SIERRA VIEW
MEDICAL CENTER

SVLHCD BOARD AGENDA

AUGUST 26, 2025

MEETING LOCATION:
Sierra View Medical Center
Board Room
465 W Olive Avenue
Porterville, CA 93257

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SIERRA VIEW
MEDICAL CENTER

AGENDA

LIST OF ITEMS TO BE DISCUSSED

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

AGENDA
August 26, 2025

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

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

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

2. Quality Division Update – Quality Report

3. Compliance Report – Quarter 4

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning (3 Items). Estimated date of disclosure July 1, 2026

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning (1 Item). Estimated date of disclosure July 1, 2026.

E. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: BETA Claim 25-0015272 Conference with Legal Counsel.

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning. Estimated date of disclosure January 1, 2026.

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).

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 (5:30 PM)

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 Report as Given

2. Quality Division Report
   Recommended Action: Approve/Disapprove Report as Given

3. Compliance Report – Quarter 4
   Recommended Action: Approve/Disapprove Report as Given.

C. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning (3 Items)
Recommended Action: Information Only; No Action Taken

D. Discussion Regarding Trade Secrets Pertaining to Services
Recommended Action: Information Only; No Action Taken

E. Discussion Regarding Significant Exposure to Litigation; Anticipated Litigation
Recommended Action: Accept/Reject BETA CLAIM 25-001572

F. Discussion Regarding Trade Secrets and Strategic Planning
Recommended Action: Information Only; No Action Taken

G. Conference with Legal Counsel
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. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. 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. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

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. July 22, 2025 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove July 22, 2025 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. July Financials 2025 Financials
Recommended Action: Approve/Disapprove July Financial Report as Presented

B. Notice of Resignation of Zone 2 Board Member Gaurang Pandya Effective September 1, 2025.
Recommended Action: Approve/Disapprove Plan to Obtain Applicants to Fill the Vacancy by Appointment by the November 25, 2025 Regular Meeting

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

Regular Board of Directors Meeting – September 23, 2025 at 5:00 p.m.

XIII. Adjournment

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING AGENDA
August 26, 2025

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 Crippen, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 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.

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

Senior Leadership Team	8/26/2025
Board of Director's Approval	
Liberty Lomeli, Chairman	8/26/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
August 26, 2025
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**
Form: • 027080 RHC Specialist Referral Form	1	Approve ↓

SIERRA VIEW MEDICAL CENTER **SPECIALIST REFERRAL FORM**

Sierra View Community Health Center – Terra Bella
9520 Road 238 Terra Bella Ca, 93270
Phone: (559)544-6815 / Fax (599)306-0125

Urgency of Referral: ☐ Routine ☐ Urgent ☐ STAT (Immediate)

Specialty Referred To: ☐ Cardiology ☐ Dermatology ☐ Endocrinology ☐ ENT
☐ Gastroenterology ☐ Neurology ☐ OB/GYN ☐ Orthopedics ☐ Psychiatry
☐ Rheumatology ☐ Urology ☐ Pulmonology ☐ Other: _____
☐ Preferred Specialist (if known): _____

Patient Information

Name: _____ Date of Birth: ___/___/___

Phone Number: _____

Referral Details

Referring Provider/ NPI

_____ / _____

Reason for Referral / Diagnosis:

_____ / _____

Clinical Question or Concern:

_____

Attached Medical Information

☐ Progress Notes ☐ Lab Results ☐ Imaging Reports ☐ Medication List
☐ Previous Specialist Notes ☐ Others: _____

Attached Documents

☐ Insurance Cards ☐ Insurance authorization ☐ Demographics ☐ Written order with signature
☐ Patient photo ID ☐ Others: _____

Additional information

_____

_____

Provider Signature _____ **Date** _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
SPECIALIST REFERRAL FORM

Form # 027080 REV 6/25

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

PATIENT'S LABEL

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	08/06/2025
BOARD OF DIRECTORS APPROVAL	
	08/26/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
August 26, 2025 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**
	• 24 Hour Urine Collection	1-2	
	• Administration of Influenza Vaccine to Inpatients	3-5	
	• Administration of Varicella Vaccine to Adults	6-9	
	• After Pharmacy Hours	10	
	• Air Quality Control	11-13	
	• Antimicrobial Stewardship	14-18	
	• Blood Bank Refrigerator Maintenance Procedures	19-20	
	• Blood Culture Collection	21-23	
	• CPOE Pharmacist Scope of Practice	24-25	
	• Clean Catch Urine Collection for Urinalysis	26	
	• Controlled Substances	27-37	
	• Criteria for Collection of Stool for Culture	38-39	
	• Delegation of Duties Laboratory Medical Director	40-41	
	• Droperidol	42	
	• Emergency Blood Release	43-44	
	• Environmental Facility Cleanliness	45-46	
	• Exposure Control Plan – Bloodborne Pathogen Standard	47-73	
	• HIV Positive Patient in Labor	74-77	
	• Hazardous Drug Handling	78-86	
	• Hiring Clinical Lab Scientist Trainees	87-92	
	• Hypertonic Saline Intravenous Administration	93-95	
	• Induction of Labor Guidelines for Cytotec (Misoprostol)	96-100	
	• Infection Control – Blood Bank	101-102	
	• Infection Control – Laboratory	103-107	
	• Infection Control – Maternal Child Health	108-109	
	• Infiltrate Management	110-122	
	• Laboratory and Moderate Complexity POC Competency	123-130	
	• Magnesium Sulfate in the Management of Hypertensive Disorders in Pregnancy	131-138	
	• Massive Transfusion	139	
	• Medication Administration Times	140-144	
	• NICU: Nursing Responsibilities and General Routines	145-149	
	• Newborn Screening Tests	150-151	
	• Occupational HIV Post-Exposure Prophylaxis	152-153	
	• Preterm Infant Care	154-161	
	• Respiratory Protection Plan	162-182	

• Risk Management Plan • Sign-Out Protocol for Blood Components • Storage of Blood Components in the Event of the Loss of Monitored Refrigeration • Terbutaline – Tocolysis • Therapeutic Drug Substitution Protocol • Transfusion Reaction Procedure • Venous Blood Collection • Zosyn Extended Infusion	183-188 189-190 191 192-195 196-206 207-213 214-215 216-219	**APPROVE**

SUBJECT: **24 HOUR URINE COLLECTION**	SECTION: **Page 1 of 2**

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

POLICY:

A complete and accurate urine collection will be done to ensure proper evaluation of tests on a 24 hour urine sample.

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

PROCEDURE:

- Have patient empty bladder first thing in the morning and discard this specimen, note time and date.
- After the first morning specimen is discarded, collect all urine passed during the next 24 hour period in a clean container.
- The final collection is when the patient empties his or her bladder the next morning at the same hour. Note time and date.
- Keep the collected urine refrigerated, or on ice, and send to the laboratory as soon as possible after the 24 hour collection is complete.

NOTES:

- Twenty four hour urine tests should be ordered in the computer.
- Urine containers for the collection of 24 hours specimens may be obtained from the laboratory.
- If 24 hour urine collections are to be made, they should be made before administration of dyes for intravenous pyelograms (IVPs) and other X-ray contrasts.

24 HOUR URINE COLLECTION GUIDE #11008

TEST / **FOOTNOTE**	**COLLECTION INSTRUCTIONS START**	**AFTER**
1. Calcium	None	None
2. Catecholamines, Frac.	None	Freeze
3. Citric Acid	None	Freeze 5 ml aliquot
4. Creatinine	None	None
5. Hydroxycorticosteroids,17	None	Freeze
6. Hydroxyindoleacetic Acid,5 (5-HIAA)	None	Freeze
7. Ketosteroids,17	None	Freeze
8. Magnesium	None	Freeze

9. Metanephrines	None	Freeze
10. Oxalate	None	Freeze
11. Phosphorus	None	Freeze
12. Potassium	None	None
13. Protein	None	None
14. Sodium	None	None
15. Uric Acid	None	None
16. Vanillylmandelic Acid (VMA)	None	Freeze

REFERENCES:

- Siemens CA document number 11110115_01_CA_ACH_EN
- Quest Diagnostics.com, Test Menu, 2021
- Siemens CREA document number 11110159_08_Crea_2_ACH_EN
- Siemens MG document number 11110175_01_Mg_ACH_EN
- Siemens PHOS document number 11110174_02_IP_ACH_EN
- Siemens A-Lyte Integrated Multisensor document number 11109447_01_IMT_NaKCl_ACH_EN
- Siemens UCFP document number 11111705_01_UCFP_ACH_EN
- Siemens URCA document number 11110187_01_URCA_ACH_EN

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

INTRODUCTION:

Influenza is a contagious, viral respiratory illness with different viral strains that circulate perennially around the world. Depending on the strain, the virus may cause mild to severe illness and possibly even death especially in high-risk populations. Therefore, Sierra View Medical Center (SVMC) will offer and administer the influenza vaccine to all inpatients who meet the criteria established by the Centers for Disease Control and Prevention (CDC) and the CDC's Advisory committee on Immunization Practices (ACIP).

POLICY:

SVMC will administer the influenza vaccine to all inpatients who meet the criteria set by the CDC and ACIP and who give consent to receive influenza vaccination.

PROCEDURE:

Influenza Season - Although each year varies, influenza season usually begins in October and may run through March/late spring. During this time, inpatients will be evaluated to determine if they are eligible influenza vaccination.

1. Influenza vaccination may be administered by nurses (see below for full description) that have met the initial and annual internal competencies. Those eligible to administer the vaccine will use the following parameters to identify inpatients in need of influenza vaccination, obtain consent and subsequently vaccinate the inpatient.
2. Eligible inpatients include:
    a. All inpatients ≥ 6 months of age
    b. Inpatients with chronic medical disorders
3. Inpatients will be screened for contraindications and precautions such as:
    a. Serious reaction (e.g. anaphylaxis) after ingesting eggs or after receiving a previous dose of influenza vaccine or an a component of the influenza vaccine
    b. Already immunized for the current flu season
    c. Admitted from a long-term care facility that routinely immunizes residents
    d. Fever (≥38°C/100.4°F)
    e. History of Guillain-Barre Syndrome
    f. Physician orders to withhold influenza vaccine
    g. Patient refused – NOTIFY PHYSICIAN

4. Plan – vaccinate all inpatients who meet criteria for influenza vaccine
    a. Treatment:
        i. Screen all adults for contraindications and precautions to influenza vaccine
        ii. For age 9 and older, administer manufacturer's recommended dose of injectable inactivated quadrivalent influenza vaccine IM (usually a 22-25 gauge, 1-1 ½ inch needle). For ages 6 months to 8 years, see manufacturer's recommendations on dosage and administration for pediatric inpatients
        iii. Monitor for serious side effects (i.e. anaphylaxis)
        iv. Consultation required – none
    b. Education:
        i. Provide a copy of the most current federal Vaccine Information Statement (VIS) sheet. You must document in the patient's medical record or office log, the publication of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language if it is available, which may be found at: www.immunize.org/vis
    c. Follow-up
        i. Reassess patient in 30 minutes or less as needed.
5. Documentation
    a. Electronic Medical Record – record the date that the vaccine was administered, the manufacturers and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal, etc.)

Staff Authorized To Perform Vaccination:

Included are:

1. Licensed Vocational Nurse (LVN)
2. Registered Nurse (RN)
3. Family Nurse Practitioner (FNP)
4. Physician Assistant (PA)
5. Physician (MD or DO)

Requirements for administration:

1. Education – licensed personnel (see list above)
2. Training as required by initial and annual internal competencies
3. Review of CDC immunization criteria upon initial training
4. Annual review of CDC immunization criteria

Development & Approval of the Standardized Procedure:

1. Method: Infection Prevention Committee, Infection Prevention Manager and the Medical Director of Infection Prevention
2. Review of schedule: yearly

REFERENCES:

Centers for Disease Control and Prevention. Seasonal Flu Vaccine Basics. Updated September 17, 2024. Accessed 19 June 2025. https://www.cdc.gov/flu/vaccines/index.html

The Joint Commission (2024). Hospital Accreditation Standards Manual. Joint Commission Resources. Oak Brook, IL. IC.06.01.01, EP 2 & EP 4.

The Joint Commission (2024). Laboratory and Point-of-Care Testing Standards Manual. Joint Commission Resources. Oak Brook, IL. IC.02.01.01, IC.02.03.01, IC 02.04.01.

U.S. Food & Drug Administration. Influenza Vaccine Composition for the 2025-2026 U.S. Influenza Season. https://www.fda.gov/vaccines-blood-biologics/influenza-vaccine-composition-2025-2026-us-influenza-season

Vaccine Information Statements (VISs). Accessed 19 June 2025.https://www.immunize.org/vaccines/vis/about-vis/

SUBJECT:	SECTION:
ADMINISTRATION OF VARICELLA VACCINE TO ADULTS (Employees)	**Page 1 of 4**

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

INTRODUCTION

Varicella, commonly known as "chickenpox", is a vaccine-preventable infectious disease. Although usually mild, varicella can be a serious disease for high-risk populations such as infants, adolescents and pregnant people. In addition to the symptoms commonly associated with Varicella (itchy rash, fever, headache, etc.), it may lead to skin infection, generalized inflammation of the cardiovascular, musculoskeletal and central nervous system. Below is the policy on varicella vaccination for SVMC staff.

POLICY

SVMC will provide for the administration of varicella vaccine to any adult staff, who meet the criteria as established by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

PROCEDURE

1. **Eligible** nurses (see below, *Requirements For Administration: Education*) will identify adult staff in need of varicella vaccination using CDC ACIP criteria and if appropriate (see *Contraindications* for exceptions) vaccinate them, especially healthcare workers, non-U.S.-born persons, or any adult staff that lacks laboratory evidence of immunity or laboratory-confirmed disease.
2. **Screen** potential recipient for contraindications and precautions to varicella vaccination. Consider the following before moving forward with vaccination:
    a. **Contraindications**
        i. A history of serious reactions such as anaphylaxis after the administration of a previous dose of varicella vaccine or a known varicella vaccine components including, but not limited to (for a full list of excipients, see Vaccine Excipient Summary at https://www.vaccinesafety.edu/wp-content/uploads/2025/01/Components-Excipients-24-1220-by-Vaccine-Name-.pdf

ii. Currently **pregnant** or may become pregnant within 1 month. Pregnant women should be vaccinated upon completion or termination of pregnancy.

iii. **Immunodeficiency** – individuals with substantial suppression of cellular immunity due to disease or medical therapy. (See: Varivax Product Insert https://www.merckvaccines.com/varivax/diluent-reconstitution/#isi-onpage

b. Precautions

i. Candidate is a recent **recipient of antibody-containing blood products** (within the past 11 months.) The specific wait time is dependent on the antibody-containing product – see product insert for each specific product.

ii. Acute moderate or severe illness with or without fever.

3. **Plan** – offer vaccination to all adult staff members who meet the criteria for varicella vaccination and enter in the appropriate record, either receipt of vaccination or a statement of declination.

a. Treatment

i. Screen all adults (staff) for contraindications and precautions to varicella vaccine.

ii. Provide all adults with a copy of the most recent CDC Vaccine Information Statement (VIS). If necessary, provide non-English speakers with a copy of the VIS in their native language if available. The most recent VISs may be found at: https://www.cdc.gov/vaccines/hcp/vis/index.html, or https://www.immunize.org/vis/).

iii. Administer 0.5 ml (23 – 25 mg) varicella vaccine subcutaneously using a 5/8" needle in the posterolateral fat of the upper arm.

iv. Administer the second dose 4 – 8 weeks after the first dose. Two doses are administered at a minimum interval of 4 weeks. https://www.merck.com/product/usa/pi_circulars/v/varivax/varivax_pi.pdf

4. Documentation

a. Employee File – record the date administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If the vaccine was not given, record the reason(s) for the refusal of the vaccine, for example, medical contraindication or refusal.

b. Personal immunization record card – record the date of vaccination, name/location of the clinic as well as the follow-up date, etc., as necessary.

5. Staff Authorized to Perform Vaccination Protocol

c. Licensed Vocational Nurses (LVNs) and Registered Nurses (RN)

d. Requirements for administration

i. Education – licensed staff only (LVN, RN, MD)

ii. Training as required by specific licensing board(s)

iii. Initial evaluation of recipient is conducted using CDC's immunization criteria and SVMC standardized procedures for immunizations

iv. Continuing evaluation every 2 years

REFERENCES

- Centers for Disease Control and Prevention. *Adult Immunization Schedule by Age*. **Page last updated**: 2024-11-21. Appendix includes info on contraindications, precautions to commonly used vaccines, vaccines in the adult immunization schedule, and contact information. (**Accessed**19 June, , 2025) **URL**: https://tools.cdc.gov/medialibrary/index.aspx#/media/id/266012

- Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. Chapter 22: Varicella. Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. (**19 June**, 2025) URL: https://www.cdc.gov/pinkbook/hcp/table-of-contents/index.html

- **FDA Vaccines VARIVAX** (refrigerated and frozen formulations), Merck Sharp & Dohme Corp. **Accessed** (19 June 2025) **Page last updated** as of: 2023. **URL**: https://www.fda.gov/vaccines-blood-biologics/vaccines/varivax-refrigerated-and-frozen-formulations
    - VARIVAX Product Insert: https://www.fda.gov/media/76008/download
    - Highlights of Prescribing Information: https://www.merck.com/product/usa/pi_circulars/v/varivax/varivax_pi.pdf
    - VARIVAX Patient Information: https://www.fda.gov/media/76904/download?attachment
    - Appendix B - Vaccine Excipient Summary: https://www.vaccinesafety.edu/wp-content/uploads/2025/01/Components-Excipients-24-1220-by-Vaccine-Name-.pdf

SUBJECT: **AFTER PHARMACY HOURS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the procedure to be followed during the hours when the inpatient pharmacy is closed.

POLICY:

The Department of Pharmacy will provide pharmaceutical care during the hours when the pharmacy is closed.

AFFECTED AREAS/PERSONNEL: *NURSING; PHARMACY*

PROCEDURE:

A. Medication Orders when the pharmacy is closed

1. Tele-pharmacy services will review and process orders for medications when Sierra View's pharmacy is closed.

2. Tele-pharmacy will be available to answer questions related to medication orders that were processed and call the nurse caring for the patient for questions and or the prescriber for clarification regarding the medication order.

3. Sierra View will have a staff pharmacist on-call to come into the hospital as needed or to provide consultative services as needed while the pharmacy is closed.

4. At the conclusion of the tele-pharmacy shift a "End of Shift Hand Off Report" will be delivered to the oncoming SVMC pharmacy staff so that unresolved patient care issues, consults, etc., will be received and follow up can occur.

B. Medication Disposition

1. On a daily basis, the pharmacist will review the medication override list and follow the procedure found in PYXIS MEDICATION OVERRIDES AND DISCREPANCY .

2. The Pyxis will record name of drug, strength, amount removed, date and time, the name of the patient to whom the drug was administered and name of nurse removing the drug.

REFERENCES

- Pharmacy Law: California Edition. (2025) San Clemente, California: Law Tech Publishing Group.

SUBJECT: **AIR QUALITY CONTROL**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define parameters of Relative Humidity (RH), Temperature and Airflow patterns within the perioperative environment, related to decreasing risks of fire hazards, microbial growth and particulates and increasing patient safety.

POLICY:

Relative Humidity in a restricted area shall be maintained within a range of 20% to 60%.
RH in a semi-restricted area is related to the function performed in that area:

- clean/sterile storage - maximum 60%
- soiled workroom/decontamination room – no recommendations
- sterilizer equipment access or corridors – no recommendations

RH in an unrestricted area is related to the function performed in that area:

- PACU – 20% to 60 %
- GI/Endoscopy suites/procedure rooms - 20% to 60 %

Temperature should be maintained within the limits recommended for each area (ie, unrestricted, semi-restricted, restricted) which are referenced in ASHE, the accepted professional guidelines for HVAC.

Temperature ranges for restricted areas should be 68˚F to 75˚F (20˚C to 24˚C) but the range may be adjusted for a limited time based on the individual (ie, pediatric, intentional hypothermia) needs of the patient.

Temperature ranges for semi-restricted areas depend on the use of the area.

- clean/sterile storage – 72˚F to 78˚F (22˚C to 26˚C)
- soiled workroom/decontamination room – 72˚F to 78˚F (22˚C to 26˚C)
- sterilizer equipment access or corridors – no recommendations

Temperature ranges for all unrestricted areas should be between 70˚F and 75˚F (21˚C and 24˚C)

Airflow direction should be maintained within the HVAC design parameters, per ANSI/ASHRAE/ASHE Standard 170-2008: Ventilation of Health Care Facilities. Section 7.4.1, and applicable others, such as California Mechanical Code.

- The restricted area should have a positive pressure relationship to the adjacent areas.

- The pressure relationship of the semi-restricted area should be based on the use of the area.
  - clean/sterile storage – positive
  - soiled workroom/decontamination room – negative
  - sterilizer equipment access or corridors – no recommendations

Free standing fans, dehumidifiers or other devices should not be used in restricted or sterile processing areas.

Doors should be kept closed except during entry and exit of patients and personnel. When doors are open, the HVAC system may be unable to maintain environmental controls such as pressurization or outside air exchanges.

- pre-planning may help reduce air turbulence from the number of door openings,
- keeping surgeons preference cards current,
- confirming all instruments and supplies are present before incision,
-
- analyze the stage of the procedure before breaks or lunches, provide education about the effects of opening doors

AFFECTED AREAS/ PERSONNEL:

MAIN OR, ASD, CENTRAL PROCESSING DEPARTMENT (CPD) STAFF, CARDIAC CATH LAB,

PROCEDURE:

1. Temperature and humidity will be monitored and recorded in the department log daily. Routinely, Orderlies will perform this task. Call-Back RN will be responsible making weekend and holiday entries when the department is normally closed. If no cases are done within a full 24 hour period, an entry of "closed" will be made in the log.

2. Variance (Out of Range) results will be documented and reported immediately by entering an electronic Engineering Service Request. The request may be made by any employee.

3. Engineering Department will make necessary adjustments to heating/air conditioning through facility control.

4. A re-check should be made within one hour of the correction, and new results documented in log.

5. After Re-check of variance, if required parameters are not met, Director of Surgery and Director of Engineering will be notified. Procedures scheduled in affected areas will be cancelled or re-scheduled to an area with proper air control.

QUALITY ASSURANCE:

Daily documentation of temperature and relative humidity results and actions will be monitored by on-going review of the department log, by Charge RN or Manager.

REFERENCES:

- ANSI/ASHRAE/ASHE. Standard 170-2021.Ventilation of Health Care Facilities. Atlanta, GA: ASHRAE; -2021.
- NFPA 99 Health Care Facilities Code. Quincy, MA: National Fire Protection Association; 2021.
- Joint Commission Online. CMS Adopts ASHRAE-Defined Range for Relative Humidity in Anesthetizing Locations. 2018. Temperature and Humidity Requirements – Guidance for Storage of Sterile Supplies. April 2021.

SUBJECT: **ANTIMICROBIAL STEWARDSHIP**	SECTION: *Medication Management (MM)* **Page 1 of 5**

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

PURPOSE:

Sierra View Medical Center is committed to optimizing antimicrobial therapy while minimizing unintended outcomes, including medication toxicity, increased antimicrobial resistance and unwarranted costs.

DEFINITIONS:

Antimicrobial Stewardship: A program with the intentions to comply with both the mandated California Senate Bill 739, and The Joint Commission Standard MM.09.01.01. The Antimicrobial Stewardship program is an organizational priority to improve the process of appropriate selection, dosing, route of administration and duration of antimicrobial therapy. A multidisciplinary approach is utilized to collect and analyze data in an effort to slow the emergence of antimicrobial resistance and transmission of resistant pathogens.

ANTIMICROBIAL STEWARDSHIP COMMITTEE:

The Antimicrobial Stewardship Committee is a subcommittee of the P&T/Infection Prevention Committee with the intention to develop and implement the Antimicrobial Stewardship program. The program will strive to foster collaboration between the Pharmacy and Medical Staff in the appropriate utilization of antibiotics.

The Committee is chaired by an infectious disease physician who will work closely with other committee members including clinical pharmacists, pharmacy administration, the Infection Prevention department and the department of Microbiology to provide guidance and education on the appropriate use of antimicrobials.

Meetings will be held at a minimum of annually to review analyzed data and discuss agenda items that will assist in meeting the following Antimicrobial Stewardship goals.

Goals:

- Promotion of appropriate use of antimicrobials
- Minimization of antimicrobial resistance
- Prevention of antimicrobial toxicity
- Improvement of patient outcomes
- Utilization of education to expand Antibiotic Stewardship practices to all healthcare employees, patients and their families

Members of the antimicrobial stewardship team may include but are not limited to:

- Infectious Disease Physician
- Clinical Pharmacist
- Infection Preventionist
- Clinical Microbiologist
- Clinical Information System Analyst
- Primary Nurse
- Dietitian

POLICY COMPLIANCE: KEY ELEMENTS:

The Clinical Pharmacists will work with the interprofessional team to optimize utilization of antimicrobials and to avoid the potential consequences of inappropriate antimicrobial therapy. This includes, but is not limited to:

- The selection of appropriate antimicrobials including empiric regimens based on evidence-based national guidelines and the organization's most recent antibiogram, which is available via link on the organization's Intranet site.
- The timely initiation, escalation, de-escalation and duration of antimicrobial therapy.
- The proper dosing, frequency, route and administration time of antimicrobial agents.
- The monitoring and tracking of related labs, cultures, drug-bug mismatch, and sensitivities in assessing optimization of antimicrobial therapy.
- The avoidance of toxicity.
- The avoidance of emergence of antimicrobial resistance or the development of hospital acquired infections (HAI).
- The prevention of increased morbidity and mortality.
- Identification of redundant therapy.
- The minimization of hospital length of stay and healthcare costs.
- The annual education of staff involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial stewardship practices.

- The education of patients and their families regarding the appropriate use of antimicrobial medication which may also be performed by patients provider or nursing staff.

AFFECTED PERSONNEL/AREAS: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

- The clinical pharmacist will employ antimicrobial stewardship practices that include the appropriate selection, dosing, route of administration and duration of antimicrobial therapy. Examples of strategies to be employed include but are not limited to the following:
    - Vancomcyin and aminoglycoside dose adjustments as allowed per policy.
    - IV to PO conversion when appropriate as allowed per policy.
    - Renal dosage adjustments/recommendations as allowed per policy.
    - A seven days auto-stop implementation for duration of antimicrobial therapy, which may be extended if therapeutically warranted after a renewal re-assessment by the prescriber and pharmacist's verification.
    - Will work with ACS in the development and maintenance of evidence-based (most recent organizational antibiogram & current IDSA guidelines) infectious disease order sets.
    - Avoid delays in initiation of appropriate antimicrobial therapy when ordered by the prescriber.
    - Collaborate with the Infection Preventionist on monitoring reports for drug-bug mismatches in cultures and susceptibilities and notifying the prescriber if a change in antimicrobial therapy is indicated.
    - Direct interaction and feedback with the prescribers, nursing, lab and infection prevention.
    - Documentation of monitoring, adjustments and interventions performed by pharmacy.
    - Pharmacists may order the following when criteria is met;
        - MRSA nasal screen- for patients on pharmacy to dose vancomycin protocol for a pneumonia indication. This may direct pharmacists to recommend discontinuation to prescribing MD.
        - Procalcitonin- To guide pharmacists recommendation to MD's for antibiotic therapy based on the following inclusion/exclusion criteria:
            - Inclusion criteria: Sepsis (SIRS, sepsis, severe sepsis, septic shock), Lower respiratory tract infections (pneumonia, COPD exacerbations, bronchitis)
            - Exclusion criteria: ESRD/HD, trauma, post-surgery, cardiac shock, pancreatitis, neoplasm of thyroid, small cell lung CA, neonates (<72hrs), recent IVIG therapy

TRACKING AND REPORTING:

Pharmacists:

- Pharmacy will track interventions/recommendations made to prescribing physicians and percent accepted will be calculated.
    - Tracking and Analysis of data will be performed using Clinical Surveillance software
- The results will be analyzed and reported at antibiotic stewardship committee and P&T quarterly.
    - Infection Prevention
    - Infection Preventionists (IP) will conduct monitoring and prevention of hospital-associated infection and will analyze and report outcomes. Specifically, MDROs will be tracked to identify trends and report results to P&T/IP.
    - IP will educate staff on strategies to optimize the use of antibiotics.
- Clinical Pharmacist will document antimicrobial stewardship interventions. These interventions are evaluated for subsequent reporting to the appropriate committees and will be analyzed to aid in the development of future performance improvement initiatives.

Institutional Reporting:

- SVMC will upload monthly antibiotic utilization data to the Center for Disease Control's National Healthcare Safety Network. This data will be void of any identifiable patient information and shall be reviewed by a pharmacist and a quality improvement analyst prior to submission.

REFERENCES:

- ASHP statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control. Copyright ©2009, American Society of Health-System Pharmacists, Inc. Pgs. 228-230.
- California Department of Public Health. Healthcare-Associated Infection (HAI) Program. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialStewardshipLandingPage.aspx. Accessed April 28, 2025.
    - CDC. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2019. https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html. Accessed April 28, 2025.

- E. Kastango, K. St John, D. Weber, Pharmacy Services. APIC Text of Infection Control and Epidemiology Copyright © 2009, Association for Professionals in Infection Control and Epidemiology, Inc. Pgs. 61-1 thru 61-7. 2)
- Infectious Diseases Society of America. Infection prevention and control of health care-associated infection. http://www.idsociety.org/Infection_Control_Policy/. Accessed 30JUN17.
- The Joint Commission. National-Hospitals Standards Manual. https://powerdms.com/manuals/publication/83753?tabid=general&nodeid=20985652. Accessed April 28, 2025.
- Schuetz, Philipp. Et al. Procalcitonin (PCT)- guided antibiotic stewardship: an international experts consensus on optimized clinical use. https://pubmed.ncbi.nlm.nih.gov/30721141/. Accessed April 7th, 2022.
- Predictive value of MRSA nasal swab in PCR assay in MRSA pneumonia. https://www.ncbi.nlm.nih.gov/pubmed/24277023. Accessed March 21, 2022.
- World Health Organization (WHO) Antimicrobial resistance. Fact sheet. http://www.who.int/mediacentre/factsheets/fs194/en. Accessed 30JUN15.

CROSS REFERENCES:

Therapeutic Drug Substitution Protocol: https://powerdms.com/link/sierraview/document/?id=2413406

SUBJECT: **BLOOD BANK REFRIGERATOR MAINTENANCE PROCEDURES**	SECTION:

POLICY:

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

AFFECTED AREAS/PERSONNEL: *LABORATORY, SURGERY*

PROCEDURE:

1. Daily:

   a. Check and record the temperature daily. The automatic recorder must correlate within 1° C of the thermometer.

   b. Perform visual inspection of blood components for any abnormal appearance and expired blood units and initial the blood bank daily check list.

   c. If the above temperature is out of range and the alarm is activated, corrective action must be taken. Refer to the policy on STORAGE OF BLOOD COMPONENTS IN THE EVENT OF THE LOSS OF MONITORED REFRIGERATION #8063 .

2. Weekly:

   a. Every Wednesday morning, the blood bank refrigerator & freezer charts must be replaced.

   b. Remove the chart, date, and initial.

   c. Write the identity of the refrigerator or freezer on each chart, date, initial and stamp the hospital name and address.

3. Quarterly:

   a. Once a quarter, an alarm check is performed by the Biomed Department. Ice water is used to activate the low temp alarm. Water at a temperature greater than 6°C is used to check the alarm for the high refrigerator temperature and for the freezer. Biomed will then provide the Blood Bank with a report which will be maintained in the Blood Bank department.

REFERENCES:

- American Association of Blood Banks, Standards for Blood Banks and Transfusion Services, 33rd Edition, Sections 3.5 through 3.6.
- Fung, Mark K., Association for the Advancement of Blood and Biotherapies Technical Manual, 21st Edition, pp.213-214, 2023.
- The Joint Commission Laboratory Accreditation, QSA.05.03.01, QSA.05.04.01and QSA.05.04.03, (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **BLOOD CULTURE COLLECTION**	SECTION: ***Provision of Care, Treatment & Services (PC)*** 3 **Page 1 of 2**

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

POLICY:

Blood culture is a widely-used tool for the detection of bacteremia or fungemia. The collection of blood cultures is a crucial step in determining the etiology of blood stream infections. This can also be critical for patients with sepsis and/or septic shock.

A positive blood culture establishes an infectious etiology for a patient's illness. The ability to perform susceptibility testing on a positive blood culture enables optimization of antimicrobial therapy. Contaminated blood cultures lead to a delay in diagnosis and care.

"A blood culture is a Laboratory test in which blood, taken from the patient, is inoculated into bottles containing culture media to determine if infection-causing organisms (bacteria or fungi) are present in the patient's blood stream" (BioMerieux, 2023).

There are 3 main aims of blood cultures:

1. Confirm infectious etiology
2. Identify the etiological agent
3. Guide antimicrobial therapy

EQUIPMENT:

- Sterile syringe of appropriate volume
- Chlorhexidine prep
- 21 or 22 gauge needle
- 2 blood culture bottles (one aerobic and one anaerobic) for each culture ordered or one aerobic pediatric bottle
- Additional venipuncture supplies (tourniquet, alcohol prep, cotton, etc.).

AFFECTED AREAS/PERSONNEL: *LABORATORY AND NURSING STAFF*

SUBJECT: **BLOOD CULTURE COLLECTION**	SECTION: ***Provision of Care, Treatment & Services (PC)*** 3 **Page 2 of 2**

PROCEDURE:

NOTE: Blood culture collection is a CRUCIAL step in the blood culture process. Standard precautions should be used, and STRICT ASEPTIC conditions in place throughout the collection of blood. A contaminated blood culture can directly affect our ability to treat the patient.

Step	Reason
1. At least 2 blood culture sets should be collected from 2 separate venipuncture sites.	For suspected bacteremia
2. Examine the bottles	Look for evidence of damage, deterioration, or contamination.
3. Check the expiration date	DO NOT use expired bottles
4. Label the bottles – clearly and correctly	Unlabeled bottles cannot be processed
5. Keep the bottles upright	
6. Ensure each set has BOTH an aerobic and anaerobic bottle	This is a proper "set"
7. Blood should be venous, not arterial	Lower contamination rate
8. If possible, avoid drawing blood from venous or arterial catheters	These devices often exhibit higher contamination rates
9. Immediately prior to venipuncture, the rubber septum on the blood culture bottle(s) should be disinfected with an alcohol prep by rubbing the rubber septum with friction, then allowing it to completely dry.	
10. Disinfect the skin THOROUGHLY: • Choose the collection site, palpate the vein and visualize landmarks. o If you need to touch the site once it is disinfected, use a sterile glove • Cleanse the venipuncture site with friction for 30 sec, using an alcohol prep • Allow site to air dry • Apply disinfectant (Chloraprep) in a cross-hatch pattern • Allow site to dry per manufacturer's recommendations • If patient is allergic to chlorhexidine, use only alcohol to prep the site. 11. Skin disinfection in Pediatric Patients: • Less than 2 months old: o Povidone-iodine and alcohol • Greater than 2 month old o Chlorhexadine or 2% iodine tincture DO NOT touch site once disinfected, unless wearing sterile gloves.	To minimize the risk of contamination of blood specimens with skin flora, the venipuncture site requires a minimum 30 second friction scrub with an appropriate disinfectant

SUBJECT: **BLOOD CULTURE COLLECTION**	SECTION: ***Provision of Care, Treatment & Services (PC)*** 3 **Page 3 of 2**
For additional information regarding pediatric blood culture collection, see Exhibit A: Biomeieux Pediatric Blood Culture Collection	
12. Collect Blood cultures Follow hand hygiene and don gloves	
13. Fill each bottle with 10 mL of venous blood (for adults). Always fill the blood culture bottles first, starting with the aerobic bottle, if blood is drawn for multiple tests. For pediatric patients, the volume used is based on the manufacturer's recommendations.	Ideal blood volume in each bottle optimizes the detection of pathogenic bacteria or fungi. The aerobic bottle is first. If you are not able to obtain enough blood for 2 culture bottles, fill the aerobic bottle.
14. Blood culture bottles should be inverted gently several times after filled with blood	To prevent clotting
15. Transport filled bottles to lab in less than 30 MINUTES	Changes in the bottle may happen after 30 min. When the bottle is placed in the incubator after 30 min, the machine may not recognize the change and may yield a false negative result, missing a positive culture.
16. Document as appropriate for your role	

References:

- bioMerieux-USA, Blood Culture: A key investigation for diagnosis of bloodstream infections, version 9, 2023.
- Emergency Nurses Association (ENA). Clinical practice guideline: Prevention of blood culture contamination https://www.guidelinecentral.com/guideline/308349/#section-320058
- Bednarek, R.S.; Nassereddin, A. & Ramsey, Michael L.(2023) Skin antiseptics. Stat Pearls, National Library of Medicine. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK507853/#:~:text=Healthcare%20Team%20Outcomes-,Antiseptic%20agents%20in%20dermatologic%20surgery%20commonly%20include%20chlorhexidine%2C%20povidone%2Diodine,as%20essential%20to%20preventing%20SSIs.
- CLSI (2022). Principles and procedures for blood cultures, 2nd ed. CLSI guideline M47. Clinical and Laboratory Standards Institute; 2022.
- UpToDate (2024) Detection of bacteremia: Blood cultures and other diagnostic tests. Retrieved from

https://www.uptodate.com/contents/detection-of-bacteremia-blood-cultures-and-other-diagnostic-tests?search=blood%20culture%20collection&sectionRank=1&usage_type=default&anchor=H835114581&source=machineLearning&selectedTitle=1%7E150&display_rank=1#H835114581

SUBJECT: **CPOE PHARMACIST SCOPE OF PRACTICE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide the necessary minimum defined role of practice of pharmacist on computerized physician order entry system.

DEFINITIONS:

1. CPOE-Computerized physician order entry.

2. EMR-Electronic medical record.

POLICY:

A. It is the policy of SVMC Department of Pharmacy to promote safe and effective use of the CPOE system and patient medication profiles.

AFFECTED PERSONNEL/AREAS: *PRESCRIBERS, PHARMACISTS, NURSING*

PROCEDURE:

A. Discontinuation of Duplicate Medications on Patient Profile

   1. Pharmacists can discontinue duplicate medication orders when and only if two or more orders are EXACTLY the same.

B. Verbal Orders

   1. Pharmacists will not take verbal orders unless an emergency, which an urgency or a delay will immediately and adversely affect the patient. A pharmacist will accept verbal orders only from a physician.

C. PRN designation

   1. Orders without a PRN qualifier will not be accepted. If unable to contact the prescriber, pharmacy will add PRN parameters into the provider comments section if they are unable to reach the prescriber on the telephone and a delay will cause harm to the patient.

D. Discontinuation/Reentering Orders

   1. Pharmacy may discontinue and reenter an exact duplicate of the prescriber's order when a technical problem may prevent the prescriber's original order from being properly processed the pharmacy or hospital computer system.

E. Range orders

1. Dosage range orders will not be accepted. If unable to contact the prescriber, the pharmacist may split the range order into two separate orders with corresponding PRN qualifiers that designate proper and safe indications.

References:

1. 2025 Lawbook for Pharmacy. The Pharmacy Law. Section 4071.1. Accessed April 28, 2025.

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: **CONTROLLED SUBSTANCES**	SECTION: ***Medication Management (MM)*** **Page 1 of 11**

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

PURPOSE:

To ensure 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.

7. Controlled substances removed from the automated dispensing cabinet or retrieved from pharmacy shall be the sole responsibility of the removing or receiving individual. Under no circumstances should the user hand off a controlled substance to another user, except in limited documented emergency situations or by a house supervisor, unit leader (including a charge nurse or nurse manager) to aid with medication availability overnight. Any exception must be clearly documented, including the reason for the exception and the names of staff involved.

8. Delegating the administration of a controlled substance that the user has removed or received constitutes a breach of this policy if an exception is not documented or appropriate.

9. This is to comply with the chain of custody for controlled substances, ensuring traceability to the responsible nurse, reducing opportunities for diversion & medication errors.

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 if waste is required.

   b. The nurse and the witness will waste the excess medication in the proximally located Cactus Sink, immediately or as soon as patient has been treated, but not to exceed 30 minutes without reasonable cause.

   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. Administration will occur within 30 minutes of removal for all controlled substances. Failure to do so may subject the user to review.

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 pharmacist in charge 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. Controlled Substance Discrepancy Algorithm
   a. Pyxis user
      1. Is the Pyxis user that created the discrepancy present?
      2. Review activity report on Pyxis. Does that Pyxis user know what caused the discrepancy?
      3. Can the discrepancy be reasonably resolved because of this cause?
         i. If YES, resolve the discrepancy on the Pyxis machine.
      4. If NO to any question above, escalate to Charge Nurse and wait for further instructions from Charge Nurse.
   b. Charge Nurse
      1. Is the Pyxis user that created the discrepancy present?
      2. Review activity report on Pyxis. Does that Pyxis user know what caused the discrepancy?
      3. Can the discrepancy be reasonably resolved because of this cause?

i. If YES, resolve the discrepancy on the Pyxis machine.

4. If NO any question above, contact Pharmacy for assistance and wait for further instructions from Pharmacy.

c. Pharmacy

1. Review activity report on Pyxis. Can Pharmacy determine what caused the discrepancy?
2. Can the discrepancy be reasonably resolved because of this cause?
   i. If YES, resolve the discrepancy on the Pyxis machine.
3. Any discrepancy that is unresolved at this point will be escalated to the PIC, pharmacy technician supervisor, and nursing manager via the incident reporting software for further investigation. The incident is to be followed up upon the next business weekday.
4. Pharmacy to contact the Charge Nurse to resume normal operations.

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

3. The narcotic technician will review the unreconciled doses as reported in surveillance software on a daily basis (Reviews of weekends and holidays will include those days on the narcotic shift's next shift). Any unresolved unreconciled doses will have an event report submitted & notification sent to the user's manager & PIC via the surveillance software for review & disciplinary actions as needed. The user's manager shall work with the PIC to complete the investigation as soon as possible and not to exceed 24 hours.

4. 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.

5. Based on the results of investigations from daily or monthly reports, 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 Pharmacist in Charge.

3. A biennial 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. Additionally products containing the following substances in the

following strengths per tablet, capsule, other unit, or specified volume, a reconciliation report at least quarterly:
A. Alprazolam, 1 milligram/unit.
B. Alprazolam, 2 milligrams/unit.
C. Tramadol, 50 milligrams/unit.
D. Promethazine/codeine, 6.25 milligrams of promethazine and 10 milligrams of codeine per 5 milliliters of product.

For any controlled substance not identified above, an inventory reconciliation report shall be prepared for identified controlled substances lost no later than three months after discovery of the loss of that controlled substance. This report shall be completed if the loss is discovered either by inventory activities or in any other manner. The report shall cover the period from the last physical count of that controlled substance before the loss was discovered through the date of discovery. At a mimimum, any pattern(s) of loss(es) identified by the pharmacist in charge shall require an inventory reconciliation report for each pattern of loss identified, as defined by the pharmacy's policies and procedures. Any reportable loss, as specified in section of 1715.6 of CCR, shall also require an inventory reconciliation report.

An inventory reconciliation report shall require:

a. A physical count of all quantities of each federal controlled substance covered by the report that the pharmacy or clinic has in inventory. The biennial inventory required by federal law may count as one of the mandated inventories, so long as the biennial inventory was taken no more than three months from the last inventory required.

b. A review of the acquisitions and dispositions of each controlled substance covered by the report since the last inventory reconciliation report covering that controlled substance.

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. Identification of each individual involved in preparing the report and 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.
   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.

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.

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:

- Tille, Patricia M., Bailey and Scott's Diagnostic Microbiology, C.V. Mosby Co., St. Louis, Missouri, 15th edition, 2021.
- 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:	SECTION:
DELEGATION OF DUTIES LABORATORY MEDICAL DIRECTOR	***ADMINISTRATION*** **Page 1 of 2**

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

PURPOSE:

In accordance with standards established by the Clinical Laboratory Improvement Amendments (CLIA) and adopted by the College of American Pathologists (CAP) TLC.11425 (Delegation of Functions), the Medical Director for Sierra-View Medical Center's clinical laboratory has delegated responsibilities and authority to Section Directors / Technical Supervisors (Section Heads) and General Supervisors, meeting the CLIA qualifications for the specialties supervised.

DEFINITIONS:

N/A

POLICY:

All section heads for Sierra-View Medical Center's clinical laboratory services meet the CLIA requirements for supervising high-complexity testing (GEN.53400). The performance of section directors/technical supervisors and General Supervisors (GEN.55525) are assessed upon initial appointment, and annually thereafter. Technical Supervisors / Technical Directors have authority and responsibilities to include:

- Ensuring availability to the laboratory section as needed for on-site, telephonic or electronic consultation.
- All technical and regulatory compliance for the assigned discipline or service. Implements and maintains CAP standards, selection of equipment and methodologies, validation and implementation of new methods and instruments, communication of laboratory data, resolution of technical problems and ensuring remedial actions are taken when necessary, and an appropriate education, research and development for the sections' disciplines.
- Ensuring policies and standard operating procedures (SOPs) are relevant and appropriate, and SOPs are reviewed biennially. Oversees biennial accreditation self-inspections on opposite years of CAP onsite inspections.
- Establishes and maintains an effective Quality Management (QM) program for the clinical service that covers all areas of the laboratory and beneficiaries of services. This includes establishing quality indicators of pre- analytic, analytic, and post-analytic phases of testing, investigating and resolving quality variances, and performs rootcause-analyses when necessary.
- Ensuring enrollment in Proficiency Testing programs for all analytes, and ensuring compliance with Quality Assurance, Quality Control, and Performance Improvement programs. Ensures a safe work environment for staff.
- Personnel Management: ensuring staff qualifications, training, competency, and continuing education requirements are met.
- All Technical Directors/Supervisors identify training needs and have authority to train and competency assess technical staff that support patient care responsibilities in their clinical sections.

Each clinical service has one or more General Supervisor(s) under the supervision of the section technical director. General Supervisors have delegated authority to:

- Resolution of technical problems in accordance with policies and procedures established by the laboratory director or technical supervisor.
- Monitoring test performance and ensure remedial actions at taken when test systems deviate from established performance specifications.
- Performing training and competency assessment in their disciplines, but must meet the general supervisor qualifications for high complexity testing if assessing staff performing high-complexity testing.
- Ensures qualified, credentialed and trained personnel perform testing, and staff records are maintained.
- Facilitate staff participation in section and NIH-wide continuing education programs.

NOTE: The following functions may not be delegated, and are only facilitated/approved by the Medical Director:

Attestation statements for Immunohematology proficiency testing.

REFERENCES:

LD.04.05.01, The Joint Commision 2024

SUBJECT: **DROPERIDOL**	SECTION: ***[Enter manual section here]*** **Page 1 of 1**

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

PURPOSE:

To define Sierra View Medical Center's position in regards to utilizing droperidol in patient care.

POLICY:

A. Due to the increased risk of serious adverse cardiac side effects and the limited therapeutic role of droperidol Sierra View Medical Center will NOT purchase, stock or administer droperidol to any of its patients.

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

SUBJECT: **EMERGENCY BLOOD RELEASE**	SECTION: **Page 1 of 2**

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

PURPOSE

To define the process for releasing blood components for transfusion in a time-sensitive emergency situation.

No blood components will be issued for transfusion before completion of processing or crossmatching. In the event of an emergency, the attending physician may request blood components from the blood bank department of the clinical laboratory and assume responsibility for the outcome of the use of those products by signing the emergency release form. This form must be returned to the blood bank department and attached to the original request for blood products. All physician requests for emergency blood products must be done so on patients who have been registered in the SVMC hospital information system, whether their identity is known or not. All requests for blood components must be accompanied with a *Request For Blood Component* form.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ABO/Rh Requirements:

   a. If time permits, a properly-labeled sample shall be obtained and the patient's ABO and Rh shall be determined. Type-specific blood shall then be issued when possible, or type-compatible blood issued if type-specific is not available.

   b. If there is insufficient time to obtain a specimen, or to perform tests to determine the ABO/Rh, Group O (PRBCs) is the only ABO group that can be administered to patients of unknown ABO. Do not rely on past records to determine the patient's ABO/Rh.

   c. Pull segments from units if the blood is issued before testing has begun.

   d. Issue blood.

   e. Units are issued in the laboratory information system (LIS) under the Emergency Issue Protocol. This will generate the Emergency Issue Card, which needs to be signed by the attending physician. If the patient has not yet been admitted into the hospital information system, the "computer down time" emergency issue card should be used.

2. Compatibility Testing:

   a. A properly collected and labeled patient sample must be collected and the routine compatibility testing procedure must begin. If the physician requires the blood for transfusion before the crossmatch is complete, it may be released if the "UNCROSSMATCHED BLOOD Emergency Unit Issue Card" has been signed, but the crossmatch must be completed in any event.

Massive Bleed Protocol:

- An elevated emergency level of response for patients that are in immediate jeopardy beyond the usual Emergency Release.
- Requires immediate communication to the Lab, "Emergency release of uncrossmatched

blood for a massive bleed in_____(location)."

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- Lab Blood Bank will tag and issue 2-4 units of PRBC and 1 unit of FFP if requested, per specific situation, and will work closely with Nursing Services to release continued blood products as needed. Crossmatched blood will be utilized upon availability.

- The other processes of Emergency Release, such as the use of the Emergency Release forms and follow up crossmatching, will still apply.

REFERENCES:

- Association for the Advancement of Blood & Biotherapies, Standards for Blood Banks and Transfusion Services, 33rd Edition, 5.27, 2022.

- The Joint Commission (2025). Laboratory accreditation standards. QSA.05.11.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **ENVIRONMENTAL FACILITY CLEANLINESS**	SECTION:

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

PURPOSE:

To establish infection control guidelines for environmental cleanliness throughout the facility.

POLICY:

1. Identify equipment and surfaces requiring scheduled cleaning.
2. Assign responsibilities.
3. Define acceptable cleaning materials and frequency.

AFFECTED AREAS/PERSONNEL: *ENIVRONMENTAL SERVICES STAFF, NURSING, VOLUNTEERS, ALL PATIENT CARE STAFF, PHARMACY, SURGICAL SERVICES, MATERIALS MANAGEMENT, DIETARY STAFF, RESPIRATORY STAFF, AND SURGERY CLINIC.*

PROCEDURE:

1. General Guidelines: Separate clean items from soiled items at all times and ensure a process for cleaning and disinfection of all equipment/supplies that are used in patient care.
2. Separation of Clean and Soiled Supplies and Equipment:
   a. Clean supplies shall not be stored near soiled supplies. Cross contamination can occur.
      - Use separate drawers, cabinets, or areas for clean and soiled supplies and equipment in patient rooms.
      - Keep drawers and cabinets closed.
      - Once removed, clean supplies and linens shall not be returned to a clean area, drawer, or cabinet.

   b. Clean Utility Room
      - Only clean supplies and equipment shall be kept in the clean utility room.
      - Unused supplies removed from an equipment cart shall not be returned. Any supplies taken into a patient or treatment room are considered "contaminated" and are not to be shared with another patient.
      - No supplies are to be stored under any sink.

c. Soiled Utility Room

- No clean supplies or equipment shall be kept in the soiled utility room.
- Equipment removed from patient rooms shall be cleaned by a designated person with a hospital-approved disinfectant solution accessed through the environmental services department. Equipment shall be taken to the soiled utility room if it needs to be processed by Central Processing.

3. For Cleaning of Specific Equipment/Areas Refer to: High Touch Surfaces Master List located in the Policy Library.

REFERENCES:

- California Code of Regulations, Title 22, Social Security. Section 70015, 70025, 70739, 70827APIC
- Center for Disease Control and Prevention. Environmental Cleaning Procedures. Accessed 21 May 2025. https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques

CROSS REFERENCE:

- Refer to High Touch Surfaces – Master List located in the Policy Library.

SUBJECT: **EXPOSURE CONTROL PLAN – BLOODBORNE PATHOGEN STANDARD**	SECTION: **Page 1 of 27**

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

PURPOSE:

The Exposure Control Plan shall be made available to Sierra View Medical Center (SVMC) personnel and to the Chief of the Division of Occupational Safety and Health of the California Department of Industrial Relations or National Institute for Occupational Safety and Health (NIOSH) or their respective designee upon request for examination and copying.

POLICY:

1. SVMC has charged the Pharmacy and Therapeutics / Infection Prevention Committee with the overall responsibility for the Blood borne Pathogen Program in compliance with Occupational Safety and Health Administration (OSHA) Instruction 29 CFR 1910.1030. The Pharmacy and Therapeutics / Infection Prevention Council have the full support and authority of the Chief Executive Officer (CEO) to ensure compliance is maintained.

   SVMC complies with OSHA regulations including, but not limited to, the following:

   a. Determining exposure risks of personnel

   b. Providing protection against exposure risks

   c. Implementing a blood borne pathogen program

   d. Providing Hepatitis B vaccinations at no cost to personnel

   e. Providing in-service training by personnel with knowledge of this topic and being available to employees' requests for additional safety protection

   f. Being available to answer all employee questions

   The Pharmacy and Therapeutics / Infection Prevention Committee has overall responsibility for implementing the Plan and will review and maintain the Plan. The Plan will be submitted to the Pharmacy and Therapeutics / Infection Prevention Committee for review, revision as needed and approval on an annual basis. The Plan will also be reviewed/approved at other committees as deemed necessary.

2. The goals of the Exposure Control Plan are:

   a. To inform personnel of the contents of the OSHA standards as it applies to Hepatitis and Human Immunodeficiency Virus (HIV).

   b. To ensure employees receive information concerning infection prevention in the work place. This information includes epidemiology, clinical presentation, modes of transmission and prevention of blood borne disease / infection, specifically Human

Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV), as well as protective measures to prevent exposure, such as the use of personal protective equipment (PPE), clothing and safe work practices including Standard Precautions and vaccination protocol.

c. To ensure employees receive information concerning the hazards that they may be exposed to in the workplace. This information includes a comprehensive hazard communication program that incorporate container labeling and other forms of warnings, material safety data sheets and appropriate protective measures to employees.

3. The Plan shall be incorporated into the hospital's departmental policies and procedures, be reviewed, updated and approved annually, or as deemed necessary by the Infection Prevention Committee. Review and revision will reflect the following:

   a. New or modified tasks and procedures which affect occupational exposure.

   b. Progress in implementation of the use of needleless systems and sharps with engineered sharps injury protection.

   c. New or revised employee positions with occupational exposure.

   d. Review and evaluation of the exposure incidents which occurred since the previous update.

   e. Review and respond to information indicating that the Exposure Control Plan is deficient in any area.

4. Information presenting the scope, content and practical application of the Plan will be given to all persons covered by this Plan. Education will be provided annually and as deemed necessary. Documentation of training will be maintained.

5. Each department shall monitor compliance with the Plan, related practices, evaluate the need for further training, and provide training in consultation with Infection Prevention. Compliance with the Plan shall be incorporated into the individual employee evaluation process.

6. Hepatitis B vaccinations, at no cost to the employee, shall be offered to all employees who may be exposed to more than one infection risk per month (blood/body fluids), within ten (10) working days of assignment to exposure-prone duties. Employees who elect not to be vaccinated *must* sign a written declination form.

7. SVMC shall ensure that all medical evaluations and procedures, including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

   a. Made available at no cost to the employee

b. Made available to the employee at a reasonable time and place

c. Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional

d. Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place.

8. SVMC shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

GENERAL FACTS ABOUT HEPATITIS

1. Hepatitis Transmission

a. Hepatitis B (HBV)

Hepatitis B can be transmitted through occupational exposure by percutaneous exposure to infected blood or bodily fluids. Healthcare workers are at risk for needle stick injuries or mucosal exposure, such as splash into eyes or mouth.

HBV is most prevalent among intravenous drug users who share needles and through sexual contact among sexually active homosexual males and prostitutes. From these groups, it spreads to the community.

Needlestick and sharps injuries (NSSI) are major occupational hazards that are commonly associated with healthcare workers' practice standards. More than 20 different types of bloodborne pathogens can be transmitted as a result of NSSIs.

HBV symptoms resemble the flu in its early stages. More severe clinical illness has symptoms that often include jaundice, a loss of appetite, nausea, and elevated liver enzyme function tests.

b. Hepatitis C

Hepatitis C (HCV),is transmitted parenterally and is responsible for many cases of sporadic acute hepatitis.

HCV is now by far the most common cause of post-transfusion hepatitis.

HCV symptoms resemble the symptoms associated with HBV.

HCV can, like HBV, develop into a chronic carrier state.

2. Hepatitis Protection

Occupational Health and Safety Administration (OSHA) enforces the Center for Disease Control and Prevention (CDC) recommendations. OSHA presently requires every healthcare worker who is exposed to more than one infection risk per month to be offered a Hepatitis B vaccination, to be trained in pathogen safety, and given all necessary protective PPE. SVMC will require that high-risk employees provide proof of immunization or immunity or signed declination prior to employment.

Hepatitis B vaccine is administered in a three (3) dose series to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, or antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons. The vaccination series will be offered within ten (10) days of hire.

NOTE: An employee who refuses vaccination must sign a declination form maintained in the Employee Health file.

Danger of infection from blood borne pathogens can be prevented or reduced in the healthcare setting by:

a. Using protection against body fluids during at-risk procedures including appropriate personal protective equipment, mechanical safety devices, *etc.*

b. Using disinfectants to reduce pathogens in the environment.

c. Taking thorough patient medical histories.

d. Washing hands between patient treatment contacts.

e. Using puncture-resistant sharps containers for needle disposal.

f. Correcting unsafe environment and work practices as they occur.

3. Human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV / AIDS)

HIV / AIDS is not as contagious in a healthcare setting as HBV, but there is still no vaccine for prevention and no means of cure. It is transmitted through body fluids so healthcare workers are exposed to HIV in their daily routine.

OSHA requires that employees be trained in HIV prevention and be required to protect themselves during at-risk procedures. Training is included in, but not limited to, New Hire Orientation and Annual Orientation.

Symptoms of HIV infection are varied and may include fatigue, fever, weight loss, night sweats, rashes, mouth sores or pneumonia.

Because there is no inoculation against HIV / AIDS, CDC recommends and OSHA enforces the use of STANDARD PRECAUTIONS in *all* healthcare settings where exposure to potentially infectious materials may take place.

4. HIV / AIDS Transmission

HIV / AIDS is usually transmitted through blood and semen. It is most commonly seen in men who have sex with men (MSM) and IV drug users.

HIV / AIDS is transmitted sexually and through blood / body fluid exposure or perinatally from mother to child. HIV / AIDS is *not* transmitted through general contact with a carrier.

STANDARD PRECAUTIONS

A. Standard Precautions applies to ALL blood and body fluids, excluding sweat, regardless of the presence or absence of visible blood.

B. Standard Precautions incorporate infection prevention procedures that protect the patient as well as the employee from disease-causing pathogens.

C. The incorporation of Universal Precautions with Standard Precautions has been referred to as STANDARD PRECAUTIONS throughout this plan, as well as the Infection Control Program Manual.

D. Under STANDARD PRECAUTIONS, the assumption is that blood and body fluids from ALL patients is potentially infected with Human Immunodeficiency Virus (HIV) Hepatitis B virus (HBV), Hepatitis C virus (HCV) and other blood borne pathogens, and must be handled accordingly.

E. STANDARD PRECAUTIONS applies to:

1. ALL blood and body fluids that are visibly contaminated with blood,

2. ALL body fluids in situations where it is difficult or impossible to differentiate between body fluids, including (but not limited to) cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal and pericardial fluid, amniotic fluid, saliva in dental procedures, vaginal secretions and semen.

3. It does not include sweat, unless it is visibly contaminated with blood.

F. Contaminated items are defined as those items that contain liquid or semi-liquid blood or are caked with dried blood or other potentially infectious material (OPIM) that are capable of releasing these materials when handled or compressed.

G. SVMC practices Standard Precautions in its regular daily activities.

DEFINITIONS OF INFECTIOUS CONDITIONS

A. Infections need 4 simultaneous conditions for transmission. If you take any condition away, the danger of infection will be reduced or eliminated. The conditions which must exist simultaneously are:

1. A sufficiently large dose of infectious particles to constitute a dangerous quantity

2. A sufficient virulence, or deadliness, to be dangerous

3. A portal of entry, such as through an open cut or the nasal passages

4. A reduced resistance level of the host. For example: If a medical worker is tired, has the flu or a cold, he/she is more susceptible to infection.

INFECTIOUS DISEASES ARE PREVENTED BY REDUCING OR REMOVING ANY OF THESE CONDITIONS. FOR EXAMPLE:

- The use of gloves and masks will reduce or eliminate portals of entry.
- Regular handwashing and the use of disinfectants will remove or reduce the dose and virulence of the disease.
- The placement of sharps and needles into approved sharps containers and the avoidance of recapping needles will reduce needle stick portals of entry.

PERSONAL PROTECTIVE EQUIPMENT

Where occupational exposure remains after implementation of engineering and work practice control, SVMC shall provide, at no cost to the employee, appropriate personal protective equipment (PPE) such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protections, mouthpieces, resuscitation bags, pocket masks, or other ventilation devices.

PPE will be considered "appropriate" only if it does not permit blood or other potentially infectious materials (OPIM) to pass through to or reach the employee's work clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

SVMC shall ensure that the employee uses appropriate PPE unless the employee temporarily and briefly declined to use PPE when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future. The employer shall encourage employees to report all such instances without fear of reprisal.

SVMC provides PPE in the appropriate sizes for all employees. This PPE can be taken to the location where infectious materials are generated. PPE and protective clothing is provided commensurate with the exposure risks.

Hypoallergenic gloves, gloves liners, powderless gloves, or other similar alternatives shall be available to those employees who are found to be allergic to the gloves normally provided.

SVMC shall make provision for cleaning, laundering, and disposal of PPE at no cost to the employee.

The employer shall repair or replace PPE as needed to maintain its effectiveness at no cost to the employee.

If an employee feels more protection should be provided for certain procedures, he / she should make this request to either his / her immediate supervisor or agency management.

The use of protective clothing is an OSHA requirement and a requirement of SVMC. If the procedure requires it, or the manufacturer recommends its use, protective clothing must be used.

Clinical Laboratory Improvement Amendments (CLIA) laboratory rules may be stricter about laboratory garments. If rules conflict, *follow the law that is stricter*.

Disposal of Personal Protective Equipment

1. If a garment is penetrated by blood or OPIM, the garment shall be removed immediately or as soon as feasible.

2. All PPE shall be removed prior to leaving the work area.

3. When PPE is removed it shall be placed in an appropriate designated area or container for storage, washing, decontamination or disposal.

    a. Reusable PPE which is heavily soiled with body fluids shall be handled as little as possible and must be bagged at the location of use in leak proof bags.

4. When removing protective clothing, avoid contamination of exposed body parts.

Gloves

1. Types

   Three basic glove types are provided by SVMC:

   a. Sterile gloves for procedures involving contact with normally sterile areas of the body and invasive procedures. These gloves cannot be reused.

   b. Examination gloves for patient diagnostic procedures not requiring the use of sterile gloves and for routine infection prevention. These gloves cannot be reused.

   c. Utility gloves of strong latex/vinyl for maintenance and scrubbing work. These are reusable until they puncture, tear, or crack.

2. Glove protocol: Gloves shall be worn when it can be reasonably anticipated that the employee may have contact with blood, OPIM, mucous membranes, and non-intact skin; when performing vascular access procedures; and when handling or touching contaminated items or surfaces.

   a. After donning gloves, examine them for physical defects.

   b. Never wear the same pair of gloves with more than one patient or on more than one occasion.

   c. Discard gloves after each patient.

   d. Disposable (single use) gloves shall not be washed or decontaminated for re-use.

   e. Don gloves so they cover the cuff of your clothing if possible to reduce the area of skin exposure.

   f. If torn or punctured or their ability to function as a barrier is compromised, disposable (single use) gloves shall be replaced as soon as feasible. If contaminated, gloves shall be replaced as soon as practical.

   g. Remove gloves before removing mask and gown if worn.

   h. Wash hands after glove disposal.

Masks, Protective Eyewear / Goggles, and Face Shields

Masks in combination with eye protection devices such as goggles, glasses with solid side shields, or chin-length face shields, shall be worn whenever contamination of the eyes, nose or mouth can be reasonably anticipated from splashes, spray, spatter or droplets of blood or OPIM. They are not required for routine care.

Gowns / Aprons or Other Protective Body Clothing

1. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

   NOTE: Gowns, aprons and/or lab coats are required when splashing, misting or aerosolization of blood or OPIM onto skin or clothing are anticipated.

   Resuscitation Equipment:

   Pocket masks, mouthpieces, resuscitation bags and / or other respiratory equipment are available for use in order to minimize exposure in case of emergency mouth-to-mouth resuscitation.

   NOTE: Surgical masks are *not* considered resuscitation equipment.

HANDWASHING

A. Wash hands regularly on the following occasions:

   1. Upon arriving at work
   2. Before gloving
   3. After gloves are removed
   4. Before and after each patient or during prolonged contact with one patient
   5. Before and after touching wounds
   6. After touching excretions / secretions
   7. Before and after performing invasive procedures
   8. Before handling medications
   9. Before and after eating, drinking or preparing food, smoking, etc.
   10. After hands have touched a potentially contaminated surface

11. Before leaving the work area and upon return

12. Upon completing work shift

13. As soon as patient safety permits, when hands and other skin surfaces become contaminated with blood or body fluids

14. After any contact with one's own personal body fluids, using the toilet, blowing or wiping the nose, or similar incidents when soiled

B. Prior to invasive procedures, use of an antimicrobial soap scrub is recommended by the CDC. The CDC recommends the use of antimicrobial soap prior to invasive procedures, when caring for newborns, between caring for patients in high-risk units, and when caring for severely immunocompromised individuals or patients infected with virulent or epidemiologically important microorganisms.

1. The policy at SVMC requires antimicrobial soap to be available in high risk patient care areas as well as isolation rooms.

C. Alcohol-based Hand Sanitizers/ Wipes

Alcohol-based hand sanitizers or wipes are available to all employees whose job performance may take them into areas where sinks are not readily available or accessible. Alcohol-based hand sanitizers or wipes disinfect the hands between patient contacts when handwashing is not possible; however, hand sanitizers and wipes do *not* replace handwashing. Handwashing must be performed as soon as handwashing facilities become available/accessible.

EXPOSURE INCIDENT OCCURRENCE

An exposure incident occurs when a patient's blood or body fluids may have gained entry into an employee during the performance of their job duties. Should this occur, the employee must follow these procedures:

A. Wash the exposed area with soap and running water.

B. Report the incident to the Supervisor immediately.

C. Complete all necessary forms to document the facts.

D. Fill out an Electronic Incident Report.

E. If possible, locate the source patient for a blood sample for serological testing for HIV, HBV and HCV.

F. Report to Employee Health Services or Emergency Room if after hours. Also, if after hours, notify the House Supervisor.

EXPOSURE INCIDENT FOLLOW-UP

Following a report of an exposure incident, SVMC shall make a confidential medical evaluation immediately available to the exposed employee.

A. The employer shall document the route(s) of exposure and the circumstances under which the exposure incident occurred.

B. The employer shall identify and document the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law.

1. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV, HCV and HIV infectivity.
If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

2. When the source individual is already known to be infected with HBV, HCV or HIV, testing for the source individual's known HBV, HCV or HIV status need not be repeated.

3. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

C. SVMC shall provide for collection and testing of the employee's blood for HBV, HCV and HIV serological status.

1. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

2. If the exposed employee consents to a baseline blood collection but not to HIV testing, the blood sample should be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

3. Additional collection and testing shall be made available as deemed appropriate on a case-by-case basis.

D. SVMC shall provide for post-exposure prophylaxis, when medically indicated.

E. SVMC shall provide for counseling and evaluation of reported illnesses.

F. Information provided to Healthcare Professionals:

1. SVMC shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

2. SVMC shall ensure that the health professional evaluating an employee after an exposure incident shall be provided the following information:

   a. A copy of this regulation

   b. A description of the exposed employee's duties as they relate to the exposure incident

   c. Documentation of the route(s) of exposure and circumstances under which exposure occurred

   d. Results of the source individual's blood testing, if available

   e. All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain

G. Healthcare Professional's Written Opinion

SVMC shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within fifteen (15) days of the completion of the evaluation.

1. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

2. The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

   a. That the employee has been informed of the results of the evaluation

   b. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment

3. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

H. Medical Recordkeeping

Medical records required by blood borne pathogen standard shall be maintained by employer's occupational health provider.

SHARPS INJURY LOG

SVMC's Employee Health Department shall establish and maintain a Sharps Injury Log, which is a record of each exposure incident involving a sharp. The exposure incident shall be recorded on the log within fourteen (14) days of the date the incident is reported to the employer. The information recorded shall include the following information, if known or reasonably available:

A. Type and brand of sharp involved in the exposure incident.

B. A description of the exposure incident which shall include:

1. Job classification of the exposed employee
2. Work area where the exposure incident occurred
3. The procedure that the exposed employee was performing at the time of the incident
4. How the incident occurred
5. The body part involved in the exposure incident
6. If the sharp had engineered sharp injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation of the mechanism or after activation of the mechanism.
7. If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury
8. The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury

EXPOSURE RESPONSE, PREVENTION AND CONTROL

The Exposure Control Plan is designed to minimize or eliminate employee exposure to blood borne pathogens for those who are potentially exposed at least once per month. These employees are protected by SVMC with safety measures identified below, according to the Blood borne Pathogen Standard of December 6, 1991, which was amended January 15, 1999.

SVMC

1. Reviews major tasks and procedures performed by personnel and identifies all high risk exposure incidents, and how frequently exposure incidents occur per month.

2. Ensures that all major tasks and procedures done by each employee is reviewed and potential exposure incidents identified.

3. Provides employees who are exposed to blood pathogens at least once per month:

   a. Safety training in blood borne pathogens

   b. the protective clothing required by OSHA against pathogen exposure

   c. written safety information from the contents of the agency health and safety manuals

4. Provides for periodic evaluation of the frequency, types and brand(s) of sharps involved in exposure incidents documented in the Sharps Injury Log.

   NOTE: Frequency of use may be approximated by any reasonable and effective method.

5. Provides for the identification of currently available engineering controls and selecting such controls, where appropriate, for the procedures performed by employees in their respective work areas.

6. Provides for documenting patient safety determinations.

7. Provides for obtaining the active involvement of employees in reviewing and updating the exposure control plan with respect to the procedures performed by employees in their respective work areas.

8. Ensures that a copy of the Exposure Control Plan is accessible to employees.

9. Shall prepare an exposure determination form. This exposure determination form shall contain the following:

   a. A list of all job classifications in which employees have occupational exposure

   b. A list of job classifications in which some employees have occupational exposure

   c. A list of all tasks and procedures or groups of closely related tasks and procedures in which occupational exposure occurs. This exposure determination shall be made without regard to the use of personal protective equipment.

A. Methods of Compliance

1. General – Standard Precautions shall be observed to prevent contact with blood or OPIM. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

2. Engineering and Work Practice Controls – General Requirements:

   a. Engineering and work practice controls shall be used to eliminate or minimize employee exposure

   b. Engineering controls shall be reviewed and maintained or replaced on a regular basis to ensure their effectiveness

   c. Routine work practice controls shall be evaluated and updated on a regular basis to ensure their effectiveness

   d. All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

3. Engineering and Work Practice Controls – Specific Requirements:

   a. Needleless Systems. Needleless systems shall be used for:

      - Withdrawal of body fluids after initial venous or arterial access is established
      - Administration of medications or fluids
      - Any other procedure involving the potential for an exposure incident for which a needleless system is available as an alternative to the use of needle devices

   b. Needle Devices. If needleless systems cannot be used, needles with engineered safety devices to prevent sharps injury shall be used for:

      - Withdrawal of body fluids
      - Accessing a vein or artery
      - Administration of medications or fluids

EXCEPTIONS:

- Market Availability. The engineering control is not required if it is not available in the marketplace.
- Patient Safety. The engineering control is not required if a licensed healthcare professional directly involved in a patient's care determines, in the reasonable exercise of clinical judgment, that use of the engineering control will jeopardize the patient's safety or the success of a medical, dental or nursing procedure involving the patient. The determination shall be documented.
- Safety Performance. The engineering control is not required if the employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing exposure incidents than the alternative used by the employer.
- Availability of Safety Performance Information. The engineering control is not required if the employer can demonstrate that reasonably specific and reliable information is not available on the safety performance of the engineering control for the employer's procedures, and that the employer is actively determining by means of objective product evaluation criteria whether use of the engineering control will reduce the risk of exposure incidents occurring in the employer's workplace.

4. Prohibited Practice

a Shearing or breaking contaminated needles and other contaminated sharps is prohibited.

b Contaminated sharps shall not be bent, recapped, or removed from devices.

EXCEPTION: Contaminated sharps may be bent, recapped or removed from devices if the procedure is performed using a mechanical device or a one-handed technique, and it can be demonstrated by the employer that no alternative is feasible or that such action is required by a specific medical or dental procedure.

c Sharps that are contaminated with blood or OPIM shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

d Disposable sharps shall be used.

e Broken glassware, which may be contaminated, shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

f The contents of sharps containers shall not be accessed unless properly reprocessed or decontaminated.

g Sharps containers shall not be opened, emptied or cleaned manually or in any other manner which would expose employees to the risk of sharps injury.

h Activities such as eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure.

i Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or OPIM are present.

B. Requirements for Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care, such as withdrawing body fluids, accessing a vein or artery or administering vaccines, medications or fluids shall be performed using effective patient handling techniques and other methods designed to minimize the risk of a sharps injury.

Immediately place contaminated sharps in puncture resistant, leak proof containers.

At all times during the use of sharps, containers for contaminated sharps shall be:

1. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found.

2. Maintained upright throughout use, where feasible.

3. Replaced as necessary to prevent overfilling.

C. Sharps Containers for Contaminated Sharps:

1. All sharps containers for contaminated sharps shall be:

   a. Rigid

   b. Puncture resistant

c. Leak proof on the sides and bottom

d. Portable, if portability is necessary to ensure easy access by the user

e. Labeled appropriately with the universal biohazard symbol

2. If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened without great difficulty.

D. Regulated Waste.

The EPA and the State Health Department administer regulated waste disposal laws in the environment **outside** the agency; OSHA administers laws **within** the agency. SVMC rigidly adheres to both.

1. General

Handling, storage, treatment and disposal of all regulated waste shall be in accordance with Health and Safety Code Chapter 6.1, Sections 117600 through 118360, and other applicable regulations of the United States and the State of California (including political subdivisions). The actual treatment and disposal of the regulated waste generated by SVMC shall be the responsibility of Stericycle, Inc., a contract biohazardous waste contractor.

Regulated waste policies must be understood by *all* personnel handling such waste.

Once regulated waste is disinfected, it is no longer considered "infectious" and may be disposed of as regular solid waste *unless* it contains sharps or dangerous materials.

2. Disposal of Sharps Containers

When any container of contaminated sharps is moved from the area of use for the purpose of disposal, the container shall be:

a. Placed in a secondary container if leakage is possible. The secondary container shall be:

- Closeable
- Constructed to contain all contents and prevent leakage during handling, storage, transport or shipping

- Labeled appropriately with universal biohazard symbol

b. Disposal of other Regulated Waste. Regulated Waste not consisting of sharps shall be disposed of in containers which are:

- Closeable
- Constructed to contain all contents
- Labeled appropriately and color-coded
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping

c. If outside contamination of a container or regulated waste occurs, it shall be placed in a secondary container. The secondary container shall be:

- Closeable
- Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping
- Labeled appropriately and color-coded
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping

E. Handling Specimens of Blood or Other Infectious Material

1. Specimens of blood or OPIM shall be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping.

   Care shall be taken to avoid contamination of the outside of the container or the laboratory slip.

2. The container for storage, transport or shipping shall be labeled or color-coded and closed prior to being stored, transported, or shipped.

3. If outside contamination of the primary container occurs, the primary container shall be placed within a second container that prevents leakage during collection, handling, processing, storage, transport, or shipping and is labeled or color-coded.

4. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container that is puncture resistant in addition to the above characteristics.

F. Servicing or Shipping Contaminated Equipment

Equipment that may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

1. A readily observable label shall be attached to the equipment stating which portions remain contaminated.

2. Information concerning any remaining contamination shall be conveyed to all affected personnel, the servicing representative, and / or manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

G. Cleaning and Decontamination of the Worksite / Housekeeping

Cleaning and decontamination of the worksite / housekeeping is addressed in this policy because many safety and health injuries occur as a result of inadequate cleaning, repair and maintenance.

1. General Requirements

a. Employers shall ensure that the worksite is maintained in a clean and sanitary condition.

b. Employers shall determine and implement an appropriate written schedule for cleaning and decontamination of the worksite.

c. The method of cleaning or decontamination used shall be effective and shall be appropriate for the specific setting as well as the type of soil or contamination present and the type of surface or equipment to be treated.

d. All equipment, environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the visit. The cleaning and decontamination of equipment and work surfaces may be required more often than is specified below.

2. Specific Requirements

a. Contaminated Work Surfaces. Contaminated work surfaces shall be cleaned and decontaminated immediately or as soon as feasible when:

- Surfaces become overtly contaminated
- There is a spill of blood or OPIM
- Apply hospital-level tuberculocidal disinfectant or fresh bleach solution (1:10) on blood spills
- If bleach solutions are used, the solution must be refreshed every 2 days. Once diluted, bleach solutions lose disinfecting strength rapidly.
- After procedures are completed
- At the end of the visit, if the surface may have become contaminated since last cleaning

b. Receptacles. All bins, pails, cans, and similar receptacles intended for reuse which have a likelihood for becoming contaminated with blood or OPIM shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

c. Instruments. In most cases, disposable instruments shall be used; however, if reusable medical instruments are used, they shall be cleaned with a disinfectant (hospital level – tuberculocidal) before being processed.

d. Protective Coverings. Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of patient care if they may have become contaminated.

e. Physical Area. All places of employment, passageways, storerooms and service areas must be kept clean and orderly and in a sanitary condition.

f. Physical Patient Care Area. Floor must be kept clean and dry. The cleaning in rooms and / or areas where blood or OPIM may be present must be as frequent as necessary to maintain a decontaminated status, giving due regard to the amount and type of contaminants present.

H. Hygiene

1. SVMC shall provide handwashing facilities that are readily accessible to employees.

2. When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser (or alcohol-based hand sanitizer) in

conjunction with clean paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as is feasible.

SVMC shall educate employees to wash their hands immediately or as soon as feasible after removal of gloves or OPIM.

3. SVMC shall educate employees to wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious material.

I. Laundry

1. Contaminated laundry shall be handled as little as possible with a minimum of agitation.

2. Whenever contaminated laundry is wet and presents a reasonable likelihood of soaking through or leakage when bundled, gloves should be worn and it should be transported in a manner which prevents soak-through, leakage of fluids to the exterior or contamination of the environment.

3. In keeping with Universal / Standard Precautions, all linen will be handled in the same manner as if potentially infectious.

INDIVIDUALS COVERED BY THE PLAN

The Exposure Control Plan practiced at SVMC applies to the following health care providers:

- Full-time, part-time, contract and temporary employees (nursing personnel, medical staff, and support staff) who have direct contact or whose duties are likely to bring them in contact with blood or body fluids of patients or patient specimens.
- Students and trainees, including those from health professional schools; students from other programs; institutions or universities; and post-graduate trainees with clinical responsibilities.
- Volunteers.
- Research personnel whose duties include processing specimens of human blood or body fluids.

TRAINING DOCUMENTATION

All high risk healthcare workers must receive education about precautionary measures, epidemiology, modes of transmission and prevention of HIV/HBV/HCV, and other associated infectious agents. SVMC provides this education at New Hire Orientation, during Annual Orientation, and when deemed necessary.

Training regarding the location and proper use of personal protective equipment, safe work practices, Standard / Universal Precautions, tagging, housekeeping to prevent contamination and needle stick or body fluid exposure procedures must also be carried out.

Training is a continuous responsibility and will occur formally on-hire and annually thereafter as well as informally during the work day with special instructions in certain situations or special departmental in service gatherings (5-minute huddles, etc.). Documentation of training will be maintained by the Staff Development Department.

All regulatory agencies (OSHA, The Joint Commission, Title 22) require documentation of and maintenance of orientation and annual training records related to Infection Control, Standard / Universal Precautions and OSHA Regulations. OSHA standards are the most specific and include the main elements required by The Joint Commission and Title 22. A plan for recordkeeping that will be maintained by the agency for five (5) years and shall include as a minimum, the following information:

- The dates of the training sessions.
- The contents of a summary of the training sessions.
- The names of the persons conducting the training.
- The names of all persons attending the training sessions.

A mechanism for maintaining records of rotation individuals shall be established by the primary educational facility, i.e., records of nursing students are maintained by their school.

All records are available to the employee, his representative, representatives from OSHA or other accrediting bodies.

IDENTIFICATION OF WORKERS "WHOSE REASONABLY ANTICIPATED DUTIES" MAY RESULT IN EXPOSURE TO BLOODBORNE PATHOGENS

RISK EXPOSURE CATEGORIES

Category 1:	HIGH RISK – Individuals whose duties are likely to bring them in contact with blood or OPIM.
Category 2:	LOW RISK – Individuals whose duties are not likely to bring them in contact with blood or OPIM.
Category 3:	NO RISK – Individuals whose duties do not bring them in contact with blood or OPIM.

All positions within the hospital which have direct patient care contact which may involve exposure to blood or OPIM or involve transportation of infectious waste or laboratory specimens have been designated to be "high risk".

Positions, which have direct patient care contact that is not likely to involve exposure to blood or body fluids such as social services, have been designated as "low risk".

Administrative personnel and clerical support personnel, who have no direct patient care contact, have been designated as "no risk".

Administration – All positions	Category 3
Biomedical – All positions	Category 2
Cardiopulmonary Services – All positions	Category 1
Central Processing – All positions	Category 1
Communications – All positions	Category 3
Data Processing – All positions	Category 3
Dietary – All positions	Category 3
Employee Health Services	
All positions	Category 1
Financial Services	
All positions	Category 3
Housekeeping	
Manager	Category 3
All other positions	Category 1
Human Resources	
All positions	Category 3
Infection Control	Category 1

Laboratory		
	Manager	Category 2
	All other positions	Category 1
Laundry		
	All positions	Category 1
Maintenance		
	Carpenter	Category 3
	Plumber	Category 1
	Painter	Category 3
	Air conditioning mechanic	Category 3
	All other positions	Category 3
Materials Management		
	All positions	Category 3
Medical Records		
	All positions	Category 3
Medical Staff Services		
	Medical Director	Category 2
	All other positions	Category 3
Medical Staff		
	All positions	Category 1
Nursing Services		
	Nursing Service Administration	Category 3
	Administrative Manager	Category 3
	Clinical Manager	Category 2
	Clerks	Category 3
	Hospital Service Aide	Category 2
	Ward Clerk	Category 2
	All other positions	Category 1

Outpatient Services	
Clerk	Category 2
All other positions	Category 1
Patient Accounting – All positions	Category 3
Pharmacy – All positions	Category 3
Physical Therapy – All positions	Category 2
Quality Management – All positions	Category 3
Radiology (including Nuclear Medicine)	
Manager	Category 2
All other positions	Category 1
Risk Management – All positions	Category 3
Social Services – All positions	Category 3
Staff Development	
Clinical Instructor, R.N.	Category 2
Clerk	Category 3
Utilization Review / Case Management – All positions	Category 3
Volunteer Services	
Those with patient contact or potential exposure to blood or other potentially infectious materials	Category 2
All other positions	Category 3

NOTE: HOUSE-WIDE POLICY:

- An employee with a draining skin lesion shall not work in direct patient care requiring physical contact.
- Non-intact skin or hands or forearms (i.e., a cut, abrasion, dry skin lesions) shall be covered with an appropriate barrier.

- Each specialty department may have additional guidelines based upon the type of activities performed. For detailed guidance, see Departmental Specific Infection Prevention Policies and Procedures.

REFERENCES:

- California Code of Regulations, Title 22 – Social Security, Division 5 – Licensing and Certification of Health Facilities. Chapter 1 General Acute Care Hospitals, Article 7. ***Cal. Code Regs. Tit. 22, § 70739 - Infection Control Program***. *Accessed June 2025* https://www.law.cornell.edu/regulations/california/22-CCR-70739

- California Code of Regulations, Title 8, Section 5193 - Industrial Relations, Records on Training and Transfer of Training Records. Subchapter 7 General Industry Safety Orders. ***Title 8, CCR § 5193 Handling of Blood.*** *Accessed June 2025* https://www.dir.ca.gov/title8/5193.html

- Needlestick and Sharps Injuries Among Healthcare Workers at a Tertiary Care Hospital: A Retrospective Single-Center Study. National Library of Medicine. 2023, Nov 6. Accessed June 4 https://pmc.ncbi.nlm.nih.gov/articles/PMC10637236/

- *Occupational Safety and Health Administration (OSHA). Code of Federal Regulations, 29 CFR 1910.1030 – Bloodborne Pathogens. Accessed June 2025 https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030*

- Occupational Safety and Health Administration (OSHA). Federal Registers Hazard Communication Standard Publication. *Accessed July 2025* https://www.osha.gov/hazcom

CROSS REFERENCES:

- HANDWASHING
- BLOODBORNE PATHOGEN EXPOSURE PROTOCOL FOR HEALTHCARE WORKERS
- ANNUAL INFECTION PREVENTION PLAN

SUBJECT: **HIV POSITIVE PATIENT IN LABOR**	SECTION: **Page 1 of 4**

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

PURPOSE:

To set nursing guidelines in the care of a human immunodeficiency virus (HIV) positive patient in labor.

POLICY:

During labor and delivery, decreasing fetal exposure to maternal blood or bodily fluids and maintaining the integrity of fetal skin are necessary to diminish the possible transmission of HIV from the mother to the fetus.

AFFECTED PERSONNEL/AREAS: *MCH DEPARTMENT, RNs*

EQUIPMENT:

Personal safety protective devices: eye protection, gowns, gloves, masks, and containers for the disposal of contaminated items.

PROCEDURE:

1. Intrapartum care:

   a. Avoid the use of internal fetal monitoring, scalp sampling, or artificial rupture of membranes unless approved by the physician.

   b. Avoid using forceps and vacuum extraction unless the benefit outweighs the risks.

   c. Avoid routine episiotomies.

   d. Labs to obtain (if not done prior to admission):

      - Rapid HIV, CD4, LFT's, RPR, Type and Screen, CBC
      - If result of Rapid HIV is positive, treat as a critical lab result and notify the provider as soon as possible.

   e. Ensure patient has two intravenous lines in place. Do not run zidovudine (azidothymidine (AZT)) in the same IV line as oxytocin or magnesium.

   f. Preparation of AZT for administration: 1,000 mg in 250 ml 5% dextrose in water. (Final concentration of 4 mg/mL). Label solution as "Zidovudine 4mg/mL."

   g. Zidovudine (AZT) should be administered by intravenous piggyback (IVPB) during labor as follows:

      - ASAP give: IV loading dose of 2 mg per kg of body weight given over 1 hour.

- Following loading dose, continuous infusion of 1 mg per kg of body weight per hour until delivery.
- Consent needs to be signed by the patient for administration to herself and the baby. (see consent to receive zidovudine or AZT)
- Discontinue IV zidovudine (AZT) when cord clamped.
- Patient should continue oral antiretrovirals with sips of water, at provider discretion. If patient is NPO discuss with provider treatment plan.

2. Universal precautions – as with all patients.

3. Cesarean delivery should be performed for women with a high viral load. Pregnant women should be counseled with the following information:

   a. Without ZDV therapy, the risk of vertical transmission is approximately 25%.

   b. With ZDV therapy the risk is reduced to 5% to 8%.

   c. With both ZDV therapy and a scheduled cesarean delivery (delivery before the onset of labor and before rupture of membranes) the risk is approximately 2%.

   d. With a viral load of less than 1,000 copies per millimeter, a vaginal delivery has a risk of 2% or less.

   e. If cesarean delivery is planned, delivery is recommended at 38 completed weeks of gestation. For women receiving ZDV therapy, adequate levels of the drug in the blood should be obtained by starting the IV infusion 3 hours preoperatively. Because morbidity is increased, prophylactic antibiotics should be considered.

   f. The available data indicates no reduction in the HIV transmission rate if Cesarean Delivery is performed after the onset of labor or rupture of membranes. The decision regarding route of delivery must be individualized under these circumstances.

4. Delivery care:

   a. Use of protective equipment includes gloves, eye protection, facemask, and gowns by health care providers and others participating in the delivery that may be exposed to blood or body secretions.

   b. Dry the infant immediately after delivery to remove all maternal blood and amniotic fluid to prevent further exposure to potentially infectious bodily fluids.

   c. Gently remove excess fluid and blood from the nares and oropharynx with a bulb syringe, mucus extractor or meconium aspirator with suction set on low setting (80 mm Hg.).

d. **All invasive procedures including injections should be delayed until the bath is given.**

e. Bathe the newborn under a radiant warmer as soon as the newborn is stable. Thorough cleansing with a mild non-medicated soap removes amniotic fluid and blood from the body surface, which is essential in reducing the chance of infection.

f. Thoroughly clean the eye area before applying antibiotic prophylaxis. Failure to remove the maternal fluids from the ocular area before prophylaxis placement can result in exposure of the mucous membranes to the virus.

g. All needles, sharps, and soiled linen should be disposed of carefully.

5. Postpartum care:

a. Careful observation for the development of any signs or symptoms of infectious process need to be maintained and reported to the physician.

b. Resume all Antiretroviral orders and any other medications that were discontinued during delivery.

c. Breast feeding is not recommended due to the possibility of vertical transmission of HIV and patient should not donate to any breast milk banks. Education needs to take place regarding not breast feeding.

d. Implement routine postpartum care guidelines.

e. Refer the patient to the hospital social worker.

f. Refer to Tulare County High Risk.

g. Educate patient regarding disposal of peripads, handwashing, and avoiding exposure of the infant to her blood and body fluids.

h. Review contraceptive plans.

i. Arrange all pediatric, gynecologic, and specialized HIV maternal follow-up needs before discharge.

j. Arrange all medication needs before discharge.

DOCUMENTATION:

Document all assessments, treatments, interventions, education, and appropriate communications on the Electronic Medical Record (EMR).

REFERENCES:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- American College of Obstetricians and Gynecologist. (2018). Practice Bulletin No. 751: Labor and delivery management of women with human immunodeficiency virus infection. Obstetrics & Gynecol 2018; 132:e131-137.
- AWHONN Standards and Guidelines for Professional nursing practice in the care of women and newborns (2019) (8th Ed). Washington, D.C.; AWHONN.
- UpToDate Inc. (n.d.). Zidovudine: Drug information. Lexicomp. Retrieved June 25, 2025, from https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7884
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SUBJECT: **HAZARDOUS DRUG HANDLING**	SECTION: 9 **Page 1 of 20**

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

PURPOSE:

To provide practice and quality standards for handling hazardous drugs (HDs) to promote patient safety, worker safety, and environmental protection. In addition, to provide for the safe receipt, storage, compounding, dispensing, administration, and disposal of hazardous drug products and preparations at Sierra View Medical Center (SVMC).

DEFINITIONS:

A. Hazardous Drugs (HDs) - Medications that in small quantities can produce severe adverse physiological effects. This category can be further subdivided into antineoplastic (Group 1), non-antineoplastic (Group 2), reproductive risk only (Group 3).

B. USP 800- Refers to a chapter from the United States Pharmacopeia (USP) publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile hazardous products.

C. Active Pharmaceutical Ingredient (API) - substance or mixture of substances intended to be used in the compounding of a drug preparation, thereby becoming the active ingredient in that preparation and furnishing pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans and animals or affecting the structure and function of the body.

POLICY:

To ensure all staff are protected from hazardous drug (HD) exposure through effective communication, training, and compliance with regulations. Sterile Hazardous Drugs planning & policy are addressed in "Sterile Hazardous Drug Handling".

AFFECTED PERSONNEL/AREAS: *Applies to all personnel who may be exposed to HDs per the latest NIOSH list and facility inventory.*

A. Hazardous Drug List Management

1. A list of hazardous drugs that are handled at Sierra View Medical Center will be maintained by the pharmacy (PIC) and reviewed against the NIOSH list for changes annually. They can be found within the policy "High-Alert Medications And Look Alike Sound Alike Medications".
   a. New medications shall be vetted when introduced via the P&T Formulary request process.

B. Containment Requirements

1. Drugs on the NIOSH list that must follow the requirements of USP 800 include:
   a. Any HD API
   b. Any antineoplastic (Table 1 "High-Alert Medications And Look Alike Sound Alike Medications") requiring HD manipulation

i. Drugs on the NIOSH list that do not have to follow all the containment requirements of USP 800 (if an assessment of risk is performed and implemented include:
   1. Final dosage forms of compounded HD preparations and conventionally manufactured HD products, including antineoplastic dosage forms that do not require any further manipulation other than counting or repackaging (unless required by the manufacturer)
   2. For dosage forms of other HDs (Table 2 and Table 3 of "High-Alert Medications And Look Alike Sound Alike Medications".) Sierra View may perform an assessment of risk to determine alternative containment strategies and/work practices.

2. Dosage forms (tablets or capsules, solid intact medications) that are administered to patients without modification shall be handled as per assessment of risk.

3. The selected containment strategy (handling precautions) will be communicated to staff in the assessment of risk or Electronic Medical Record or pharmacy labels.

4. The facility risk assessment shall be reevaluated annually.

C. Responsibilities of Personnel Handling Hazardous Drugs

1. The pharmacist-in-charge will be responsible for developing and implementing appropriate procedures and overseeing entity compliance with USP 800.

   a. Program integrity will be assured through the following:

   - Testing of product, environment, and personnel as needed.
   - Correcting actionable results when necessary.
   - Hand-hygiene and use of PPE shall be employed at each phase of hazardous drug (HD) handling, e.g., receipt, transport, compounding, administration, spill, and disposal.

2. Staff are responsible for following all procedures and safe handling practices as written in applicable policies in regards to the hazardous drugs.

D. Receipt and Unpacking of HDs

   a. A pharmacist will receive the HDs from the wholesaler in an area neutral/normal pressure. After receipt a pharmacy staff member will utilize appropriate PPE to stock medications into their appropriate tote within pharmacy based on the individual product's assessment of risk. At minimum this should include ASTM D6978 (or its successor) gloves. Goggles & disposable gown made of polyethylene-coated polypropylene or other laminate material that offers better protection should be used if a spill or breakage is suspected i.e. damaged shipping container, smells from container, etc.

   b. If the shipping container appears damaged:

c. Seal the container without opening and contact the supplier.

d. If the unopened package is to be returned to the supplier, enclose the package in an impervious container and label the outer container "Hazardous".

e. If the supplier declines return, dispose of as hazardous waste.

f. If a damaged shipping container must be opened:

- Seal the container in a plastic or an impervious container.
- Transport it to a negative-pressure CACI/BSC and place on a plastic-backed preparation mat.
- Open the package and remove undamaged items.
- Wipe the outside of the undamaged items with a disposable wipe.
- Enclose the damaged item(s) in an impervious container and label the outer container "Hazardous."
- If the supplier declines return, dispose of as hazardous waste.
- Deactivate, decontaminate, and clean the CACI/BSC and discard the mat and cleaning disposables as hazardous waste.
- Hand washing shall occur after handling and PPE has been doffed.

E. STORAGE & TRANSPORT

1. HDs must not be stored on the floor.

2. HDs must be stored on secured shelves with raised front lips.

3. Antineoplastic HDs that require manipulation other than counting or repackaging of final dosage forms must be stored separately from non-HDs. These antineoplastic shall be stored at the Cancer Treatment Center within the negative pressure suite.
   a. Non-antineoplastic, reproductive risk only, and final dosage forms of antineoplastic HDs may be stored with other inventory of the pharmacy.

4. Refrigerated antineoplastic HDs should be stored in a dedicated refrigerator in the negative pressure suite of the cancer treatment center.

5. HD's must be transported in a sealable bag (ex zip lock) to prevent leakage during transport. Ideally transport should occur using a tote, or cart, to minimize the potential for breakage or leakage.

6. After stocking or transporting, hand washing should be completed.

F. COMPOUNDING

1. There shall be no compounding sterile or nonsterile of antineoplastic at SVMC Main pharmacy. Only sterile compounding of antineoplastic may be done at the Cancer

Treatment pharmacy & in accordance with "Sterile Hazardous Drug Handling" policy.

2. Other hazardous drugs may be compounded according to the assessment of risk, alternative containment strategies.

3. Any sterile preparations of hazardous (non-antineoplastic or reproductive risk only drugs) shall follow procedures for IV Preparation & Dispensing & in accordance with USP 797.
   a. If a hazardous drug is compounded in main pharmacy from (Table 2 or 3) the following must occur:
   - If the PEC is used for hazardous drug compounding, an additional decontamination step must occur after preparation.
     - Use of Water, 70% IPA and Peridox after compounding the hazardous drug.
     - Add a label "Hazardous-dispose of properly" or similar.

G. DISPENSING & LABELING

a. Any hazardous drug that does not require any further manipulation other than counting or repackaging of the final dosage form must not be placed into an automated counting machine unless otherwise specified by its Assessment of Risk.

b. Sterile HDs must be clearly labeled as per USP 797 at all times during transport and include labels such as, "Chemotherapy-dispose of properly" or "Hazardous drugs- dispose of properly".

c. Hazardous Drugs will be labeled by various means to ensure staff are aware of handling precautions.
   - Pharmacy- Medications shall be stored in yellow totes
   - Pyxis- CDM shall notify staff that medication requires special handling
   - Meditech- Note in drug dictionary to notify staff medication this should translate to the EMR as a second nursing reminder.

H. ADMINISTERING

a. Administration of all hazardous drugs shall be performed in accordance with the assessment of risk (for non-antineoplastic HD's) and in accordance with "Sterile Hazardous Drug Handling" at the cancer treatment center for the products compounded there.

b. It is administering personnel's responsibility to review if medication is deemed hazardous (in policy) and use appropriate ppe during administration process. If staff is uncertain they should reach out to their supervisor to review if antineoplastic or the associated assessment of risk.

c. For antineoplastic the following PPE should be worn.
   - ASTM D6978 (or its successor), *two pairs)
   - Disposable gowns that resist permeability by HDs.
   - Gowns to be changed per manufacture's information, if none available change every 3 hours or immediately after spill or splash. Gowns may not be worn to other areas.
   - Appropriate eye and face protection when risk for spills or splashes of HDS (administration in surgical suite, working at or above eye level, or cleaning a spill).
     - Full face piece respirator provides eye and face protection
     - Goggles (not eye glasses) meet the standard for eye

protection when it is needed.

d. For other HDs follow assessment of risk.

I. DISPOSAL

1. All personnel who perform custodial waste removal and cleaning activities will be trained to prevent and protect themselves from accidental exposure and contamination of the environment.

2. At minimum ASTM D6978 (or its successor) gloves should be used by staff removing pharmaceutical waste bins.

3. Staff shall refer to "Pharmaceutical Waste" policy for instruction on correct bin waste.

4. Hand washing shall occur after proper PPE has been doffed.

J. Spill Control

a. Pharmacy personnel involved in handling HDs will receive annual training in the use of personnel protective equipment.

b. Spills must be contained and cleaned immediately by qualified personnel with appropriate PPE.

c. Signs must be used to restrict access to spill.

d. Spill kits must be available at all times while HDs are being handled.

e. All used spill kit items must be disposed of as hazardous waste.

f. Spill kits are located in CTC HD Pharmacy and Main Pharmacy.

g. Face pieces must be used if capacity of kit is exceeded or if vapors are known or suspected.

h. Material Safety Data Sheets are accessible 24 hours a day via the SVMC intranet.

a. If skin is exposed, wash the affected areas with copious amounts of non-medicated soap and water for 20 minutes.

b. If mucous membranes are exposed (i.e. eyes), rinse with copious amounts of clean water for at least 15 minutes.

1. Spills should be cleaned up immediately by the person responsible. An Environmental Services Supervisor is available during business hours. Call the Supervisor to assist if the spill is complicated (i.e., >50ml or >12 inches in diameter, or difficult to contain, for example liquid mercury spills) or the area is difficult to clean. The supervisor may also be called as an information resource on cleaning spills.

2. A written procedure for spill management is included in each spill kit. Components of a spill kit include, but may not be limited to, the following:

i. 2 pairs of disposable HD gloves

j. Low permeability gown and shoe covers

k. Goggles or face shield

l. Respirator mask (unless included in face shield)

m. Plastic backed absorbent sheets or spill pads (sufficient to absorb a spill of up to 1000mL)

n. Disposable towels or swabs for absorbing and cleaning liquid spills

o. At least 2 sealable plastic waste bags "Hazardous Drug" or "Chemotherapy"

p. Disposable scoop for collecting glass fragments

q. Puncture-resistant container for glass fragments, clearly labeled as waste container

r. Cleaning solution for cleaning and decontamination of area

s. Instructions on the management of a spill

t. Warning signs to alert other staff to the hazard and isolate the area of the spill

K. General clean-up procedure:

3. Assess the size and scope of the spill.

4. Spills that cannot be contained by two spill kits may require outside assistance and supervisor should be alerted.

5. Post signs to limit access to spill area & obtain spill kit.

6. Don PPE, including inner and outer gloves and mask.

7. Once fully garbed, contain spill using spill kit.

8. Carefully remove any broken glass fragments and place them in a puncture-resistant container.

9. Absorb liquids with spill pads.

10. Absorb powder with damp disposable pads or soft toweling.

11. Spill cleanup should proceed progressively from areas of lesser to greater contamination.

12. Completely remove and place all contaminated material in the disposal bags.

13. Rinse the area with water and then clean with detergent, sodium hypochlorite solution/wipes and neutralizer.

14. Rinse the area several times and place all materials used for containment and cleanup in disposal bags. Seal bags and place them in the appropriate final container for disposal as hazardous waste.

15. Carefully remove all PPE using the inner gloves. Place all disposable PPE into disposal bags. Seal bags and place them into the appropriate final container.

16. Remove inner gloves; contain in a small, sealable bag; and then place into the appropriate final container for disposal as hazardous waste.

17. Wash hands thoroughly with soap and water.

18. Once a spill has been initially cleaned, have the area re-cleaned by housekeeping, janitorial staff, or environmental services.

L. After the spill has been cleaned up and the people who came in contact with the hazardous drugs have washed the involved skin areas for 20 minutes, consider the following:

1. If the spill is on a patient, notify the physician.

2. If the spill is on an employee:

   a. Call Employee Health Services during business hours or the emergency room for further instructions. The Employee Health nurse or emergency room physician will assess for injury related to the exposure with particular attention to the skin, eyes, and mucous membranes. If a baseline CBC has not been drawn, a CBC with differential will be done.

   b. A CBC with differential and follow-up exam may be done by the Employee Health Service nurse at the time of the expected nadir (the lowest point of circulating blood counts (e.g., WBCs and RBCs) of the drug.

3. Complete an incident report if a spill occurs anywhere or if a spill occurs on a patient or employee.

M. DOCUMENTATION AND STANDARD OPERATING PROCEDURES

1. Must be reviewed by the pharmacist-in-charge every 12 months.

2. Any changes to policy or records must be communicated and documented to all personnel handling HDs.

N. MEDICAL SURVELLIANCE

1. Pharmacy personnel involved in routine handling of HDs may be enrolled into SVMC's medical surveillance program which is administered through employee health.

2. All employees with potential exposure to hazardous drugs will be informed by their department of the potential risks and the need to follow the procedures related to handling of chemotherapy. Training in the policies will be provided as appropriate for the department involved.

3. Employees will be informed by their department of the potential reproductive hazards and if they so request, staff members who are pregnant or breast-feeding, will be transferred to comparable duties that do not involve handling cytotoxic drugs.

4. ACTIONS IN RESPONSE TO EXPOSURE-RELATED HEALTH CHANGES

   a. Post-exposure examination tailored to type of exposure.

   b. Compare performance of controls with recommended standards.

   c. Consider environmental wiping samples.

   d. Verify that all engineering controls are operating properly.

   e. Verify and document that employee complied with existing policies.

   f. Develop and document a plan of action that will prevent future exposure.

   g. Ensure a confidential two-way communication between employee and employee health regarding notification of a change in health condition.

   h. Provide and document a follow-up medical survey to demonstrate actions that are effective.

   i. Ensure that any exposed employee receive notification of any adverse health effect.

   j. Provide ongoing medical surveillance of all employees that handle HDs to ensure plan implemented is effective.

O. TRAINING

1. Personnel will be trained annually

2. Environmental Services, Nursing, and Pharmacy shall read and sign "Hazardous Drug Risk" form that acknowledges risk of HDs to employees.

3. Personnel shall receive training on exposure prior to handling HDs or when there are hazard changes.

4. Personnel of reproductive capability shall confirm in writing that they understand the risk of handling HDs.

P. HAZARD COMMUNICATION PROGRAM

1. Standards of handling HDs shall be implemented and evaluated thru annual employee competencies.

2. All waste containers of HDs shall be labeled with the identity of the material and appropriate hazard warning.

3. Material Data Sheets are available for all employees 24 hours a day via the SVMC intranet link.

REFERENCES:

- USP 800 Hazardous Drugs- Handling in Healthcare Settings (2020). Retrieved from http://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/general-chapter-800.pdf. Accessed 5/6/2025.
- "ASHP Guidelines on Handling Hazardous Drugs." *American Journal of Health-System Pharmacy* 63, no. 12 (June 15, 2006): 1172–1191. doi:10.2146/ajhp050529. Accessed: November 6, 2018.
- Occupational Safety and Health Administration (OSHA) Guidelines for Controlling Occupational Exposure to Hazardous Drugs Accessed 6/24/20.https://www.osha.gov/SLTC/hazardousdrugs/index.html.
- 2025 Lawbook for Pharmacy. Business and Professions Code 4000. https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf .

CROSS REFERENCES:

- MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL
- IV PREPARATION AND DISPENSING
- COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM
- DRUG RECALL PROCEDURE
- STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE

SUBJECT:	SECTION:
HIRING CLINICAL LAB SCIENTIST TRAINEES	***HUMAN RESOURCES*** **Page 1 of 6**

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

PURPOSE:

- To define the hiring requirements and steps in the training process for a Clinical Lab Scientist (CLS) Trainee.
- To delineate timelines and requirements of trainees.

POLICY:

Testing of human specimen in clinical laboratories plays a crucial role in the detection, diagnosis, and treatment of human diseases. California licensed clinical laboratory scientists (CLS) and specialists perform most laboratory tests. Those licensed personnel require a high level of interpersonal skills, the ability to work independently and interdependently, the ability to prioritize and manage multiple tasks simultaneously, and must possess communication skills and leadership qualities. The CLS and CLS trainee work in many different areas of the clinical laboratory, which include:

1. **Clinical Chemistry and Body Fluids**
   The CLS performs analysis on blood and other body fluids, utilizing some of the most sophisticated diagnostic techniques and instrumentation to analyze human body chemistry, such as glucose, cardiac and liver markers, electrolytes, kidney function tests, drugs of abuse and many more.

2. **Clinical Microbiology**
   The CLS performs analysis on various body specimens to identify pathogenic Microorganisms, including bacteria, mycobacteria, fungi, viruses, and parasites utilizing the latest isolation and identification techniques.

3. **Hematology**
   The CLS performs analysis on blood, bone marrow specimens and other body fluids, utilizing some of the most advanced diagnostic instruments and techniques to detect hematopoietic diseases such as anemia, leukemia, hemoglobinopathies and coagulation syndromes.

4. **Immunohematology (Blood Banking and Transfusion Services)**
   The CLS performs various tests on patient blood utilizing the latest diagnostic instruments and techniques to ensure safe transfusion and component therapy.

5. **Immunology**
   The CLS performs various tests employing the latest methodologies and instrumentations in use for the detection and identification of immune complex diseases.

6. **Molecular Biology**
   The CLS performs various tests employing the use of DNA and RNA methodologies for detection of disease-causing organisms.

All laboratory tests performed require a high level of accuracy, judgment, and knowledge of test principles, procedure, and interpretation. The laboratory results reported to the treating physician have direct influence on the medical treatment a patient receives.

Sierra View Medical Center (SVMC) believes in and supports the hiring of CLS Trainees to attract potential new recruits to the facility. Starting the trainee as soon as possible provides a greater opportunity in the growth and development of the laboratory professional.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE:

HIRING CLS TRAINEE

Academic Requirements of the Program

Candidates seeking admission into the CLS training program must possess a minimum of a baccalaureate degree or higher from a regionally accredited college or university. All candidates must complete the program's required courses within **5 years** prior to applying for the CLS trainee program, with a preferred minimum cumulative GPA of 3.0. The academic requirements are based on the requirements established by the California Department of Public Health/ Laboratory Field Services. The training curriculum of all six training programs is challenging and requires individuals to be dedicated, self-motivated, and disciplined to achieve success.

Eligibility Requirements

1. Coursework and degree requirements as listed above.
2. Courses in molecular biology, immunohematology, parasitology and genetics are highly desirable.
3. Laboratory experience, lab/research techniques is preferred, but not mandatory.
4. Completed application packet.
5. Valid Clinical Laboratory Specialist Trainee License issued by California Department of Public Health/Laboratory Field Services.
6. Graduates of foreign colleges or universities must have their academic credentials evaluated by the American Association of Collegiate Registrars and Admissions Officers (AACRAO). Contact AACRAO at (202) 293-9161 or at www.aacrao.org
7. Foreign degrees must be equivalent to a baccalaureate or higher degree from a regionally accredited college or university in the United States.

Objectives of the Training Program

The duration of the clinical laboratory specialty training is one year. Training is 40 hours per week and takes place during the day shift. The training program provides students with the opportunity to develop, demonstrate, apply, and evaluate scientific knowledge and competencies necessary to achieve skills through integration of the program objectives as listed below:

1. Be given a description of the full role of the clinical laboratory in the delivery of health care.
2. Understand the importance of quality control (QC) and quality assurance (QA) in the clinical laboratory.
3. Learn, through information provided by the clinical laboratory staff and independent studies, how to correlate test results with disease states.
4. Understand and interpret laboratory test procedures, principles of reactions, specimen type, normal/critical values, and sources of errors and clinical interpretation of results.
5. Understand, operate, and troubleshoot a variety of automated and manual tests.
6. Assume responsibility for reading assignments, running parallel testing, timely completion of unknown specimen, quizzes/exams, practical evaluation, and discussions with the instructors of all modules.
7. Describe the functions of laboratory management principles.
8. Emphasize the need for continued education.

Trainee Responsibilities

During the 52 weeks of training, each student will be expected to:

1. Observe and adhere to all of SVMC's policies and procedures.
2. Develop a disciplined and balanced schedule of independent study, attendance, and other required assignments.
3. Take initiative to perform and reflect on applied learning skills at the bench.
4. Seek assistance, when appropriate from section supervisors, instructors, or other resource personnel.
5. Complete examinations and assignments.
6. Use sound judgment in making maximum effective use of time at the bench.

7. Successfully complete all competency checklists. Competency checklists are guides used to maintain a record of a student's progress while providing a listing of the laboratory tests to be performed during each training module. Competency checklists give the student and the instructor a clear expectation of what is to be accomplished in order to satisfy the completion of the terminal objectives of each module. Upon completion of each module, the student and the instructor will sign off the checklists acknowledging that pertinent training is completed successfully. Student competency is assessed during and upon completion of each training module. Ways to evaluate competency include:

   - Direct observation of test performance; including pre-analytical, analytical, and post analytical variables.
   - Correct recording and reporting of test results.
   - Assessment of quality control, instrument function checks and preventive maintenance.
   - Assessment of problem solving, troubleshooting, behavioral and cognitive skills.

8. Maintain a satisfactory performance level as measured by:

   - The attainment of a minimum score of 75% in each of the modules written quizzes/ examinations, 90% score on practical examinations and unknown specimen assignments of manual procedures. These minimum score of 75% must also be achieved on the final examination. Failure to successfully complete any two measured levels of performance as defined above (practical and/or theoretical) of the training program can and may result in dismissal from the CLS training program at the discretion of the CLS Program Coordinator. In addition, the Laboratory Manager will work directly with the Human Resources Department to evaluate and assess a trainee's job performance, lack of competency, progress in the program, and failed scores on examinations prior to a trainee being dismissed from the CLS Trainee program. Prior to formal removal from the CLS Trainee Program, the VP of HR and Respective VP of Laboratory Services will be notified of intent to send dismissal letter to the Clinical Laboratory Services.
   - Adherence to established policies and procedures.
   - Willingness to do additional work or accept additional assignments to improve practical skills.
   - Showing courtesy and respect to colleagues, supervisors, and patients.

Trainees who fail to meet the standards of performance as outlined above or who violate any of SVMC's policies or procedures will be subject to the disciplinary action policies of SVMC.

CLS Trainee Evaluations

CLS Trainees will receive a performance evaluation after 90 days, at the completion of each module, and at 12 months as indicated by institutional policies.

Review

Time will be allotted at the end of the training program for review. This period will be defined on the trainees schedule.

Completion of Training

A certificate of completion will be awarded to successful trainees at the end of the one-year training program. Notification of anticipated completion for each student will be submitted to Laboratory Field Services approximately one month prior to completion of training.

*** CLS trainees who have completed the one year training program and are waiting for a date to take the exam to obtain their CLS license will have two options:

1. If the trainee has enough Vacation/Holiday leave to carry them through until the exam can be taken (no longer than two months), the trainee will be allowed to remain employed with SVMC during the interim. This will allow the employee to apply and interview for a Clinical Lab Scientist position (should one be available and posted on the SVMC website) without a break in employment. If the trainee obtains his/her CLS license during this time period and applies and interviews for a CLS position and is not offered the position, he/she will be placed on a 2-week Administrative Leave of Absence to allow them to apply for another position within the District for which they are qualified. If after two weeks they are unable to find such a position, they will be terminated from employment.

2. If the employee does not have enough Vacation/Holiday leave to carry them through until the exam can be taken and results returned or the employee does not wish to use his/her Vacation/Holiday leave, he/she will have the option of going on an Administrative Leave of Absence for a period no longer than two months. During the time the employee is on the Administrative Leave, he/she will be required to pay the full cost of their medical/dental/vision insurance. This will allow the employee time to apply and interview for a Clinical Lab Scientist position (should one be available and posted on the SVMC website) without a break in employment. If the employee is not offered a CLS position or does not apply for another position within the District for which they are qualified during the specific time period, they will be terminated from employment.

Licensing

Successful students of the specialty training program will be eligible to take a California-approved certification exam. Six weeks prior to completion of the training program, trainees must apply to this site http://secure.cps.ca.gov/cltreg to allow sufficient time to process the application.

At the same time, trainees must also apply to: http://www.ascp.org/services/SelectCertification.aspx to arrange a testing date, time and location.

For further assistance, visit the Laboratory Field Services website at: http://www.cdph.ca.gov/programs/lfs/Pages/default.aspx Laboratory Field Services will issue a license to students who complete the entire application process and pass the CLS examination. Licensed individuals can engage in performance of high complexity laboratory testing as well as moderate and or waived laboratory testing in all sections of the clinical laboratory after documentation of competency by the medical director of the clinical laboratory.

REFERENCES

- American Society for Clinical Pathology (ASCP) Board of certification (BOC) (2019). Retrieved from ascp.org/content/board-of-certification.

- California Department of Public Health (CDPH) (2019). Retrieved from https://cdph.ca.gov/Programs/OSPHLD/LFS/pages/ClinicalLaboratoryPersonnel.aspx.

SUBJECT: **HYPERTONIC SALINE INTRAVENOUS ADMINISTRATION**	SECTION: ***Medication Management (MM)*** **Page 1 of 3**

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

PURPOSE:

To give guidance for 3% Hypertonic Saline in treating hyponatremia at Sierra View Medical Center.

POLICY:

A. This policy addresses the administration and monitoring of 3% Hypertonic Saline use in correcting moderate to severe hyponatremia. 3% Hypertonic Saline has a variety of off-label clinical indications that should be monitored in a similar way. The following is not an all-inclusive list:

1. Refractory elevated Intracranial Pressure (ICP) due to various etiologies
2. Subarachnoid hemorrhage with hyponatremia (ie, ≤135 mEq/L) to enhance cerebral perfusion
3. Traumatic brain injury with elevated ICP

AFFECTED PERSONNEL/AREAS: *ICU, ED, OR, TELE, PHARMACY*

EQUIPMENT:

- Alaris Guardrails Smart Pump

PROCEDURE:

A. Principles of Treating Moderate to Severe Hyponatremia

1. In hyponatremic patients who are treated to increase the serum sodium, we recommend that the serum sodium initially be increased by 4 to 6 meq/L during the first 24 hours andthe recommended maximum rate of correction should be 8 mEq/L in any 24-hour period... This rate of correction can be repeated until the sodium is normal or near normal. In patients who require emergency therapy, the goal of a 4 to 6 meq/L increase should be achieved quickly, over six hours or less; thereafter, the serum sodium can be maintained at a constant level for the remainder of the 24-hour period to avoid overly rapid correction. In patients who require non-emergency therapy, this goal can be achieved slowly.
2. Orders will be entered in a non-titratable fashion. Any need for increase in rate to achieve a goal will require a new order with the updated rate, done in small increments recommended at 5 to 10 mL/hr.

B. Treatment Regimens

1. Bolus orders (First six hours of therapy goal correction of 4 to 6 mEq/L):

   a. Symptomatic hyponatremic patients which are experiencing symptoms that may be related to increased intracranial pressure (seizures, obtundation, coma, respiratory, arrest, headache, nausea, vomiting tremors, gait or movement disturbances or confusion) may be treated with a 100 mL bolus of 3 percent saline, over 10 minutes to attempt to achieve a rapid correction of 4 to 6 mEq/L over a few hours to alleviate symptoms and prevent herniation. If initial bolus fails to resolve symptoms up to two additional 100 mL doses (to a total of 300mL) may be given. [1]

   b. Asymptomatic acute hyponatremic patients with serum <130 mEq/L may be treated with a 50 mL bolus of 3 percent saline over ten minutes to prevent sodium from falling further. Further correction strategies should be driven by further sodium checks.

   c. Bolus orders shall be restricted to ICU/ED/OR with cardiac monitoring or in emergency situations when moving from non-approved area to ICU/ED/OR would potentially delay life-saving therapy. If moving patient is not immediately possible then the physician must be at bedside during administration.

2. Continuous infusions

   a. Asymptomatic patients with severe hyponatremia (serum sodium <120 mEq/L) may have 3% saline with a recommended starting rate of 15 to 30 mL/hour, which may be administered via a large bore peripheral vein with cardiac monitoring.

   b. For patients with a moderate hyponatremia (serum sodium 120 to 129 mEq/L) it is recommended to take normal measures to identify and correct cause, while limiting water intake, before initiating a continuous infusion.

C. Administration

1. Administration through a central line is recommended due to high osmolarity and tonicity. If peripheral line must be used rate should not exceed 40 ml/hr & a large bore vein is recommended, but a central line should be placed as soon as possible. If greater than 24 hour therapy of continuous infusion is needed a central line should be placed.

2. Any signs of phlebitis or infusion site intolerance with peripheral use will result in patient requiring a central line for further treatment, so long as it does not prevent lifesaving therapy.

D. Lab monitoring & Calculations

1. Patients receiving emergency bolus therapy should have their serum sodium measured every one to two hours to ensure that it has increased at the desired rate and prevent overcorrection. Other patients who are treated for chronic hyponatremia in the hospital should have their serum sodium measured often enough to ensure an appropriate rate of correction and to allow the clinician to react quickly to impending overly rapid correction (eg, every four hours). The urine output should also be monitored.

2. Utilize the following Hypertonic and Normal Saline Infusion Calculator to double check that the prescribed infusion rate is appropriate. Consult pharmacy as needed for rate/projected volume.

REFERENCES:

- Jones G.M., Bode L, Riha H, Erdman MJ. Safety of Continuous Peripheral Infusion of 3% Sodium Chloride Solution in Neurocritical Care Patients. Am J Crit Care 2016; 26:37.
- Stearns, Richard. Overview of the Treatment of Hyponatremia in Adults. In: Post TW (Ed), Waltham, MA. (Accessed on April 28, 2025) https://www.uptodate.com/contents/overview-of-the-treatment-of-hyponatremia-in-adults
- Sodium Chloride, Lexicomp Online (Accessed on April 28, 2025)

SUBJECT:	SECTION:
INDUCTION OF LABOR GUIDELINES FOR CYTOTEC (MISOPROSTOL)	**Page 1 of 5**

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

PURPOSE:

To enable the nurse to safely care for the patient who is receiving Cytotec (Misoprostol) for cervical ripening/induction of labor for patients at or near term and fetal demise at any gestational age. This policy serves as a guide for the use of Cytotec (Misoprostol) for induction of labor and reflects emerging clinical and scientific advances.

POLICY:

1. Induction of labor is the initiation of uterine contractions before the spontaneous onset of labor by medical and/or surgical means for the purpose of delivery. It may be categorized as elective or indicated.

2. Cytotec (Misoprostol) may be administered intravaginally or orally by a Physician (MD), Certified Nurse Midwife (CNM), or Registered Nurse (RN) for the following purposes:

    a. Cervical ripening/induction of the patient at or near term

    b. Induction of labor in a patient with a fetal demise at any gestational age

3. Electronic fetal monitoring is to be obtained for 20 minutes prior to administration to evaluate fetal well-being (except in the case of a fetal demise) and uterine activity. After administration of Cytotec (Misoprostol), fetal monitoring is to be continuous, with the above exception of fetal demise. Patient may ambulate after 30 minutes of administration and a Category I strip with MD orders.

4. Intravenous (IV) access with # 18 gauge catheter is to be placed, as ordered, prior to administration of Cytotec (Misoprostol) for continuous IV infusion or heplock.

5. Cytotec (Misoprostol) and oxytocin are not to be administered concurrently. Oxytocin may be administered four (4) hours after the last dose of Cytotec (Misoprostol).

6. Cytotec (Misoprostol) will be used only for patients with the following criteria (please note exceptions with fetal demise):

    a. Singleton gestation (unless multifetal demise)

    b. Cephalic presentation (unless fetal demise)

    c. Intact membranes (may give if ruptured when fetal demise or orally)

    d. Cervical dilation less than 4 cm

    e. Category I fetal heart rate pattern (unless demise)

    f. 39 0/7 weeks gestation unless medically indicated (or fetal demise)

7. Contraindications for the use of Cytotec (Misoprostol):

   a. Category II fetal Heart Tracing

   b. History of prior cesarean section or significant uterine surgery (unless fetal demise)

   c. Spontaneous uterine contractions (greater than 5 contractions in 10 minutes or persistently greater than 120 seconds in duration)

   d. Cervical dilation greater than or equal to 4 cm

   e. Placenta previa, vasa previa, placental abruption or unexplained vaginal bleeding

   f. Patients in whom vaginal delivery is contraindicated (i.e., active herpes simplex infection; unless fetal demise)

   g. Patients in whom there is evidence or strong suspicion of marked cephalopelvic disproportion

   h. Patients with prolapsed umbilical cord (unless fetal demise)

   j. Non-vertex presentation (for cervical ripening/induction of infant at or near term). Does not necessarily apply to fetal demise.

8. Conditions that may require medical provider to be readily available:

   a. Maternal cardiac disease

   b. Polyhydramnios

   c. Grand multiparity

   d. Severe hypertension

   e. Presenting part above the pelvic inlet

   f. Fever and/or chorioamnionitis

AFFECTED PERSONNEL/AREA: *MCH DEPARTMENT, RNs*

EQUIPMENT:

- Sterile gloves
- IV access

- Fetal monitor
- Cytotec (Misoprostol) tablets for administration

PROCEDURE:

1. Review prenatal records or call medical provider to obtain prenatal history prior to initiating the Cytotec (Misoprostol) for cervical ripening/induction.

2. Assure medical provider's orders are written for Cytotec (Misoprostol) induction/cervical ripening.

3. Have patient void prior to procedure.

4. Apply electronic fetal monitor and obtain a 20-minute evaluation of fetal heart rate pattern (except in cases of fetal demise) and uterine activity. A reactive Non Stress Test (NST) or a normal Fetal Heart Rate (FHR) tracing is a prerequisite. NOTE: A Category I fetal heart tracing on an external monitor is defined as average variability between 110 and 160 bpm and with the absence of decelerations.

5. Assess and document vital signs per Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) standards.

    a. Temperature, pulse, respirations(TPR), Blood pressure (B/P), FHR and Pain scale on admission

    b. TPR, B/P every two hours or more frequently as indicated

    c. Continuous fetal monitoring will be maintained up to 30 minutes after PO ingestion or vaginal insertion of Cytotec.

    d. Uterine contractions will be assessed every 30 minutes in early labor

    e. Uterine contractions will be assessed every 15 minutes in active labor, or if abnormal or tachysytole uterine pattern develops, documentation needs to be done every 30 minutes.

6. Cytotec (Misoprostol) 25mcg will be inserted in the posterior vaginal fornix every 3 – 6 hours as ordered, using sterile gloves and without lubricant or Cytotec (Misoprostol) 25 mcg – 50mcg orally every 3-6 hours as ordered.

7. Cytotec (Misoprostol) in higher doses (50 mcg every 6 hours) may be used in some situations.

8. Instruct the patient to remain in lateral supine position for 30 – 60 minutes following vaginal application to enhance absorption.

9. Restrict patient to sips of water and ice chips.

10. Should tachystole (defined as greater than 5 contractions in 10 minutes) occur, the following should be done:

    a. Turn the patient to left or right side, apply oxygen at 10 L/mask, start IV bolus, notify medical provider and charge nurse immediately.

    b. Continue to monitor the patient closely and document assessments and interventions on the labor progress record.

11. Cytotec (Misoprostol) 25 mcg may be administered at the direction of the physician every 3-6 hours until one of the following occurs:

    a. Adequate contraction pattern with 3 or more uterine contractions in 10 minutes

    b. Bishop score 8 or greater

    c. Abnormal fetal heart rate

    d. Uterine tachystole (defined as greater than 5 contractions in 10 minutes)

    e. Cervical dilation greater than 4 cm

    f. Administration of six doses of Cytotec (Misoprostol) or 200 micrograms in a 24 hour period, whichever comes first.

12. If needed, start oxytocin (per physician order), 4 hours after the last Cytotec (Misoprostol) dose according to labor and delivery protocol.

PATIENT EDUCATION:

- Explain procedure, action of medication, expected outcome and plan of care to patient and support person before initiating Cytotec (Misoprostol).
- Keep patient and family informed of labor progress.

DOCUMENTATION:

- Patient's understanding of plan of cervical ripening/induction
- Bishop Score prior to administration
- Initial starting dose, time and placement of Cytotec (Misoprostol)
- Subsequent doses of Cytotec (Misoprostol)

- Patient vital signs
- Contraction pattern, labor progress and fetal heart response as applicable
- Intake and output
- MD/CNM visits and orders
- Patient tolerance of any procedures
- Document per policy for laboring patients

PRESCRIBING GUIDELINES FOR HEALTHCARE PROVIDERS:

- Start with an initial dose of 25 mcg of Cytotec (Misoprostol), and place in posterior fornix of the vagina or orally. Repeat the dose every 3 – 6 hours until adequate labor or a favorable cervix is achieved.
- Cytotec (Misoprostol) higher doses of 50 mcg every 6 hours may be appropriate in some circumstances and may be associated with an increased risk of complications, including tachysystole with fetal heart rate decelerations.
- Induction of labor for fetal demise at or greater than 28 weeks uterine size:. 25 mcg Cytotec (Misoprostol) vaginally every 3-6 hours.
- Induction of labor for fetal demise less than 28 weeks uterine size: 400mcg of Cytotec (Misoprostol) vaginally every 3 hours for up to five doses. A vaginal loading dose of 600 mcg - 800 mcg of Cytotec (Misoprostol) followed by 400mcg administered vaginally every 3 hours may be more effective.

REFERENCES:

- American College of Obstetricians and Gynecologist. (2016). Practice Bulletin No. 107: Induction of labor. Obstetrics and Gynecol 2009; 114:386-97.
- American College of Obstetricians and Gynecologist. (2013). Practice Bulletin No. 135: Second-trimester abortion . Obstetrics & Gynecol 2013;121:1394-1406.
- AWHONN Standards and Guidelines for Professional nursing practice in the care of women and newborns (2019) (8th Ed). Washington, D.C.; AWHONN.
- Simpson, K. R., & Creehan, P. A. (2014). AWHONNs perinatal nursing (4th ed.). Philadelphia: Lippincott Williams & Wilkins Health.

SUBJECT: **INFECTION CONTROL - BLOOD BANK #5021**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide guidelines for the safe handling of blood and blood products to lessen the risk of exposure of hospital patients and Laboratory personnel to blood borne infections.

POLICY:

STAFF RESPONSIBILITIES:

All Laboratory staff who are on duty in or rotate through the Blood Bank area are responsible for adhering to established Blood Bank policies and procedures and infection control guidelines (both Sierra View Medical Center and Departmental).

BLOOD SCREENING PROCEDURES:

Infectious Agent Screening:

Blood products are received from the Central California Blood Bank (CCBB) and are screened for infectious agents according to Association for the Advancement of Blood and Biotherapies (AABB) acceptable standards.

BLOOD PRESERVATIONS/SAFETY MEASURES:

All red cell products are kept refrigerated at 1 – 6 degrees C. Refrigerators are equipped with alarms to signal significant deviations from acceptable temperature levels.

Blood is to be administered to the patient within two (2) to three (3) hours and it is to hang no longer than four (4) hours.

The Blood Bank will not accept blood for return, which has been away from the Laboratory Blood Bank for a period longer than 30 minutes. (Also see Blood Bank Quality Control/General Lab Manual.)

The Blood Bank dispenses by single units. More than one unit per patient at a single time is released only in emergency cases (e.g. traumatic hemorrhaging) or to Surgery, where blood can be stored in a monitored refrigerator and returned to Laboratory, Blood Bank department, at the end of the day.

All platelet (apheresis) units are cultured for the CCBB by Community Regional Medical Center Microbiology Department. Any positive findings will have gram stains phoned STAT and organism identification with antibiotic sensitivities available to our clinicians for pertinent patient care.

GENERAL LABORATORY PROCEDURES:

Protective Clothing:

All personnel must wear personal protective clothing (lab coats) in the Blood Bank area.

Lab coats and other protective clothing in the Lab area must be removed before going to the cafeteria or leaving the hospital at the end of the shift. Protective apparel must be worn in the restricted (biohazard) area of the lab.

Cleaning Procedures:

Blood spills should be flooded with Clorox bleach solution (1:10) or an approved disinfectant and allowed to stand for a period of 10 minutes before wiping or mopping up.

All flat surfaces are cleaned with a bleach solution or approved disinfectant as recommended by the general Laboratory Manual at the end of each day or more often as needed during the course of a day.

Medical Waste (Infectious Waste):

All blood is considered a possible source of infection and is treated as such by using proper protection (e.g., use gloves for handling specimens).

Blood bags from the patient care areas of the hospital are to be disposed in the biohazard trash by the transfusionist or nursing designee after completion of transfusion.

REFERENCES:

- Association for the Advancement of Blood and Biotherapies (AABB), Standards for Blood Banks and Transfusion Services, 33rd Edition, Section 10, 2022.
- Fung, Grossman, Hillyer and Westhoff, Association for the Advancement of Blood and Biotherapies (AABB), Technical Manual, 21st Edition, 2023.

SUBJECT: **INFECTION CONTROL - LABORATORY**	SECTION: **Page 1 of 5**

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

PHILOSOPHY:

The Laboratory and Laboratory Director, recognizes the need for developing and adhering to infection control policies and procedures specific to the department and its work place risks.

Microorganisms in the Laboratory can be inhaled, ingested or inoculated through the skin. There is also a danger of exposure to blood and body fluids via needle puncture, leaking syringes or contamination while separating needles from syringes. Other commonly recognized exposure incidents include spills and breakage, resulting in sprays (aerosol) of infectious materials and injuries with broken glass or other sharp instruments.

Therefore, all Laboratory personnel are expected to strictly adhere to health and safety practices.

The following department-specific infection control policies and procedures have been extracted from departmental manuals. Refer to specific manuals for further delineation.

POLICY:

- Sierra View Medical Center's general infection control policies and procedures are observed.
- Sierra View Medical Center's employee health and safety policies and procedures are observed.
- Standard Precautions are observed and practiced at all times.
- All personnel are expected to be knowledgeable regarding and practice the requirements as outlined in the Medical Waste Management Plan and Exposure Control Plan.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

Hand Washing/Sanitization:

Hand washing is one of the most important aspects of infection control in the Laboratory. Hands must be washed or sanitized with appropriate product, whether gloves are worn or not worn.

- Before and after contact with all patients
- Before and after gloving
- After handling any specimen
- Accession labeling, centrifugation
- Specimen transfers

- After skin contact with any biological sample of any reagent
- Prior to and after eating, drinking, smoking
- Prior to and after use of restroom
- After completing work

Attire:

Laboratory coats, uniforms or fluid resistant gowns must be worn by all Laboratory staff during specimen procurement, handling and testing. Fluid resistant gowns may not be worn out of the Lab. Clinical laboratory scientists (CLS) must wear coats during testing. Phlebotomists may wear uniforms.

Laboratory coats, uniforms, or fluid-resistant gowns upon which biological material has been spilled are a biohazard and must be expediently removed and sent to be laundered or disposed of appropriately. The fluid resistant gown may be placed in the regular trash, if it is disposable.

Refer to the Exposure Control Plan for complete information.

Oral and Body Surfaces:

No smoking, donning of earrings or application of cosmetics are permitted in any Laboratory working area. Smoking is not allowed anywhere on the Sierra View Medical Center campus.

Oral and ocular contact with any surface, including hands, capable of harboring and transmitting infectious agents is prohibited.

Food and Beverages:

Neither foods nor beverages may be prepared in any part of the Laboratory.

Coffee is available in the Laboratory break room and may be consumed in the front office, the administrative office, and the pathology offices.

Specimen Collection/Handling:

Standard Precautions must be adhered to when obtaining, handling or processing ALL blood/body fluid specimens or potentially infectious materials. (See Exposure Control Plan.)

Handling of Sharps:

Needles should not be recapped by hand. Use safety caps and sharps containers.

Needles are not to be cut or bent.

Centrifuges:

Centrifuges must be disinfected weekly unless breakage occurs, in which case cleaning and disinfection must be immediate. All centrifuge surfaces, including carrier cups, must be cleaned with a disinfectant solution.

Whenever possible, samples should be stoppered when centrifuged in order to prevent aerosol formation and spillage.

Centrifuges must always be balanced prior to operation.

Opening Specimen Containers and Transfer of Specimens:

Observe caution with Vacutainer corks. Cork popping can generate aerosols, prime sources for blood borne disease transmission. Cover rubber corks with gauze and twist them off gently. (NOTE: The lab uses "Hemagard" safety caps. They do not require covering with gauze.) When disposed, corks and gauze must be disposed of as medical waste.

Any specimen spillage on containers is hazardous. Care should be taken to avoid all spillage during transfer steps.

Control Sera and Reagents from Biological Sources:

All materials prepared from biological sources are biohazardous in that they are high probability agents for transmission of disease. All such materials must be treated as though they were specimens from high risk patients.

Spillage of Biological Samples:

Paper, or any worksheet, request or report upon which a biological sample has been spilled, will be recopied or reprinted and then the original disposed of. If the paper is duplicated via the copy machine, cover the biological sample with clear tape before copying. The copier will be cleaned after the copy is made.

Spills on non-disposable surfaces must be cleaned promptly with an aqueous 1:10 dilution of bleach or approved disinfectant.

Pipetting:

Mouth pipetting of any substance is prohibited. Propipettes, rubber bulbs or suitable alternative devices must be used.

Rubber bulbs and tubing used for capillary tube pipetting must be disposed of periodically in the regular trash.

Pasteur pipettes must be disposed of as medical waste.

Storage of Biological Samples:

All containers with biological samples in them shall be sealed or covered or kept in sealed containers unless currently being analyzed.

Cleaning Procedures:

Bench tops are cleaned at least daily, with a 1:10 aqueous solution of bleach or approved disinfectant.

Floors, hand washing sinks, chairs and other furniture are cleaned by the Environmental Services Department personnel.

Refrigerators, machines and computers are cleaned on a routine basis by department personnel.

Pathology Medical Waste Disposal:

A reference service is contracted to perform pathology technical functions. Sections of specimens (tissues, organs, etc.) are placed in 10% formalin prior to transporting off site for slide preparation.

Specimens are disposed of by the contracted medical waste service.

Laboratory's Role in Infection Control Program:

Laboratory Services provide a copy of significant serology, virology and microbiology reports to the Infection Control Practitioner to assist in the surveillance program.

The Microbiology Department provides antibiotic profiles and antibiotic sensitivity patterns of the most commonly isolated bacteria. Such information may be useful in determining the etiology of some infections as well as a useful tool in identifying trends in the emergence of resistant organisms and changes in the hospital flora or provides valuable data for antibiotic usage.

Reporting Infectious/Communicable Diseases and Conditions:

Contract and on site Laboratory Services are responsible for reporting as required, certain diseases to the local Public Health Office. (See Reportable Disease Policy.) All in-house testing reports to Tulare County Public Health automatically through the CalRedie interface.

The Laboratory will also notify the Infection Control Practitioner, Nursing Manager/ Supervisor and Attending Physician of cases of positive acid-fast smears or cultures on inpatients and outpatients.

Education/Orientation:

All new employees are oriented to the Infection Control Program for the department. Workplace risks are discussed. Education programs will be scheduled for the department relative to departmental infection control policies by the Department Manager.

All new employees are to attend the general Sierra View Medical Center Orientation Program for orientation to the hospital-wide Infection Control Program.

Employees are scheduled to attend the Annual Orientation Program, as provided by the hospital, which includes a review of infection control and workplace risks.

REFERENCE:

- The Joint Commission (2025). Hospital and Laboratory Accreditation Standards. EC.02.02.01, EC.02.01.03, IC.04.01.01, IC.06.01.01, IC.07.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **INFECTION CONTROL: MATERNAL CHILD HEALTH**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose of the policy is to prevent healthcare to patient, patient to healthcare and patient to patient associated infections within the department of Maternal Child Health. The policy pertains to all areas of Maternal Child Health (Labor and Delivery, Postpartum, Nursery and NICU).

POLICY:

1. All employees will comply with the hospital policies regarding infection control, and hand hygiene.

2. The Maternal Child Health department will also follow any mandated infection control screening and processes for the flu season, RSV season, and any other mandated screening during outbreaks (i.e., Pertussis).

3. Visitors to the Neonatal Intensive Care Unit (NICU)/Nursery will be excluded from visiting the patients if they have signs and symptoms of a communicable disease.

4. The Maternal Child Health staff will follow Infection Control policies and procedures regarding hand washing within the department.

5. All parents will be instructed to wash their hands to their elbow for 30 seconds using hospital provided and approved soap.

6. All visitors will be instructed to wash their hands with antimicrobial liquid solution or soap and water before handling the infants.

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

PROCEDURE:

1. All rooms have sinks available for visitors and patients to wash their hands before handling the normal newborns.

2. Antimicrobial liquid solution is also available for visitors and patients to use before handling the infants.

3. Newborn and Intensive Care Nursery:

    a. In general, visitors to the nursery and NICU must maintain the same hand hygiene and protective measures as the department staff.

    b. All visitors entering the NICU or Nursery will wear a patient gown to cover their clothing. Mothers will be required to wear another gown facing to the back to cover their gown.

c. All visitors entering the NICU or Nursery will wash their hands in the ante room up to their elbows for 30 seconds using the hospital approved soap.

d. It is the responsibility of the nurse caring for the newborns to discuss proper infection control procedures with the visitors. Parents must clearly understand the importance of hand hygiene, gowning and personal health.

4. Any issues of visitors not understanding the importance of infection control will be referred to the charge nurse or unit manager.

REFERENCE:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist . (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.

CROSS REFERENCE:

- Infection Control Policy: "Hand Washing"

SUBJECT: **INFILTRATE MANAGEMENT**	SECTION: **Page 1 of 13**

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.

   b. Remove the dressing and withdraw the catheter.

   c. Use a dry gauze pad to control bleeding.

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

   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 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.

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 150 units/1 ml vial
2. Appropriate 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.

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

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.

iv. Begin subcutaneous injections of hyaluronidase using 0.2ml 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.

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.

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.

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

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. Appropriate 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.

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

iii. 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.

iv. 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.

v. 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.

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.

vi. 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.

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

viii. 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.

ix. 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

Mechanisms and treatment regimens for noncytotoxic drug extravasations

Primary mechanism of injury	Drug	Toxicity	Compresses*	Potential antidote(s) for peripheral catheter extravasation
Acidic	Amiodarone	Necrosis	Cold or warm	None
	Gentamicin	Necrosis	Cold	None
	Metronidazole	Necrosis, gangrene	Cold	None
	Nicardipine	Necrosis	Cold	None
	Promethazine	Necrosis	Cold or warm	None
	Vancomycin	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase may be considered based on mechanism of injury¶
Alkaline	Acyclovir	Necrosis	Cold	None
	Aminophylline	Ischemia	Cold	None
	Furosemide	Necrosis	Cold	None
	Ganciclovir	Necrosis	Cold	None
	Phenobarbital	Necrosis	Cold	None

	Phenytoin	Necrosis, purple glove syndrome	Warm	Hyaluronidase¶ or topical nitroglycerinΔ may be considered based on mechanism of injury
Chemical	Amphotericin	Phlebitis	Cold	None
	Digoxin	Inflammation, apoptosis	Cold	None
	Foscarnet	Phlebitis, arteritis	Cold	None
	Propofol	Necrosis	Cold	None
Hyperosmotic (osmolarity >290 mOsm/L) tissue damage may resemble compartment syndrome	Contrast media, radiographic	Pressure necrosis	Cold or as per radiologist	None
	Calcium solutions	Necrosis, calcinosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase¶ Severe forms of cutaneous calcinosis have been treated with sodium thiosulfate infusions, eg, once weekly for 3 weeks
	Dextrose ≥10%	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	
	Magnesium sulfate	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	None
	Mannitol >5%	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase¶

	Nafcillin	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase¶
	Parenteral nutrition/amino acids solutions	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase¶
	Potassium chloride >40 mEq/L	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase¶
	Sodium bicarbonate	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	Hyaluronidase¶
	Sodium chloride >1%	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	None
	Valproate sodium	Necrosis	Warm if hyaluronidase used; cold may be used if hyaluronidase is not used	None

Vasoconstriction (causing local ischemia)	Dobutamine	Necrosis	Warm	2% topical nitroglycerin ointmentΔ and/or terbutaline administered subcutaneously may be considered
	Dopamine	Necrosis	Warm	**Preferred:** Phentolamine◊ **Alternative:** 2% topical nitroglycerin ointmentΔ Terbutaline administered subcutaneously has been used if phentolamine is unavailable
	Epinephrine	Necrosis	Warm	
	Methylene blue	Cellular toxicity	Warm	
	Norepinephrine	Necrosis	Warm	
	Phenylephrine	Necrosis	Warm	
	Vasopressin	Necrosis	Warm	None documented; 2% topical nitroglycerin ointmentΔ followed by phentolamine◊ may be considered based on mechanism of injury

Recommended treatment regimens for cytotoxic drug extravasations

Drug	Treatment	Route	Frequency	Duration
Vinca alkaloids (vinblastine, vincristine, vinorelbine)	Heat	Topical	15 to 20 minutes at least 4 times daily.	24 to 48 hours
	Hyaluronidase	Subcutaneously	One-time dose: 1 mL (150 units) as 5 separate injections of 0.2 mL each, each injected subcutaneously into the extravasated site using a separate 25 gauge or smaller needle.	

Etoposide	Heat	Topical	15 to 20 minutes at least 4 times daily.	24 to 48 hours
Anthracyclines (daunorubicin, doxorubicin, epirubicin, idarubicin)	Cold	Topical	30 to 60 minutes, then every 15 minutes; discontinue at least 15 minutes prior to dexrazoxane therapy.	Day 1 only
	Dexrazoxane	Over 1 to 2 hours IV in a large vein away from the extravasation area[1,2]	1000 mg/m2 within 6 hours, 1000 mg/m2 after 24 hours, and 500 mg/m2 after 48 hours.	
	DMSO	Topical	For peripheral-line extravasations if dexrazoxane is unavailable or cannot be started within 6 hours: apply a few drops of 50% DMSO to the site using a sterile gauze pad every 8 hours. Allow to air dry; do not cover site.	7 days
Liposomal anthracyclines (daunorubicin, doxorubicin)	Cold	Topical	15 to 20 minutes at least 4 times daily.	24 hours
Mitomycin	Cold	Topical	15 to 20 minutes at least 4 times daily.	24 hours
	DMSO	Topical	Apply a few drops of 50% DMSO to the site using a sterile gauze pad every 8 hours. Allow to air dry; do not cover site.	7 days
Taxanes (docetaxel, paclitaxel)	Heat	Topical	15 to 20 minutes at least 4 times daily.	24 hours

	Hyaluronidase*	Subcutaneously	One-time dose: 1 mL (150 units) as 5 separate injections of 0.2 mL each, each injected subcutaneously into the extravasated site using a separate 25 gauge or smaller needle.	
Mechlorethamine	Cold	Topical	For 6 to 12 hours following sodium thiosulfate antidote injection.¶	6 to 12 hours
Bendamustine				
Carboplatin				
Cisplatin				
Dacarbazine	Sodium thiosulfateΔ	Subcutaneously	One-time dose: inject 2 mL of the 1/6 Molar solution for each mg of mechlorethamine suspected to have extravasated.¶ Inject solution subcutaneously into the extravasation site using a 25 gauge or smaller needle.	
Oxaliplatin	Corticosteroids	Oral		
	Heat	Topical	15 to 20 minutes at least 4 times per day.	1 to 2 days. Exposure to cold may precipitate or worsen the acute neuropathy associated with oxaliplatin.
Other agents	Cold	Topical	15 to 20 minutes at least 4 times per day.	24 hours

SUBJECT:	SECTION:
LABORATORY AND MODERATE COMPLEXITY POC COMPETENCY	1 8 **Page 4 of 9**

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

PURPOSE:

Provides a mechanism for executing and evaluating the competencies needed by employees to provide safer practices and desired quality outcomes to customers; to identify areas of growth and professional development; and provide opportunities for ongoing passive and active learning to achieve continuous quality improvement.

DEFINITION:

Competency: ability to meet the performance standards in the application of knowledge, skills and behaviors that are required to meet organizational and departmental requirements under the varied and unpredictable circumstances of the healthcare setting.

POLICY:

The staff member's competency assessment includes the following: Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen collection, handling, processing and testing; Monitoring, recording and reporting of test results; Review of intermediate test results or worksheets, QC, proficiency testing, and preventive maintenance performance; Direct observation of performance of instrument maintenance function checks and calibration; Test performance as defined by laboratory policy; Problem solving skills as appropriate to the job.

AFFECTED PERSONNEL/AREAS: *Laboratory, Cath Lab*

PROCEDURE:

The following assessment methods will be utilized for all testing personnel:

1. Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen collection, handling, processing and testing.
2. Monitoring, recording and reporting of test results.
3. Review of intermediate test results or worksheets, QC, proficiency testing, and preventive maintenance performance.
4. Direct observation of performance of instrument maintenance function checks and calibration.
5. Test performance as defined by laboratory policy.
6. Problem solving skills as appropriate to the job.

PROCEDURE:

Competency Accountability - The accountability for competency assessment will occur at three levels:

1. Organizational – collaborative oversight will be provided by the Human Resources, Education and Quality departments

2. Designated director for each department - The Director in each department is responsible for:

   a. Conducting a needs assessment to identify both unit specific and house-wide competencies based on low volume, high risk, new workflow/process/equipment, problem prone areas

   b. Receiving and distributing information from Human Resources, Education and Quality departments

   c. Establishing a mechanism to identify unit-specific competencies with staff involvement

   d. Creating an environment that promotes timely competency assessment and ongoing growth and development

   e. Providing education to employees on the competency process

   f. Monitoring employees progress

   g. Participating in evaluation of the competency process

3. The employee is responsible for:

   a. Completing competencies as indicated

   b. Participating in competency development

Validation of Individual Competencies

1. The employee will be deemed "competent" when the competency assessment method has been completed and documented.

2. If successful completion is not achieved, the employee will be remediated and an action plan to complete the required competencies will be created in collaboration with the department manager/director, Human Resources, and Education Departments as applicable.

3. At the end of the action plan, if the employee has not completed their competencies as indicated, they will be removed from the work schedule and placed on a two (2) week Administrative Leave without pay, to seek another position for which they may be qualified and competent. Paid Time Off may not be utilized during the Administrative Leave.

4. At the end of the two (2) week Administrative Leave, if no other position has been sought or accepted, the employee will be separated from employment with the District.

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- OMH CLAS Standards – Standards 2 and 6

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CROSS REFERENCES:

- Performance Review Process

APPENDIX A

JOB CODE	JOB TITLE
81018	CARDIAC CATH LAB RAD TECH
8103	CARDIAC CATH LAB/IR RAD TECH LEAD
1505	CARE TRANSITION COACH
2729	CARE TRANSITION COORDINATOR
1862	CASE MANAGER
1862T	CASE MANAGER - AGENCY
1862B	CASE MANAGER - PD
1070	CENTRAL SUPPLY SUPERVISOR
8503	CERTIFIED HEMODIALYSIS CHIEF TECHNICIAN
8502	CERTIFIED HEMODIALYSIS MACHINE/SUPPLY TECHNICIAN
8500	CERTIFIED HEMODIALYSIS TECHNICIAN
8500R	CERTIFIED HEMODIALYSIS TECHNICIAN - AGENCY
8500B	CERTIFIED HEMODIALYSIS TECHNICIAN - PD
2712	CHARGE NURSE
9600	CHIEF RADIATION THERAPIST
1182	CLINICAL DIETITIAN
1182T	CLINICAL DIETITIAN - AGENCY
1182B	CLINICAL DIETITIAN - PD
9501T	CLINICAL LAB SCIENTIST - AGENCY
9501	CLINICAL LAB SCIENTIST INFORMATICS
9500	CLINICAL LAB SCIENTIST LEAD
9500B	CLINICAL LAB SCIENTIST LEAD - PD
9502	CLINICAL LAB SCIENTIST SPECIALIST
9506B	CLINICAL LAB SCIENTIST SPECIALIST - PD
9503	CLINICAL LAB SCIENTIST TRAINEE
1173	CLINICAL NUTRITION MANAGER
1656	CLINICAL PHARMACIST
1815	CLINICAL TEAM LDR/OR TECH
9500T	CLS - AGENCY
9501B	CLS I - PD
95001	CLS I (0 - 24 months experience)
9502B	CLS II - PD
95002	CLS II (25+ months experience)
4579	CNA
4581T	CNA - AGENCY
4580	CNA - LTC
4580B	CNA - LTC - PD
4579B	CNA - PD
4581R	CNA - REGISTRY
9905	CONTRACT STAFF-PHARMACIST
1179	COOK

1179B	COOK - PD
1180	COOK LEAD
1073	CP TECH I - NON CERT
1073B	CP TECH I - NON CERT - PD
1079	CP TECH II - CERTIFIED
1079B	CP TECH II - CERTIFIED - PD
81021	CT TECH
8102T	CT TECH - AGENCY
8102B	CT TECH - PD
81033	CT/MRI TECH LEAD
6278	DIET AIDE
6278B	DIET AIDE - PD
8104	ECHO TECH LEAD
1864	ED CARE COORDINATOR
1292	EDUCATOR, CLINICAL
1292B	EDUCATOR, CLINICAL - PD
5820	EMERGENCY DEPARTMENT COORDINATOR
1824	EMERGENCY SERVICES COORDINATOR
1824B	EMERGENCY SERVICES TECH - PD
1816	ENDO TECH
1816B	ENDO TECH - PD
6239	EVS AIDE I
6239T	EVS AIDE I - AGENCY
6239B	EVS AIDE I - PD
6249	EVS AIDE II
6249B	EVS AIDE II - PD
6255	EVS AIDE III
6255B	EVS AIDE III - PD
6250	EVS AIDE IV LEAD
0500	EVS SUPERVISOR
6270	FOOD SERVICE LEAD
6279	FOOD SERVICE WORKER
6279B	FOOD SERVICE WORKER - PD
6279T	FSW/DIETARY AIDE - AGENCY
1425	HEALTH CARE INTERPRETER
2738	INFECTION PREVENTION MANAGER
2737	INFECTION PREVENTION RN
81015	INTERV/ANGIO TECH
0421	LAB CLERK LEAD
2119	LABORATORY MANAGER
2727	LACTATION SPECIALIST
2727B	LACTATION SPECIALIST-PD
1501	LIC CLINICAL SOCIAL WORKER
1501B	LIC CLINICAL SOCIAL WORKER - PD
3462	LVN
3464T	LVN - AGENCY

3482	LVN - LTC
3482B	LVN - LTC - PD
3492	LVN - MDS COOR - LTC
3492B	LVN - MDS COOR - LTC - PD
3472	LVN - ONOCOLOGY
3462B	LVN - PD
3453	LVN - PI
3484R	LVN - REGISTRY
3442	LVN - UR NURSE
81061	MAMMOGRAPHY TECH
8106B	MAMMOGRAPHY TECH - PD
8106	MAMMOGRAPHY TECH LEAD
1504	MASTERS OF SOCIAL WORK
1504T	MASTERS OF SOCIAL WORK - AGENCY
1822	MEDICAL ASSISTANT
1820	MONITOR TECH
1820B	MONITOR TECH - PD
81031	MRI TECH
8103T	MRI TECH - AGENCY
8103B	MRI TECH - PD
7010	NEW GRADUATE/NOVICE RN - TIER 0
81051	NUCLEAR MED TECH
8105T	NUCLEAR MED TECH - AGENCY
1819	OBSTETRICAL TECHNICIAN - CERTIFIED
1818	OBSTETRICAL TECHNICIAN - NON CERT
1696	OCCUPATIONAL THERAPIST
1696B	OCCUPATIONAL THERAPIST - PD
1261	PALLIATIVE CARE MANAGER
1651	PERFORMANCE IMPROVEMENT PHARMACIST
1651B	PERFORMANCE IMPROVEMENT PHARMACIST-PD
1293	PERIOPERATIVE CLINICAL EDUCATOR
2728	PERITONEAL DIALYSIS RN COORDINATOR
2728B	PERITONEAL DIALYSIS RN COORDINATOR - PD
1652T	PHARMACIST - AGENCY
1650	PHARMACY CLINICAL COORDINATOR
5663	PHARMACY TECH
5664	PHARMACY TECH - EMERGENCY DEPT
5663B	PHARMACY TECH - PD
0671	PHARMACY TECH SUP
0442	PHLEBOTOMIST CERTIFIED LEAD
1684T	PHLEBOTOMIST/LAB AIDE - AGENCY
1684	PHLEBOTOMIST/LAB AIDE CERTIFIED
1684B	PHLEBOTOMIST/LAB AIDE CERTIFIED - PD
1692T	PHYSICAL THERAPIST - AGENCY
1692	PHYSICAL THERAPIST - STAFF
1692B	PHYSICAL THERAPIST - STAFF - PD

1695	PHYSICAL THERAPIST LEAD
4589	PHYSICAL THERAPY AIDE
4589B	PHYSICAL THERAPY AIDE - PD
4593T	PHYSICAL THERAPY ASSISTANT - AGENCY
4593R	PHYSICAL THERAPY ASSISTANT - REGISTRY
4593	PHYSICAL THERAPY ASST
4593B	PHYSICAL THERAPY ASST - PD
4590	PHYSICAL THERAPY COOR
0811	PHYSICAL THERAPY MANAGER
5807	PHYSICAL THERPAY AUTHORIZATION COORDINATOR/SCHEDULER
96001	RADIATION THERAPIST
9601B	RADIATION THERAPIST - PD
1724	RADIATION THERAPY AIDE
1724B	RADIATION THERAPY AIDE - PD
81011	RADIOLOGIC TECH
8101T	RADIOLOGIC TECH - AGENCY
8101B	RADIOLOGIC TECH - PD
8105	RADIOLOGIC TECH LEAD
8102	RADIOLOGY AIDE
8100T	RADIOLOGY AIDE - AGENCY
8108B	RADIOLOGY AIDE - PD
9204T	RCP - AGENCY
9204R	RCP - REGISTRY
9201B	RCP I - PD
92001	RCP I (0 - 36 months experience)
9204B	RCP II - PD
92004	RCP II (37+ months experience)
0600	RCP LEAD
2700	REGISTERED NURSE
7005T	RN - AGENCY
7005R	RN - REGISTRY
2712T	RN CHARGE NURSE - AGENCY
0914	RN CLINIC MANAGER
0911	RN CLINICAL MANAGER
2732	RN FIRST ASSIST
2732T	RN FIRST ASSIST - AGENCY
2732B	RN FIRST ASSIST - PD
7010	RN NEW GRADUATE
2102	RN NURSING SUPERVISOR
2102B	RN NURSING SUPERVISOR - PD
7001C	RN Per Diem Tier II
7002C	RN Per Diem Tier III
7003C	RN Per Diem Tier IV
7004C	RN Per Diem Tier V
7005C	RN Per Diem Tier VI
7006C	RN Per Diem Tier VII

2722	RN PRECEPTOR (2nd Position Only)
2730	RN PRE-HOSPITAL LIAISON
4909	RNA - LTC
81046	RVT ULTRASONOGRAPHER TECHNOLOGIST
1503	SOCIAL SERVICES DESIGNEE
1502	SOCIAL WORK ASSISTANT
1502B	SOCIAL WORK ASSISTANT - PD
1694	SPEECH THERAPIST
1694B	SPEECH THERAPIST - PD
1652	STAFF PHARMACIST
1652B	STAFF PHARMACIST - PD
1810	SURGICAL ORDERLY
1810B	SURGICAL ORDERLY - PD
1814T	SURGICAL TECH - AGENCY
1814	SURGICAL TECH - CERTIFIED
1814B	SURGICAL TECH - CERTIFIED - PD
1813	SURGICAL TECH - NON CERT
1813B	SURGICAL TECH - NON CERT - PD
81041	ULTRASONOGRAPHER
8104T	ULTRASONOGRAPHER - AGENCY
8104B	ULTRASONOGRAPHER - PD
8104R	ULTRASONOGRAPHER - REGISTRY
81047	ULTRASONOGRAPHER LEAD
5885	UNIT CLERK
5885B	UNIT CLERK - PD
2735	WOUND CARE RN SPECIALIST
1294	CERTIFIED LACTATION EDUCATOR/SECRETARY
1294B	CERTIFIED LACTATION EDUCATOR/SECRETARY - PD

SUBJECT: **MAGNESIUM SULFATE IN THE MANAGEMENT OF HYPERTENSIVE DISORDERS OF PREGNANCY**	SECTION: **Page 1 of 8**

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

PURPOSE:

To provide nursing guidelines for the safe administration of Magnesium Sulfate to reduce and/or prevent convulsions in the patient with Hypertensive Disorders of Pregnancy (HDP

POLICY:

1. A physician's order is required to infuse Magnesium Sulfate.
   - Magnesium sulfate for seizure prophylaxis should be initiated when indicated/ ordered; at the onset of labor or induction, or prior to and throughout the duration of a cesarean section.
   - For patients with normal renal function:
     - Loading dose 4 to 6 gm over 20 minutes followed by 1 to 2 g/hr as a continuous infusion.
   - For patients with renal insufficiency:
     - loading dose 4 to 6 gm
     - If serum creatinine >1.1 and <2.5 mg/dl, maintenance dose of 1 g/hr
     - If serum creatinine >- 2.5 mg/dl, no maintenance dose should be given

2. If a patient was on Magnesium Sulfate prior to delivery, there is to be a physician's order to continue the magnesium sulfate infusion postpartum (labor orders should be reconciled during the transfer process and the Magnesium order set continued).

3. Recommended duration of Magnesium Sulfate therapy for hypertensive disorders of pregnancy is 24-48 hours post-delivery.

4. Antepartum patients receiving magnesium sulfate are to be cared for in Labor and Delivery with continuous fetal monitoring and close supervision by the Registered Nurse.

5. Magnesium sulfate must be administered with an IV pump and Burette Set.

6. Magnesium sulfate is always a piggyback or secondary IV.

7. Nurse will remain in patient's room during IV bolus, monitoring O2 stats and respiratory rate.

8. Routine check for therapeutic magnesium levels in all patients is not necessary unless determined otherwise by the physician.

9. Recommended magnesium levels therapeutic range: 4.8 to 8.4 mg/dl.

10. Suggested frequency for serum magnesium levels is as follows per physician order set:

    - Renal insufficiency (creatinine >1.1 mg/dl) every 4 to 6 hrs
    - Signs/symptoms of magnesium toxicity, magnesium levels should be checked and maintenance dose should be decreased or stopped. If magnesium level is >9.6 mg/dl, levels

should be obtained every two hours. Infusion can be restarted at a lower rate when magnesium levels are <8.4 mg/dl as needed.

11. Calcium Gluconate 1 gram (10mL of 10% solution) is to be readily available for use as antagonist for Magnesium Sulfate intoxication. It is given intravenous push (IVP) over 3 minutes when ordered by physician.
12. Contraindications for Magnesium Sulfate administration:

a. Myasthenia Gravis

b. Hypersensitivity to any component of the formulation; heart block (see **Note**); myocardial damage; IV use for preeclampsia/eclampsia during the 2 hours prior to delivery (see **Note**)

Note: Although the manufacturers' labeling for some IV formulations state use in preeclampsia/eclampsia during the 2 hours prior to (cesarean) delivery is contraindicated due to interaction with neuromuscular-blocking agents intraoperatively; stopping magnesium sulfate prior to cesarean delivery in these patients is not recommended and increases the risk of seizure. Instead, magnesium should be continued prior to and during the delivery (ACOG 2013). Additionally, the manufacturers' labeling for some IV formulations contraindicate the use of magnesium sulfate in the setting of heart block; however, the use of magnesium is appropriate in patients with serious conditions requiring magnesium therapy who either have mild degrees of heart block (eg, first degree) or more severe forms of heart block with a temporary or permanent cardiac pacemaker.

c. Incompatibilities:

a. Common Incompatibilities (this list is not all inclusive, use pharmaceutical resources to verify compatibility of medications not listed below)
   i. Calcium gluconate
   ii. Calcium Chloride
   iii. Phytonadione (Aquamephyton)
   iv. Sodium Bicarbonate
   v. Polymyxin B

d. Symptoms of toxicity serum magnesium levels greater than 8mg/dL:

- Deep tendon reflexes disappear
- Respiratory depression
- Cardiac arrhythmias including arrest

SUBJECT: **MAGNESIUM SULFATE IN THE MANAGEMENT OF HYPERTENSIVE DISORDERS OF PREGNANCY**	SECTION: **Page 3 of 8**

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

AFFECTED AREAS/PERSONNEL: *MATERNAL CHILD HEALTH (MCH) REGISTERED NURSES (RN)'S*

EQUIPMENT:

- IV supplies:
  - 1000 ml solution and tubing as ordered for mainline IV
  - IV pump/controller
  - IV tubing that is vented with Burette Set.
- Standard pre-mix Magnesium Sulfate = 20 grams Magnesium Sulfate in 500 ml IV solution and tubing
- Standard pre-mix piggy back Magnesium Sulfate for bolus
- Monitoring equipment:
  - Automatic Blood Pressure machine
  - Pulse oximeter
  - Fetal monitor
- Calcium Gluconate 10 ml of 10% solution
- Reflex hammer
- Padding for side rails
- O2 setup available
- Suction canister and supplies
- Indwelling Catheter

PROCEDURE:

1. Review Physician's order for Magnesium Sulfate infusion.
2. Weight and height must be recorded in Electronic Medical Record (EMR).
3. Obtain baseline vital signs – pulse, respirations blood pressure, bilateral deep tendon reflexes (DTRs), clonus check, assessment of lung/breath sounds and neurological status, i.e. presence of headache, visual disturbances. Assess for epigastric pain.

4. Obtain vital signs – pulse, respirations, blood pressure, SPO2, level of consciousness, and deep tendon reflexes every 15 minutes for 1 hour, then every 30 minutes during the second hour and hourly during the maintenance infusion or per physician order

   a. Deep tendon reflexes:

   - 0 – no response/absent
   - +1 – Diminished
   - +2 – Average, normal reflex response
   - +3 – Brisker than average
   - +4 – Very Brisk, hyperactive, associated with clonus

   b. Assessing Clonus: support the knee in a partially flexed position. With the other hand, sharply dorsiflex the foot and maintain it in dorsiflexion. If clonus is present, the foot will move back and forth in small rhythmic movements. This is charted as "number of beats of clonus."

   c. Physician may change vital signs to every 4 hours when stable.

      i. Maintenance should only be continued if deep tendon reflex is present, RR > 12/min, urinary output >100 mL over 4 hours

5. Provide patient education:

   a. Explain importance and rationale of therapy.

   b. Explain side effects of magnesium sulfate that the patient may experience:

   - Feeling warm or flushed
   - Dry mouth
   - Blurred vision
   - Lethargy/weakness

   c. Explain reasons for fluid restriction and accurate I & O.

   d. Discuss Fall-Risk Precautions/Patient Safety – out of bed only with assistance.

6. Initiate intravenous (IV) with 18-guage catheter if one not already in place.

7. Put 2 side rails up and be prepared to pad.

8. Monitor fetal heart tones and O2 saturation, place on fetal monitor and pulse oximeter.

9. Keep environmental stimulation to a minimum; darkened room, minimize visitors, TV off or volume down, provide additional help with the baby after delivery.

10. Piggyback Magnesium Sulfate into main IV and infuse bolus over 20 minutes.

11. Nurse to remain 1:1 for bolus period.

12. Obtain pre-mixed Magnesium Sulfate (20gm/500 mL) and piggy back into mainline, use port closest to hub of IV catheter.

13. Infuse maintenance dose after loading dose is complete:

- Dose is 1 – 3 grams per hour as ordered by physician (see graph below)
- The Magnesium Sulfate solution is always piggybacked into the mainline at the lowest port (Magnesium Sulfate is compatible with Pitocin)

FOR DOSE OF:	SET IV PUMP/CONTROLLER AT:
1 gm/hr	25 ml/hr
1.25 gm/hr	31 ml/hr
1.5 gm/hr	38 ml/hr
1.75 gm/hr	44 ml/hr
2 gm/hr	50 ml/hr
2.25 gm/hr	56 ml/hr
2.5 gm/hr	63 ml/hr
2.75 gm/hr	69 ml/hr
3 gm/hr	75 ml/hr
3.25 gm/hr	81 ml/hr
3.5 gm/hr	88 ml/hr
3.75 gm/hr	94 ml/hr
4 gm/hr	100 ml/hr

14. Complete assessment is to be done every shift or with change in patient condition

15. Accurate intake and output (I & O) is to be maintained per urinary catheter, or with urine collector if patient has bathroom privileges.

a. Record strict intake and output at least every 4 hours. Assess urine output more frequently if decreased urine output is noted.

b. Notify the physician if less than 30mL/hour.

c. Check urine protein as ordered by physician.

d. Maintain fluid restriction as ordered by physician.

16. Notify physician for any of the following:

a. Elevated BP (+30 / +15 over baseline or greater than 140/90)

b. Urinary output of less than 30mL/hour times 2 hours

c. Magnesium level greater than 7.0 mg/dl

d. DTRs absent

e. Change in level of consciousness

f. Increasing hyperreflexia

g. Respirations less than12

h. Pulse greater than 120

i. Respiratory distress or chest pain

j. Symptomatic hypotension, systolic less than 90

k. Onset of epigastric pain, headache, visual disturbances or clonus

l. Any change in fetal heart patterns

17. Laboratory Tests:

a. Admission Labs for Pre-Eclampsia for patients on Magnesium:

- CBC with platelet count
- Complete Metabolic Panel (CMP)
- Uric acid
- Lactate Dehydrogenase

- Fibrinogen
- Urinalysis (UA) for protein count

b. Draw magnesium level 1 hour after initial loading dose per physician order set as listed on page 1 of section Policy.

c. Repeat Magnesium level every 6 hours past the loading dose. After 24 hours, repeat Magnesium level every 12 hours.

18. Notify the nursery staff and Pediatrician of mother's Magnesium level. Magnesium readily crosses the placenta, the baby will have the same serum concentrations of Magnesium as the mother. As in the mother, the newborn's kidneys will excrete the drug over the following 36 – 48 hours.

19. Observe newborn for signs of magnesium toxicity including neuro-muscular or respiratory depression, or hypocalcemia.

20. If loading dose is repeated, repeat Magnesium level per physician order.

21. Documentation:

a. VS, O2 Sats, DTRs and clonus:as indicated per provider order

b. Document Magnesium sulfate bolus and maintenance infusion rate on the Medication Administration Record (MAR).

c. Fetal surveillance and uterine activity

d. Strict I&O every 4 hours, if preeclamptic with severe features and decreased urine output strict I&O must be done hourly

e. Patient's response to medication

f. Signs and symptoms of hypertension disorders of pregnancy

g. Application of fetal monitor

h. Calcium Gluconate available via MAR

i. Interventions (environmental controls, seizure precautions etc.)

j. Patient and family education

REFERENCES:

- American College of Obstetricians and Gynecologist. (2020). Practice Bulletin No. 222: Gestational hypertension and preeclampsia. Obstetrics & Gynecol 2020; 135:e237-60
- Baker, B. & Janke, J. (2024). Core curriculum for maternal- newborn nursing (6th ed.) St. Louis, MO: Elsevier Saunders.
- Troiano, N.H., Witcher, P.M., Baird, S, M. (2019). High-risk & critical care obstetrics (4th ed.). Philadelphia: Wolters Kluwer.

SUBJECT: **MASSIVE TRANSFUSION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish the criteria for activating the massive transfusion protocol.

PRINCIPLE:

Following massive transfusion, there is such a small volume of the patient's blood left that complete crossmatching has limited benefit. The pretransfusion sample no longer represents currently circulating transfused blood and sensitive AHG testing on the current specimen accomplishes virtually nothing. It is usually only necessary to confirm ABO compatibility of subsequently transfused blood.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. The crossmatch can be abbreviated in those instances in which the patient has received a volume of blood approximately equal to their own blood volume within a 24 hour period. For an average adult this can be assumed to be 10 units.

2. In cases of massive transfusions as defined above, an immediate spin major crossmatch is all that is required prior to transfusion provided that the patient has had a negative antibody screen performed within the last 3 days.

3. If the antibody screen is positive and:

    a. If the antibody has been identified, units known to be negative for the target antigen may be transfused after immediate spin crossmatch only.

    b. If the specificity of the antibody has not been determined, or if the antigen has not been tested for in the donor units, then a complete major crossmatch is required.

4. This procedure applies up to 24 hours after the occurrence of a massive transfusion.

REFERENCE:

- Association for the Advancement of Blood & Biotherapies (AABB) Technical Manual, 21st Edition, pg 609 - 611, 2023.
- Association for the Advancement of Blood & Biotherapies (AABB) Standards, 33rd Edition, p46, 5.19.6, 2022

SUBJECT: **MEDICATION ADMINISTRATION TIMES**	SECTION: ***Medication Management (MM)*** 5 **Page 1 of** 4

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

PURPOSE:

To ensure that medications administered at Sierra View Medical Center (SVMC) are done so in accordance with a Medical Staff approved standardized administration time schedule, to provide consistent patient care.

POLICY:

Standardized medication administration times are approved by the Medical Staff through the Pharmacy & Therapeutics (P&T) Committee. Exceptions are specifically designated by administration time in accordance with published recommendations, due to interactions with food, and for patient comfort. This is a house-wide policy.

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

PROCEDURE:

1. Routine orders are those written for a specified schedule.

   Unless specifically stated otherwise in the medication order, all medications are eligible for the following standard routine order times:

DAILY, QDAY, QD	0900
HS	2100
BID	0900, 2100
Q12HR	0900, 2100
TID	0600, 1400, 2100
Q8HR	0600, 1400, 2200
QID	0600, 1200, 1700, 2100
Q3HR	0100, 0400, 0700, 1000, 1300, 1600, 1900, 2200
Q4HR	0200, 0600, 1000, 1400, 1800, 2200
Q6HR	0600, 1200, 1800, 2400

Medication-Specific Exceptions: (Below medications should not follow above scheduled dosing times)

1. Cholesterol lowering medications (i.e., "Statin" class, etc.)	2100
2. Coumadin (Warfarin)	1200
3. Oral Hypoglycemics	0730, 1730

2. Non-routine administration times.

Medication orders for non-routine administration times will be administered as follows:

AC	Given ½ hour (30 minutes) before meals.
PC	Upon finishing the meal (or same as with meal).
STAT	To be filled by pharmacy immediately and administered within 30 minutes from the time of the order.
NOW	To be filled by pharmacy and administered within 60 minutes from the time of the order.
Pre-Op	Time designated.
One Time Only	Given once on the day the order is written.
PRN	Given only as needed by the patient. (Order must include dose, frequency and indication).

3. Critically Timed Medications

A. The majority of medications should be administered within 1 hour or their scheduling dosing time, but the following medications, due to pharmacokinetic considerations, should be administered within 30 minutes of their scheduled dosing time to ensure therapeutic effectiveness: effectiveness (See Table 1). Notification to provider should be done if Rx not administered within the designated time frame.
Any orders for medications due at or around mealtimes require nursing judgment for the exact scheduled time of administration that can change due to meal delivery time, patient status, and quantity of meal consumed.

Scheduled medication can be given a time critical designation by a provider by indication in the electronic medication administration record entry by placing a one-time STAT or NOW order.

Non-Time-Critical

Delayed or early administration within a specified range of either one or two hours should not cause harm or result in substantial sub-optimal therapy or pharmacological effect (see Table 2).

First or Loading Doses
Certain medications first doses are essential to be given in a timely manner. (See Table 3).

Table 1: Time Critical Medications

Time-Critical Scheduled Medications	Reason "Time-Critical"
Dosing scheduled more frequent than every 4 hours	Small dosing intervals require timely administration to avoid toxicity or sub-optimal therapy. For electrolyte replacements, if multiple products must be administered for a given order, the first dose will be considered time critical.
Opioids	Scheduled use for chronic pain or palliative care (not PRN); Inconsistencies with timely admin may result in unnecessary break-through pain
Immunosuppressants Tacrolimus (Prograf) Cyclosporine (SandIMMUNE) Sirolimus Mycophenolate	When used for prevention of organ transplant rejection.
Itraconazole Ketoconazole	Antacids may decrease serum concentrations. Itraconazole should be given 1 hr after or 2 hours before antacids and ketoconazole at least 2 hours before antacids.
Rapid Acting Insulin Lispro, Aspart, or glulisine	Administration required to occur within 15 minutes before a meal.
Pyridostigmine Neostigmine	Short duration of action: When used for the treatment of Myasthenia gravis. The timely administration is required to maintain symptomatic benefit.

Table 2: Non-Time Critical Medications

Non- Time-Critical Scheduled Medications	Timing
Daily, weekly, monthly medications Notify Provider if medication not administered within the time designated in next column.	Administer within 2 hours before or after the scheduled time; to prevent accidental omission of doses that might be more easily forgotten if delayed more than 2 hours.
Medications prescribed more frequently than daily, but not more frequently than every 4 hours.	Administer within 1 hour before or after the scheduled time.

Table 3: First/Loading Doses

First/Loading doses	Targeted time frame of administration
Antiepileptic agents (IV)	Within 15 minutes of medication order.
Antibiotics (IV)	Indication of Sepsis – within 30 minutes of order.
Anticoagulation (IV)	tPA for PE or stroke – within 15 minutes of order post verification of no contraindications

The registered nurses' (RNs) electronic medication administration record (eMAR) will be updated to reflect the need to administer these medications within a 30-minute window of the dosing schedule.

If a medication is unable to be administered within the hour window (30 min window for critically timed meds) of the scheduled dosing time, then the RN should administer as soon as possible and provide note in the patient's chart explaining the circumstances that led to the delay in administration.

Pharmacy will perform random audits of medication administration times on a quarterly basis.

4. Administration Adjustment Chart (1st doses)

SIERRA VIEW DISTRICT HOSPITAL - STANDARDIZED MEDICATION TIMES (ADJUSTMENT CHART)

QD — SCHEDULE IS QD (DAILY): 0900 HOURS *(IF 1ST DOSE ORDERED BETWEEN 0400 & 1400 HOURS)*

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
SEE DOSING SCHEDULE FOR 2100 HOURS				GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY												SEE DOSING SCHEDULE FOR 2100 HOURS							

* *Exception: H2 antagonists, i.e. Pepcid, Zantac, Tagamet, etc., give @ 1800 hours. Coumadin @ 1200 hours.*

Q3HR — SCHEDULE IS Q 3 H (EVERY 3 HOURS): 0100, 0400, 0700, 1000, 1300, 1900 & 2200 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0400			GIVE 1ST DOSE & REPEAT @ 0700			GIVE 1ST DOSE & REPEAT @ 1000			GIVE 1ST DOSE & REPEAT @ 1300			GIVE 1ST DOSE & REPEAT @ 1900					GIVE 1ST DOSE & REPEAT @ 2200				GIVE 1ST DOSE & REPEAT @ 0100		

Q4HR — SCHEDULE IS Q 4 H (EVERY 4 HOURS): 0200, 0600, 1000, 1400, 1800 & 2200 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600				GIVE 1ST DOSE & REPEAT @ 1000				GIVE 1ST DOSE & REPEAT @ 1400				GIVE 1ST DOSE & REPEAT @ 1800				GIVE 1ST DOSE & REPEAT @ 2200				GIVE 1ST DOSE & REPEAT @ 0200		

Q6HR QID — SCHEDULE IS Q 6 H (EVERY 6 HOURS): 0600, 1200, 1800 & 2400 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600				GIVE 1ST DOSE & REPEAT @ 1200						GIVE 1ST DOSE & REPEAT @ 1800						GIVE 1ST DOSE & REPEAT @ 2400					GIVE 1ST DOSE & REPEAT @ 0600		

Q8HR TID — SCHEDULE IS Q 8 H (EVERY 8 HOURS): 0600, 1400 & 2200 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600						GIVE 1ST DOSE & REPEAT @ 1400								GIVE 1ST DOSE & REPEAT @ 2200								GIVE 1ST DOSE & REPEAT @ 0600		

Q12HR BID — SCHEDULE IS Q 12 H (EVERY 12 HOURS): 0900 & 2100 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0900									GIVE 1ST DOSE & REPEAT @ 2100 HOURS												GIVE 1ST DOSE & REPEAT @ 0900 HOURS		

* *Exception: Diuretics give @0600 & 1800 & Oral Hypoglycemic @0730 & 1730*

HS — SCHEDULE IS HS: 2100 HOURS

24	01	02	03	04	05	060	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY				SEE DOSING SCHEDULE FOR 0900 HOURS												GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY							

* *Exception: H2 antagonists, i.e. Pepcid, Zantac, Tagamet, etc., give @ 1800 hours. Coumadin @ 1200 hours.*

REFERENCES:

- The Joint Commission (2021). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- CMS Conditions of Participation. Retrieved November 25, 2020 from https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html.
- ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications. Retrieved May 26th, 2022. https://www.ismp.org/sites/default/files/attachments/2018-02/tasm.pdf

CROSS REFERENCES:

MEDICATION ORDERING

SUBJECT: **NICU: NURSING RESPONSIBILITIES AND GENERAL ROUTINES**	SECTION: **Page 1 of 5**

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

PURPOSE:

To set guidelines for nursing care of infants and nursing responsibilities in the NICU.

POLICY:

- The RN is responsible for the total care of her or his assigned patient load. The nursing process, as identified in the patient care guidelines, is used to assess, plan, delegate, implement, and evaluate care.
- The charge nurse takes a brief report at the beginning of the shift from the previous shift's charge nurse on all patients.
- Assignments should be posted at the beginning of each shift. Nurses take individual bedside reports on their assigned patients at the beginning of each shift.
- Assignments should be made with consideration for patient needs, RN's or patient care assistant capabilities, and unit geography. Assignments should be rearranged by the charge nurse when deemed necessary.
- RNs should keep the charge nurse informed about major changes in a patient's condition, possible transfers, and possible discharges.
- An RN must be available to observe and monitor all infants. Breaks and lunches should be scheduled according to unit activity.
- Upon receiving report at the bedside, both the NICU outgoing and incoming RN will identify the baby per policy; check intravenous site if any and make sure correct intravenous fluid is running at the prescribed rate.
- The incoming RN will check resuscitative equipment (bag and mask; suction apparatus; O2 source, etc)at the bedside and make sure they are in good working condition; check setting and parameters for cardio respiratory monitor and pulse oximeter.

AFFECTED AREAS/PERSONNEL: *NURSING*

PROCEDURE:

1. Admission Assessment

   a. An admission note and initial newborn assessment shall be done in the Electronic Medical Record (EMR)

   b. Reassessing infant status and checking vital signs are an ongoing responsibility of the RN caring for the infant. Document status and vital signs at least every 4 hours or more often when appropriate.

c. Narrative documentation may be used if indicated.

2. Charting

a. All documentation is completed in the Electronic Medical Record (EMR).

3. Monitoring

a. Infants should be continually monitored, unless otherwise ordered. Alarm systems must be properly functioning. Heart rate and apnea alarm limits should always be on. These limits may be adjusted based on the assessment of the individual infant, with a physician's order.

b. Apply disposable electrodes according to the package directions. Place chest leads above the nipple line on the lateral aspect of the chest. Place the ground lead as far as possible from the chest leads; it is usually placed on the anterior thigh or abdomen.

c. Document episodes of apnea, or bradycardia in the EMR. Documented episodes should reflect direct observations, not information gathered via the monitor history function.

4. Vital Signs

a. Vital signs include temperature, blood pressure, apical pulse, and respiratory rate and pulse oximetry. Vital signs should be taken as frequently as indicated by the patient's acuity level and as ordered per physician.

- Monitor Level II infants every 4 hours. Take blood pressure at least every 12 hours.
- Stable grower/feeders every 8 hours. Take blood pressure at least every 24 hours.

b. Report abnormal vital signs to the physician as soon as possible, for prompt management; reassess and document accordingly.

5. Intake and Output

a. Intake

- Record hourly IV intake and site checks on the IV section of the (EMR)Record feeding intake on the feeding section of the EMR. Cumulative totals should be documented hourly, and then a 24 hour total should be completed.

b. Output

- All infants on IV fluids should have all output measured, if possible. Diapers should be weighed and urine output recorded in the EMR. Level II infants being fed by mouth do not need output measured, unless otherwise ordered. Total output should

be calculated and documented every shift and at 24 hour.

6. Weighing

   a. All patients should be weighed upon admission and once daily, unless otherwise ordered by the physician. The time and date that the patient is weighed should be documented in the EMR

   b. Weight should be compared to the previous documented weight and weight gain or loss should be documented in the EMR. Weight gain or loss more than or equal to 60 grams should be rechecked and reported to the physician.

7. Medications

   a. Medications should be administered at the time designated on the electronic medication administration record (EMAR). A scheduled medication may be administered 1 hour before or 1 hour after the designated time.

   b. All narcotics should be secured. A supply of emergency drugs should be stocked on the neonatal crash cart.

   c. Record vaccine administration in the EMAR.

8. Newborn Eye Prophylaxis

   a. Guidelines:

      - Each newborn should have erythromycin ophthalmic ointment (0.5%) instilled into both eyes. Prophylaxis should be given shortly after birth. A delay of up to 1 hour is acceptable and may facilitate initial maternal-infant bonding. The medication should be instilled before the infant leaves the delivery area or as soon as possible after admission to the NICU.

   b. Procedure:

      - Carefully clean the infant's eyelids and the surrounding area.
      - Gently open the infant's eyelid and place a thin ribbon of ointment at least ½ in. (1–2 cm) long along the bulbar and palpebral junction of the lower lid. Try to cover the whole lower conjunctival area. Do not touch the eyelid or eyeball with the tip of the tube.
      - Carefully manipulate the lids to ensure the spread of the ointment.
      - Repeat the procedure for the other eye. If the eyes are fused, apply the ointment topically at the eyelid junction; do not force the eyes open.

- Discard the tube after instillation.
- Gently wipe excess ointment from the infant's eyelids and the surrounding tissue after 1 min.
- Document the administration of the erythromycin ointment on the Electronic Medication Administration Record (EMAR).

9. Vitamin K Administration

   a. Vitamin K should be given to all infants shortly after birth. Dosing is as follows:

   - <1,000 g 0.5 mg (0.25 ml)
   - >1,000g1.0 mg (0.5 ml)

   b. Vitamin K is administered only by intramuscular injection in the left thigh.

10. Hepatitis B Administration/HBIG Administration

   a. The Hepatitis B vaccine should be given to all infants within 24 hours of birth, after consent is obtained.

   b. Hepatitis B vaccine is administered only by intramuscular injection in the right thigh.

   c. Refer to the MCH policy HBIG Immunoglobulin-HbsAg positive or unknown status for HBIG administration.

11. Cardiopulmonary Resuscitation

   a. All nurses must be certified in cardiopulmonary resuscitation and complete the neonatal resuscitation program within the first 6 months of employment.

   b. The first person to the bedside is responsible for responding to the immediate needs of the patient. All drugs should be given as ordered. Documentation should be completed in the EMAR

12. General Routines

   a. The infant is no longer under jurisdiction of the obstetrician, if nursery staff is in attendance, when the umbilical cord is clamped.

   b. Baths should be routinely given and documented by the nurse. To optimize parent participation, schedule bath times to accommodate parents. It is recommended to bathe infants twice a week.

c. Umbilical cords should be kept dry and open to the air or covered loosely with clean clothing.

d. The method of feeding is determined by a physician's order, individualized to an infant's needs (see Policy NICU Feedings). Collaboration with a physician is necessary before initiating gavage feeding for a previously nipple-fed infant and also before initiating nipple feeding for an infant who was previously gavage fed (see Policy NICU Feedings). Indwelling feeding tubes should be considered when planning the infant's care. Parents may feed their infants at the nurse's discretion and in consideration of the infant's capabilities. The abdominal girth of gavage-fed infants should be checked and documented every shift.

e. Glucose level should be determined on admission to the NICU, as ordered by the physician, and when glucose concentrations change or there is evidence of glucose instability.

f. The infant's axillary temperature should be taken before bathing. Respiratory rate, pulse, and blood pressure should be taken before caring for the infant.

g. Check to be sure the infant is wearing two ID bracelets, and verify infant identification. If the bracelets get too tight, replace them with new ones, being sure to include the patient identification numbers. Document the infant's ID band number each shift.

h. Both nares should not contain catheters or tubes because neonates are obligatory nose breathers.

i. Infants should not be taken out of designated patient care areas or walked around.

j. Patient care concerns and questions should be organized so that they may be clarified or articulated during physician rounds.

k. Infant head circumference and infant length should be taken as ordered, and documented in EMR.

REFERENCES:

- Verklan, M. T., & Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.). St. Louis, MO: Elsevier Saunders.
- Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2016). Merenstein & Gardners handbook of neonatal intensive care (8th ed.). St Louis, MO: Elsevier.

SUBJECT: **NEWBORN SCREENING TESTS**	SECTION: **Page 1 of 2**

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

POLICY:

To comply with California State Department of Health Services Newborn Screening Program Regulations (CCR Title 17, sub chap 9, article 1) and to assure a high quality of collection, documentation, and transport of the newborn screening sample.

INITIAL SPECIMEN:

1. On receipt of written or electronically transmitted Lab orders for Newborn Screening (NBS) from the Maternal Child Health (MCH) Department, a nurse will obtain a whole blood sample by skin puncture from the heel as described in the current circular distributed by the State Health Department.

2. The appropriate timing for the NBS draw will be determined by the Maternal Child Health (MCH) Department.

3. The State approved NBS collection form will be used and obtained through the Maternal Child Health Department. The Maternal Child Health Department will fill out all areas of the form including **DATE, SPECIMEN COLLECTED,** and **INITIALS OF PERSON DRAWING SPECIMEN**.

4. The person drawing specimen will remove the goldenrod copy (AFTER completing the Lab portion of the NBS form) and give to MCH for placement in the newborn's medical record.

5. After collection, MCH personnel will take the NBS form (less goldenrod copy) to the Lab and allow to dry for three hours.

6. The Lab will log the NBS patient on the NEWBORN SCREENING SPECIMEN TRANSPORT LOG and retain the yellow copy of the log for documentation. The Lab should request additional NBS TRANSPORT LOGS from the State-designated Lab.

7. The Lab will then place the NBS specimens and the Transport Log in a special GSO courier envelope pre-addressed to the State designated lab. The GSO courier will pick up the envelope from the Sierra View Medical Center (SVMC) draw station front office Monday through Friday. The Lab should request additional forms, as needed, from the State designated lab, and additional envelopes with address labels from GSO.

8. A charge will be made for the initial NBS test in accordance with current regulations.

INADEQUATE SPECIMEN:

1. Upon notification from the Newborn Screening Coordinator (NSC), outpatient retesting will be done by the Lab.

2. The NBS form will be obtained from the FBC by Lab personnel and labeled with a new reference number as given by the NSC.

3. Demographic and clinical data as stated on the original form will be written on the repeat NBS form by the Lab.

4. These forms will be handled and mailed by the lab in the same way as Initial Specimens.

5. There will be no charge for this service.

RECALL SPECIMEN:

1. Upon notification from the NSC, outpatient retesting will be done by the Lab. The NSC will provide two ID numbers and other date to be used on the NBS form.

2. The lab will obtain a NBS form from the Newborn Screening Program Department and place a special Department of Health Services (pink) "RECALL SPECIMEN" sticker on it. The Lab will write the two ID numbers (see #1) on the sticker. Other information will be written on the form according to any additional data provided by the NSC and/or the parent.

3. The lab will send the NBS form to the State-designated laboratory as stated on the RECALL SPECIMEN sticker by the next business day.

4. A handling charge will be applied.

AFFECTED AREAS/PERSONNEL: *LABORATORY, MATERNAL CHILD HEALTH (MCH)*

REFERENCE:

- California Code of Regulations Title 17, Subchapter 9, Article 1.

SUBJECT: **OCCUPATIONAL HIV POST-EXPOSURE PROPHYLAXIS**	SECTION: **Page 1 of 2**

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

POLICY:

The hospital may provide medications to employees and non-employees exposed to blood and body fluids of an HIV positive individual within or being transferred to or from our hospital. Exposure may occur through three routes: percutaneous, mucous membrane, or topical exposure to skin.

PROCEDURE:

1. Upon potential exposure, each patient is to be admitted to the ED and evaluated by a physician for the relative risk factor as outlined in the **Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post exposure Prophylaxis**

   - https://doi.org/10.1086/672271

2. The prescriber, before dispensing, offers to give a written prescription to the patient that the patient may elect to have filled at a pharmacy of their choice.

3. Patients physician will provide a pre-packaged 72-hour supply of the following medications:

   - Truvada (emtricitabine 200 mg and tenofovir 300mg) one tablet by mouth daily.

   - Isentress (raltegravir 400 mg) one tablet by mouth twice daily.

4. As part of the treatment, employees may receive with their specific drugs, copies of monographs for their education. Additional copies may be made from the original provided with the exposure kits. Any questions may be forwarded to the pharmacist during normal business hours.

5. The dispensing prescriber shall follow all requirements of BPC 4170, including all recordkeeping requirements, use of childproof containers, all labeling requirements of Section 4076.
   - Labeling requirements:

(1) Each of the following items, and only these four items, shall be clustered into one area of the label that comprises at least 50 percent of the label. Each item shall be printed in at least a 12-point sans serif typeface, and listed in the following order:

(A) Name of the patient

(B) Name of the drug and strength of the drug

Either the manufacturer's trade name of the drug, or the generic name and the statement "generic for xxx_" where the brand name is inserted, and the name of the manufacturer.

(i) if the brand name is no longer widely used, the label may list only the generic name of the drug, and the manufactuer's name may be listed outside the patient centered label.

(C) The directions for the use of the drug.

(D) The condition or purpose for which the drug was prescribed if the condition or purpose in indicated ont eh prescription.

REFERENCES:

- Kuhar DT, Henderson DK, Struble KA et al., US Public Health Service Working Group. Updated US public health service guidelines for the management of occupational exposures to human immunodeficiency virus and recommendations for postexposure prophylaxis. Infect Control Hosp Epidemiol. 2013 34: 875– 892. Available from: http://www.jstor.org/stable/10.1086/672271. Accessed on April 28, 2025.

- 2025 Lawbook for Pharmacy. The Pharmacy Law (Business and Professions Code 4000 et seq.

- Zachary K. Management of health care personnel exposed to HIV. Updated March 13th, 2025. (Accessed on April 28, 2025).

SUBJECT: **PRETERM INFANT CARE**	SECTION: **Page 1 of 8**

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

PURPOSE:

To set nursing guidelines in the care of the preterm infant or other infants who require continuous observation/care in the Neonatal Intermediate Care Unit Level IIA.

To provide a developmentally supportive environment for both the preterm infant and family.

POLICY:

A. Infants delivered before the completion of the 37th week are considered preterm.

B. A low birth weight (LBW) infant is one whose birth weight is less than 2,500 grams (5 lb. 8 oz) regardless of gestational age.

C. A very low birth weight (VLBW) infant is one whose birth weight is below 1,500 grams regardless of gestational age.

D. Infants requiring respiratory support (ventilator greater than 4 hours will be transferred to a higher level of care facility.

E. The physician , will determine whether to keep a baby on Bubble CPAP greater than 4 hours upon his discretion based on the baby;s status at the time.

F. The physician will use the Telemedicine for consultation/ treatment- for all neonates requiring transfer to higher acuity NICU and/or neonates that may benefit from the Telemedicine consultation to prevent unnecessary separation of mom and baby.

G. All preterm infants will be individually assessed and identified in order to manage and maintain their basic requirements:

1. Respiratory function
2. Thermoregulation
3. Hydration and nutrition
4. Prevention of complications

AFFECTED PERSONNEL: *MCH STAFF, RNs*

EQUIPMENT:

- Infant warmer/isolette

- Non-invasive blood pressure monitor
- Bedside glucose monitor
- Oxygen set-up
- Cardio-respiratory monitor
- IV pump

PROCEDURE:

1. Obtain accurate body measurements:
   a. Head circumference – frontal-occipital circumference (FOC) one finger above eye brows, using parallel lines of tape around head
   b. Abdominal girth – one finger above umbilicus, mark location
   c. Length from heel – crown
   d. Weight in grams
2. Use the new Ballard Scoring Calculator Form to determine gestational maturity of the newborn infant.(Attached as appendix).
   a. Observation of physical and neurological characteristics that change predictably with growth and maturation. Ideally done in the first 12 to 24 hours of life.
   b. Later, adjusted or corrected age will be determined once the infant reaches term (40 weeks after conception). Chronologic age is adjusted for prematurity by taking gestational age – 40, plus chronologic age = developmental or corrected age. This is the age the infant would have been if he had been born at 40 weeks.
3. Assist with laboratory testing as ordered for blood gases, blood glucose, CBC, electrolytes, calcium and bilirubin.
4. Daily weight.
5. Assessment is to be documented initially and every 2,3 or (4) hours or as condition changes.
   a. Observe for respiratory complications.
      - Increased respirations (greater than 60), nasal flaring, grunting, or retractions
      - Document skin color and any color changes

- Document lung sounds (be aware of the potential for pneumothorax, especially if bag and mask resuscitation was implemented)
- Document oxygen and pulse oximeter use including any changes
- Check the pulse oximeter site every four (4) hours and rotate site every eight (8) hours.
- Maintain oxygen saturation above 92%, titrating oxygen via head hood or follow specific MD orders. Notify MD if increasing amounts of oxygen are required.
- Positioning:
  - Position infant to allow for easy ventilation, paying careful attention to maintaining body alignment and facilitating hand-to-mouth positioning.
  - Elevate head and trunk to decrease pressure on diaphragm from abdominal organs.
  - Consider prone positioning to improve oxygenation in preterm infants with respiratory compromise.
  - Parents should be instructed to never fall asleep with the infant in the bed to avoid the infant falling out of the bed with the parent and avoid possible suffocation of the infant. (For growing preterms who have been determined and ordered by provider meeting criteria to be with mom).

b. Cardiac (document every 2 to 4 hours and prn):

- Monitor and document cardiac activity per MD order.
  All preterm infants will be on cardio-respiratory and pulse oximetry monitoring while in the NICU.
- Evaluate and document presence or absence of murmur at each assessment.
- Observe for color changes (mottling, harlequin, ruddy, pale), especially with crying.
- Observe for increased (more than 180/bpm) or irregular heart rate that may indicate cardiac or circulatory difficulties.
- Monitor B/P on all four extremities as soon as possible and prn as ordered – hypotension may be caused by hypovolemia. Document Mean Arterial Pressure with systolic and diastolic readings. BP should be checked and documented at least once per shift.

c. Consider any medications given to mother before birth:

- Narcotics (bradycardia, decreased respiratory rate, decreased muscle tone)

- Terbutaline (increased heart rate)
- Magnesium sulfate (poor muscle tone, respiratory depression)

d. Gastrointestinal

- Do not feed PO if there are signs of RDS as listed above.
- Hypoglycemia may result from inadequate glycogen stores, respiratory distress and cold stress.
  - Check POC(Point of Care) blood sugar on admission, 1 hour, 2 hours, 4 hours and 6 hours of age.
  - Notify physician of results < 40.
- Gestational age less than 34 weeks, observe for and record signs of coordinated suck/swallow before attempting to feed.
- Note first voiding – may not occur up to 36 hours after birth.
- Note stools – abdominal distention and lack of stools may indicate feeding intolerance.
- Measure abdominal girth with initial assessment and every shift.
- Document bowel sounds with initial assessment and every shift.
- Start feedings as ordered by the MD. Observe the infant for and document signs of RDS with feeding, also observe for apnea, decrease in oxygen saturation, or bradycardia.
- Consult the policy "Gavage Feeding" if necessary
- Encourage breast feeding.

e. Skin (observe and document every 2 to 4 hours and prn):

- Use pectin-based tape (pink Hy-Tape) where possible to avoid tissue damage and use minimal tape for IV's etc.
- Remove all betadine/chlorhexidine post procedures with sterile water or normal saline.
- Tegaderm may be used to secure feeding tubes, IV's etc.

- Avoid use of band-aids.
- Delay initial bath until stable, then bathe every other day with mild soap and water.
  Use appropriate developmental positioners as indicated. (shoulder roll, gel pillow, nest, etc).
- Use the skin probe for temperature control.
- Observe and document any signs of hyperbilirubinemia as greater than 75% of preterm infants are affected. Immediately notify the MD for any signs of jaundice noticed in the first twenty-four (24) hours.

f. Cord:

- Careful use of alcohol is recommended in the preterm infant due to absorption.
- Document number of vessels in the cord with the first assessment after birth.
- Document the condition of the cord every shift (moist, dry, exudate, redness) and each time cleaning with alcohol or cord care is done.

g. Intravenous (IV) Fluids:

- The staff will administer intravenous therapy to the neonate through intravenous (IV) pump using safety guardrails at all times..
- Maintain no more than two (2) hours amount of solution in the Burette at any time.
- Check the IV site every hour, and document with each assessment.
- Change the IV solution/bag every twenty-four (24) hours.
- Change the IV tubing every seventy-two (72) hours.
- Change medication tubing every 24 hours.

h. Psychosocial and educational needs: family

- Explain all procedures and treatments as fully as possible.
- Initially decrease stimulation and noise.

- Instruct parents on infant's cues for signs of overstimulation.
- When infant is stable, allow as much interaction as possible.
- Refer to the chaplain or Social Services as indicated.
- Assess and document infant's activity level (active, sleeping, quiet awake, alert).
- Consider that a preterm or compromised infant is more likely to have decreased muscle tone, inappropriate or exaggerated reactions to pain, and shorter wake cycles.

i. Infection control - Protect the infant from infection by:

- Following hand hygiene guidelines
- Maintaining sterile field where indicated during procedure (ex. Lumbar tap, etc)
- Minimizing infant's contact with non-sterile equipment
- Minimizing the number of people who come in contact with the infant

J. Thermoregulation—place neonate on servo-control / isolette and wean as appropriate.(Refer to Neutra thermal environment (NTE) policy.

DOCUMENTATION:

1. Respiratory status (oxygen use, method, and saturation)
2. Cardiac status
3. Intake and output
4. Vital signs
5. Skin condition and care
6. Procedures
7. Family and physician visits
8. Behavioral states

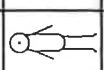
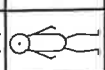
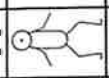
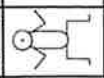
REFERENCES:

- [Title 22, 70547 (b)(9)]; LD, EC, PC, RI
- American Academy of Pediatrics & American College of Obstetrics and Gynecologist. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2016). Merenstein & Gardners handbook of neonatal intensive care (8th ed.). St Louis, MO: Elsevier.

MATURATIONAL ASSESSMENT OF GESTATIONAL AGE (New Ballard Score)

NAME _____ SEX _____
HOSPITAL NO. _____ BIRTH WEIGHT _____
RACE _____ LENGTH _____
DATE/TIME OF BIRTH _____ HEAD CIRC. _____
DATE/TIME OF EXAM _____ EXAMINER _____
AGE WHEN EXAMINED _____
APGAR SCORE: 1 MINUTE _____ 5 MINUTES _____ 10 MINUTES _____

NEUROMUSCULAR MATURITY

NEUROMUSCULAR MATURITY SIGN	SCORE							RECORD SCORE HERE
	-1	0	1	2	3	4	5	
POSTURE								
SQUARE WINDOW (Wrist)	 >90°	 90°	 60°	 45°	 30°	 0°		
ARM RECOIL		 180°	 140–180°	 110–140°	 90–110°	 <90°		
POPLITEAL ANGLE	 180°	 160°	 140°	 120°	 100°	 90°	 <90°	
SCARF SIGN								
HEEL TO EAR								
							TOTAL NEUROMUSCULAR MATURITY SCORE	

SCORE
Neuromuscular _____
Physical _____
Total _____

MATURITY RATING

SCORE	WEEKS
-10	20
-5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

GESTATIONAL AGE (weeks)
By dates _____
By ultrasound _____
By exam _____

PHYSICAL MATURITY

PHYSICAL MATURITY SIGN	SCORE							RECORD SCORE HERE
	-1	0	1	2	3	4	5	
SKIN	sticky friable transparent	gelatinous red translucent	smooth pink visible veins	superficial peeling & / or rash, few veins	cracking pale areas rare veins	parchment deep cracking no vessels	leathery cracked wrinkled	
LANUGO	none	sparse	abundant	thinning	bald areas	mostly bald		
PLANTAR SURFACE	heel-toe 40–50 mm: -1 < 40 mm: -2	>50 mm no crease	faint red marks	anterior transverse crease only	creases ant. 2/3	creases over entire sole		
BREAST	imperceptible	barely perceptible	flat areola no bud	stippled areola 1–2 mm bud	raised areola 3–4 mm bud	full areola 5–10 mm bud		
EYE / EAR	lids fused loosely: -1 tightly: -2	lids open pinna flat stays folded	sl. curved pinna; soft; slow recoil	well-curved pinna; soft but ready recoil	formed & firm instant recoil	thick cartilage ear stiff		
GENITALS (Male)	scrotum flat, smooth	scrotum empty faint rugae	testes in upper canal rare rugae	testes descending few rugae	testes down good rugae	testes pendulous deep rugae		
GENITALS (Female)	clitoris prominent & labia flat	prominent clitoris & small labia minora	prominent clitoris & enlarging minora	majora & minora equally prominent	majora large minora small	majora cover clitoris & minora		
							TOTAL PHYSICAL MATURITY SCORE	

Reference
Ballard JL, Khoury JC, Wedig K, et al: New Ballard Score, expanded to include extremely premature infants. *J Pediatr* 1991; 119:417–423. Reprinted by permission of Dr Ballard and Mosby-Year Book, Inc.

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72474.004/MARCH 2010

SUBJECT: **RESPIRATORY PROTECTION PLAN**	SECTION: **Page 1 of 21**

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

PURPOSE:

To ensure that all employees that are required to wear respiratory protection as a condition of their employment are protected from respiratory hazards through the proper use of respirators. To meet the Occupational Safety and Health Administration (OSHA) Respiratory Protection Standard, 29 CFR 1910.134.

DEFINITIONS:

1. **Aerosol-generating procedures**— Procedures that may increase potential exposure to aerosol transmissible disease pathogens due to the reasonably anticipated aerosolization of pathogens. Aerosol-generating procedures may also be known as high hazard or cough inducing procedures.

2. **Airborne infection isolation room (AIIR)** - A single-occupancy patient-care room designed to isolate persons with suspected or confirmed airborne infectious diseases. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that can be spread from person-to-person by the airborne route. AIIRs should maintain negative pressure relative to adjacent rooms and halls), an air flow rate of 6–12 air changes per hour, and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter.

3. **Airborne Precautions** - A category of Transmission-Based Precautions that Centers for Disease Control and Prevention (CDC) and Healthcare Infection Control Practices Advisory Committee (HICPAC*) may recommend when Standard Precautions alone are not sufficient to prevent the transmission of disease. When Airborne Precautions are required, patients should be placed in airborne infection isolation rooms and healthcare personnel sharing patients' airspaces should wear respirators.

4. **Air-purifying respirator (APR)** - A respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through an air-purifying element.

5. **Aerosol transmissible disease (ATD) or aerosol transmissible disease pathogen** - Any disease or pathogen requiring Airborne Precautions and/ or Droplet Precautions.

6. **Droplet Precautions** - A category of Transmission-Based Precautions that CDC and HICPAC may recommend when Standard Precautions alone are not sufficient to prevent the transmission of disease. When Droplet Precautions are required, patients should be spatially separated, preferably in separate rooms with closed doors. Healthcare personnel should wear surgical masks for close contact and, if substantial spraying of body fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles). Patients should be masked during transport.

7. **Employee Exposure** - Exposure to a concentration of an airborne contaminant that would occur if the employee were not using respiratory protection.

8. **Facemask** - A loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Facemasks may be labeled as surgical, laser, isolation, dental, or medical procedure masks and are cleared by the FDA for marketing. They may come with or without a face shield. Facemasks do not seal tightly

to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection.

9. **Filter**- A component used in respirators to remove solid or liquid aerosols from the inspired air.

10. **Fit Test** - A protocol to quantitatively or qualitatively evaluate the fit of a tightfitting respirator on an individual.

11. **Food and Drug Administration (FDA)** - An agency within the U.S. Department of Health and Human Services. The FDA is responsible for, among other things, protecting the public health by assuring drugs, vaccines, and other biological products and medical devices intended for human use are safe and effective.

12. **Healthcare Infection Control Practices Advisory Committee (HICPAC) -** A federal advisory committee assembled to provide advice and guidance to the CDC and the U.S. Department of Health and Human Services regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections and antimicrobial resistance in United States healthcare settings. CDC and HICPAC authored the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, which describes Standard and Transmission-Based Precautions used for infection control. (At the time of this revision, HICPAC has been dismantled by Trump Administration)

13. **Healthcare personnel (HCP) -** Paid and unpaid persons who provide patient care in a healthcare setting or support the delivery of healthcare by providing clerical, dietary, housekeeping, engineering, security, or maintenance services.

14. **High-efficiency particulate air (HEPA) filter** - The NIOSH classification for a filter that is at least 99.97% efficient in removing particles and is used in powered air-purifying respirators (PAPRs). When high-efficiency filters are required for non-powered respirators, N100, R100, or P100 filters may be used.

15. **N95 respirator** - A generally used term for a half mask air-purifying respirator with NIOSH approved N95 particulate filters or filter material (i.e., includes N95 filtering facepiece respirator or equivalent protection).

16. **Personal protective equipment (PPE) -** Specialized clothing or equipment worn by an employee to protect the respiratory tract, mucous membranes, skin, and clothing from infectious agents or other hazards. Examples of PPE include gloves, respirators, goggles, facemasks, surgical masks, face shields, footwear, and gowns.

17. **Powered air-purifying respirator (PAPR) -** An air-purifying respirator (APR) that uses a blower to force air through filters or cartridges and into the breathing zone of the wearer. This creates a positive pressure inside the facepiece or hood, providing more protection than a non-powered or negative-pressure half mask APR.

18. **Respirator program administrator (RPA)** - Individual designated to oversee a facility's respiratory protection program (RPP).

19. **Respiratory protection program (RPP)** - Program required by OSHA under the Respiratory Protection standard that includes development and implementation of detailed policies and worksite-specific procedures for respirator use for control of respiratory hazards.

20. **Surgical mask -** A loose-fitting, disposable type of facemask that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Surgical masks are fluid resistant and provide protection from splashes, sprays, and splatter. Surgical masks do not seal tightly to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection.

POLICY:

Sierra View Medical Center (SVMC) Respiratory Protection Program (RPP) is designed to minimize or eliminate occupational exposure of heath care workers to infectious airborne transmissible diseases (ATDs) through the provision and use of appropriate respiratory protective devices. This program was developed in accordance with the Centers for Disease Control and Prevention (CDC) and California OSHA ATD control enforcement guidelines. The RPP program includes:

1. A plan for annual risk assessment.
2. The methods by which employees are educated concerning the risks associated with airborne transmissible diseases in the healthcare setting.
3. The high-risk procedures for ATD transmission
4. Engineering, work practice controls, and personal protective equipment, to minimize employee exposures to ATDs.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES WHO COULD POTENTIALLY BE EXPOSED TO AIRBORNE RESPIRATORY ILLNESSES DURING NORMAL WORK OPERATIONS, AND DURING NON-ROUTINE OR EMERGENCY SITUATIONS*

EQUIPMENT:

- Powered Air-Purifying Respirator (PAPR)
- N-95
- N95 fit testing equipment

PROCEDURE:

I. Respiratory Protection Program responsibilities:

A. PROGRAM ADMINISTRATORS: The Infection Prevention Department and Employee Health are responsible for administering the Plan:

1. Infection Prevention Department will provide the knowledge of infection control principles and practices and oversight of Employee Health as they apply to SVMC, and be responsible for:

    a. Conducting an annual evaluation of the respiratory protection program. Any new hazards or changes in policy that would require respirator use are presented to and acted upon by the Infection Control and Prevention Committee.
    b. Responding to any Aerosol Transmissible Disease (ATD) Alerts sent by public health departments and/or the Center for Disease Control (CDC).

2. Employee Health (EHS) will have oversight of implementing the RPP with employees and providing employee education; due to knowledge of healthcare worker exposure protocols, testing, and the potential need for employee follow-up. EHS will be responsible for:

    a. Identifying work areas, processes, or tasks that require respiratory protection
    b. Monitoring OSHA policy and standards for changes and making changes to SVMC's policy
    c. Coordinating selection of respirator protection products, in conjunction with the Infection Prevention and Control Coordinator, Respiratory Therapy and Materials Management
    d. Monitoring respirator use to ensure that respirators are used in accordance with their certification
    e. Distributing and evaluating medical questionnaire
    f. Arranging for and/or conducting training and fit testing in conjunction with Respiratory Therapy
    g. Ensuring proper storage and maintenance of respirator protection equipment in conjunction with Respiratory Therapy
    h. Providing data regarding any suspected or known employee exposure to ATDs
    i. Conducting any necessary testing to confirm exposure to ATDs
    j. Conducting any necessary follow-up with any employee with confirmed ATD exposure.

B. PURCHASING AGENT – Materials Management Supervisor is responsible for the RPP equipment storage and inventory:

1. Purchasing respiratory protection equipment

2. Assuring that all respiratory protection equipment purchased has been approved by the National Institute of Occupational Safety and Health (NIOSH)

C. STORAGE AND MAINTENANCE OF CAPRs/PAPRs – The manager of the Emergency Department (ED), and the Intensive Care Unit(ICU), will be responsible for:

1. Maintaining Carts - ED Cart and ICU Cart

   a. Clean/free of clutter
   b. Stocked
   c. Locked when not monitored

2. Daily inspection of helmets and reusable equipment PAPR Sets (ED-1 through ED-6 helmets and ICU-1 through ICU-6 helmets, battery, and charger). If any set is signed out, inspect set when logged back in:

   a. No tear or breaks of helmets and accessories
   b. No contamination from blood or other bodily fluids
   c. No damage or distortion of filter
   d. No physical damage or tampering of Lithium Ion Batteries (LIB)
   e. No compromise between the filter and filter cover seal
   f. LED light working properly (if yellow or red light on, see manual instruction for further instruction or contact IP)

3. Storing of PAPRs in designated cart

4. Checking and maintaining supplies:

   a. Check on par levels of disposable items daily
   b. Perform the LIB Check Procedure every 3-6 months (see Monthly Inspection Log)

5. Checking battery charge status daily

6. Logging of the sign-in/sign-out sheet for the PAPRs daily

7. Documentation of ***Sign In/Sign Out Log, Daily Inspection Log, and Monthly Log*** will be kept in binder on or near the designated carts

D. DIRECTORS and MANAGERS are responsible for:

1. Knowing which hazards within their areas require respiratory protection
2. Knowing the types of respirators that need to be used
3. Enforcing the use of respiratory protection in areas where it is required

4. Ensuring that employees are knowledgeable about the respiratory equipment for the areas in which they work.

E. EMPLOYEES are responsible for:

1. Participating in all training
2. Wearing respirator when indicated
3. Maintaining equipment:
   a. Logging PAPR in and out with witness initials in Log Binder
   b. Cleaning of helmet and reusable accessories after each use and prior to returning PAPR to designated cart
      i. Inspect the system and perform any assembly/dis-assembly instructions necessary for disposable items and for all components that have become worn or damaged
      ii. Apply a suitable wipe with a decontamination agent over all outside reachable surfaces, and then over all inside surfaces
      iii. Let air dry and re-assemble or place in storage
   c. Properly dispose of all disposable items

4. Reporting equipment malfunctions or concerns to their manager

II. Respiratory Protection Program Elements

A. Medical evaluations for respirator users

1. A medical evaluation will be conducted to determine each individual's fitness to wear a respirator (see Appendix C). These evaluations consist of administering a medical questionnaire and/or providing a physical examination that elicits the same information as the questionnaire.

2. All new hires and current employees involved in patient care shall be required to complete a Medical Evaluation form. Each employee involved in patient care shall receive a medical clearance by a licensed HCP stating they are able to wear a PAPR prior to performing any of the designated activities that require respiratory protection.

3. Follow-up medical examinations will be provided to employees as required by Employee Health:

   a. If an individual gives a positive response to any question among questions 1-8 in Section 2, Part A of Appendix C of the OSHA Respiratory Standard (20 CFR 1910.134) (attached to policy) (NOT DONE ON MD)
   b. If the initial medical examination demonstrates the need for a follow-up medical examination.

c. These follow-up exams must include any medical tests, consultations, or diagnostic procedures that Employee Health deems necessary to make a final decision.

4. All employees will be granted the opportunity to speak with Employee Health about their medical evaluation, if they so request.

5. After an employee has received clearance and has begun to wear a respirator, a medical re-evaluation will occur under the following circumstances:

   a. Employee reports physical symptoms that are related to the ability to use a respirator (e.g. wheezing, dizziness, shortness of breath, chest pain).
   b. It is identified that an employee is having a medical problem during respirator use.
   c. Employee Health or the employee's Supervisor/Director determines that the employee needs to be reevaluated and the frequency of the evaluation.
   d. If a change occurs in workplace conditions (e.g. physical work effort, protective clothing, and temperature) that may result in substantial increase in physiological burden placed upon respirator users.

B. Documentation and Record Keeping

1. All examinations, evaluation and questionnaires are to remain confidential between the employee and Employee Health.
2. All employee medical records will be maintained by Employee Health. Relevant medical information will be maintained for the duration of the employment of the individual plus thirty years.
3. E-Learning will keep a record of HCWs completing the Annual Competency module on *"PAPR Use"*.
4. Department Leaders will keep a record of all staff within their department completing PAPR training.

C. Respirator Training

1. Employees will be trained prior to the use of a respirator and thereafter when deemed necessary by knowledgeable department designee.

2. Training will include:

   a. Identification of hazards, potential exposure to these hazards and health effects after exposure to hazards.
   b. Respirator fit, improper fit, usage, limitations and capabilities for maintenance, usage, cleaning and storage.
   c. Emergency use, if applicable.
   d. Inspecting, donning, doffing, seal check and trouble shooting.

e. Explaining the respirator program policies and procedures.
f. The following will be done annually:
   1. Departments required to wear a PAPR will take the E-Learning module on *PAPR Use*.
   2. Departments required to use the PAPR will perform the donning and doffing steps in **Departmental Competencies** and add to initial department checklist.

D. Respirator Use

1. No employee shall wear any type of respirator until they have been trained and medically cleared to wear the respirator.
2. Employees will use their respirators under conditions specified by this program and accordance with the training they receive on the use of each particular model. In addition, the respirator shall not be used in a manner for which it was not certified by NIOSH or by its manufacturer.
3. Employees who detect problems, with, or experience failure of, the respirator shall leave the hazardous environment immediately and notify their supervisor.
4. No employee shall be assigned to tasks requiring the use of a respirator if Employee Health determines that the individual will be unable to function normally while wearing a respirator.
5. EHS will provide documentation of individuals unable to wear a PAPR by notifying the employee's manager.

E. Emergency Fit Testing – The Infection Prevention and Control Committee will activate emergency fit testing for use of an N95 Mask.

1. N95 fit testing will be required for employees who are anticipated to have direct patient care contact with a known ATD.

2. A PAPR may be available to be used by employees unable to be fitted with a N95 respirator.

3. Fit testing will be conducted prior to an employee being allowed to wear an N95 respirator.

4. Employee Health will conduct fit tests following the protocol found in Appendix B of the 29 CFR 1910.134 OSHA Respiratory Protection Standard.

F. Cleaning and Disinfecting Respirators

1. PAPRs should be cleaned according to manufacturer's recommendations, after every use by HCW:

   a. All outer and inner surfaces of the assembled system may be wiped down with approved cleaning solution/wipes between uses
   b. Replace the front headband comfort strip.

c. The rear closed cell foam comfort strip may be cleaned for reuse by cleaning with approved cleaning solution/wipes.
d. Allow hood to air dry

G. Inspecting, Maintenance and Repairs of the PAPR is to be done by HCW before and after every use:

1. Examine the helmet for physical damage; if parts are damaged, contact BioMed.

2. Check for airflow prior to use.

3. Follow manufacturer's recommendations on maintenance, including battery recharging.

4. The battery will hold a charge for one year. As with all rechargeable batteries, the amount of charge will decline slowly when not in use or during storage. The Manager of the unit where the carts are kept will check charge status every 6 months or more often if needed.

III. Risks for Occupational Exposure to ATDs (e.g. Mycobacterium tuberculosis, Severe Acute Respiratory Syndrome (SARS), measles, smallpox, and/or COVID-19)

A. All employee job classifications that include direct patient care are at risk of exposure to ATDs.

B. Risk from exposure to high-hazard medical procedures in patients with an ATD include, but are not limited to:

1. Respiratory care procedures such as tracheotomy, endotracheal tube care or sputum induction.

2. Diagnostic medical procedures such as fiber optic endoscopic evaluation of swallow (FEES), laryngoscopy, bronchoscopy and pulmonary function testing.

3. Any medical procedure performed on a "suspect" or "confirmed" infectious TB case which can aerosolize body fluids or tissue likely to be infected with TB bacteria.

4. Resuscitative procedures performed by any personnel.
5. Invasive procedures such as tracheotomy, thoracentesis, insertion of chest tube, or lung biopsy.

C. All employees entering the room or assisting with a high hazard procedure on a patient with an ATD will use respiratory protection in accordance with OSHA regulations, such as a PAPR as designated by OSHA and CDC, and follow contact precautions to use Personal Protective Equipment (PPE) - gloves and gown.

D. Employees attending a patient who has been determined to have or may have an ATD are at risk of exposure to ATDs and are required to use Personal Protective Equipment (PPE) and respiratory protection.

IV. Control Measures and Early Detection of ATD

A. Engineering controls: Patients with potential ATD will be placed in a negative air pressure room or private room with a HEPA filter.

B. Work Practice Controls: To prevent or minimize employee exposure to airborne, droplet, and contact transmission of aerosol transmissible pathogens (ATP), precautions are in accordance with the CDC Guidelines.

1. Hand hygiene
2. (PPE): Gloving, gowning, mask, face shield/goggles
3. Cleaning and disinfecting contaminated surfaces, articles and linens.

C. Available personal protective equipment (PPE) includes, but is not limited to:

1. A NIOSH-approved PAPR or NIOSH-approved N-95 respirator
2. Eye Protection
3. Gown
4. Gloves

D. Source Control Measures

1. At the first point of contact with a potentially infected person, standard precautions are implemented, which include respiratory hygiene and cough etiquette.

2. Persons identified to have or are suspected of having an airborne transmissible disease will be masked with a surgical mask for source control.

3. Visual alerts to instruct patients and visitors to practice respiratory hygiene and cough etiquette will be posted until the infected person is transferred.

4. Employees and visitors are made aware of placement of disposable tissues and hand hygiene dispensers.

5. Infected persons are placed in an area where contact with others not wearing respiratory protection is eliminated or minimized until transfer to another facility with an airborne isolation room.

6. Respiratory hygiene and cough etiquette measures include:

a. Cover nose and mouth when coughing or sneezing.
b. Use tissues to contain respiratory secretions and dispose of them immediately after use in the nearest waste receptacle.
c. Wash hands with soap and water or alcohol-based hand rub after contact with respiratory secretions, contaminated objects or materials.

7. Health care workers will wear a PAPR or approved N-95 when examining a patient in airborne isolation precautions.

ATTACHMENTS:

- Appendix A: Respiratory Assignments by Task or Location
- Appendix B: Information for Voluntary Users
- Appendix C: OSHA Respirator Medical Evaluation Questionnaire
- Appendix D: Max Air CAPR Sign In and Out Log
- Appendix E: Max Air CAPR Respirator Monthly Inspection Log
- Appendix F: PAPR Cart Daily Log
- Appendix G: Competency Assessment Tool

REFERENCES:

- *Healthcare Workers: Healthcare Respiratory Protection* (2025, Jan 15, accessed May 2025). Retrieved from Centers for Disease Control and Prevention: Chttps://www.cdc.gov/niosh/healthcare/respiratory-protection/?CDC_AAref_Val=https://www.cdc.gov/niosh/npptl/hospresptoolkit/policies.html
- Occupational Safety and Health Administration *Hospital Respiratory Protection Program Toolkit*. updated April 2022, accessed May 2025. https://www.osha.gov/Publications/OSHA3767.pdf
- Occupational Safety and Health Administration. Appendix B of the 29 CFR 1910.134 OSHA Respiratory Protection Standard. (2020). Accessed May 2025 from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134.
- *Max Air Systems User's Instuctions*. (n.d.). (accessed May 2025).https://maxair-systems.com/user-manuals-ifus (accessed May 2025).
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RPP Appendix A: Respirator Assignments by Task or Location

Task or Location	Potential Exposure	Respiratory Protection	Employees Included

Performing aerosol-generating procedures on patients suspected or confirmed with a disease requiring Airborne Precautions or present when such procedures are performed **[see HICPAC 2007 or other public health guidance for lists of diseases], including**: • Sputum induction • Bronchoscopy • Aerosolized administration of medications • Pulmonary function testing • Manual Ventilation • Open suctioning of air ways • Endotracheal Intubation and Extubation • Cardiopulmonary resuscitation • Non-invasive ventilation (BiPAP, CPAP)	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR) ***[Note: PAPR use for aerosol-generating procedures on patients with a disease requiring Airborne Precautions is High Priority]***	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Performing aerosol-generating procedures on patients suspected or confirmed with influenza cases or present during such procedures.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Entry into airborne infection isolation room or other area occupied by patients suspected or confirmed with a disease requiring Airborne Precautions.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Performing, or present during, routine patient care and support operations on a patient suspected or confirmed with a disease requiring Airborne Precautions	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Cleaning/decontaminating an area occupied by a patient suspected or confirmed with a disease requiring Airborne Precautions, or cleaning/decontaminating such an area after a patient has left but before the space has been adequately ventilated.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• EVS • RT • Lab techs • IR techs • OR techs • Radiology techs
Laboratory operations involving aerosol transmissible disease pathogens **[see HICPAC, CDC, OSHA]** for which requires respiratory protection	Infectious aerosols	As specified in biosafety plan	• Lab techs • Lab personnel

NOTE ** Priority PAPR use for staff who **failed** the N-95 *"Fit Test"* and staff providing AGPs **

RPP Appendix B: Information for Voluntary Users

Information Taken From OSHA Appendix D to Sec. 1910.134: (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1) Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations.

2) Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.

3) Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors or very small solid particles of fumes or smoke.

4) Keep track of your respirator so that you do not mistakenly use someone else's respirator.

APPENDIX C: OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

SIERRA VIEW MEDICAL CENTER

OSHA Respirator Medical Evaluation Questionnaire

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: _____ Your age (to nearest year):_____

Your name:_____ Dept: _____

Job title:_____ Sex : Male/Female

Height: _____ft. _____ in. Your weight: _____ lbs.

Type of respirator you will use: NIOSH approved, disposable, R- rated filter mask, non- cartridge type.

Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

If you answer "YES" to any of the following questions, you will be contacted by a Licensed Health Care Professional for further clarification. You may call EHS at the hospital to obtain the name and contact information of the health professional who will be reviewing the questionnaires.

Please provide a phone number where you can be reached by the health care professional who will review this questionnaire (include the Area Code): _____

The best time to phone you at this number: _____

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month:

○ Yes ○ No

2. Have you ever had:	YES	NO
Seizures		
Diabetes		
Allergic reaction that interferes with breathing		
Claustrophobia(fear of closed places)		
Trouble smelling odors		
3. Have you ever had any of the following pulmonary or lung problems:	**YES**	**NO**
Asbestosis		
Asthma		
Chronic Bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax		
Lung Cancer		
Broken Ribs		
Any chest injury or surgery		
Any other lung problem you have been told about		
4. Do you currently have any of the following symptoms of pulmonary or lung illness?	**YES**	**NO**
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:		
Shortness of breath when walking with other people at an ordinary pace on level ground:		
Have to stop for breath when walking at your own pace on level ground:		
Shortness of breath when washing or dressing yourself		

ADDENDUM (A)

Employee Name:_____Dept:_____

The following questions below must be answered by every employee who has been selected to use either a full-face piece respiratory or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

1. Have you ever lost vision in either eye (temporarily or permanently): ☐ Yes ☐ No
2. Do you currently have any of the following vision problems:
   a. Wear contact lenses: ☐ Yes ☐ No
   b. Wear glasses: ☐ Yes ☐ No
   c. Color blind: ☐ Yes ☐ No
   d. Any other eye or vision problems: ☐ Yes ☐ No

	YES	NO
1. Have you ever had an injury to your ears, including a broken ear drum		
Do you currently have any of the following hearing problems?		
a. Difficulty hearing ☐ Yes ☐ No		
b. Wear a hearing aid ☐ Yes ☐ No		
c. Any other hearing or ear problems ☐ Yes ☐ No		
2. Have you ever had a back injury:	YES	NO
3. Do you currently have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No		
b. Back pain ☐ Yes ☐ No		
c. Difficulty fully moving your arms and legs: ☐ Yes ☐ No		

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Max Air: CAPR RESPIRATOR DAILY SIGN IN/OUT LOG

Prior to each use, if any of the following issues are discovered for any system component(s), replace the particular item(s) by following the assembly/dis-assembly procedures for the particular item(s).

CAPR SET: **ED** **ICU**
(Please circle)

____/____
Month Year

Employee name	CAPR SET	Date	Print corresponding number: • Helmet (1) • Battery (2) • Charger (3) • Belt (4)	No contamination	No damage to filter cartridge, batteries or threat to proper function	No yellow or red indicator lights	No compromise between the filter cartridge and helmet seal	Return Date and Time	User initials	Witness Initials	Comments

APPENDIX E: MAX AIR CAPR RESPIRATOR MONTHLY INSPECTION LOG

SIERRA VIEW MEDICAL CENTER
Infection Prevention

Max Air: CAPR RESPIRATOR MONTHLY INSPECTION LOG												
Log begin date: **Log end date:**	**CART: ED 1-6 (sets) ICU 1-6 (sets)** Circle appropriate Cart											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Monthly respirator cleaning record	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X
Helmet: Intact, clean, without breaks or visible damage												
Helmet Power Cord: Intact, clean, and securely connected to helmet												
Filter: Clean, without tears or breaks; proper seal between Filter and helmet (Visual inspection **ONLY**; Do **NOT** remove Filter Cover)												
Filter Cover (FC): FC is secured and helmet mounting is stable; no tears or breaks												
Battery: • Lithium Ion Battery (LIB) connected to charger. If charger LED light is green, disconnect LID from charger • LIB is free from visible damage • Perform the LIB Check Procedure every 3-6 months (See back of page)												
Daily Log: Daily Log is up-to-date												
Note: If any boxes above are marked **X** address item and/or contact **IP: Ext: 3795 or 3781**												
IP contact on date:												
Supervisor monthly review (initial):												

Notes: Which item needs to be addressed (e.g., ER-1 helmet; ICU-3 Battery), discrepancy, and any needed descriptive information need to clarify the issue:

_____

_____

_____

Y:\Administrative Assistant\Policy & Procedure Committee\8-19-2020 Max Air Monthly Check List.docx

SIERRA VIEW MEDICAL CENTER
Infection Prevention

LIB Check Procedure - MAXAIR LIB Test for Diminishing Battery Capacity

CAUTION: If the LIB performs in one of the "Suspect LIB" categories below, discontinue using it and replace that LIB as soon as possible.

Case 1: The LIB has been connected to a charger and the charger green LED is on.

- **Procedure:** Unplug the LIB from the charger and plug the helmet power cord to the LIB. Allow the helmet to settle for about 10 seconds.
  - **A. Good LIB:** The helmet runs with 3 or 2 green indicator lights on.
  - **B. Suspect LIB:** The helmet runs with only 1 green indicator light on.
  - **C. Suspect LIB:** The helmet runs with the red indicator light on.
  - **D. Suspect LIB:** The helmet doesn't run.

Case 2: The LIB has been in storage.

- **Procedure:** Plug the helmet power cord to the LIB to be tested. Allow the helmet to settle for about 10 seconds.
  - **A. Good LIB:** The helmet runs with 3, 2 or 1 green indicator light on.
  - **B. Suspect LIB:** The helmet runs with the red indicator light on.
  - **C. Suspect LIB:** The helmet doesn't run.

Case 3: The LIB is connected to the MAXAIR Charger.

- **A. Good LIB:** the LIB is felt to be about room temperature.
- **B. Suspect LIB:** the LIB is warm or hot to touch.

APPENDIX F: PAPR CART DAILY LOG

SIERRA VIEW MEDICAL CENTER
Infection Prevention

Month: _____ **Year**_____

PAPR Cart Daily Log							
DATE:	PAPRS	Batteries	Chargers	Belts	Cart stock with DLC and Helmet Liner	Signature	Comments
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
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31							

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APPENDIX G: COMPETENCY ASSESSMENT TOOL

SIERRA VIEW MEDICAL CENTER
Infection Prevention

MAX AIR: CAPR SYSTEM
Competency Assessment Tool

Name: _____ Unit: _____

Skills Validation Method of Evaluation: DO-Direct Observation VR- Verbal Response WE-Written Exam OT-Other				
	MAX AIR: CAPR SYSTEM	Method of Evaluation	Initials	Comments
	Assemble the Cuff to the Helmet			
1	Attach Lens to Helmet			
2	Remove Lens Protective Cover from Lens			
	Donning			
1	Connect Power Cord to Battery			
2	Loosen Headband Ratchet Knob prior to Donning helmet			
3	Don Helmet per Manufacture Instructions			
	Doffing the Helmet			
1	Reverse Donning steps			
2	Connect Battery to Charger, leaving Cord attached to helmet			
4	Wipe down all reusable item surfaces with approved cleaning solution			
5	Dispose of Lens at end of patient care (shift)			

Name of Person Validating the Skills:_____

Signature of Skills Validator:_____ Date:_____

Employee Signature:_____ Date:_____

References

Max Air Systems User's Instructions. (n.d.). Retrieved from Max Air Systems: http://maxair-systems.net/ManualsUIMIFU/78SP_Rev_F.pdf

SUBJECT: **RISK MANAGEMENT PLAN**	SECTION: ***Improving Organizational Performance (PI)*** **Page 1 of 6**

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

PURPOSE:

The Risk Management Plan is designed to support the mission and vision of the organization as it pertains to clinical risk, as well as potential business, operational, and property risks.

GUIDING PRINCIPLES:

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program.

The organization's Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution
- Trend analysis of events, near misses, and claims

GOVERNING BODY LEADERSHIP

The success of the organization's Risk Management Program requires top-level commitment and support. The Governing Board authorizes the formal program and adoption of this Plan as documented in Board meeting minutes.

Risk management will provide quarterly reports. to the governing body summarizing activities, achievements, and ongoing risk management issues that have occurred since the prior report. As necessary, the Board will receive interim reports of new risk exposures that require board intervention and action.

PROGRAM GOALS AND OBJECTIVES

The Risk Management Program goals and objectives are to:

- Minimize adverse effects of errors, events, and system breakdowns when they occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements.
- Protect human and intangible resources (e.g., reputation).

SCOPE AND FUNCTIONS OF THE PROGRAM

The organization's Risk Management program interfaces with many operational departments and services throughout the organization. Risk Management's role is to influence, persuade and educate leaders within the organization in order to achieve quality care in a safe environment and protect the organization's resources.

Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with facility-wide performance improvement activities, Risk Management will work with the various committees structured to enhance the performance of the facility in the communication and resolution of risk-related issues. Risk management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.1 Functional Interfaces

Risk Management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.2 Risk Management Program Functions

Risk Management functional responsibilities include, but are not limited to:

- Promoting the quality of patient care, in collaboration with quality/performance improvement activities.
- Enhancing patient satisfaction.
- Minimizing the frequency and severity of adverse events.
- The timely reporting of events as it pertains to the following:
  - Centers for Medicare and Medicaid Services (CMS) established reportable requirement for certain restraint and seclusion events.
  - Assists in Food and Drug Administration (FDA), Safe Medical Device Act both mandatory and voluntary reporting elements related to device malfunctions and/or biological malfunctions.
- Assisting in the maintenance of a robust event reporting system that is used to report actual events or events with the potential of causing adverse patient outcomes or other injuries to people, property or other assets of the organization. (Refer to housewide policy & procedure, *Patient Safety Event*).

- Managing of patient and family complaints/grievances as required by CMS. (refer to house-wide policy and procedure, Complaints and Grievances, Handling of)
- Maintaining a robust insurance portfolio to safeguard the organization against financial risk arising from claims made.
- Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.
- Enhancing environmental safety for patients, visitors and staff through participation in various improvement committees.
- Utilizing risk management strategies to identify and minimize the frequency and severity of near misses, incidents and claims.
- Monitoring adverse events and injuries to minimize financial loss to include employment-attributed injury and illnesses (worker's comp).
- Evaluating systems that can contribute to patient care, error or injury.
- Educating stakeholders on emerging and known risk exposures and risk reduction initiatives.
- Serving as a resource for staff concerning actual or potential legal matters related to the provision of care.
- Contributing to the achievement of requirements implemented by accrediting organizations.
- Complying with state-specific scope of practice, applicable laws, regulations and standards.
- Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:
  - Claims and claim trends
  - Ongoing risk assessment information
  - Patient's and/or family's perceptions of how well the organization meets their needs and expectations
  - Quality performance data

- Research data
- Completing insurance and deeming applications.

1. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Risk Management Program is administered through the Risk Department's leadership, and reports to the Vice President of Quality & Regulatory Affairs. Department leadership interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Leader (or alternate as designated by VP) chairs the activities of the Patient Safety Committee and the Threat Assessment Team. The two committee's activities are an integral part of patient safety, quality improvement, and risk mitigation activities.

Risk Leadership is responsible for overseeing day-to-day monitoring of patient safety and risk management activities to include the investigation of and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contractsk Risk Leadership serves as the primary contact between the organization and other external parties on matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. Risk Leadership or alternative as designated by VP of Quality and Regulatory Affairs oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

2. ANNUAL PROGRAM EVALUATION

Risk Management/Patient Safety, in concert with members of the Performance Improvement and Patient Safety (PIPS) Committee, analyzes data and trends. During the year, events that have shown a trend of reoccurrence, a high likelihood of harm to patients or staff, or that have created delays in care across two or more departments are reviewed by responsible leadership in collaboration with Risk Management and Patient Safety. The events are reviewed via the Crisis Management Team (CMT) and Root Cause Analysis (RCA) process. CMTs and RCAs are reported quarterly to the PIPS Committee. At the end of each year, a risk assessment is conducted based on CMT, RCA, and Incident Reporting System data using a numeric scoring to assign a degree of likelihood, consequence and response to arrive at a collective risk score and a hierarchy of action. Specific risk reduction goals will focus on elements scored in the upper quartile. The reduction of risk-related exposures is a facility-wide initiative and is owned by everyone. The successful attainment of the identified goals will involve stakeholders who have influence and experience with key components of the issue.

7.1 GOALS FOR 2025-2026

1. Continue occurrence reporting training housewide to ensure quality data
2. Continue Just Culture training to support Culture of Safety in organization.

3. Maintain a current and robust insurance portfolio
4. Remain current on grievance and complaints (logs and correspondence)

3. PROTECTION OF RISK MANAGEMENT INFORMATION

Any and all documents and records that are part of the risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, patient safety work product, and peer review protections.

REFERENCES:

- California Evidence Code §1157 (January 1, 2018). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EVID&sectionNum=1157.
- Department of Health and Human Services, FDA: 21 CFR Parts 803 and 804 (April 1, 2021). Retrieved from https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=803.
- California Health & Safety Code, §1279.1(b): 1279.2, 1279.3, 1279.4, &100171 (January 1, 2008). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC
- *The Safe Medical Devices Act of 1990 and the Medical Device Amendments of 1992.* (1993). Washington, D.C.: U.S. Dept. of Health and Human Services, Public Health Services / Food and Drug Administration, Center for Devices and Radiological Health.
- Code of Federal Regulations 482.13(e)-(g) (September 30, 2019). Retrieved from https://www.law.cornell.edu/cfr/text/42/482.13.
-
- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES

- Housewide Policy & Procedure Manual, *Serious Clinical Adverse Event*
- Housewide Policy & Procedure, *Complaints and Grievances, Handling of*
- Housewide Policy & Procedure, *Patient Safety Plan*

- *Environment of Care Policy and Procedure Manual, Medical Device Tracking & FDA Reporting Product Recalls*

SUBJECT: **SIGN-OUT PROTOCOL FOR BLOOD COMPONENTS**	SECTION:

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, using a patient's registration chart label, 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. At the time of issue, the CLS will select the patient in Meditech using the account number, examine the unit for appearance and expiration date and indicate the acceptability by documenting on the transfusion issue card. 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 will sign the blood bank transfusion issue card (both copies).

- 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 if the patient is receiving dialysis or if they have two separate peripheral lines, 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:

- Association for the Advancement of Blood & Biotherapies, "Standards for Blood Banks and Transfusion Services", 33rd Edition, 5.22 through 5.25.

- The Joint Commission (2025). Laboratory accreditation standards. QSA.05/03/01. QSA.05.10.01, QSA.05.14.01, QSA.05.17.01, QSA.05.18.01, QSA.05.22.01, QSA.05.24.03. Joint Commission Resources. Oak Brook, IL.

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

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

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. (2023). AABB Technical Manual, 21st Ed.
- The Joint Commission Laboratory Standards (2025). 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: **TERBUTALINE – TOCOLYSIS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide guidelines in the use of Terbutaline Sulfate for suppression of premature labor, reduction of tachysytole, uterine hypertonis, or prophylactic for procedures such as version or amniocentesis.

POLICY:

A. A Registered Nurse will manage the patient undergoing beta mimetic tocolytic therapy in collaboration with and ordered by the physician.

B. Terbutaline Sulfate may be given for:

1. Suppression of premature labor
2. Reduction of uterine tachysystole
3. Prophylactic for procedures such as version or amniocentesis

C. Terbutaline may be given subcutaneous.

AFFECTED AREAS/PERSONNEL: *MATERNAL CHILD HEALTH (MCH) DEPTARTMENT, REGISTERED NURSES (RN)s*

CONTRAINDICATIONS:

1. Cardiac disease:
   a. Ventricular outflow obstruction
   b. Cardiac arrhythmia or conduction defects
2. Eclampsia or severe PIH (pregnancy induced hypertension)
3. Severe bleeding
4. Chorioamnionitis
5. Sickle cell disease
6. Hyperthyroidism
7. Uncontrolled Diabetes Mellitus (increases blood surgar)
8. Known drug sensitivity

9. Patients on Monoamine oxidase inhibitors (MAOIs)

10. Asthmatics on beta-adrenergic medications

PROCEDURE:

1. Review Prenatal Record, Assess patient, and patient's complaints. (Sterile vaginal exam only after Fetal Fibronectin obtained.)

2. Patient must be on continuous fetal monitoring. Verifying uterine contractions and palpate uterus for intensity.

3. Take and record vital signs prior to medication administration, **HOLD** dose and call physician if blood pressure greater 90 systolic or heart rate is greater than 120 beats per minutes (bpm). (Usual procedure is to recheck pulse after 30 minutes, continue to hold if greater than 120 bpm, give the next dose if less than 120 bpm).

4. Terbutaline is given initially subcutaneous (SQ). Usual dosage 0.25 milligrams (mg) SQ.

   a. **Subcutaneous route:**

   - 0.25 mg Terbutaline SQ every 1-4 hours times 24 hours maximum dose per doctor orders
   - An extra 0.25mg SQ dose may be given after 30 minutes if contraction persist or begin again.
   - Total SQ dose will **not exceed 5mg in 24 hours (20 doses).**

5. Assess the following every shift and record:

   a. Maternal Vital signs (blood pressure (BP), pulse, respiratory status)

   - Presence of dyspnea and chest pain (if symptomatic, obtain STAT electrocardiogram (EKG) and notify doctor)
   - Monitor lung sounds for risk for pulmonary edema due to increased capillary permeability causing increased leakage into interstitial space in the lung
   - Tachypnea

   b. Maternal cardiac status

   - Tachycardia > 140 bpm

c. Strict intake and output (for risk of pulmonary edema)

- Avoid "over-hydration"

d. Fetal heart rate (fetus may become tachycardic)

e. Tremors

f. Anxiety

6. Reportable conditions – notify the physician immediately:

a. Shortness of breath

b. Chest pain

c. Apical pulse greater than 120 bpm

d. BP less than 90/60 or a drop in systolic greater than 20% of baseline

e. Intake & Outake (I&O) imbalance (plus or minus 200mL) (urine output less than 30 millileters (mL)/hr.

f. Contractions less than 20 minutes apart

g. Baseline fetal heart rate greater than 170 bpm

h. Category II and Category II trending to a Category III heart rate tracing.

7. Provide patient education:

a. The need to take Terbutaline as ordered to prevent premature delivery;

b. Sign and Symptoms or complications

c. Shortness of breath and cough

d. Palpitations

8. Review labor precautions

a. Rupture of membranes

b. Vaginal bleeding

c. Uterine contractions, back pain and cramps

d. Follow-up care with Physician

DOCUMENTATION:

- Uterine contractions, frequency and strength.
- Patient perception of pain (contractions) prior to and during Terbutaline therapy is essential.
- Any sign and symptoms of adverse symptoms.
- Education provided.

REFERENCES:

- The Joint Commission (2017). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- American Academy of Pediatrics & American College of Obstetrics and Gynecologist. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- Mattson, S. & Smith, J. E. (2016). Core curriculum for maternal-newborn nursing (5th ed.). St. Louis, MO: Elsevier Saunders
- Simpson, K. R., & Creehan, P. A. (2014). AWHONNs perinatal nursing (4th ed.). Philadelphia: Lippincott Williams & Wilkins Health.
- Troiano, N. H., Harvey, C.J., & Chez, B.F. (2018). High-risk & critical care obstetrics (4th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health.
- ACOG website: www.acog.orgU.S. Food and Drug Administration. (2017). FDA Drug Safety Communication: New warnings against use of terbutaline to treat preterm labor. Retrieved September 24, 2018, from https://www.fda.gov/Drugs/DrugSafety/ucm243539.htmFDA Drug Safety Communication: New warnings against use of terbutaline to treat preterm labor. 2/17/11.

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

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

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

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

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

If patient has documented allergy to therapeutic substitute, the substitute will not take place.

DEFINITIONS:

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

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

Appendix A: Proton Pump Inhibitor:

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

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

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

Appendix B: Nasal Corticosteroid Products

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

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

Appendix C: Inhaled Combination Medication Therapeutic Interchange

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

Appendix D: Insulin Therapeutic Interchange

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

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

Appendix E: Antihistamine agents

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

Appendix F: HMG CoA Reductase Inhibitors

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

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

Hepatic impairment prior to treatment initiation:

Child-Turcotte-Pugh Class A: No dosage adjustment necessary

Child-Turcotte-Pugh class B: Initial 20mg once daily; maximum recommended dose 20mg/day

Child-Turcotte-Pugh class C: Convert patient to rosuvastatin per table.

Appendix G: Angiotensin II Receptor Blocker

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

Appendix H: Angiotensin Converting Enzyme (ACE)

Substitutive Agent- Therapeutic Interchange Equivalent Daily Dosage	Non-Form
Lisinopril 10mg (Max 40mg)	Benazepril 10mg
Lisinopril 10mg (Max 40mg)	Enalapril 5mg
Lisinopril 10mg (Max 40mg)	Fosinopril 10mg
Lisinopril 10mg (Max 40mg)	Moexipril 7.5mg
Lisinopril 10mg (Max 40mg)	Perindopril 4mg
Lisinopril 10mg (Max 40mg)	Quinapril 10mg
Lisinopril 10mg (Max 40mg)	Ramipril 2.5mg
Lisinopril 10mg (Max 40mg)	Trandolapril 2mg

Appendix I: Biosimilar Medications

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

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

Cancer Treatment Center Procedure:

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

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

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

Dose Rounding for Continuous Infusion of Oncology Medications

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

Duplicate Orders

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

Interchange between liquid and solid dosage forms

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

Therapeutic Duplications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix: IV to PO Subsection

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

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

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

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

Inclusion Criteria

- The patient must be on IV therapy for at least 24 hours before IV to PO conversion consideration.
- The patient is tolerating scheduled medications and diet (orally, or via NG or G tube).

- The patient is not on a pre-operative or -procedure or post-operative or -procedure fast.
- The patient has not experienced any recurrent nausea, vomiting or diarrhea for at least 24 hours.
- The patient does not have documented esophophageal sphincter incompetence.
- The patient does not have an active gastrointestinal bleed.
- The patient does not have documented problems with oral absorption (i.e., ileus, short bowel syndrome, celiac sprue, and inflammatory bowel disease or malabsorption syndrome).
- The patient is not at risk for aspiration (e.g., decreased consciousness, seizures, etc.).

Additional criteria for antibiotic/antifungal agents

- The patient is afebrile for at least 24 hours (temp < 100.4° F).
- The patient is clinically improving (white blood cell count decreasing, bands decreasing, improved signs and symptoms as documented in prescriber progress notes).
- The infection is at a site where an oral agent will achieve an adequate level (not endocarditis, meningitis, brain abscess, orbital cellulitis, other CNS infections, osteomyelitis, and endophthalmitis).
- The patient is not septic, and is hemodynamically stable (heart rate ≤ 100 beats/minute, respiratory rate ≤ 24 breaths/minute, and systolic blood pressure > 90 mm Hg without vasopressor support).
- For documented fungemia, fluconazole will continue IV for 7 days before PO switch.

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

Antimicrobials

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

Others

Medication	Intravenous Dose	Oral Equivalent
Acetaminophen IV	IV to PO is equivalent	Same dose regimen and frequency. May need to adjust in multiples of

(Ofirmev) (restricted only for those with strict NPO)		325mg. IV acetaminophen doses limited to 2 doses for PRN orders and 4 doses for scheduled orders.
Famotidine	20 mg IV every 12 hrs.	20 mg PO every 12 hours
Pantoprazole	40 mg IV daily	40 mg PO daily (lansoprazole 30mg NG daily)
Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

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

REFERENCES:

- CMS Standards for Conditions of Participation guidelines on Antibiotic Stewardship beginning on July 1, 2015. **(HSC §1288.8 (a)(3))**
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SUBJECT: **TRANSFUSION REACTION PROCEDURE**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 7**

PURPOSE:

To establish guidelines for the handling, determining and reporting of adverse transfusion reactions.

POLICY:

1. In the event of a suspected transfusion reaction, the nursing personnel shall report patient symptoms to the physician. If the physician elects to stop transfusion:

   a. The Registered Nurse shall discontinue the transfusion and notify the blood bank personnel. The transfusion reaction workup will reflex order from the data entered into the Transfusion Administration Record (TAR) in Meditech. If the department is not using TAR or it is a delayed transfusion reaction, the nurse will order the transfusion reaction workup in Meditech.

   b. The Registered Nurse will call the lab to draw blood sample.

   c. Prepare the blood component bag and blood tubing and return to Blood Bank.

   d. Return the "Report of Suspected Transfusion Reaction" form (Addendum A) with blood component bag and tubing.

   e. The Registered Nurse will verify patient identification and document as indicated on the Reaction form.

   f. The Registered Nurse will obtain physician order, and collect the urine specimen for a post transfusion urinalysis and send it to the lab.

   g. The Laboratory will collect a new, properly labeled, blood sample (avoiding hemolysis) from the patient.

2. The Laboratory will perform the following "Partial Transfusion Reaction" work-up:

   a. Urine check for Hgb. If positive, check for RBC.

   b. The label on the blood containers, pre and post patient sample tubes, requisitions and computer records will be checked to detect whether there has been a clerical error made in identifying the patient or the blood.

   c. The patient's post-reaction serum shall be inspected for evidence of hemolysis, using a pre-reaction sample for comparison if available.

d. A blood type, Rh, and DAT will be performed on the patient's post-reaction transfusion specimen.

e. The results of these above mentioned procedures shall be documented in the appropriate spaces on the "Transfusion Reaction Form" with the Clinical Laboratory Scientist (CLS) performing the work-up signing, dating and timing the form.

f. The CLS will make copies of all reports and keep one copy in Blood Bank file under Transfusion Reactions, and send original to Pathologist. Preliminary documentation of the findings will be entered into Meditech.

g. The CLS will immediately contact the Pathologist informing him / her if any of the findings are positive and then perform full workup. The CLS will order the extended transfusion reaction workup in Meditech.

h. The transfusion reaction form will be submitted to the Pathologist for his/her signature and interpretation. The Pathologist will submit a progress report. A copy of this report will be filed in Blood Bank and another submitted to the Risk Manager. The Risk Manager will forward the Progress Report to Medical Records and keep the Report to document the incident.

i. In the event a hemolytic transfusion reaction is suspected the testing protocol shall include (but not be limited to) the following procedures:

- Retesting of the patient's pre and post-transfusion specimen for ABO, Rh, and antibody screen.
- Compatibility retesting of the donor specimen in question using patient's pre and post-reaction specimen samples.
- The CLS will culture the donor blood bag if temperature rise of >4° F.
- Bilirubin determinations on the patient.
- Hemoglobin determinations will be performed on the patient.
- If reaction is suggestive of a hemolytic reaction or bacterial contamination the attending physician shall be notified immediately.
- All transfusion reactions are to be reported to the Rad/Path Committee for review.

DEFINITION OF POSSIBLE ADVERSE BLOOD TRANSFUSION REACTIONS:

1. Hemolytic Transfusion Reaction:

   a. Cause:

   Antibodies in the recipient's plasma react with antigens on donor red blood cells. This leads to donor cell agglutination and capillary occlusion, blocking blood flow and oxygen to vital organs. Eventually, the red blood cells break down and release free hemoglobin into plasma and urine. This free hemoglobin may block the renal tubules, resulting in renal failure.

   b. Signs and Symptoms:

   Chills, fever, backache, leg pain, rigors, chest pain, tachycardia, hypotension, cyanosis, hemoglobinemia, hemoglobinuria, oliguria, anuria, hematuria, jaundice, shock, vascular collapse, nausea, vomiting, restlessness, anxiety, pallor, pulmonary edema, precordial distress.

   c. Definitive Laboratory Testing:

   - Positive Direct Coombs test post-transfusion.
   - Gross hemolysis of serum post-transfusion.
   - Occult blood positive test in post-transfusion urine analysis.
   - Elevated Bilirubin post-transfusion.

2. Significant Hemolytic Transfusion Reactions:

   a. All verified hemolytic transfusion reactions are considered and reported as significant.

   b. All suspected hemolytic transfusion reactions will have a repeat ABO Type and Rh of both the recipient and the donor blood.

3. Allergic Transfusion Reaction:

   a. Cause:

   Probable mechanism of reaction due to allergens in donor blood with antibodies in recipient blood.

   b. Signs and Symptoms:

   Urticaria, pruritus, chills, nausea, vomiting, headache, nasal congestion, wheezing, bronchospasm, dyspnea, laryngeal edema, circulatory collapse, fever, diaphoresis, anxiety, restlessness, headache, pallor, erythema.

   c. Definitive Laboratory Testing:

   All suspected allergic reactions will have direct Coombs testing performed by Laboratory to determine type of reaction. If direct Coombs testing are within normal limits, the Pathologist will be notified to determine if further testing is required.

   d. Significant Allergic Reactions:

   Significant Allergic reactions are defined as: bronchospasm, laryngeal edema, severe dyspnea, circulatory collapse, pulmonary edema, skin sloughing as a result of severe pruritus and/or erythema.

4. Febrile Transfusion Reaction:

   a. Cause:

   Recipient sensitivity to donor leukocytes or platelets.

   A febrile transfusion is defined as an increase of 2° F above baseline temperature.

   b. Signs and Symptoms:

   Fever, chills, flushing, back pain, malaise, tachycardia, headache, confusion, nausea and vomiting.

   c. Definitive Laboratory Testing:

   The same procedure is followed as with allergic reactions.

d. Significant Allergic Febrile Reactions:

A significant febrile transfusion reaction is defined as: A rise in temperature greater than two (2) degrees from pre-transfusion temperature.

5. TRALI – Another possible adverse effect of transfusion is Transfusion Associated Acute Lung Injury (TRALI). This is a rare but potentially life-threating reaction to plasma containing blood components. As it is most common in donations from multiparous women, Central California Blood Center (CCBC) has instituted a policy of only collecting plasma from male donors. Platelet transfusion reactions should be monitored for fever, chills, dyspnea, cyanosis and hypotension. The Medical Director and CCBC should be notified of any suspected cases of TRALI.

6. All possible transfusion reactions are reported to the Pathology Department, Quality Improvement Committee, Transfusion Committee, Medical Executive Committee, and the Governing Body at least on a quarterly basis.

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

REFERENCES:

- Association for the Advancement of Blood and Biotherapies (AABB) Standards, 33rd edition, pp 94-96, 7.5 - 7.5.3; , 2022
- Association for the Advancement of Blood and Biotherapies (AABB) Technical Manual, 21st edition, pp 683 - 684, 2023.
- The Joint Commission (2024). Hospital accreditation standards (QSA.05.18.01, QSA.05.19.01, QSA.05.19.03, QSA.05.19.05). Joint Commission Resources. Oak Brook, IL.

ADDENDUM A

SIERRA VIEW DISTRICT HOSPITAL — **REPORT OF SUSPECTED TRANSFUSION REACTION**

NURSING

Steps: Discontinue transfusion, flush line with saline, monitor vs. notify physician & lab, transport blood product to lab, collect U/A & blood specimen

Date _____ *Room #* _____ *BBK#* _____ *Unit ID #* _____ Blood Unit Label matches Patient ID band and Transfusion Issue Card YES NO (Circle)

Product: ❑ PC ❑ FFP ❑ PLAT

Diagnosis _____

Patient History

Previous transfusions ❑ Yes ❑ No Date of previous tranfusions _____

Number of pregnancies ❑ N/A # _____ Number of deliveries

Tranfusion Date	Time Started	Temperature	Discontinued	Temperature	Amount Given

Concurrent administration of other intravenous fluids or drugs? ❑ NO ❑ YES (please specify)

Reactions Noted

❑Chills	❑Nausea	❑Anxiety	❑Pallor	❑Erythema	❑Anuria	❑Shock	❑Pain_____ (where)
❑Fever	❑Vomiting	❑Restlessness	❑Urticaria	❑Hematuria	❑Jaundice	❑Cyanosis	❑Pulmonary Edema
❑Sweating	❑Rigor	❑Headache	❑Bronchospasm	❑Oliguria	❑Dyspnea	❑Pruritis	❑Precordial Distress

Time of Onset _____ Signature _____ RN/LVN

LABORATORY

Unit ID# _____ Exp. date _____ Amount of blood returned to lab _____

POST-TRANSFUSION FINDINGS (LAB)

Check for identification errors: OK? YES NO (Circle)

Serum appearance: Pre-transfusion: Hemolysis? YES NO (Circle)

Post-transfusion: Hemolysis? YES NO (Circle)

DIRECT COOMBS on post-transfusion blood
AHG _____
TYPE _____
Rh _____

Urine Check: Post-transfusion: Hemglobin? POS NEG (Circle) Note: If positive spin down specimen and check for RBCs.
Compare pre-transfusion urine HBG if available.

CONCLUSION: IF ALL FINDINGS ARE NEGATIVE, NO ADVERSE REACTION.

NOTE: If all findings are negative at this point, notify floor and submit report to pathologist. CLS Signature: _____
If findings are questionable complete the remainder of workup and notify pathologist and patient physician of findings.

RECHECK OF TYPINGS, ANTIBODY SCREEN, AND CROSSMATCH

	ABO Typing DIRECT ANTI A	B	A,B	BACK CELLS A	B	Rho (D) Typing ANTI D	Du	CONCLUSION:
Pt's pre-transfusion blood								TYPE Rh
Pt's post-transfusion blood								TYPE Rh
Donor blood								TYPE Rh

MAJOR CROSSMATCH							ANTIBODY SCREEN						
SALINE				ALBUMIN			SALINE				ALBUMIN		
I.S.	R.T.	37	AHG	I.S.	R.T.	AHG	I.S.	R.T.	37	AHG	I.S.	R.T.	AHG

Donor unit gram stain _____ Culture to follow _____

Medical Director's Signature _____ Date _____

Comment: _____

SIERRA VIEW District Hospital Porterville, California 93257
REPORT OF SUSPECTED TRANSFUSION REACTION

Form # 013979 REV. 1/13 CVBF

PATIENT'S LABEL

SUBJECT: **VENOUS BLOOD COLLECTION**	SECTION:

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.

SUBJECT: **ZOSYN EXTENDED INFUSION**	SECTION: ***Drug Therapy*** **Page 1 of 4**

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

PURPOSE:

This policy aims to optimize our economic and clinical outcomes with prolonged piperacillin-tazobactam (Zosyn) infusions in patients suspected of infections, and specifically in patients with a confirmed pathogen & elevated MIC (16mg/L). The purpose is also to educate staff that this is a widely accepted and utilized protocol with extensive literature support in terms of the maximization of bactericidal activity by prolonging the infusion period.

DEFINITIONS:

1. MIC- Minimum Inhibitory Concentration
2. Intermittent Infusion- infusion lasting 30 to 60 minutes
3. Extended Infusion- infusion lasting 3 to 4 hours

POLICY:

A. The goal of this policy is to outline procedure for ordering & administration of Pipercillin-Tazobactam (Zosyn) at SVMC.

   1. Define parameters for automatic substitution for extended infusions.

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

EQUIPMENT:

- Pipercillin-Tazobactam
- Infusion Pumps

PROCEDURE:

A. Ordering in CPOE

   1. Any order for Pipercillin-Tazobactam will default to the extended infusion regimen, with the exception of one-time orders in the Emergency Department (ED), Operating Room/Post Anesthesia Care Unit (OR/PACU), Pediatrics, and ambulatory care areas.

      a. The intermittent infusion orders will be restricted to PHA (Pharmacy). Providers will be allowed to order intermittent infusions, but must note applicable exclusion criteria from exclusion table provided in this policy.

      b. First doses will default to the one-time 30 minute infusion to prevent a delay in care, while future maintenance doses will be adjusted to extended infusions.

B. Pharmacist Verification

1. Pharmacists will review each order to confirm no normal exclusion criteria exist for treatment. (Allergies, indication, drug interactions etc.)

2. With no objection to medication selection, the pharmacist will then proceed with automatic interchange protocol by adjusting to extended infusion so long as the patient/order does not meet any exclusion criteria.

3. The pharmacist will also be responsible for automatic dosage adjustment for Renal Dose Adjustment as defined in Dosing Recommendations Table.

4. In the event that a pharmacist finds the extended infusion regimen cannot work for a particular patient, they may adjust to intermittent infusion without physician order, but must document the intervention in the electronic medical record (EMR).

5. Timing of the regimen will also be done in a manner to avoid overlap with other IV medications with compatibility issues, if appropriate. (See Zosyn Compatibility Sheet)

C. Dosing Recommendations

1. Pharmacists will be responsible for addressing & adjusting a patient's dose with extended infusions following the dosing chart below.

Renal Function	CrCl > 40 ml/min	CrCl 20-40 ml/min	CrCl < 20 ml/min	IHD, PD	CRRT
Intermittent Dosing (30-min infusion)					
General	3.375 IV Q6H	2.25 gm IV Q6H	2.25 gm IV Q8H	2.25 gm IV Q12H	3.375 gm IV Q6H
Pseudomonas/ nosocomial PNA/CF	4.5 gm IV Q6H	3.375 gm IV Q6H	2.25 gm IV Q6H	2.25 gm IV Q8H	
Extended-Infusion Dosing (4-hour infusion)†					
General, Pseudomonas, nosocomial PNA,CF	3.375 gm IV Q8H (4.5g IV Q8H in select populations*)		3.375 gm IV Q12H	3.375 gm IV Q12H	3.375 gm IV Q8H*

* In select cases, more intensive Zosyn® dosing may be warranted, e.g. critically ill patients with severe or deep seated infections, infections with MIC > 16

D. Criteria for Exclusion

1. Orders for Pipercillin-Tazobactam originating from the ambulatory clinics, pre-op OR/PACU doses, or Emergency Department pre-admission orders.

2. Patients less than 18 years of age.

3. When there are unresolvable conflicts with scheduling and/or compatibilities with other medications that cannot be resolved by placing additional lines.

4. If there are other non-pharmaceutical interventions that would be unable to be performed as a result of the prolonged infusion. (i.e., physical therapy, discharge)

5. Patients that are already on a prolonged course of antibiotics that are clinically improving, AND organism has MIC < or equal to 4.

E. Nursing Role & Administration

1. It is recommended to have a dedicated line for administration of Pipercillin-Tazobactam, to resolve compatibility issues, but this is not required.

2. Follow Medication Administration Guidelines as per SVMC policy.

3. Contact the pharmacist if the patient's access is limited and/or concerns with compatibility issues.

4. Be able to use Lexicomp/Uptodate for reference of IV compatibility.

REFERENCES:

- Drusano GL. Antimicrobial pharmacodynamics: critical interactions of 'bug and drug'. *Nature reviews. Microbiology.* Apr 2004; 2(4):289-300.
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- Roos JF, Bulitta J, Lipman J, Kirkpatrick CM. Pharmacokinetic-pharmacodynamic rationale for cefepime dosing regimens in intensive care units. *The Journal of antimicrobial chemotherapy.* Nov 2006; 58(5):987-993.
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- Lomaestro BM, Drusano GL. Pharmacodynamic evaluation of extending the administration time of meropenem using a Monte Carlo simulation. *Antimicrobial agents and chemotherapy.* Jan 2005; 49(1):461-463.
- Kuti JL, Dandekar PK, Nightingale CH, Nicolau DP. Use of Monte Carlo simulation to design an optimized pharmacodynamic dosing strategy for meropenem. *Journal of clinical pharmacology.* Oct 2003; 43(10):1116-1123.
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- Ariano RE, Nyhlen A, Donnelly JP, Sitar DS, Harding GK, Zelenitsky SA. Pharmacokinetics and pharmacodynamics of meropenem in febrile neutropenic patients with bacteremia. *The Annals of pharmacotherapy.* Jan 2005; 39(1):32-38.
- Kim A et al, Optimal Dosing of Piperacillin-Tazobactam for the Treatment of *Pseudomonas aeruginosa* Infections: Prolonged or Continuous Infusion?*Pharmacotherapy* 2007;27(11):1490–1497
- Mui, Emily, Medication Administration: Extended-Infusion Pipercillin/Tazobactam (Zosyn) Protocol, *Standford Health Care (Pharmacy Department Policy)* Mar 2015; 1-7.
- Rhodes NJ et al, Impact of loading doses on the time to adequate predicted beta-lactam concentrations in prolonged and continuous infusion dosing schemes, *Clin Infect Dis*. 2014 Sep 15;59(6):905-7
- Trissel, L.A. *Handbook on Injectable Drugs16th Edition*. Bethesda, Maryland: American Society of Health-System Pharmacist, 2011. Print
- Patel GW, Patel N, Lat A, et al. Outcomes of extended-infusion piperacillin/tazobactam for documented Gram-negative infections. Diagn Microbiol Infect Dis 2009;64(2):236–40.
- Moehring, R. Sarubbi, C. Prolonged infusions of beta-lactam antibiotics. Accessed October 11, 2022. https://www.uptodate.com/contents/prolonged-infusions-of-beta-lactam-antibiotics/print?search=zosyn&source=Out%20of%20date%20-%20zh-Hans&selectedTitle=4~86

CROSS REFERENCE:

- Medication Administration

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

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

The monthly **July 24, 2025 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman Lomeli called the meeting to order at 5:03 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present (Arrived at 5:20 p.m.)
- Hans Kashyap, Director – Absent
- Gaurang Pandya, Director - Present

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Jeff Hudson, Patient Care Services Strategy Advisor, Brandy Irwin, Interim Chief Nursing Officer, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor-DeShazo, Director of Marketing and Communications, Silvia Roberts, Director of Care Integration, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff.

I. Approval of Agenda:

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

KASHYAP	Absent
MARTINEZ	Absent
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:09 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 Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

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

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services. Estimated date of disclosure January 1, 2026.

Director Martinez arrived to the meeting at 5:20 p.m. during the Closed Session Item C.

Closed Session Items D and E were deferred to the conclusion of Open Session, as there was not sufficient time to address these items prior to the scheduled start of Open Session.

III. Open Session: Chair LOMELI adjourned Closed Session at 5:36 p.m., reconvening in Open Session at 5:36 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.
Information Only; No Action Taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – Quality of Care/Peer Review/Credentials
This item was deferred to the end of Open Session.

C. Discussion Regarding Trade Secret
Information Only; No Action Taken

IV. Public Comments

Kathleen Adams – Submitted a photocopy of a recent Porterville Recorder article regarding Emergency Room improvements, accompanied by a letter summarizing her dissatisfaction with her patient 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). Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director PANDYA, and carried to approve the Consent Agenda. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Abstain
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director PANDYA and seconded by Director MARTINEZ to approve the June 24, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

VII. Business Items

A. June 2025 Financials

Craig McDonald, CFO presented the Financials for June 2025.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair REDDY and carried to approve the June 2025 Financials as presented. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

B. Capital Report – Quarter Ending June 30, 2025

Craig McDonald, CFO presented the quarterly capital report.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair REDDY and carried to approve the Capital Report Quarter ending June 30, 2025 as presented. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

C. Investment Report – Quarter Ending June 30, 2025

Craig McDonald, CFO presented the quarterly investment report .

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair REDDY and carried to approve the Investment Report Quarter Ending June 30, 205 as presented. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

VIII. SVLHCD Board Chair Report

Chairman Lomeli announced that he is no longer working for Family Health Care Network and therefore no longer has a conflict of interest. He has accepted a position working for a local dermatologist.

IX. CEO Report

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

IX. Announcements:

A. Regular Board of Directors Meeting – August 26, 2025 at 5:00 p.m.

X. Closed Session: Chairman LOMELI adjourned Open Session at 6:11 p.m., reconvening in Closed Session at 6:19 p.m.

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

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

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

Director Pandya briefly accepted a phone call and immediately ended the call.

E. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Item).

XI. Open Session: Chairman LOMELI adjourned Closed Session at 7:05 p.m., reconvening in Open Session at 7:06 p.m.

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director Martinez and carried to approve the Evaluation – Quality of Care/Peer Review/Credentials as presented. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Abstain
REDDY	Yes
LOMELI	Yes

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

E. Conference with Legal Counsel
Recommended Action: Information Only; No Action Taken

XII. Adjournment

The meeting was adjourned at 7:06 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Jul-25

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
July 2025

Statistic	Jul-25 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 25 YTD	Increase/ (Decrease) Jul-24	% Change
Utilization											
SNF Patient Days											
Total	-	56	(56)	-100.0%	-	56	(56)	-100.0%	31	(31)	-100.0%
Medi-Cal	-	56	(56)	-100.0%	-	56	(56)	-100.0%	31	(31)	-100.0%
Sub-Acute Patient Days											
Total	1,069	970	99	10.2%	1,069	970	99	10.2%	1,047	22	2.1%
Medi-Cal	496	516	(20)	-3.8%	496	516	(20)	-3.8%	557	(61)	-11.0%
Acute Patient Days	1,753	1,618	135	8.3%	1,753	1,618	135	8.3%	1,559	194	12.4%
Acute Discharges	480	429	51	11.9%	480	429	51	11.9%	429	51	11.9%
Medicare	184	170	14	8.2%	184	170	14	8.2%	170	14	8.2%
Medi-Cal	242	191	51	26.7%	242	191	51	26.7%	191	51	26.7%
Contract	51	62	(11)	-17.7%	51	62	(11)	-17.7%	62	(11)	-17.7%
Other	3	6	(3)	-50.0%	3	6	(3)	-50.0%	6	(3)	-50.0%
Average Length of Stay	3.65	3.77	(0.12)	-3.2%	3.65	3.77	(0.12)	-3.2%	3.63	0.02	0.5%
Newborn Patient Days											
Medi-Cal	190	148	42	28.8%	190	148	42	28.8%	147	43	29.3%
Other	42	33	9	25.5%	42	33	9	25.5%	34	8	23.5%
Total	232	181	51	28.2%	232	181	51	28.2%	181	51	28.2%
Total Deliveries	119	92	27	29.3%	119	92	27	29.3%	92	27	29.3%
Medi-Cal %	81.82%	83.43%	-1.61%	-1.9%	81.82%	83.43%	-1.61%	-1.9%	83.70%	-1.88%	-2.2%
Case Mix Index											
Medicare	1.3362	1.6368	(0.3006)	-18.4%	1.3362	1.6368	(0.3006)	-18.4%	1.6067	(0.2705)	-16.8%
Medi-Cal	1.0458	1.1975	(0.1517)	-12.7%	1.0458	1.1975	(0.1517)	-12.7%	1.2171	(0.1713)	-14.1%
Overall	1.1640	1.3724	(0.2084)	-15.2%	1.1640	1.3724	(0.2084)	-15.2%	1.4048	(0.2408)	-17.1%
Ancillary Services											
Inpatient											
Surgery Minutes	7,987	8,105	(118)	-1.5%	7,987	8,105	(118)	-1.5%	6,345	1,642	25.9%
Surgery Cases	97	89	8	9.2%	97	89	8	9.2%	77	20	26.0%
Imaging Procedures	1,738	1,574	164	10.4%	1,738	1,574	164	10.4%	1,515	223	14.7%
Outpatient											
Surgery Minutes	16,020	14,760	1,260	8.5%	16,020	14,760	1,260	8.5%	13,600	2,420	17.8%
Surgery Cases	205	205	0	0.2%	205	205	0	0.2%	169	36	21.3%
Endoscopy Procedures	193	195	(2)	-1.0%	193	195	(2)	-1.0%	209	(16)	-7.7%
Imaging Procedures	4,196	4,385	(189)	-4.3%	4,196	4,385	(189)	-4.3%	3,504	692	19.7%
MRI Procedures	341	318	23	7.4%	341	318	23	7.4%	268	73	27.2%
CT Procedures	1,394	1,319	75	5.7%	1,394	1,319	75	5.7%	1,248	146	11.7%
Ultrasound Procedures	1,480	1,421	59	4.1%	1,480	1,421	59	4.1%	1,361	119	8.7%
Lab Tests	35,940	33,776	2,164	6.4%	35,940	33,776	2,164	6.4%	32,923	3,017	9.2%
Dialysis	7	4	3	98.6%	7	4	3	98.6%	-	7	

Sierra View Medical Center
Financial Statistics Summary Report
July 2025

	Jul-25				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 25 YTD	(Decrease) Jul-24	% Change
Cancer Treatment Center											
Chemo Treatments	2,125	2,105	20	0.9%	2,125	2,105	20	0.9%	2,419	(294)	-12.2%
Radiation Treatments	1,180	2,007	(827)	-41.2%	1,180	2,007	(827)	-41.2%	2,432	(1,252)	-51.5%
Cardiac Cath Lab											
Cath Lab IP Procedures	16	15	1	9.4%	16	15	1	9.4%	10	6	60.0%
Cath Lab OP Procedures	33	35	(2)	-5.2%	33	35	(2)	-5.2%	26	7	26.9%
Total Cardiac Cath Lab	49	49	(0)	-0.9%	49	49	(0)	-0.9%	36	13	36.1%
Outpatient Visits											
Emergency	3,243	3,374	(131)	-3.9%	3,243	3,374	(131)	-3.9%	3,371	(128)	-3.8%
Total Outpatient	15,109	14,964	145	1.0%	15,109	14,964	145	1.0%	13,844	1,265	9.1%
Staffing											
Paid FTE's	909.38	900.16	9.22	1.0%	909.38	900.16	9.22	1.0%	879.65	29.73	3.4%
Productive FTE's	762.92	772.13	(9.21)	-1.2%	762.92	772.13	(9.21)	-1.2%	730.04	32.88	4.5%
Paid FTE's/AOB	4.99	5.44	(0.45)	-8.3%	4.99	5.44	(0.45)	-8.3%	5.27	(0.28)	-5.4%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,821	11,922	(1,102)	-9.2%	10,821	11,922	(1,102)	-9.2%	11,109	(288)	-2.6%
Cost/Adj.Patient Day	2,615	3,006	(391)	-13.0%	2,615	3,006	(391)	-13.0%	2,671	(57)	-2.1%
Revenue/Adj. Discharge	51,461	58,837	(7,376)	-12.5%	51,461	58,837	(7,376)	-12.5%	54,001	(2,540)	-4.7%
Cost/Adj. Discharge	12,435	14,832	(2,398)	-16.2%	12,435	14,832	(2,398)	-16.2%	12,986	(551)	-4.2%
Adj. Discharge	1,188	1,039	149	14.3%	1,188	1,039	149	14.3%	1,064	124	11.7%
Net Op. Gain/(Loss) %	1.30%	0.48%	0.82%	170.6%	1.30%	0.48%	0.82%	170.6%	-3.19%	4.50%	-140.8%
Net Op. Gain/(Loss) $	194,980	74,560	120,420	161.5%	194,980	74,560	120,420	161.5%	(427,527)	622,507	-145.6%
Gross Days in Accts Rec.	89.17	95.03	(5.86)	-6.2%	89.17	95.03	(5.86)	-6.2%	92.76	(3.59)	-3.9%
Net Days in Accts. Rec.	37.23	57.75	(20.51)	-35.5%	37.23	57.75	(20.51)	-35.5%	46.66	(9.43)	-20.2%

Sierra View Local Health Care District
Balance Sheet

	Jul-25	Jun-25
Assets		
Current Assets:		
Cash & Cash Equivalents	20,639,841	22,428,191
Short-Term Investments	1,499,446	-
Assets Limited As To Use	1,062,085	5,499,933
Patient Accounts Receivable	176,718,952	173,258,474
Less Uncollectables	(13,692,139)	(14,220,797)
Contractual Allowances	(143,913,973)	(139,641,335)
Other Receivables	21,954,330	20,268,455
Inventories	4,513,125	4,492,911
Prepaid Expenses and Deposits	3,202,007	2,619,918
Less Receivable - Current	279,983	279,983
Total Current Assets	**72,263,657**	**74,985,732**
Assets Limited as to use, Less		
Current Requirements	32,368,359	32,278,190
Long-Term Investments	137,671,971	139,055,728
Property, Plant and Equipment, Net	71,125,559	71,549,704
Intangible Right of use Assets	267,111	279,156
SBITA Right of use Assets	3,349,249	3,498,677
Lease Receivable - LT	703,090	727,672
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,237,797	1,258,777
Total Assets	**319,236,793**	**323,883,637**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	101,471	693,525
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	854,806	939,806
Account Payable and Accrued Expenses	4,807,327	5,147,989
Accrued Payroll and Related Costs	6,389,342	6,462,574
Estimated Third-Party Payor Settlements	4,772,037	4,408,713
Lease Liability - Current	128,275	130,007
SBITA Liability - Current	1,694,214	1,696,245
Total Current Liabilities	**22,982,471**	**23,713,858**
Self-Insurance Reserves	2,115,953	2,129,089
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	33,275,000
Bonds Premium Liability - LT	2,033,056	2,078,576
Lease Liability - LT	162,087	172,542
SBITA Liability - LT	2,040,472	2,157,786
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	921,530	946,027
Total Liabilities	**59,295,569**	**64,472,878**
Unresticted Fund	259,410,759	259,410,759
Profit or (Loss)	530,465	-
Total Liabilities and Fund Balance	**319,236,793**	**323,883,637**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Jul-25**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,851,201	5,278,322	572,879	11%	5,851,201	5,278,322	572,879	11%
Inpatient - Ancillary	18,901,475	19,962,552	(1,061,077)	(5%)	18,901,475	19,962,552	(1,061,077)	(5%)
Total Inpatient Revenue	**24,752,676**	**25,240,874**	**(488,198)**	(2%)	**24,752,676**	**25,240,874**	**(488,198)**	(2%)
Outpatient - Ancillary	36,382,805	35,910,670	472,135	1%	36,382,805	35,910,670	472,135	1%
Total Patient Revenue	**61,135,482**	**61,151,544**	**(16,062)**	(0%)	**61,135,482**	**61,151,544**	**(16,062)**	(0%)
Medicare	(20,650,187)	(20,240,092)	(410,095)	2%	(20,650,187)	(20,240,092)	(410,095)	2%
Medi-Cal	(22,858,976)	(18,785,146)	(4,073,830)	22%	(22,858,976)	(18,785,146)	(4,073,830)	22%
Other/Charity	(3,305,276)	(7,190,155)	3,884,879	(54%)	(3,305,276)	(7,190,155)	3,884,879	(54%)
Discounts & Allowances	(104,342)	(19,138)	(85,204)	445%	(104,342)	(19,138)	(85,204)	445%
Bad Debts	17,350	(244,606)	261,956	(107%)	17,350	(244,606)	261,956	(107%)
Total Deductions	**(46,901,431)**	**(46,479,137)**	**(422,294)**	1%	**(46,901,431)**	**(46,479,137)**	**(422,294)**	1%
Net Service Revenue	**14,234,051**	**14,672,407**	**(438,356)**	(3%)	**14,234,051**	**14,672,407**	**(438,356)**	(3%)
Other Operating Revenue	733,206	818,039	(84,833)	(10%)	733,206	818,039	(84,833)	(10%)
Total Operating Revenue	**14,967,258**	**15,490,446**	**(523,188)**	(3%)	**14,967,258**	**15,490,446**	**(523,188)**	(3%)
Salaries	6,180,099	6,071,526	(108,573)	(2%)	6,180,099	6,071,526	(108,573)	(2%)
S&W PTO	693,972	715,488	21,516	3%	693,972	715,488	21,516	3%
Employee Benefits	1,465,787	1,460,204	(5,583)	(0%)	1,465,787	1,460,204	(5,583)	(0%)
Professional Fees	1,474,104	1,889,826	415,722	22%	1,474,104	1,889,826	415,722	22%
Purchased Services	651,091	911,743	260,652	29%	651,091	911,743	260,652	29%
Supplies & Expenses	2,425,818	2,378,769	(47,049)	(2%)	2,425,818	2,378,769	(47,049)	(2%)
Maintenance & Repairs	210,606	303,754	93,148	31%	210,606	303,754	93,148	31%
Utilities	266,477	306,217	39,740	13%	266,477	306,217	39,740	13%
Rent/Lease	30,196	30,041	(155)	(1%)	30,196	30,041	(155)	(1%)
Insurance	144,808	122,727	(22,081)	(18%)	144,808	122,727	(22,081)	(18%)
Depreciation/Amortization	812,022	811,079	(943)	(0%)	812,022	811,079	(943)	(0%)
Other Expense	417,299	414,512	(2,787)	(1%)	417,299	414,512	(2,787)	(1%)
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**14,772,278**	**15,415,886**	**643,608**	4%	**14,772,278**	**15,415,886**	**643,608**	4%
Net Gain/(Loss) From Operations	**194,980**	**74,560**	**120,420**	**162%**	**194,980**	**74,560**	**120,420**	**162%**
District Taxes	138,477	138,477	-	0%	138,477	138,477	-	0%
Investment Income	509,936	488,226	21,710	4%	509,936	488,226	21,710	4%
Other Non - Operating Income	29,057	40,308	(11,251)	(28%)	29,057	40,308	(11,251)	(28%)
Interest Expense	(75,620)	(70,649)	(4,971)	(7%)	(75,620)	(70,649)	(4,971)	(7%)
Non-Operating Expense	(62,857)	(39,854)	(23,003)	(58%)	(62,857)	(39,854)	(23,003)	(58%)
Total Non-Operating Income	**538,992**	**556,508**	**(17,516)**	(3%)	**538,992**	**556,508**	**(17,516)**	(3%)
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**733,972**	**631,068**	**102,904**	**16%**	**733,972**	**631,068**	**102,904**	**16%**
Net Incr/(Decr) in the Fair Value Invstmt	(203,507)	162,500	(366,007)	(225%)	(203,507)	162,500	(366,007)	(225%)
Net Gain/(Loss)	**530,465**	**793,568**	**(263,103)**	(33%)	**530,465**	**793,568**	**(263,103)**	(33%)

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SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
July-25

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	194,980	194,980
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	812,022	812,022
Provision for bad debts	(528,658)	(528,658)
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	812,160	812,160
Other receivables	(1,685,875)	(1,685,875)
Inventories	(20,215)	(20,215)
Prepaid expenses and deposits	(582,089)	(582,089)
Advance refunding of bonds payable, net	20,980	20,980
Accounts payable and accrued expenses	(340,662)	(340,662)
Deferred inflows - leases	(24,497)	(24,497)
Accrued payroll and related costs	(73,232)	(73,232)
Estimated third-party payor settlements	363,324	363,324
Self-insurance reserves	(13,136)	(13,136)
Total adjustments	(1,259,878)	(1,259,878)
Net cash provided by (used in) operating activities	(1,064,898)	(1,064,898)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	138,477
Noncapital grants and contributions, net of other expenses	(52,504)	(52,504)
Net cash provided by (used in) noncapital financing activities	85,973	85,973
Cash flows from capital and related financing activities:		
Purchase of capital assets	(375,832)	(375,832)
Proceeds from sale of assets	-	-
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	24,582	24,582
Principal payments on debt borrowings	(4,235,000)	(4,235,000)
Interest payments	(694,491)	(694,491)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(67,104)	(67,104)
Net changes in assets limited as to use	4,347,679	4,347,679
Net cash provided by (used in) capital and related financing activities	(1,000,166)	(1,000,166)
Cash flows from investing activities:		
Net (purchase) or sale of investments	1,180,250	1,180,250
Investment income	509,936	509,936
Net cash provided by (used in) investing activities	1,690,186	1,690,186
Net increase (decrease) in cash and cash equivalents:	(288,905)	(288,905)
Cash and cash equivalents at beginning of month/year	22,428,191	22,428,191
Cash and cash equivalents at end of month	22,139,287	22,139,287
	22,139,287	22,139,287
	-	-

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
July 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Aug-24	10,684,807	298,095	10,982,902
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	14,933,404	1,420,062	16,353,466
Nov-24	11,872,571	1,402,779	13,275,350
Dec-24	13,002,191	6,026,303	19,028,494
Jan-25	12,353,155	4,293,154	16,646,309
Feb-25	9,516,870	8,335,277	17,852,147
Mar-25	13,111,820	451,259	13,563,079
Apr-25	13,460,422	8,143,789	21,604,211
May-25	12,344,513	9,292,615	21,637,128
Jun-25	10,549,177	4,753,556	15,302,733
Jul-25	**13,219,919**	**932,239**	**14,152,158**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues, sale of assets

- Medi-Cal OP Supplemental and DSH Funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP Supplemental Funds
- Medicare interim payments

July 2025 Summary of Other Activity:

206,990	M-Care Temporary Allowance Cost Report FY13
207,591	M-Care Temporary Allowance Cost Report FY12
253,428	M-Care interim payments
264,230	Miscellaneous
932,239	07/25 Total Other Activity