent adult and acts in conjunction with the State of California and County of Tulare County Elder Abuse Reporting Laws.

AFFECTED AREAS/ PERSONNEL: *ALL PERSONNEL*

PROCEDURE:

Recognizing and Reporting Elder Abuse and/or Neglect:

1. The law specifies that all licensed nurses, physicians, non-medical practitioners, psychiatrists, psychologists, social services workers, residents, interns, and any other person currently licensed under the Business and Professions Code must report suspected elder abuse or neglect when acting in his/her professional capacity or within the scope of his/her employment. The SOC 341 form is to be used for reporting elder abuse and/or neglect. Appropriate documentation will be made on the admission sheet and on the medical record.

2. None of the above-mentioned licensed personnel will incur any civil or criminal liability as a result of making this report.

3. "Dependent Adult" is defined as any person residing in this state, over the age of 18, who has physical or mental limitations which restrict his/her ability to carry out normal activities or to protect his/her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

4. Elder abuse should be reported if an observation is made that an elder or dependent adult has had a physical injury or injuries that appear to have been inflicted upon him/her by other than accidental means by any person. When appropriate, photographs will be taken by nursing personnel of suspected areas of decubitus or neglect. A social work referral should be entered into the electronic health record.

   If two or more mandated reporters have jointly observed or been made aware of an abuse of a dependent adult or elder, if there is agreement among them, the telephone and written report

can be made by one member of the group. Any individual who believes the report was not made, shall submit their own report.

If the elder/dependent person is transferred to the hospital from a licensed health facility or Adult Day Care, contact: Long Term Care Ombudsman (LTCOP) at (559) 582-3211 ext. 2823.

If the abuse is believed to have occurred in a Long Term Care (LTC) facility and it has resulted in a serious bodily injury, report by telephone to the local law enforcement immediately and no later than two (2) hours after observing or being made aware of the physical abuse. A written report must also be submitted to the (LTCOP) within two hours of observing or being made aware of the physical abuse.

Signs/Symptoms of Physical Abuse:

Physical indications of abuse occur more commonly in clusters of symptoms than as a single symptom. Assess for the presence of two or more of the following:

- Bruises
- Welts
- Lacerations
- Puncture Wounds
- Dehydration
- Malnutrition
- Fractures
- Signs of over-medication
- Burns
- Poor hygiene
- Lack of needed medical attention
- Multiple injuries in various stages of healing

- Injuries inconsistent with explanation
- Injuries during pregnancy

Fiduciary Abuse:

1. A situation in which a person who stands in a position of trust with the elder or dependent adult willfully steals the money or property of that elder or appropriates the elder's money or property to any use of purpose not in the due and lawful execution of his/her trust.

2. Elder and dependent adult financial abuse includes lack of money to buy food or medication, someone consistently visiting around the first of the month when Social Security checks are received and/or checks written to strangers.

Neglect Includes:

1. Failure to assist in personal/hygiene or in providing food and clothing for an elder or dependent adult.

2. Failure to provide medical care for an elder or dependent adult's physical and mental health needs, although a person's voluntarily relying upon treatment by spiritual needs through prayer in lieu of medical treatment does not constitute neglect.

3. Failure to protect an elder or dependent adult from health and safety hazards.

4. Failure to prevent an elder or dependent adult from suffering malnutrition.

Abandonment:

Abandonment is defined as a situation in which a person who has the care of or custody of an elder or dependent adult, deserts or willfully forsakes the elder under circumstances in which a reasonable person would continue to provide care or custody.

It is the responsibility of the licensed employee who observes the suspected abuse to initiate the reporting process by contacting Adult Protective Services by telephone and filling out suspected abuse report. A written referral will also be given to the Social Services Department, who will ensure that sufficient follow up has taken place and review the written report.

Any licensed employee suspecting elder abuse or neglect of any patient coming into the Emergency Department or being admitted to the hospital is required to call Adult Protective Services (APS) prior to the patient's discharge. A 24-hour emergency response hotline is available for APS referrals, 559-623-0651. This call is to take place as soon as one has knowledge of abuse/neglect of an elder or dependent adult, and a written report must be completed within 24 hours.

The staff with primary knowledge of the situation will:

- Discuss the patient's condition with the physician and/or nursing staff.
- Refer to Social Worker, who will interview the patient and family, if appropriate, to obtain background information. Social Worker, if appropriate, will provide community resources to the victim/family that can arrange or assess for ongoing needs.

A copy of the Adult Protective Services (APS) reporting form is placed on the patient's medical record, a copy is placed in a file in the Social Service office, and the original is mailed or faxed to Adult Protective Services.

REFERENCES:

- Ca. Welf. And Inst. Code § 15630
- Ca. Welf. And Inst. Code § 15658 (a)(1)
- The Joint Commission Comprehensive Accreditation Manuel (2021). Patient Rights chapter.
- CMS Conditions of Participation (2021). Published by HCPro.

CROSS REFERENCE:

SOC 341 – REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

SUBJECT: **SEASONAL INFLUENZA PLAN**	SECTION: **Page 1 of 4**

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

PURPOSE:

The purpose of the SVMC Seasonal Influenza Plan is twofold:

1. To implement prevention control measures to address seasonal influenza. The expected results are a reduction of cases with reduced severity of seasonal influenza cases.
2. To describe the processes that will ensure the safety of patients, visitors, volunteers and healthcare personnel in the event of severe seasonal influenza.

INTRODUCTION:

- Influenza (the 'flu') is a contagious viral respiratory illness. Influenza virus strains perennially circulate throughout the world. In this area, the influenza season can begin as early as October and continue through late May.
- The influenza virus can cause mild to severe illness, which may sometimes lead to death. The elderly, young children and individuals with specific health conditions such as metabolic diseases or a weakened immune system, etc., are at higher risk for serious complications from influenza. Research shows that the best way to prevent influenza is through yearly vaccination.
- Influenza is a disease that is transmitted by droplets expelled when an infected person coughs, sneezes or speaks. Less often, a person may contract influenza via fomite (surfaces that harbor viral particles) followed by touching their own face, especially the mouth, eyes or nose.
- Most individuals are able to transmit the influenza virus to others one day before symptoms appear and up to and through the 7th day after the appearance of symptoms.

POLICY:

- Sierra View Medical Center (SVMC) will monitor guidance and recommendations from the Centers for Disease Control (CDC), as well as state and local health officials, and may revise this flu season policy as more information becomes available.
- SVMC seeks to minimize the risk of influenza infection in patients, staff, students and visitors.
- The seasonal influenza plan and respiratory isolation precautions shall be implemented in the event of signs/symptoms of influenza.

AFFECTED AREAS/PERSONNEL: *ALL PATIENTS/VISITORS/STAFF*

PROCEDURE:

1. Visual alerts in Spanish and English will be posted in all appropriate entrances to the facility instructing all persons with signs/symptoms of infectious disease, especially respiratory, to:
    a. Inform reception and healthcare personnel when they first register for care that they may be infectious.

b. Practice respiratory hygiene/cough etiquette: covering mouth and nose when coughing or sneezing, using tissues and disposing of them correctly.

2. The waiting area will be set up to enable patients with respiratory symptoms to sit at least 3 feet away from other patients and visitors.

3. Signs promoting respiratory hygiene/cough etiquette will be placed in areas such as patient rooms to serve as reminders to all persons in the facility. The signs will instruct persons to:

   a. Cover the nose/mouth when coughing or sneezing.

   b. Use tissues to contain respiratory secretions.

   c. Dispose of tissues in the nearest waste receptacle after use.

   d. Patients with respiratory signs/symptoms will be given masks upon entry to the facility with instructions to wear them until evaluated and admitted or discharged.

   e. Perform hand hygiene after contact with respiratory secretions.

4. Personal protective measures:

   a. Early self-isolation of those feeling ill, feverish and having other symptoms of influenza (e.g., coughing, sneezing)

   b. Avoid close contact with sick people

   c. Avoid touching one's eyes, nose or mouth

5. Sierra View Medical Center (SVMC) will provide appropriate materials in waiting areas for patients and visitors:

   a. Tissues and waste receptacles for used tissue disposals.

   b. Conveniently located dispensers of hospital-approved alcohol-based hand sanitizers.

   c. Soap and disposable towels for hand washing where sinks are available.

   d. If the condition is respiratory in nature and infectious, family members accompanying the patient will be asked to wear masks.

   e. Visitors will be limited to those necessary for patient's emotional well-being and care.

   f. Visitors will be required to wear surgical mask while visiting an infected patient.

g. Visitors will be instructed on hand hygiene practices (washing hands with soap and water or using alcohol-based hand sanitizer for at least 20 seconds).

6. SVMC staff, volunteers, healthcare personnel and students are required NOT to report to work if they have a fever greater than 100.4° Fahrenheit (38° Celsius), combined with one or more of the following symptoms:

- Cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Headache
- Chills
- Fatigue
- Diarrhea
- Vomiting

7. Prevention of illness:

a. SVMC endorses and encourages all healthcare personnel, staff, volunteer, and students to adhere to the guidance of the CDC to minimize the risk of becoming sick with seasonal flu.

- Get the influenza vaccination
- Practice good hand hygiene by washing hands often with soap and water or by using alcohol-based hand sanitizer, especially after coughing or sneezing.
- Practice good respiratory etiquette by covering the mouth and nose with tissue when coughing or sneezing. If a tissue is not available, the cough or sneeze should be directed into a sleeve, elbow, or shoulder, but **not into hands**. Avoid touching eyes, nose or mouth.
- Individuals who are sick with influenza-like illnesses (ILI) should stay home.

Health Care System and Provider Actions

- Vaccinate health care workers.
- Review plans and prevention strategies for seasonal influenza in the health care setting, including implementation of respiratory hygiene, appropriate management of ill staff, and infection control precautions.
- Coordinate with the CDC to identify likely influenza strains that could affect California during the next influenza season:

1. CDC guidance can be found at: http://www.cdc.gov/flu/professionals/index.htm.

- Monitor any disease outbreaks with patients exhibiting upper-respiratory infections or symptoms of ILI.
- Monitor ILI-activity in hospital emergency departments for statistically significant warnings and threats.
- Conduct laboratory testing to identify and confirm any influenza cases prior to the beginning of influenza season or early influenza activity phase.
- Monitor adverse reactions to vaccine.

REFERENCES:

- Advisory Committee on Immunization Practices (ACIP). www.cdc.gov/vaccines/hcp/acip-recs/general- recs/downloads/generalrecs.pdf. Accessed on August 28, 2022.
- Grohskopf LA, Blanton LH, Ferdinands, et al. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season. MMWR Recomm Rep 2022; 71(No. RR-1): 1-28. ISSN: 1057-5987 (Print). Accessed Aug. 27, 2022. https://www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm?s_cid=rr7101a1_w
- Influenza (Seasonal) 2018. Accessed August 29, 2022, from World Health Organization: https://www.who.int/en/news-room/fact-sheets/detail/influenza.
- Centers for Disease Control and Prevention. Chapter 12: Influenza, in Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book). Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. Accessed August 27, 2022 at https://www.cdc.gov/vaccines/pubs/pinkbook/

SUBJECT:	SECTION:
SEEING/HEARING/COMPANION DOG (SERVICE ANIMALS)	***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 3**

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

PURPOSE:

The purpose of this policy is to establish ADA-based guidelines for accommodating patients, visitors and/or employees the use of seeing/hearing/guide service dogs as an auxiliary aid within the confines of SVMC facilities.

DEFINITIONS:

ADA – American with Disabilities Act, which in 2020, celebrated 30 years of being signed into federal law

AOC – Administrator-on-call

PACU – Post-Anesthesia Care Unit

Service Animal – ADA regulations narrowly define a "service animal" as any dog that is specially and individually trained to do work or perform tasks for the benefit of a disabled individual. Emotional support animals are expressly excluded from qualifying as a service animal under the ADA.

SVMC – Sierra View Medical Center

AFFECTED AREAS/PERSONNEL:

This policy covers all SVMC personnel, patients and visitors.

POLICY:

SVMC will allow any patient, visitor, or employee the use of a service dog(s) as an auxiliary aide. The dog may be used in all situations *except* where it is clearly demonstrated that the presence or use of a service dog would pose a significant health risk, or when a dog's behavior is uncontrollable and/or disruptive.

PROCEDURE:

Hand Hygiene

1. Anyone handling or touching a Seeing/Hearing/Companion Service Dog(s) must perform hand hygiene after each and every contact.

Outpatient Areas

1. Service dogs will be allowed to work in any outpatient setting where the public and patients are routinely allowed to go.

Inpatient Areas

1. Any patient with a disability will be allowed to keep their service dog in a private room for the duration of their hospital stay. The patient is responsible for all service animal care, including grooming, feeding, and toileting the dog. If the patient is unable to care for the service dog, the patient can make arrangements for a family member or friend to come to the hospital to provide this care.
2. If the patient is unable to care for the service animal or is unable to arrange for someone else to care for the service dog, the hospital may place the dog in a boarding facility until the patient is released, or make other appropriate arrangements. However, the hospital must give the patient the opportunity to make arrangements for the dog's care before taking such steps.
3. Hospital staff is not obligated to supervise or otherwise care for a service animal. In an extreme emergency, the House Supervisor will be notified to assist with toileting.

Visitors

1. Visitors may make use of a service dog in accordance with the Hospital's Visitor Guidelines Policy.

Employees

1. Any disabled individual offered employment at SVMC will be allowed the use of a service dog while at work.

EXCEPTIONS:

1. Areas where service dogs will not be allowed may include, but are not limited to: the operating room, the labor and delivery room, the newborn nursery, sterile processing and sterile processing storage areas, PACU, and the kitchen.
2. A case-by-case assessment will be made with medically qualified personnel, and the AOC in situations not covered by this list.
3. Proof of immunizations and training may be requested in specialized cases or as needed in conjunction with ADA regulations.

REFERENCES:

1. Timeline of the Americans with Disabilities Act. Website last updated in August, 2022. URL: https://adata.org/ada-timeline
2. ADA.gov – Information and Technical Assistance on the Americans with Disabilities Act. Retrieved on August 18, 2022, last updated on August 1, 2022. URL: https://www.ada.gov/
3. ADA.gov BETA – The Americans with Disabilities Act (ADA) Protects People with Disabilities from Discrimination. Retrieved on August 18, 2022. URL: https://beta.ada.gov/

4. ADA.gov BETA – Service Animals. Retrieved on August 18, 2022. URL: https://beta.ada.gov/topics/service-animals/

5. ADA.gov BETA – ADA Requirements: Service Animals. Last updated February 2020. Retrieved on August 18, 2022. URL: https://beta.ada.gov/resources/service-animals-2010-requirements/

6. ADA.gov BETA – Frequently Asked Questions about Service Animals and the ADA. Update July 2015, retrieved August 18, 2022. URL: https://www.ada.gov/regs2010/service_animal_qa.html

SUBJECT: **SIGN-OUT PROTOCOL FOR BLOOD COMPONENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

At the time a unit is issued, Blood Bank Standards require a final check of transfusion service records, the patient's identification, and each unit of blood or component.

POLICY:

- All units of blood and blood components must be signed out by a clinical lab scientist (CLS) and another clinical care representative. The CLS and clinical care representative must be on staff at Sierra View Medical Center (SVMC).

PROCEDURE:

- The clinical care representative must present a copy of the blood bank transfusion request containing complete patient identification when coming to pick up blood or blood components.
- After successful crossmatch of the unit, the clinical lab scientist will utilize printed unit "luggage tags" and attach them to the appropriate unit. The transfusion luggage tag with the patient's name, medical record number, the donor unit number, the patient and donor unit ABO/Rh, and the expiration date of the unit will be compared with the identical information contained on the transfusion issue card, by both the CLS and the clinical care representative. All information must agree before the unit can be signed out for transfusion. ANY DISCREPANCIES MUST BE RESOLVED BEFORE ISSUE.
- After determining that the above information is in agreement and the identity of the recipient and donor are confirmed, the clinical care representative and the CLS will initial, date and time the blood bank transfusion issue card (both copies).
- The CLS will examine the unit for appearance and expiration date and indicate the acceptability by documenting on the transfusion issue card.
- The clinical care representative will now be able to take the unit along with the transfusion issue card back to the nursing unit for transfusion.
- A clinical care representative will be allowed to sign-out more than one unit at a time for transfusion on the same patient, but will not be allowed to sign-out units on different patients simultaneously.
- Units of blood issued to surgery will be placed in resealable plastic bags with the patient name, date of birth, and Blood Bank number boldly written on the resealable plastic bag.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

REFERENCES:

- American Association of Blood Banks, "Standards for Blood Banks and Transfusion Services", 31st Edition, 2018, 5.22 through 5.25.

- The Joint Commission (2020). Laboratory accreditation standards. QSA.05.10.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **STERILE PRODUCTS:EDUCATION AND COMPETENCY**	SECTION: **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 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 CACI 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; 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 pass three successive evaluations in the deficient area 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 times initially and then quarterly.
   c. Media-Fill testing- Quarterly
   d. Cleaning and Disinfecting-After a change in cleaning or disinfecting procedures
   e. After a Pause in Compounding- Personnel who have not compounded in 3 months must be requalified.

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 must not be reused.

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 CACI/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 CACI/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 CACI.

      - 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

Record 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.
- USP 800. (n.d.). Retrieved April 26, 2019 , from http://www.usp.org/compounding/general-chapter-hazardous-drugs-handling-healthcare.

CROSS REFERENCES:

- COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM

SUBJECT:	SECTION:
STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE	**Page 1 of 13**

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

PURPOSE:

To provide procedures to ensure that sterile products prepared at Sierra View Medical Center (SVMC) are of high quality and sterility.

DEFINITIONS:

Admixture – The final product resulting from the addition of one or more drugs to an IV solution.

CACI- Compounding Aseptic Containment Isolator. CACI is a workbench that provides filtered air to prevent particulate contamination in the preparation of sterile products.

ISO Class 5- Is an airborne particulate standard that states there are no more than 3,520 particles of 0.5 micron in size per cubic meter.

PEC- Primary Engineering Control is a device that provides an ISO Class 5 or better environment through the use on non-turbulent air, unidirectional HEPA-filtered first air for compounding sterile preparations.

USP 797- United States Pharmacopeia (USP) is a national quality agency that creates the sterile product quality standards. The "797" designation is the chapter that relates specifically to the sterile product environment.

Segregated Sterile Compounding Area- Space designated for sterile-to-sterile compounding where a PEC is located within a demarcated area (of at least 3 foot perimeter). This area will be void of activities and materials extraneous to sterile compounding. This area shall not be in a location that has unsealed windows or doors that connect to outdoors, location with high traffic flow, or adjacent to food preparation areas or construction.

POLICY STATEMENT:

It is the policy of SVMC that all admixed IVs prepared by pharmacy personnel will adhere to USP 797 standards of practice for sterile product preparation. No sterile product drug preparation shall be compounded if it is known, or reasonably known, that the environment fails to meet criteria specified in the pharmacy's written policies and procedures for the safe compounding of sterile drug preparations.

PROCEDURE:

I. SVMC will use the concept of Process Validation to ensure a quality product.

   A. Process validation uses established processes that, when used consistently, produce a quality product that meets USP 797 specifications.

   B. Process validation is assured by using simulated production of the aseptic processes in use at SVMC, substituting growth media for medications to check sterility.

C. All staff compounding sterile products must be trained in aseptic technique and demonstrate competency by direct observation and successful passing of a growth media end product test.

II. The sterile product preparation area will be cleaned as per USP 797 established standards. All cleaning materials must be non-shedding and dedicated to use in compounding areas and shall not be removed except for disposal.

A. Cleaning of the compounding areas must be documented on cleaning log.

B. Disinfection of CACI and hoods will be done with sterile water followed by sterile 70% isopropyl alcohol, and Peridox RTU © (agent must be applied and be visibly wet for 3 minutes) at the beginning of each shift and at the end of each shift, after a spill, when compounding activities exceed 30 minutes, or when surface contamination is known or suspected.

C. Daily wiping down of work surfaces, outside of PEC, and counters with 70% isopropyl alcohol.

D. Daily mopping of the floor using a clean/non-shedding mop. Mop must be kept in the pharmacy sterile products room and only be used for cleaning the sterile product room floor. Mopping will be done by trained personnel using approved cleaning agents and will mop in a direction from clean area to dirty area. To ensure proper contact time, the mopped floor must remain visibly wet for 10 minutes.

E. Competency records of housekeeping staff will be kept in pharmacy for a minimum of three years after employment.

F. Weekly cleaning

1. Hoods must be disinfected using an approved disinfecting agent, Peridox© will be used (agent must be applied and be visibly wet for 3 minutes) Disinfection will occur after the use of sterile water and sterile 70% alcohol.

2. Walls, ceiling, storage shelving, and plastic curtains will be wiped down with sterile water and then 70% isopropyl alcohol.

G. Fixed glove assembly will be changed at least every 3 months or:

1. When there is a visible tear;

2. When a positive culture is obtained from sampling;

3. When there is suspected contamination of product.

III. Monthly cleaning

A. In addition to above cleaning, all surfaces in ISO classified areas or segregated compounding area will be wiped with sterile water and then sterile 70% alcohol including the inside of storage bins, carts, wheels, outside of hood, and wire racks, shelves, walls and ceilings, stools, and all other items in segregated compounding area

B. A sporicidal will be used on the entire room and the outside AND inside of the CACI or hood. SVMC will use Peridox© (agent must be applied and be visibly wet for 5 minutes).

IV. CACI and Hood Viable Sampling

A. **CACIs and hoods will be recertified every six months by an outside agency**. The agency will also check viable and non-viable particulate count in the CACI ISO class 5 environment. All sampling will be done under dynamic conditions that mimic actual production.

B. The Department of Pharmacy will check CACI/Hood surfaces for viable particles every three months and the counter tops and work surfaces every month.

C. An actionable level of colony-forming units (CFUs) upon viable surface sampling of the CACI is:

1. Greater than 3 CFU's or upon any culture positive with:

- Gram negative rods
- Coagulase Positive Staph Aureus
- Any mold or fungus

D. An actionable level of CFU for viable air sampling shall be:

Any positive result for bacterial or fungal growth or greater than zero CFU's:

- Gram negative rods
- Coagulase Positive Staph
- Any mold or fungus

E. Any positive viable culture, as defined above, will result in the following action:

1. Immediate cessation of activity in the CACI.
2. Immediate sanitization and sterilization, use of sporicidal of CACI and entire segregated compounding room.

3. Resampling of affected area after sanitization and sterilization completed.

4. Evaluation of engineering controls.

5. Communication with Infection Control and expert infectious disease consultation.

6. Communication with Risk Department and investigation for any product potentially contaminated.

7. Review of cleaning and compounding operations and facility management.

F. Decontamination and terminal cleaning will occur immediately AFTER each CACI/Hood recertification.

G. Nonviable Particle Count

1. Will be performed every 6 months

2. A nonviable particle count that fails to meet ISO standards will be immediately addressed PRIOR to the vendor testing the CACI/Hood or before leaving SVMC.

2. Corrective Actions May Include:

- Replacing HEPA filters
- Re-measuring the airborne particle count.
- Searching for mechanical causes.

V. The following technique will be used when collecting viable surface samples to monitor environmental sterility:

A. A sterile cotton swab will be used to sample the hood area. The hood will have a sample from the antechamber (zone 1), from the left half of the mixing chamber in the CACI (zone 2), and from the right half of the mixing chamber (zone 3). (See Appendix A for diagram). A total of three samples from each CACI.

B. The swab will be wiped across the work area as well as corners and around equipment while rolling swab in hand. The contact swab will be rolled across the work surface, allowing the swab head to come into contact with the work surface to pick up any possible fomites.

C. The swab will then be used to inoculate a TSA plate using a zig-zag motion while rolling swab in hand.

D. The staff member inoculating the TSA plate will label the plate with the date, time and location of the sample and their initials.

E. Pharmacy will submit a request to lab through the electronic medical record (EMR), indicating the exact location sampled on each order under "Comments to Lab" section.

F. The samples will then be delivered to lab at SVMC for processing.

G. At the end of the incubation period, the pharmacy director or his designee will retrieve results utilizing the electronic medical record (EMR) and will document the results.

H. If any sample is observed to contain growth, the hoods will be disinfected with 70% isopropyl alcohol and 2% bleach and then re-sampled. Any positive culture will be immediately reported to infection control and the attending infectious disease physician, for interpretation and consultation. In addition, any positive results will be included in the quarterly Sterile Products report presented to the Pharmacy, Therapeutics and Infection Prevention Committee.

VIII. Random monitoring of sterile technique along with fingertip glove sampling or end product testing will occur at the end of production monthly as needed.

A. Different personnel should be sampled with a goal of each employee being monitored yearly.

IX. Aseptic technique will be monitored and critiqued.

A. Retraining will be considered if major technique violations are seen. Major violations may include:

1. Violations of gowning, gloving and hand-washing policy
2. Touching of critical sites
3. Failure to wipe stoppers
4. Failure to work within proper hood area
5. Blockage of "first air" to critical sites
6. Failure to clean hood properly and keep clean during compounding

X. Fingertip sampling should occur after production of IVs but before sterilization with alcohol.

A. A CFU greater than zero is an actionable level on initial certification and greater than 3 CFU's from both hands upon subsequent quarterly recertification:

1. Employee will be retrained in hand-hygiene, garbing, glove and surface disinfection and conduct in compounding area. Sampling will be repeated and didactic testing repeated.

2. Actionable levels will result in removal from compounding duties and require retraining.

3. Repeated actionable levels will require complete retraining and removal from compounding until sampling meets minimum standards. Root cause for repeat positive sampling will be sought out by the pharmacist in charge.

XI. Sterility verification of an end product will occur monthly.

A. A random IV that had been made at least one day prior will be chosen.

B. In the event of a positive culture:

1. The physicians involved in that patient's care and infection control officer will be notified of possible exposure as well as organism(s) involved in order to evaluate the patient.

2. Organism will be identified and reported to Infection Control.

3. Technician who compounded IV will be retrained in hand hygiene, garbing, gloving, and surface disinfection. Fingertip and end product testing will be repeated under observation for technique. Technician will stop making sterile products until a negative test is obtained.

4. If repeat testing results in a positive response, the technician will be removed from compounding duties and completely retrained.

5. In addition to the above, if the product is a batched product where more than one dose of a preparation has been made:

- The lot number of the product will be identified
- Potential patients exposed to contaminated product will be identified using dispensing and administration records
- The physicians involved in that patient's care and infection control officer will be notified of possible exposure as well as organism(s) involved in order to evaluate the patient.

C. Risk, Infection Control and Chief Nursing Officer will be immediately informed.

D. Environmental Monitoring

1. Surface Sampling

a. Routine surface sampling will occur at least every six months for all sterile-to-sterile compounding~~monthly~~ in each compounding area and shall include equipment, work surfaces and will be taken during normal operations:

b. Counter or cart in buffer area, pass through(s), and one more area located within the buffer area.

c. Surface sampling must also take place in any of the following circumstances:
   i. Part of certification of new facilities and equipment.
   ii. Following any servicing of facilities or equipment
   iii. In response to any problems, sterility features: a complaint of a patient infection when CSP is considered a potential source.
   iv. In response to identified trends(e.g. repeated positive cultures of staff fingertips, failed media fill simulations, repeated surface or air contamination).

d. Action Levels for Surface Sampling

ISO CLASS	Work surface Sampled Using Plates (CFU/Plate)	Work Surfaces Sampled using swabs (CFU/25cm^2)	Non-Work Surfaces using plates (CFU/Plate)	Non-Work Surfaces using swabs (CFU/25cm^2)
5	>3	>3	N/A	N/A
7	>5	>5	>10	>10
8	>25	>25	>50	>50

1. If levels measured exceed above action levels, an investigation and corrective action must be taken to prevent future deviations.
2. When ISO class 5 PEC exceed criteria above, compounding must cease, if they are exceeded for Class 7 and 8, a corrective action plan must be implemented immediately.
3. Corrective action plans may include a change in procedure, facility, or equipment.

2. Viable Air Sampling

a. Shall be performed at least semiannually (i.e. every 6 months) as part of re-certification of facilities and equipment.

b. Evaluate counts against actionable levels below and examine in relation to previous data to identify adverse effects or trends.

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ISO Class	Air Sampling Action Levels (CFU/m^3)
5	➢ Or = 1
7	➢ Or = 10
8	➢ Or = 100

c. Corrective actions if the levels above are exceed then screening and characterization of organism must be done.

i. Highly pathogenic organisms (HPO) require immediate cleaning and disinfection regardless of CFU count:

a. coag positive staph, molds, yeasts, gram-negative rods.

d. The genus of the organism must be identified, when possible for non HPO.

XIII. Quantification testing shall be performed at a minimum of twice a year to ensure product integrity and to validate labeled strength.

A. A random IV will be sent out to a qualified laboratory for verification of potency, quantification of endotoxin, viable sampling. Pharmacy will follow the process outlined by the contracted laboratory.

B. If the drug sample is identified as below any standards for integrity, potency, quality, or labeled strength:

a. The technician and pharmacist making/checking the product will be removed from sterile product processing and retrained

b. A complete analysis of the compounding process will occur.

C. An additional product will be sent out for validation

D. All of the above steps will be performed and BUD dating will be confirmed by using standard reference materials and research.

XIV. Compounding Room Temperature and Lighting

A. The sterile compounding area shall have a well-lighted working environment

B. A room temperature of 68 degrees Fahrenheit and humidity below 60% is ideal for sterile compounding. The temperature and humidity will be recorded daily.

1. In the event of an out of range recording:

- Engineering will be contacted for temperature or humidity correction

Pharmacist in charge will be contacted

- If it is known that the temperature>40 C for 4 hours, then any CSP exposed to these excursions will be discarded.

XV. Pressure Differential

a. A minimum of 0.02-inch water column is required for positive pressure to separate each ISO classified area, except in segregated compounding areas.

b. Negative pressure will be 0.01-0.03 inches of water.
c. A pressure gauge or velocity meter will be used to monitor airflow between the ante-area and buffer area and the ante area and the general environment outside of the classified areas.
d. The pressures will be documented and reviewed daily or by a continuous monitor.

XVI. In the event of a product recall, SVMC will follow the established policy of DRUG RECALL PROCEDURE

XVII. All records will be retained for a minimum of three years.

XVIII. 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.

EDUCATION:

SVMC Pharmacy Staff: All pharmacists and pharmacy technicians will receive education regarding the preparation of pharmacy-prepared IV admixtures.

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 March , 11, 2020 , from http://www.usp.org/compounding/general-chapter-797.
- CCR 1751.4 Facility and Equipment Standards for Sterile Compounding. Retrieved November 24, 2021, from https://www.law.cornell.edu/regulations/california/16-CCR-Sec-1751-4.

CROSS REFERENCES:

- DRUG RECALL PROCEDURE

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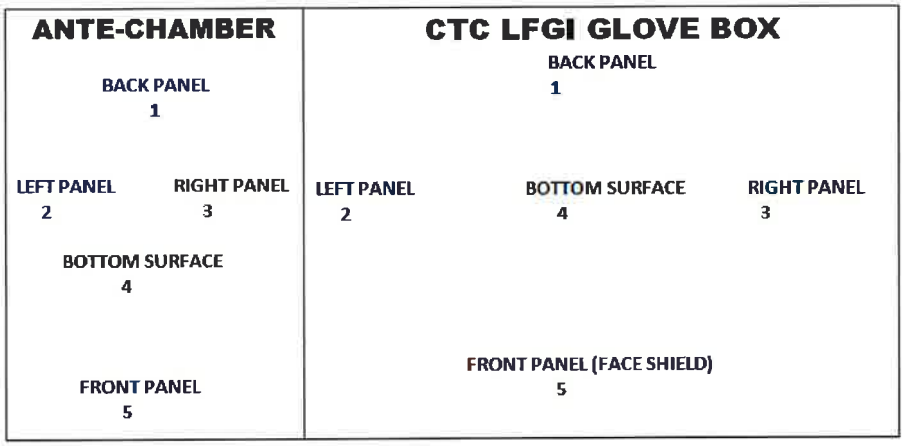
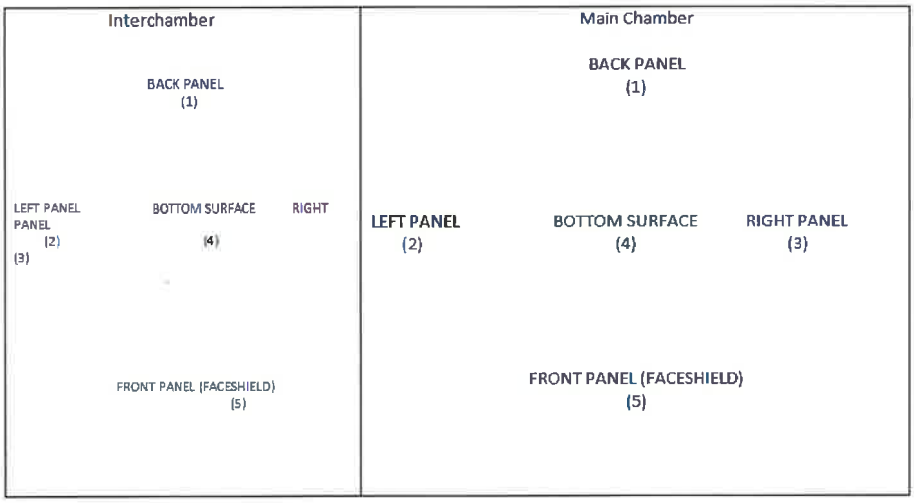
APPENDIX A (See attachment)

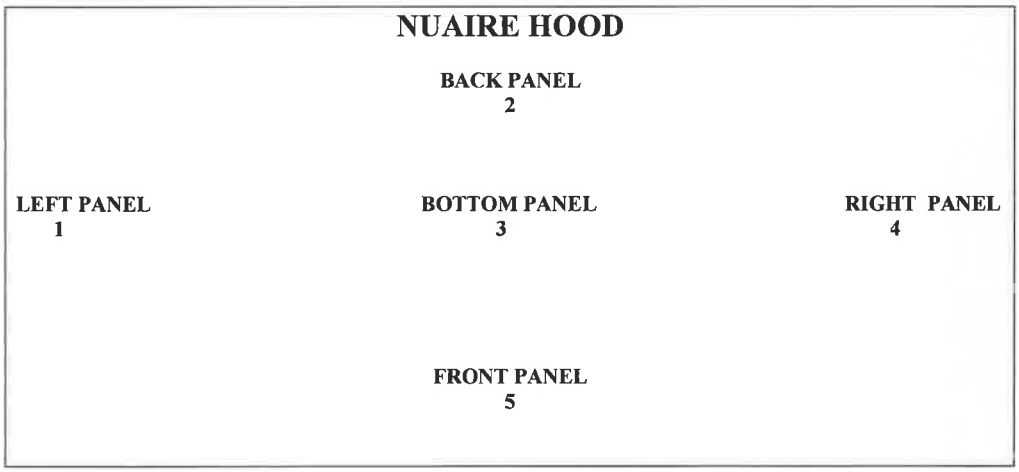
Map of GERMFREE LAMINAR FLOW GLOVEBOX ISOLATOR - CTC

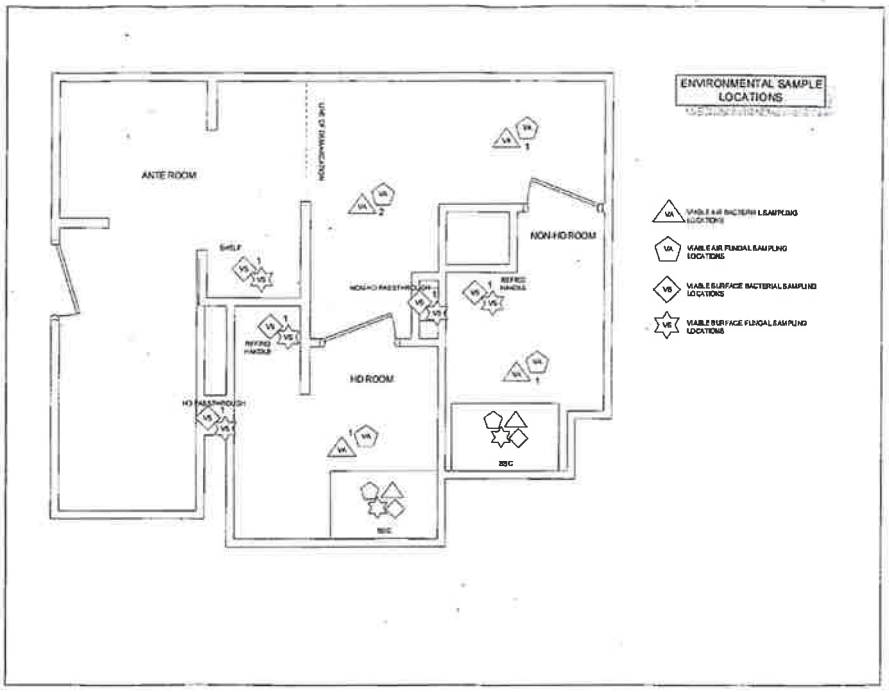


Map of NuAire COMPOUNDING ASEPTIC ISOLATOR – Main Pharmacy



SUITE "B" POSITIVE & NEGATIVE PRESSURE HOODS ENVIRONMENTAL SAMPLING MAP




ENVIRONMENTAL SAMPLE LOCATIONS
ANTE ROOM
NON-HD ROOM
HD ROOM
VA
VB
VS

SUBJECT:	SECTION:
STORAGE OF BLOOD COMPONENTS IN THE EVENT OF THE LOSS OF MONITORED REFRIGERATION #8063	**Page 1 of 1**

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POLICY:

1. In the event that monitored refrigeration is disrupted, the following procedure is to be followed:

   a. For fresh frozen plasma (FFP) and Cryoprecipitate:

   - Store all units in the lab backup freezer in chemistry which is electronically monitored. The temperature of the freezer should not get warmer than -20° C.

   b. For Refrigerated Blood Components, Samples and Reagents:

   - Store all units, samples and reagents in the blood bank back up refrigerator. The refrigerator is alarmed and monitored. The temperature of the refrigerator should remain between 1°-6° C.

   - In the event that all refrigeration is lost in the laboratory or that the back-up refrigeration/freezer units do not conform to established temperature criteria, the following procedure is to be followed:

     – The blood units will be transferred to the monitored refrigerator in surgery.

     – The FFP and Cryoprecipitate will be transferred to the backup freezer in microbiology. This freezer is monitored also.

AFFECTED AREAS/PERSONNEL: *LABORATORY, SURGERY*

REFERENCES:

- Fung, Mark K. (2020). AABB Technical Manual, 20th Ed.
- The Joint Commission Laboratory Standards (2022). QSA.05.04.01. Joint Commission Resources. Oak Brook, IL.
- American Association of Blood Banks, Standards for Blood Banks and Transfusion Services, 33rd Edition, 2022, Sections 3.6 and 5.1.8.1.3.

SUBJECT:	SECTION:
URINARY CATHETER DISCONTINUATION PROTOCOL	**Page 1 of 3**

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

URINARY CATHETER DISCONTINUATION PROTOCOL

PURPOSE:

To reduce the incidence of catheter-associated urinary tract infections (CAUTI).

PRINCIPLES:

Urinary tract infection is the most common hospital-acquired infection; 80 percent of these infections are attributable to an indwelling urethral catheter.

The duration of catheterization is the most important risk factor for development of infection.

DEFINITION:

Catheter-Associated Urinary Tract Infection: A hospital-acquired urinary infection that can develop in patients who have had an indwelling urinary catheter for more than 2 consecutive days.

PROTOCOL:

Upon admission, patients will be assessed for symptoms of existing urinary tract infection. Further, patients meeting specific criteria will have their urinary catheter removed by the nurse

Surgical patients will have urinary catheter removed on Post-Operative Day 1, with date of surgery as "zero" unless physician documents otherwise. Surgical patients are the exception, and will require a physician order prior to removal of catheter.

Non-surgical patients with indwelling urinary catheters will be assessed each shift and have catheter removed as soon as patient no longer meets any of the criteria for placing an indwelling urinary catheter.

CRITERIA FOR PLACING AN INDWELLING URINARY CATHETER:

- Obstruction of the urinary tract distal to the bladder
- Alteration in BP (blood pressure)or volume status requiring accurate volume measure
- Continuous bladder irrigation for urinary tract hemorrhage/TURP (Transurethral Resection of Prostate).
- Pre-op catheter insertion for patient going to OR (operating room) procedure
- Neurogenic bladder dysfunction, acute urinary retention or bladder outlet obstruction
- Incontinence in patients with open sacral or perineal wounds (Key Point: Incontinence alone in general is not an indication)
- Prolonged immobilization (e.g. unstable thoracic or lumbar spine, pelvic fractures, etc.)
- Improve comfort for end of life care

SUBJECT:	SECTION:
URINARY CATHETER DISCONTINUATION PROTOCOL	**Page 2 of 3**

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DISCONTINUATION OF INDWELLING URINARY CATHETER:

Following removal of urinary catheter:

- Document removal of urinary catheter in EMR
- Monitor patient's ability to urinate post-catheter removal within 6 hours.
    - If patient voids within 6 hours $\geq$ 300 mls, no action is required.
    - If patient voids $\leq$ 300 mls in 6 hours, use Bladder scan, and then contact physician for further orders.

STAFF AUTHORIZED TO PERFORM THE STANDARDIZED PROTOCOL: CNA's LVN's, RNs

REQUIREMENTS TO PERFORM STANDARDIZED PROCEDURE:

A. Education: Licensed Personnel (e.g. CNA, LVN, RN, MD)

B. Training: Meets initial and annual competency for the standardized procedure

C. Experience: All RNs, LVN's and CNA's that have completed competency for this standardized procedure.

DEVELOPMENT & APPROVAL of the STANDARDIZED PROCEDURE:

A. **Method:** Infection Prevention Committee, Infection Prevention Manager, and Medical Director of Infection Prevention.

B. **Review Schedule:** Yearly

REFERENCES:

Carr, H, Urinary Tract Infection. In: Boston K.M., et al, eds. APIC Text. Published 2014. Available at: https://text.apic.org/toc/prevention-measures-for-healthcare-associated-infections/urinary-tract-infection#embed-16980 Accessed August 22, 2022.

Gould, Carolyn V.; Umscheid, Craig A.; Agarwal, Rajender K.; Kuntz, Gretchen; Pegues, David A. Guideline for prevention of catheter-associated urinary tract infections 2009. Updated June 6, 2019. Corporate Authors(s) : Healthcare Infection Control Practices Advisory Committee (U.S.); Centers for Disease Control and Prevention (U.S.). Available at: https://stacks.cdc.gov/view/cdc/49910. Accessed August 22, 2022.

Musco, S., Giammò, A., Savoca, F., Gemma, L., Geretto, P., Soligo, M., Sacco, E., Del Popolo, G., & Li Marzi, V. (2022). How to Prevent Catheter-Associated Urinary Tract Infections: A Reappraisal of Vico's Theory-Is History Repeating Itself?. *Journal of clinical medicine*, *11*(12), 3415. https://doi.org/10.3390/jcm11123415

Perry, A., & Potter, P. (2021). Urinary Elimination (Chapter 34) in Clinical Nursing Skills & Techniques. 10th ed. St. Louis, MO: Moseby. ISBN-10: 0323708633

SUBJECT: VENOUS BLOOD COLLECTION	SECTION:
	Page 1 of 2

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

PURPOSE:

To instruct personnel of the proper procedure for collecting a specimen via venipuncture.

SYNONYMS:

Venipuncture, phlebotomy, venous blood collection.

CONTAINER:

Syringe with 20-21 gauge needles for volumes to 10 ml. Vacutainer or similar system for multiple specimens or anticoagulants.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. Verify the patient's identity using two identifiers.
2. Cleanse hands. Put on fresh pair of gloves.
    a. Apply tourniquet.
3. Select a suitable site for venipuncture. Prepare the site by scrubbing with 70% alcohol (isopropanol). Dry with sterile gauze.
4. Cleanly puncture the skin.
5. Apply gentle suction.
6. Release the tourniquet.
7. Remove the needle and fill the tubes without delay.
8. Gently invert the tubes 10 times to assure mixing of anticoagulants.
9. Aftercare:
    a. Apply pressure to the venipuncture site and elevate the arm until bleeding stops. If bleeding persists, apply a pressure dressing to the site.
10. Limitations:
    a. Venipuncture is technically difficult in obese patients, infants, children and patients with collapsed veins, such as those in shock. Hemolysis may occur as a result of excessive

suction during collection, violent mixing of specimen, or vigorous transfer of the specimen from syringe to tube.

NOTES: See individual test for specific collection requirements.

REFERENCE:

- Turgeon, Mary Louise, Linne and Ringstrud's Clinical Laboratory Science, 8th Edition, 2019.

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 72 hours of surgery, EKG & chest x-ray within six months unless approved by Anesthesia. Weigh pt on admit (actual, not stated). Do not repeat any order by the admitting physician.
1.	**CBC:** Hx of anemia; major surgery; actual 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.
3.	**EKG:** Age over 40 or cardiac history, hypertension, diabetes.
4.	**Complete Metabolic Panel:** patients over 60, those with diabetes, renal disease, on diuretics 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.
6.	**Fingerstick glucose:** Day of surgery for Diabetic patients or those at risk (obesity, steroids, family history)
7.	**Renal panel** after last dialysis, for patients on dialysis.
8.	**PT** (*INR*): patients with history of chronic hepatitis, cirrhosis, or on Anticoagulants
9.	**Liver function tests** for chronic hepatitis or cirrhosis.
	Thyroid function tests for patients with thyroid disease.
10.	**Drug levels** for patients taking seizure medications, theophylline, digoxin.
11.	**IV Orders:** Lactated Ringers (for adult patients & children over 50kg) Start IV with at least 20 gauge catheter unless blood ordered, then use 18 gauge catheter @ TKO.
	Patients with Renal disease use 500ml NS with minidrip.
	Children over 5 yrs & under 50kg, start IV LR, 20-22g catheter with minidrip after topical use of EMLA cream. **Consult anesthesiologist for IV on children under age 5:**_____.
12.	**Respiratory:** Small volume Nebulizer 2.5mg Albuterol in 3 ml NS. (Patients with asthma or COPD)
13.	**Cardiac History:** If evaluated by cardiologist within past year, obtain copy for chart. Obtain copy of ECHO, angiogram, carotid doppler, pulmonary function tests, or stress tests within past year.
14.	**Pacemakers or implanted defibrillators** – Obtain copy of devise confirmation within the last 6 mo. and response of device to external magnets. *Must deactivate defibrillators immediately prior to the procedure and reactivate once procedure is completed.
15.	**Medications:** Hold oral hypoglycemic meds and MAO 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.**
16.	Screen patient for BETA BLOCKER use and document last dose on Procedural Patient Assessment form.
17.	Initiate warming therapy in FlexCare.
18.	Rapid COVID swab unless proof of prior positive test within 90 days
	Physician Signature: _____ **Date:** _____ **Time:** _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

ANESTHESIA
PRE-OPERATIVE ORDERS

Form # 013643 REV. 7/22

CHART - MEDICAL RECORD

PATIENT'S LABEL

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SIERRA VIEW MEDICAL CENTER

PROCEDURAL SEDATION FLOW SHEET

Date:_____BBK#:_____Age:_____Sex:_____ Location Performed ❑ER ❑ICU ❑Endo ❑Radiology ❑ PACU

Allergies:_____

ASA # (Assigned by MD)_____ Prosthesis _____

Airway Clear ❑ Pre - Procedure ❑ Post - Procedure

Physician:_____

Sedation Nurse:_____

Staff:_____

Pre OP Vitals: BP_____ PULSE _____ RR _____ SPO2 _____

Mental/Emotional Status: ❑ Alert ❑ Oriented ❑ Agitated ❑ Disoriented ❑ Unresponsive ❑ Lethargic ❑ Vegetative State ❑ Developmentally Delayed

Positioning: ❑ Supine ❑ Prone ❑ High Fowlers ❑ Semifowlers ❑ Right Lateral ❑ Left Lateral ❑_____

Positioning Aides: ❑ Pillow_____ ❑ Towel roll _____ ❑ Blanket_____ ❑ Bite Block

Pre-procedural Diagnosis:_____

Post-procedural Diagnosis:_____

Procedure Performed:_____

_____

Clinical alarms on & audible_____

Patient In:_____

Time out performed by team:_____

Procedure Start:_____

Procedure End:_____

Patient Out:_____

Peripheral IV: Fluid_____

Site:_____Gauge#_____

Fluid Volume:_____

Skin Condition (General)_____

ESU Grounding Site Pre _____

Post_____

Electrocautery Unit:_____

Cut_____Coag_____Blend_____

Lot# of ESU Pad:_____Exp:_____

Skin Prep:_____Area _____

Specimens/Lab collected:_____

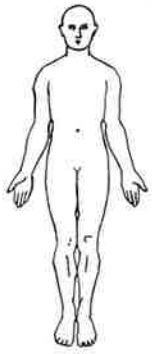
TIME:																		TOTAL MEDS
MED	ROUTE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE	
O2																		
Joules																		
Cetacaine Spray																		
TIME:																		

BP. • •
PULSE •
#

200
150
100
50

Resp.
CO2
SpO2
SCL
Rhythm
Pain

ESU Ground ☐
Monitor Lead ◯
BP Cuff ╳



SCL Sedation / Consciousness Level

Awake. Alert, normal response to auditory stimuli	4
Mildly drowsy but awake. Slow response to auditory stimuli	3
Drowsy. delayed response to loudness & touch	2
Very drowsy. Arouses only to prodding, shaking, pain	1
No response	0

❑ PT tolerated procedure well **TRANSFER SECTION:** Transported via: ❑ Gurney ❑ w/O2/Monitor ❑ Bed

Report to:_____Room#:_____ R.N. Signature: _____ Date:_____ Time:_____

Physician Signature: _____Date:_____ Time:_____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PROCEDURAL SEDATION FLOW SHEET

Form # 014175 REV. 8/22

WHITE - MEDICAL CHART CANARY - OR SCHEDULER

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

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER

POST PROCEDURAL SEDATION FLOW SHEET

TIME															
NIB/P															
P															
R															
SpO2															
O2 Rx															
PAIN #															
LOCATION															
DESCRIP															
RHYTHM															

Arrival Temp: **DC Temp:**

ADMISSION EVALUATION

Airways: ❑ Clear ❑ Obstructed

Lung Sounds: ❑ Clear ❑ Diminished
❑ Wheezing ❑ Crackles
❑ Other:_____

Skin: ❑ Warm ❑ Cool ❑ Dry ❑ Moist
Skin color: ❑ Normal ❑ Pale ❑ Cyanotic
❑ Jaundice ❑ Other: _____
Dressing: ❑ Dry & Intact _____

Abdomen: ❑ Soft ❑ Firm ❑ Rigid ❑ Flat
❑ Rounded ❑ Distended
Bowel Sounds: ❑ Audible all 4 quadrants
❑ Hypoactive ❑ Hyperactive

Post Anesthesia Recovery Score (Aldrete Score)			
Motor Activity	Time:		
Moves 4 extremities vol/command	2		
Moves 2 extremities vol/command	1		
Moves 0 extremities vol/command	0		
Respiration			
Deep breathe & cough freely	2		
Dyspnea or limited breathing	1		
Apneic	0		
Circulation			
B/P + 20 mmHg of pre-proc level	2		
/P +20-50 mmHg of pre-proc level	1		
B/P + 50 mmHg pre-proc level	0		
Neurologic Status			
Fully awake and oriented	2		
Arousable on calling-drifts to sleep	1		
Not responding or responds to pain	0		
Oxygen Saturation			
O2 sat ↑ 92% on room air	2		
Needs O2 for O2 sat ↑ 90%	1		
O2 sat ↓ 90% even with O2	0		
Total			

BLOOD GLUCOSE

	TOTAL INTAKE	IV AMOUNT / SOLUTION	BLOOD	OTHER
PACU				
FLEX				

	TOTAL OUTPUT	FOLEY VOID	NG EMESIS	DRAIN-AGE	EBL	OTHER
PACU						
FLEX						

❑ **Transferred to room #:**_____
via gurney
Time:_____
Report to:_____

TIME:	

Outpatient post anesthesia recovery score Assess at discharge-reassess if criteria is not met			
Time of assessment			
Dressing Dry & clean Wet but stationary/marked Growing area of wetness	2 1 0		
Pain Pain free Mild-handled by oral meds Severe-req. parenteral meds	2 1 0		
Ambulation Stands up/walk straight Vertigo when erect Dizziness when supine	2 1 0		
Fasting-Feeding Able to drink fluids Nauseated Nausea & vomiting	2 1 0		
Urine output Has voided Unable to void/comfortable Unable to void/uncomfortable	2 1 0		
Total: DC score must be within 2 points of total items that apply to patient			

Discharge Instructions given to: ❑ Patient
❑ Other Adult_____ ❑ With verbal understanding
❑ Home via W/C or ambulatory to private auto accompanied by volunteer with all personal belongings
❑ Via ambulance/all personal belongings to: ❑ PDC ❑ SNF
❑ Follow-up with MD visit confirmed ❑ Responsible adult escort present
❑ D/C PER PROTOCOL TIME:_____

R.N. Sign:_____ Date: _____ Time: _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PROCEDURAL SEDATION FLOW SHEET

Form # 014175 REV. 8/22

WHITE - MEDICAL CHART CANARY - OR SCHEDULER

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

PATIENT'S LABEL

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 **September 27, 2022 at 4:30 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 4:34 p.m.

Directors Present: BEHL, LOMELI, REDDY, PANDYA
Directors Absent: SORRELLS
Others Present: Anamandula, Anil, MD, Blazar, Dan, Patient Experience Officer, Camacho, Lorena, Director of Enterprise Risk Management Canales, Tracy, VP of Human Resources, Marketing and Public Relations, Cartwright, Susan, Director of Medial Staff Services, Conner, Brian, Moss Adams, Dickson, Doug, Chief Financial Officer, Eckhoff, Richard, Community Member, Fenesis, John, Moss Adams, Franer Julie, Admin Director of Patient Financial Services, Gilman, Robin, Community Member, Gomez, Cindy, Director of Compliance, Hefner, Donna, President/Chief Executive Officer, Hudson, Jeffery, VP Patient Care Services, CNE and DIO, Jimenez, Alejandra, Project Management, Parsons, Malynda, Senior Marketing and Community Relations Specialist, Pryor-DeShazo, Kim, Director of Marketing, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, MD, Souza, Kelvin, Family HealthCare Network Legal Counsel, Chief of Staff, 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:

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

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 4:35 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

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 – June 2023

Closed Session Items D -G 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 5:03 p.m., reconvening in Open Session at 5:04 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, Harpreet Sandhu, M.D. 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 Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Abstain
BEHL	Yes
PANDYA	Yes

2. Quality Division Report.

Following review and discussion, it was moved by Vice Chairman LOMELI, 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	Yes
SORRELLS	Abstain
BEHL	Yes
PANDYA	Yes

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

IV. Public Comments

Ron Wheaton, VP Professional Services and Physician Recruitment introduced Dr. Anil Reddy Anamandula to the Board of Directors. Dr. Anamandula will practice Internal Medicine in the community.

Richard Eckhoff, Community Member shared his recent hospital stay experience and thanked the staff for his care.

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 SORRELLS, seconded by Vice Chairman LOMELI, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director BEHL and seconded Chairman REDDY to approve the August 23, 2022 Minutes of the Regular Meeting of the Board of Directors. The motioned carried and the vote of the Board, is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Abstain
BEHL	Yes
PANDYA	No

VII. Hospital CEO Report

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

In the District:
Volunteer League 2022 Scholarship recipients: Anneth Gomez, Leonel Florez, Randal Garcia, Crystal Hurtado, Arub Rahman, Trisha Swanson, Jayson Tabucao

Annual Competencies: Nursing Competencies took place September 12-16 for all Clinical Staff, Extending/Returning Travelers, Seasonal Per Diems and Pharmacy High-quality CPR is the primary component influencing survival from cardiac arrest. High quality CPR performance includes a Chest Compression Fraction (CCF) above 80% (per AHA standards). Congratulations to the CPR team of Vicki Ramos, Lori Poso, Vicky Severance, Bernadine Valdez & Jason Torres who reached a CCF of 90.4%

2022 Engagement Survey launched September 14th. The goal is to survey and gather insight and feedback from staff. It is an opportunity to share honest perspectives and feedback about SVMC as confidentiality of responses and objectivity of the process is maintained.

Sierra View launches Health Insights Magazine to be distributed to the community quarterly.

Visitation Update: Vaccination status no longer required to enter. Screening questionnaire and masking guidelines continue to apply.

Service Line Update:
Sepsis is a medical emergency and its symptoms must be treated rapidly to reduce the risk of death. In honor of Sepsis Awareness Month, we are encouraging everyone to learn the signs of sepsis. Take the time to learn the signs. You could help save a life.
To date, for the months of June and July, for the patient satisfaction question regarding Discharge Communication, we have a perfect score on all 31 surveys returned. These scores indicate that the new practice put in place does have a positive effect on the patient's satisfaction while in the hospital. Phase Two to follow.

Foundation Events:
10/1/2022 A Night of Dueling Pianos - Sierra View Foundation kicked off its Marketing efforts for the upcoming Dueling Pianos battle that will take place at the Ramirez Home in Porterville. Funds raised will be donated to the hospital to purchase 20 WOWs (Workstations on Wheels) for various departments throughout the district. For sponsorship opportunities visit: sierra-view.com/duelingpianos.

CTC Fundraiser: Denim Day – September 15th

Employee Recognition and Engagement:
ACNL inducted Jeffery Hudson-Covolo, DNP, R.N. NEA-BC, FACHE into the Central San Joaquin Valley Nursing Hall of Fame

Welcome New DPSNF Director Jennelyn "Jean" Sampag Labayen and new Director of Cardiac Cath Lab and Interventional Radiology, Shay Moore.

COVID 19 Public Health Emergency (PHE):
The Centers for Medicare & Medicaid Services (CMS) encouraging providers to prepare for end of PHE. Secretary Xavier Becerra extended PHE 10/15/22 will provide 60-day

notice before ending. Roadmap to end Waivers and Flexibilities. SVMC will address the return to normal standards and operational practices. Anticipating PHE end on 1/11/2023.

VIII. Business Action Items

A. August 2022 Financials

Doug Dickson, CFO presented the Financials for August 2022. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,580,476. Supplemental Funds were $938,362. Total Operating Expenses were $14,247,547. Loss from operations were $1,667,071.

Following review and discussion, it was moved by Director BEHL, seconded by Vice Chairman LOMELI and carried to approve the August 2022 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

B. Single Audit

Brian Conner and John Fenesis presented the Single Audit report to the Board of Directors.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director BEHL and carried to approve the Single Audit report as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	No

C. Tree of Angels Request

Following review and discussion, it was moved by Chairman REDDY, seconded by Vice Chairman LOMELI and carried to approve a donation of $10,000 to the Tree of Angels . The vote of the Board by roll call is as follows:

REDDY	Yes

LOMELI	Yes
SORRELLS	Abstain
BEHL	Yes
PANDYA	No

D. 09.27.2022 Fiduciary Responsibility Delegation Charter – Retirement Plan

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Chairman REDDY and carried to approve the 09.27.2022 Fiduciary Responsibility Delegation Charter – Retirement Plan. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

E. 09.27.2022.01 Amending the Composition and Signature Authority of the Retirement Plan Administration Committee

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Chairman REDDY and carried to approve the 09.27.2022.01 Amending the Composition and Signature Authority of the Retirement Plan Administration Committee as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

F. Capital Budget Quarter 3 and Quarter 4

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Chairman REDDY and carried to approve Capital Budget for Quarter 3 and Quarter 4 as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

G. Conflict of Interest Code

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Chairman REDDY and carried to adopt and approve the Conflict of Interest Code as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

IX. Closed Session: Board adjourned Open Session at 5:57 p.m. and went into Closed Session at 5:59 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54956.9(d)(2); Conference with Legal Counsel about significant exposure to litigation involving a matter of compliance; privileged communication (1Item)

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2023

Chairman REDDY out at 6:44 p.m.

Chairman REDDY returned at 6:45 p.m.

F. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel: Public Employee Performance Evaluation (2 Items)

G. 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 8:07 p.m. and went into Closed Session at 8:07 p.m. to discuss the following items:

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

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

F. Discussion Pertaining to Personnel. No items were discussed at the request of the personnel involved.

G. Conference with Legal Counsel. Information only; no action taken.
Notice was provided that Ms. Hefner's contract is being reviewed to update HIPAA language and will appear on the agenda for October 2022.

XIII. Announcements:

A. Regular Board of Directors Meeting – September 27, 2022

Adjournment: There being no further business, the meeting was adjourned 8:08 p.m.

Respectfully submitted,

Kent Sorrells
Secretary
SVLHCD Board of Directors
KS: ww

FINANCIAL PACKAGE
September 2022

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
September 2022

Statistic	September 2022 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 22 YTD	Increase/ (Decrease) Sep-21	% Change
Utilization											
SNF Patient Days											
Total	120	75	45	60.0%	344	225	119	52.9%	233	111	47.6%
Medi-Cal	90	55	35	63.9%	214	192	22	11.6%	216	(2)	-0.9%
Sub-Acute Patient Days											
Total	828	903	(75)	-8.3%	2,559	2,709	(150)	-5.5%	2,725	(166)	-6.1%
Medi-Cal	586	550	36	6.6%	1,793	1,686	107	6.4%	1,696	97	5.7%
Acute Patient Days	1,857	1,923	(66)	-3.4%	5,461	5,768	(307)	-5.3%	6,785	(1,324)	-19.5%
Acute Discharges	503	469	34	7.2%	1,435	1,407	28	2.0%	1,465	(30)	-2.0%
Medicare	184	174	10	5.6%	524	521	3	0.5%	544	(20)	-3.7%
Medi-Cal	252	215	37	17.1%	719	674	45	6.7%	703	16	2.3%
Contract	66	75	(9)	-12.3%	184	199	(15)	-7.7%	206	(22)	-10.7%
Other	1	4	(3)	-76.8%	8	12	(4)	-31.0%	12	(4)	-33.3%
Average Length of Stay	3.69	4.10	(0.41)	-10.0%	3.81	4.10	(0.29)	-7.2%	4.63	(0.83)	-17.8%
Newborn Patient Days											
Medi-Cal	215	179	36	20.4%	569	526	43	8.2%	556	13	2.3%
Other	43	34	9	24.7%	101	113	(12)	-10.8%	114	(13)	-11.4%
Total	258	213	45	21.1%	670	639	31	4.9%	670	-	0.0%
Total Deliveries	124	112	12	10.7%	370	336	34	10.1%	355	15	4.2%
Medi-Cal %	79.67%	82.98%	-3.30%	-4.0%	83.01%	82.98%	0.04%	0.0%	83.52%	-0.51%	-0.6%
Case Mix Index											
Medicare	1.5777	1.6783	(0.1006)	-6.0%	1.5520	1.6783	(0.1263)	-7.5%	1.7228	(0.1708)	-9.9%
Medi-Cal	1.1606	1.2438	(0.0832)	-6.7%	1.1883	1.2438	(0.0555)	-4.5%	1.2578	(0.0695)	-5.5%
Overall	1.3114	1.4431	(0.1317)	-9.1%	1.3293	1.4431	(0.1138)	-7.9%	1.4586	(0.1293)	-8.9%
Ancillary Services											
Inpatient											
Surgery Minutes	10,166	8,728	1,438	16.5%	27,321	26,184	1,137	4.3%	27,706	(385)	-1.4%
Surgery Cases	133	100	33	33.0%	336	300	36	12.0%	316	20	6.3%
Imaging Procedures	1,473	1,231	242	19.7%	4,315	3,693	622	16.8%	4,606	(291)	-6.3%
Outpatient											
Surgery Minutes	13,082	13,010	72	0.6%	35,400	39,030	(3,630)	-9.3%	37,598	(2,198)	-5.8%
Surgery Cases	201	198	3	1.5%	535	594	(59)	-9.9%	561	(26)	-4.6%
Endoscopy Procedures	194	185	9	4.9%	509	555	(46)	-8.3%	551	(42)	-7.6%
Imaging Procedures	3,615	3,880	(265)	-6.8%	11,499	11,640	(141)	-1.2%	10,428	1,071	10.3%
MRI Procedures	333	290	43	14.8%	943	870	73	8.4%	917	26	2.8%
CT Procedures	1,104	1,009	95	9.4%	3,558	3,027	531	17.5%	3,039	519	17.1%
Ultrasound Procedures	1,012	904	108	11.9%	3,038	2,712	326	12.0%	2,646	392	14.8%
Lab Tests	33,840	30,494	3,346	11.0%	104,595	91,482	13,113	14.3%	121,587	(16,992)	-14.0%
Dialysis	-	5	(5)	-100.0%	1	15	(14)	-93.3%	14	(13)	-92.9%

Sierra View Medical Center
Financial Statistics Summary Report
September 2022

Statistic	September 2022 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 22 YTD	Increase/ (Decrease) Sep-21	% Change
Cancer Treatment Center											
Chemo Treatments	1,686	1,794	(108)	-6.0%	5,148	5,382	(234)	-4.3%	5,251	(103)	-2.0%
Radiation Treatments	1,556	1,817	(261)	-14.4%	4,479	5,451	(972)	-17.8%	5,172	(693)	-13.4%
Cardiac Cath Lab											
Cath Lab IP Procedures	11	9	2	22.2%	29	27	2	7.4%	29	-	0.0%
Cath Lab OP Procedures	31	24	7	29.2%	92	72	20	27.8%	86	6	7.0%
Total Cardiac Cath Lab	42	33	9	27.3%	121	99	22	22.2%	115	6	5.2%
Outpatient Visits											
Emergency	3,369	3,249	120	3.7%	10,231	9,747	484	5.0%	9,540	691	7.2%
Total Outpatient	13,296	13,731	(435)	-3.2%	39,469	41,193	(1,724)	-4.2%	37,929	1,540	4.1%
Staffing											
Paid FTE's	907.02	935.67	(28.65)	-3.1%	906.58	935.67	(29.09)	-3.1%	899.41	7.17	0.8%
Productive FTE's	765.74	804.83	(39.09)	-4.9%	761.95	804.83	(42.88)	-5.3%	758.47	3.48	0.5%
Paid FTE's/AOB	5.28	5.33	(0.05)	-1.0%	5.27	5.46	(0.19)	-3.5%	5.03	0.24	4.7%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,058	10,468	590	5.6%	10,438	10,315.97	122	1.2%	10,493	(55)	-0.5%
Cost/Adj.Patient Day	2,868	2,575	293	11.4%	2,679.48	2,591.14	88	3.4%	2,328.54	351	15.1%
Revenue/Adj. Discharge	50,486	53,412	(2,926)	-5.5%	49,551	52,637	(3,086)	-5.9%	63,044	(13,492)	-21.4%
Cost/Adj. Discharge	13,092	13,139	(47)	-0.4%	12,720	13,221	(501)	-3.8%	13,990	(1,270)	-9.1%
Adj. Discharge	1,129	1,032	97	9.4%	3,336	3,090	246	8.0%	2,739	597	21.8%
Net Op. Gain/(Loss) %	-21.37%	-5.62%	-15.75%	280.4%	-19.18%	-5.62%	-13.56%	241.5%	1.96%	-21.15%	-1076.3%
Net Op. Gain/(Loss) $	(2,601,613)	(720,874)	(1,880,739)	260.9%	(6,828,828)	(2,889,893)	(3,938,935)	136.3%	767,804	(7,596,632)	-989.4%
Gross Days in Accts Rec.	86.54	85.78	0.76	0.9%	86.54	85.78	0.76	0.9%	80.87	5.67	7.0%
Net Days in Accts. Rec.	75.87	66.37	9.50	14.3%	75.87	66.37	9.50	14.3%	65.81	10.05	15.3%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	SEP 2022	AUG 2022
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 8,299,882	$ 13,190,642
SHORT-TERM INVESTMENTS	6,847,690	2,336,681
ASSETS LIMITED AS TO USE	1,813,335	1,812,996
PATIENT ACCOUNTS RECEIVABLE	155,481,579	156,231,886
LESS UNCOLLECTIBLES	(23,912,817)	(23,701,522)
CONTRACTUAL ALLOWANCES	(103,162,820)	(104,342,138)
OTHER RECEIVABLES	12,529,336	11,056,490
INVENTORIES	3,976,974	3,912,226
PREPAID EXPENSES AND DEPOSITS	1,876,313	2,899,907
TOTAL CURRENT ASSETS	63,749,471	63,397,167
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	30,846,851	30,331,004
LONG-TERM INVESTMENTS	135,728,785	142,663,970
PROPERTY, PLANT AND EQUIPMENT, NET	90,926,900	91,291,694
INTANGIBLE RIGHT OF USE ASSETS	430,682	450,507
OTHER ASSETS:		
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,951,103	1,972,083
TOTAL ASSETS	$ 323,883,792	$ 330,356,424

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	SEP 2022	AUG 2022
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 434,975	$ 289,983
CURRENT MATURITIES OF BONDS PAYABLE	3,880,000	3,880,000
CURRENT MATURITIES OF LONG TERM DEBT	1,188,800	1,188,800
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	6,370,343	6,274,313
ACCRUED PAYROLL AND RELATED COSTS	7,578,323	9,167,186
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,966,339	4,029,415
LEASE LIABILITY - CURRENT	205,499	216,902
TOTAL CURRENT LIABILITIES	23,624,279	25,046,599
SELF-INSURANCE RESERVES	1,853,000	1,853,000
CAPITAL LEASE LIAB LT	2,695,678	2,777,770
BONDS PAYABLE, LESS CURR REQT	41,565,000	41,565,000
BOND PREMIUM LIABILITY - LT	3,989,055	4,053,961
LEASE LIABILITY - LT	225,183	233,605
OTHER NON CURRENT LIABILITIES	375,854	375,854
TOTAL LIABILITIES	74,328,048	75,905,788
UNRESTRICTED FUND	258,903,635	258,903,635
PROFIT OR (LOSS)	(9,347,891)	(4,452,999)
TOTAL LIABILITIES AND FUND BALANCE	$ 323,883,792	$ 330,356,424

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

SEP 2022 ACTUAL	SEP 2022 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,215,641	5,482,863	267,222	(5)%	INPATIENT - NURSING	15,122,120	16,129,191	1,007,071	(6)%
20,229,340	19,567,392	(661,948)	3%	INPATIENT - ANCILLARY	56,132,514	57,931,486	1,798,972	(3)%
25,444,981	25,050,255	(394,726)	2%	TOTAL INPATIENT REVENUE	71,254,634	74,060,677	2,806,043	(4)%
31,533,148	30,050,052	(1,483,096)	5%	OUTPATIENT - ANCILLARY	94,036,664	88,579,400	(5,457,264)	6%
56,978,129	55,100,307	(1,877,822)	3%	TOTAL PATIENT REVENUE	165,291,298	162,640,077	(2,651,221)	2%
				DEDUCTIONS FROM REVENUE				
(17,642,642)	(17,761,495)	(118,853)	(1)%	MEDICARE	(50,688,209)	(52,420,585)	(1,732,376)	(3)%
(20,852,667)	(17,597,660)	3,255,007	19%	MEDI-CAL	(59,096,266)	(51,892,748)	7,203,518	14%
(6,298,789)	(6,898,859)	(600,070)	(9)%	OTHER/CHARITY	(19,419,797)	(20,362,463)	(942,667)	(5)%
(107,595)	(10,755)	96,840	900%	DISCOUNTS & ALLOWANCES	(171,424)	(31,747)	139,677	440%
(275,731)	(494,652)	(218,921)	(44)%	BAD DEBTS	(1,468,519)	(1,460,070)	8,449	1%
(45,177,425)	(42,763,421)	2,414,004	6%	TOTAL DEDUCTIONS	(130,844,214)	(126,167,613)	4,676,601	4%
11,800,704	12,336,886	536,182	(4)%	NET SERVICE REVENUE	34,447,084	36,472,464	2,025,380	(6)%
373,343	496,385	123,042	(25)%	OTHER OPERATING REVENUE	1,155,355	1,489,154	333,799	(22)%
12,174,048	12,833,271	659,224	(5)%	TOTAL OPERATING REVENUE	35,602,440	37,961,618	2,359,179	(6)%
				***** OPERATING EXPENSE *****				
5,466,295	5,049,768	416,527	8%	SALARIES	15,773,902	15,308,241	465,661	3%
982,734	636,583	346,151	54%	S&W PTO	2,284,053	1,928,710	355,343	18%
1,520,962	1,419,096	101,866	7%	EMPLOYEE BENEFITS	4,106,149	4,276,918	(170,769)	(4)%
1,915,986	1,862,473	53,513	3%	PROFESSIONAL FEES	6,081,155	5,592,179	488,976	9%
937,973	744,677	193,296	26%	PURCHASED SERVICES	2,475,933	2,233,347	242,586	11%
2,129,911	2,006,662	123,249	6%	SUPPLIES & EXPENSES	6,222,865	6,028,665	194,200	3%
184,135	211,644	(27,509)	(13)%	MAINTENANCE & REPAIRS	617,656	655,338	(37,682)	(6)%
294,363	212,617	81,746	38%	UTILITIES	794,997	637,851	157,146	25%
51,790	45,029	6,761	15%	RENT/LEASE	142,355	135,087	7,268	5%
120,593	100,975	19,618	19%	INSURANCE	373,914	302,925	70,989	23%
818,642	874,731	(56,089)	(6)%	DEPRECIATION/AMORTIZATION	2,472,619	2,626,104	(153,486)	(6)%
352,277	389,890	(37,613)	(10)%	OTHER EXPENSE	1,085,671	1,126,146	(40,475)	(4)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,775,661	13,554,145	1,221,516	9%	TOTAL OPERATING EXPENSE	42,431,268	40,851,511	1,579,757	4%
(2,601,614)	(720,874)	1,880,740	261%	NET GAIN/(LOSS) FROM OPERATIONS	(6,828,829)	(2,889,693)	3,938,936	136%
112,969	112,969	0	0%	DISTRICT TAXES	338,907	338,908	1	0%
245,183	169,712	(75,471)	45%	INVESTMENTS INCOME	895,252	509,136	(386,116)	76%
65,372	37,741	(27,631)	73%	OTHER NON OPERATING INCOME	154,847	113,224	(41,623)	37%
(83,968)	(84,840)	(872)	(1)%	INTEREST EXPENSE	(252,449)	(254,520)	(2,071)	(1)%
(13,136)	(50,590)	(37,454)	(74)%	NON-OPERATING EXPENSE	(145,515)	(151,767)	(6,252)	(4)%
326,419	184,992	(141,427)	77%	TOTAL NON-OPERATING INCOME	991,042	554,981	(436,061)	79%
(2,275,194)	(535,882)	1,739,312	325%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(5,837,787)	(2,334,912)	3,502,875	150%
(2,619,698)	0	2,619,698		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	(3,510,104)	0	3,510,104	
(4,894,892)	(535,882)	4,359,010	813%	NET GAIN/(LOSS)	(9,347,891)	(2,334,912)	7,012,979	300%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
09/30/22

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(2,601,614)	(6,828,829)
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation and amortization	818,642	2,472,619
Provision for bad debts	211,295	885,465
Changes in assets and liabilities:		
Patient accounts receivable	(429,012)	74,905
Other receivables	(1,472,846)	(3,922,545)
Inventories	(64,748)	(31,479)
Prepaid expenses and deposits	1,023,594	401,940
Advance refunding of bonds payable	20,980	62,940
Accounts payable and accrued expenses	96,030	(1,848,651)
Accrued payroll and related liabilities	(1,588,863)	(344,455)
Estimated third-party payor settlements	(63,076)	(189,228)
Self-insured program reserves	-	-
Total adjustments	(1,448,004)	(2,438,489)
Net cash provided by (used in) operating activities	(4,049,618)	(9,267,318)
Cash flows from noncapital financing activities:		
District tax revenues	112,969	338,907
Noncapital grants and contributions, net of other expenses	52,224	9,003
Net cash provided by (used in) noncapital financing activities	165,193	347,910
Cash flows from capital and related financing activities:		
Purchase of capital assets, net of disposals	(453,848)	(1,832,083)
Intangible right of use assets	19,825	59,351
Principal payments on debt borrowings	-	(3,715,000)
Interest payments	(3,870)	(964,338)
Net change in notes payable and lease liability	(101,917)	(305,377)
Net changes in assets limited as to use	(516,186)	3,158,218
Net cash provided by (used in) capital and related financing activities	(1,055,996)	(3,599,229)
Cash flows from investing activities:		
Net (purchase) or sale of investments	4,315,487	(1,502,182)
Interest and dividends received from investments	245,183	895,252
Net cash provided by (used in) investing activities	4,560,670	(606,930)
Net increase (decrease) in cash and cash equivalents:	(379,751)	(13,125,567)
Cash and cash equivalents at beginning of month/year	15,527,323	28,273,139
Cash and cash equivalents at end of month	15,147,572	15,147,572

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
September 2022

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Oct-21	10,376,691	1,244,630	11,621,321
Nov-21	10,974,393	1,575,199	12,549,592
Dec-21	13,662,211	6,342,016	20,004,227
Jan-22	9,101,598	3,002,395	12,103,993
Feb-22	9,223,160	1,873,199	11,096,359
Mar-22	11,160,102	6,179,876	17,339,978
Apr-22	10,302,842	5,121,377	15,424,219
May-22	10,717,469	760,349	11,477,818
Jun-22	11,174,875	4,902,151	16,077,026
Jul-22	10,591,327	206,562	10,797,889
Aug-22	11,384,869	198,928	11,583,797
Sep-22	**11,025,336**	**384,733**	**11,410,069**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - cash receipts for Cafe and Coffee Corner sales, rebates, refunds, and receipts from miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH funds received
- Medi-Cal and Medi-Care Tentative Cost Settlements received for prior year
- Grants, IGT, & HQAF
- Medicare interim payments received