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

AGENDA
March 25, 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

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning. Estimated date of Disclosure: January 1, 2027

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

E. 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

F. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (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 Update – Quality Report
   Recommended Action: Approve/Disapprove Report as Given

C. Discussion Regarding Trade Secrets Pertaining to Service
   Recommended Action: Information Only; No Action Taken

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

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
   Action Recommended: Information Only; No Action Taken

F. 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. **February 25, 2025 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove February 25, 2025 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. **Porterville Academy of Health Science (PAHS) Health Career Scholarship**
Recommended Action: Approve/Disapprove

B. **February 2025 Financials**
Recommended Action: Approve/Disapprove Report as Given

C. **Conflict of Interest Code**
Recommended Action: Approve/Disapprove Adoption of Conflict of Interest Code

D. **Request to Increase OR Air Handler Unit Capital Project Budget**
Recommended Action: Approve increase in capital budget set in 2020 to reflect current project costs

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – April 22, 2025 at 5:00 p.m.

B. Form 700 due April 1, 2025. Disclosure forms must be on file with the Board Administrator by that date.

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of

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

Senior Leadership Team	3/25/2025
Board of Director's Approval	
Liberty Lomeli, Chairman	3/25/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
MARCH 25, 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**
Policies:		Approve ↓
• Benefits	1-6	
• Conflict of Interest	7-11	
• Meal Discount	12-13	

SUBJECT: **BENEFITS**	SECTION: **Page 1 of 6**

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

PURPOSE:

To describe the philosophy, governance and general circumstances of providing benefit plans which offer reasonable protection, income security, and rest and relaxation to eligible employees of SVMC.

POLICY:

To provide benefits, in a consistent manner, that enhances the Hospital's ability to recruit and retain quality employees.

AFFECTED PERSONNEL/AREAS: *ALL ELIGIBLE EMPLOYEES*

PROCEDURE:

The Human Resources Department shall advise employees individually about their eligibility, and provide information about their benefits at the following times:

(1) During the employees initial orientation,
(2) At the time of any employment status changes,
(3) Specifically defined qualifying events on a group basis:
(4) During open enrollment periods,
(5) Not less than annually.

- Employees are responsible to enroll in a group health, dental, and vision plan and/or voluntary benefits with the enrollment company prior to the expiration of eligibility dates.

- Employees are responsible for making changes to their benefits with SVMC Benefits Center each year or during a qualifying event. All benefit changes require the employee's confirmation.

GENERAL ELIGIBILITY

Benefit eligibility is defined by employment status as determined by scheduled hours worked. Effective dates appearing on Employee Change of Status Notices determine eligibility, waiting periods, accruals and payment determinations. (*See Employment Status Policy).*

Eligibility Defined by Employment Status:

1. **Full-time (FT)** Employees are eligible for employer-sponsored benefits.

2. **Part-time (PT)** Employees do not participate in employer-sponsored paid or accrued benefits. Part-time employees may purchase healthcare insurance, and other elective benefit plans and pay 100% of the premiums. However, employees who worked an average of 30 hours per week during the last measurement period will pay the same cost as a full time employee until the end of the year in which the employee qualified for. The measurement period begins every year on November 1st and runs through the next year to October 31st. Part-time employees may participate in 125 Savings Accounts and Voluntary Deferred Savings Accounts.

3. **Per-diem (PD)** Employees are not eligible to participate in the benefit plans and may not purchase healthcare insurance or elective benefit plans. However, PD ACA eligible employees who worked an average of 30 hours per week during the last measurement period will be offered healthcare insurance benefits for the next stability period. For more information, contact the HR department.

4. **Temporary (TEMP)** Are not eligible to participate in benefit plans and may not purchase healthcare insurance or other elective benefit plans.

ENROLLMENT PROCESS

Employer Sponsored Benefits:

Eligible employees must enroll within thirty-days (30) from their date of hire or status change. The effective date is the first of the month following thirty (30) days from the employee's date of hire or status change. Employees who fail to enroll within the thirty day window are required to wait until the next annual open enrollment period.

A dependent's effective date for benefit purposes is normally the same date as the employee's, (providing the dependent is properly enrolled at that time), or the date of the "qualifying event". New dependents must be enrolled within thirty (30) days of the qualifying event. Employees who fail to enroll new dependents after thirty (30) days of the defined date of eligibility are required to wait until the next annual open enrollment period.

Benefit Premiums:

Full time, part time, and ACA PD employee contributions for benefit plans occur through payroll deductions with the employee's authorization, unless otherwise designated under the policy plan documents. If ACA PD employee does not have enough earnings to cover contribution amounts, ACA PD employee is responsible to make payment arrangements with HR. Missed contribution amounts must be paid within 30 days from date contributions were missed. Changes to benefit related payroll deductions may be made during the year when an employee experiences certain "qualifying events."

Qualifying Events:

Employees may qualify for enrollments occurring after the initial enrollment, and outside of the Open Enrollment Period. Each benefits plan separately defines a "qualifying event" for purposes of enrollment of benefits outside of the initial enrollment and/or Open Enrollment Period. Depending upon the specific plan, the following life events may be deemed a "qualifying event":

1. Change in marital status.

2. A new dependent as a result of marriage or a registered domestic partner, birth, adoption or placement for adoption, and within the time period applicable by California and Federal statutes or plan administration.

3. When a court has ordered coverage for a spouse or minor child, or it is required by State and Federal Legal obligation.

4. Termination of former insurance for employee or dependents. Employee must present proof that the alternative insurance terminated.

5. Employee goes on a Leave of Absence.

For all qualifying events, employees must complete their new enrollment within thirty (30) days of the date of the event. There will be a 30 day waiting period. Benefits will become effective the first of the month following the 30 day waiting period.

Employment Status Changes:

All benefits affected by a change in status will be effective the first day of the month following thirty days of the change. *(See Employment Status Policy)*

FT, PT to PD Status Change

- The employee's benefits will cease at the end of the month in which the status change is made.
- If elected, the employee may continue individual and family healthcare benefits by paying full cost of the benefits through COBRA plans.
- If employee has worked an average of 30 hours per week in the past year (measurement period), they can continue benefits at the same cost as a full time employee until the end of the year in which the status change occurred. However, the employee must elect to continue their existing coverage within 30 days of the status change.
- Participation in the District's retirement plan will cease the pay period following the change in status.

PT, PD, TEMP to FT Status Change

- The employee's benefits will become effective the first of the month following thirty (30) days of the date of the status change.

Termination

- Benefits will terminate on the last day of employment.

125 Spending Accounts - Payroll Deductions:

Regular contributions for 125 spending accounts occur through payroll deductions upon receipt of the employee's authorization. Employees may elect tax-deferred 125 spending accounts for outside medical

premiums, dependent care expenses, as well as unreimbursed medical expenses. The Internal Revenue Code does not permit employees who are electing payroll deductions to change their elections until the beginning of the next plan year. *Exceptions are: Spouse loses job and/or change in family status, such as marriage, divorce, death, and additional dependents.*

Retirement Plan Contributions: 401(a)/457(b):

Voluntary retirement plans are available to full-time and part-time employees subject to the waiting periods as defined below. Employees may obtain a summary plan description and enrollment information from Human Resources.

401(a):
A 401(a) plan is a retirement plan designed to allow employers to supplement their employees existing retirement benefits by contributing to the plan on the employees' behalf. Contributions and any earnings on contributions are tax-deferred until the money is withdrawn. The plan provides employer contributions in the amounts detailed below. Employees must complete six (6) months of service, and meet the minimum 457(b) voluntary salary contribution, to receive the 401(a) employer match.
Employees hired prior to 8/1/20, are eligible for a 6% match if they are contributing a minimum of 4% of their pay after 6 months of service and a 10% match if they are contributing a minimum of 10% of their pay after 3 years of service. Employees hired prior to 8/1/20 are 100% vested upon hire.
Employees hired on or after 8/1/20, are eligible for 4% match if they are contributing a minimum of 4% of their pay after 6 months of service and a 6% match if they are contributing a minimum of 6% of their pay after 3 years of service. Employees hired on or after 8/1/20 are 100% vested at 5 years of service, with a 20% increase each year.

457(b):
A 457(b) deferred compensation plan is a retirement savings plan that allows eligible employees to supplement any existing retirement benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are subject to ordinary income tax. Employees may contribute to the 457(b) plan and are 100% vested as of date of hire.

LEAVES OF ABSENCE

Employees on Family Medical Leave (FMLA), Pregnancy Disability Leave (PDL), and/or California Family Rights Act (CFRA) protected leave of absence will continue to receive health benefits at the same level as if they were working as required by law. *(See Leave of Absence-FMLA/CFRA policy or Leave of Absence-Pregnancy Disability policy.)*

Employees on unprotected leaves of absence may continue coverage in the group medical, vision, and dental plans by paying full cost plus 2% administration fees of the benefits under COBRA. *(See Leave of Absence- Personal policy, Leave of Absence-Administrative policy and Reasonable Accommodations policy.)*

Re-employment:

If an employee terminates employment and is later re-employed; he or she will be treated like a new employee with respect to all employer-sponsored paid, unpaid, and accrued benefits, with the exception of retirement. For retirement benefits, any previous employment will apply if records can be obtained in order to calculate the match eligibility for both the 401 (a) and 457 (b). Re-hires with an original date of hire prior to 8/1/20 are grandfathered to the match eligibility for employees hired prior to 8/1/20 and are 100% vested on former 401(a) balance however 100% vested at 5 years of cumulative service on the 401(a) balance contributed from date of re-hire.

CONTINUATION OF COVERAGE (COBRA)

Current benefit participants and their dependents may elect to continue existing benefits at group rates where coverage under the plan would otherwise end. Employees have the right to choose continuation of coverage under COBRA (Consolidation Omnibus Budget Reconciliation Act of 1986) if employees lose group health coverage because of a COBRA qualifying event. Payments are made directly to SVMC Benefits Center.

Employees are provided with notice regarding continuation of coverage at the time they are hired, and employees and covered dependents are provided additional notice when qualifying events occur or employment ceases.

GOVERNANCE AND COMPLIANCE

Benefit Administration and Compliance:

The District shall on a regular basis, or at least annually, review benefit plans for adequacy of coverage, cost-effectiveness, consistency with District values and objectives and make recommendations to the Board of Directors. The Board of Directors shall review and approve employee-employer healthcare premium allocations, and benefit vendors annually, or on an as needed basis.

The District shall administer benefit plans and operating practices in full compliance with California and Federal statutes. Questions regarding the administration or operating practices shall default in favor of, and always reflect revision of, statute, either known or unknown.

Disclaimer:

Benefit plans are governed by their summary plan documents, copies of which are continuously available for review in the Human Resources Department. Disputes regarding the operation or payment of benefits are subject to the appeal process provided in the plan and are not subject to the District's "Employee Concerns" policy. This policy is a general statement about administration of employee benefits and does not supersede California and Federal statutes or applicable plan documents.

REFERENCES:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA). (2018, September 14). Retrieved October 21, 2020, from https://www.cdc.gov/phlp/publications/topic/hipaa.html.
- Family and Medical Leave Act. (n.d.). Retrieved October 21, 2020, from https://www.dol.gov/agencies/whd/fmla.
- Pregnancy Disability Leave: Everything You Need to Know. (n.d.). Retrieved October 21, 2020, from https://www.upcounsel.com/pregnancy-disability-leave.
- California Family Rights Act - DFEH. (n.d.). Retrieved October 21, 2020, from https://www.dfeh.ca.gov/wp-content/uploads/sites/32/2019/08/DFEH_CFRA_Pamphlet.pdf.

CROSS REFERENCES:

- Employment Status
- Employee Grievance/Concerns
- Vacation/Holiday Leave
- Leave of Absence- FMLA/CFRA
- Leave of Absence-Pregnancy Disability
- Leave of Absence- Personal
- Reasonable Accommodations

SUBJECT: **CONFLICT OF INTEREST**	SECTION: **Page 1 of 5**

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

PURPOSE:

To ensure the integrity of business and patient care decisions made by individuals on behalf of the organization. Business and patient care decisions should be free of personal bias, interest or gain. The intent of this policy will be met when decisions are made fairly and objectively, for the benefit of the organization and the community we serve.

POLICY STATEMENT:

Personal interests will be disclosed when they present actual or potential conflicts with the interests of Sierra View Medical Center (SVMC), or appear to conflict with the objectivity and integrity of professional roles and responsibilities. Decisions about SVMC's operation and the use or disposition of its assets are made in terms of the benefits for the organization's mission and purpose. SVMC takes steps to ensure that such decisions are not influenced by actual or possible conflicting interests of the individuals affiliated with SVMC.

AFFECTED AREAS/PERSONNEL:

ALL EMPLOYEES, BOARD MEMBERS, AND OTHERS AS MAY BE DETERMINED BY THE BOARD OR CHIEF EXECUTIVE OFFICER (CEO).

DEFINITIONS:

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

Conflict of Interest: An actual, potential or perceived conflict of interest occurs in those circumstances where an individual's judgment could be affected because the individual has a personal interest (including a financial interest) in the outcome of a decision over which the individual has control or influence. A personal interest exists when an individual or a member of his or her immediate family stands to directly or indirectly gain as a result of a decision.

Interested Person: Any board member or employee of SVMC (or other agent or professional of SVMC as may be determined by the governing board or CEO) who has a direct or indirect financial interest, as defined below, is an *interested person*. If a person is an interested person with respect to SVMC or any entity owned or managed by SVMC, he or she is an interested person with respect to all entities in the SVMC health care organization.

Financial Interest: A financial interest does not necessarily implicate a conflict of interest. A person who has a financial interest may have a conflict of interest only if the *determining body* decides that a conflict of interest exists. A person has a financial interest if he/she has, directly or indirectly, through business, investment, or family: (1) an ownership or investment interest in any entity with which SVMC has a transaction or arrangement, (2) a financial arrangement with SVMC or with any entity or individual with which SVMC has a transaction or arrangement, or (3) a potential ownership or investment interest in, or financial arrangement with, any entity or individual with which SVMC is negotiating a transaction or arrangement.

Inappropriate Use or Disposition of SVMC Assets: All assets, including funds, equipment, staff, and space, are to be used in accordance with the mission and purpose of SVMC. Inappropriate use of such assets for personal gain is a conflict of interest which shall be treated as a "financial interest" and shall be subject to the procedures detailed below.

Supplier of any entity of SVMC: Includes any organization which provides services or supplies to SVMC, any subcontractor to a supplier of any entity of SVMC, or any individual who provides services or supplies to any entity of SVMC.

Immediate Family: For the purposes of this Conflict of Interest policy, the term immediate family is defined as the employee's or Board member's spouse, child, sibling, birth or adoptive parent, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, brother-in-law or sister-in-law; grandparent or grandchild; and spouse of grandparent or grandchild, and those relatives of the employee's spouse who live in the same household as the employee.

Employee: Includes all regular full-time, part-time, per diem, and temporary employees.

Board Member: A publicly elected director who is a member of the Board of Directors.

PROCEDURE:

1. Duty to Disclose:

   Any individual who would fall within the definition of "interested person" who believes that he/she has a financial interest which could put them in a conflict of interest situation must disclose the facts in a memorandum to his/her supervisor within 15 days of identifying the financial interest. A copy must be filed with the Compliance Officer (CO). The individual is then obligated to remove themselves from any decision related to business with the entity in which they have a financial interest, at least until such time as a determination is reached as to whether a conflict of interest situation exists. If a conflict of interest is determined to exist, the interested person will remove themselves from any discussions which may lead to such decisions, and abstain from participating in those decisions.

   The Political Reform Act requires local government agencies to adopt and promulgate a conflict of interest code. This code is designed to ensure that board members and employees do not engage in government decision making in which the officer or employee may have a financial interest. Board members and decision making employees designated in SVMC's Conflict of Interest Code are required to file periodic public statements disclosing their personal economic interests (Form 700). See separate policy Conflict of Interest Code.

2. Determination of Conflict:

A group or committee at least one level higher in the leadership hierarchy than the person disclosing (or exhibiting) a potential conflict of interest would be appropriate for reviewing the facts and making a determination as to whether a conflict of interest situation exists. For example, if the subject is a director, that person's VP (or Senior Management as a whole) could make the determination. The designation of this group or committee shall be the responsibility of the CEO, based upon the recommendation of the CO, following receipt of a disclosure of a potential conflict of interest. In the event that the CO or the interested person disagrees with the determination of conflict, the CEO and/or Board may review the determination and agree or revise accordingly. A potential conflict of interest involving a Board member will be reviewed and determination made by the CO or designee in conjunction with the Board's legal counsel.

3. Investigation of Potential Violations:

The CO will assess the case, and provide results of the investigation to the determining body. If someone is found to have violated this policy, the violator will be subject to disciplinary measures as determined by the CEO or CO. In the event of any such violation, the CO will also assess whether any additional actions must be taken by SVMC as a result of the violation.

4. Documentation:

Results of reviews, investigations and/or determinations related to conflict of interest situations should be reflected in the minutes of the determining body's meetings or otherwise reflected in a written memorandum, and kept on file by the CO, as well as included in the official employment file of the interested person.

5. Detection and Prevention:

Periodic reviews of financial arrangements should be conducted by the CO or designee. Additionally, leadership will at least annually remind interested persons of their self-disclosure responsibilities, and shall conduct routine monitoring to ensure policy processes are being followed. Reviews will be periodically conducted to ensure relationships between SVMC (and/or its employees and Board members) and other care providers, educational institutions, and payers are compliant with federal and state laws and regulations.

6. Conflict Situations:

While impossible to list all circumstances giving rise to a possible conflict of interest, the following are examples of implicit or explicit conflicts, which are prohibited:

a. Pursuit of any outside activities similar to or in competition with the business or functional support activities of any entity of SVMC.

b. Use or disposition of SVMC assets in a manner which is inconsistent with SVMC's mission and purpose, for example, using SVMC staff or resources to advance an outside personal business.

c. Current employee, Board member or immediate family member entering into a fee-for-service contract with any entity of SVMC. Any Board member or immediate family member accepting employment in any capacity with SVMC.

d. Substantial financial interest by the employee or Board member or member of his/her immediate family, whether as a significant stockholder (or other owner) or creditor, in any enterprise of which a substantial part of the business involves acting as a supplier of any entity of SVMC, or in any such organization that is a competitor or substantial customer of any entity of SVMC. Exceptions can apply if disclosure of such interests is forthcoming, a supportive *determination* is made, and the employee or board member abstains from participating in business decisions regarding these enterprises.

e. Substantial interest by the employee or Board member or member of his/her immediate family, whether as a significant stockholder (or other owner) or creditor, in any enterprise with which the employee deals directly or indirectly on behalf of any entity of SVMC, whether or not the volume of business transacted with such enterprise is substantial.

f. Taking advantage of any "Proprietary Information" gained in the course of employment or in serving on the Board of Directors for the purpose of speculating in any business including the business of any entity of SVMC

g. Political Activity: SVMC and its employees and Board members are prohibited from expending public funds to promote a candidate in an election campaign. This means no SVMC employee or Board member shall partake in any form of support for a political candidate while on company time. Such an infraction could jeopardize SVMC's status as a not-for-profit entity. Nor are employees or Board members permitted to endorse any candidate or political entity as a representative of SVMC. Such an infraction could jeopardize SVMC's status as a not-for-profit entity.

h. Placing personal financial interests above the welfare of our patients; any conflict of interest that impacts or has the potential to impact the safety, quality of care, treatment, or services provided by the hospital, should be disclosed. In some cases, a potential conflict of interest concerning patient care can be managed (if a supportive *determination* is made) by formal disclosure with patients (i.e., via the informed consent process).

i. Acceptance of gifts or entertainment with excessive value during the course of your duties as an agent, board member, employee, volunteer or contractor of SVMC. For further details, see the "Gifts and Business Courtesies, Exchange Of" policy, which provides details on limitations and allowances.

REFERENCES:

- The Joint Commission (2021). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

  2 CCR 18730.
- US DHHS OIG General Compliance Program Guidance, November 2023
- Federal Register / Vol. 70, No. 19 / Monday, January 31, 2005, OIG: Supplemental Compliance Program Guidance for Hospitals.

CROSS REFERENCES:

- Conflict of Interest Code (Compliance with the Political Reform Act of 1974) Link
- Gifts and Business Courtesies, Exchange Of Link
- Code of Conduct Link
- Outside Employment Link

SUBJECT: **MEAL DISCOUNT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish meal discount guidelines for personnel working.

POLICY:

Personnel who are working and wearing their Sierra View Medical Center (SVMC) badge will receive a meal discount when eating food from the café. The Food and Nutrition Service (FNS) Director is responsible to monitor department costs and present meal cost analysis to the Senior Leadership Team.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PHYSICIANS, VOLUNTEERS, ON SITE SECURITY GUARDS & STUDENTS*

PROCEDURE:

1. Personnel must be wearing their SVMC badge and be on duty to receive discounted meal prices. Regular pricing will apply to employees without a SVMC badge and/or who are off-duty.

2. Items eligible for discount are established by the FNS Department, and pre-set and maintained in the Point of Sale (POS) computer software system.

3. Personnel (including, but not limited to, hospital staff, physicians, volunteers, security guards and students with SVMC badges) are eligible for meal discounts.

4. Complimentary coffee and brewed tea made in the Café is provided for all personnel on duty at no charge.

5. The café will charge for all to-go containers.

6. The café offers fountain soda refills for a reduced cost, with proof of receipt for the same day.

7. An appropriate charge for condiments and disposable products will be charged for customers utilizing these products for foods purchased off-site.

8. Bulk food purchases have the potential to deplete prepared food supplies for staff, visitors and physicians working and will not be permitted.

9. Discounted pricing applies to personnel as specified in this policy, and may not be extended to friends or family of qualifying personnel.

10. Complimentary (free) meals:
    a. The following personnel are eligible:
        - Emergency Department Physicians
        - Hospitalists
        - Intensivists
        - Anesthesiologists & CRNA's
        - Surgeons

    b. Convenient food items such as chips, pre-packaged items, bottled beverages, etc. are excluded and must be purchased.

    c. One meal per four (4) hour shift is permitted. Complementary meals may not be given or shared with non-eligible personnel.

11. Meal Allowance (Stipend)
    a. The following personnel are eligible:
        - Food Service Staff
        - GME Residents

    b. Meal stipends are funds linked to an employee's badge and are intended for use by the assigned employee only. They may not be shared or transferred to others.

    c. The meal stipend is designed to support the purchase of food and beverages consumed during working hours. While employees are welcome to purchase food for off-site consumption, such purchases are not covered by the stipend and must be paid for separately.

    d. Certain items, such as holiday cookies, are not eligible for purchase with the meal stipend, and must be paid for separately.

12. With the assistance of the FNS Director, the Senior Leadership Team will review meal cost analysis a minimum of annually and adjust prices as necessary.

MEDICAL EXECUTIVE COMMITTEE	03/05/2025
BOARD OF DIRECTORS APPROVAL	
	03/25/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
March 25, 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**
• Annual Infection Prevention Plan	1-32	
• Bloodborne Pathogen Exposure Protocol for Healthcare Workers	33-41	
• Code Blue/Code White	42-53	
• Crash Carts – Exchanging, Restocking, Security and Verification	54-62	
• Mitomycin Intravesical Instillation	63-65	
• Tablo Set Up, Treatment, and Post Device Care	66-71	
• Tuberculosis Control Plan	72-99	
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SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 1 of 32**

PURPOSE:

The goal of the Annual Infection Prevention Plan is to establish a comprehensive Infection Prevention (IP) and Control Program. By doing so, SVMC will continue to have a functioning, coordinated process in place to reduce the risks of endemic and epidemic healthcare-associated infections (HAIs) in patients, personnel, volunteers, independent licensed practitioners, and the community.

The update of the Annual Infection Prevention Plan is based on current epidemiological principles and methods. This will ensure appropriate standards and measures are set to maintain awareness and working knowledge of guidelines and recommendations that are published by regulatory and accrediting agencies (such as The Joint Commission and others), professional allied health organizations (APIC, SHEA, AORN and others) that provide current, evidence-based infection control services. The Infection Prevention Manager, under the guidance of the Pharmacy, Therapeutics and Infection Prevention Committee (P&T/IPC) and the IP Chairperson, will develop and conduct infection surveillance, prevention and control to promote optimal health of patients, personnel and the community surrounding Sierra View Medical Center (SVMC).

The Infection Prevention and Control Program will incorporate the following items in a continuing series within this policy:

- Surveillance, prevention and control of infections throughout the organization, in both inpatient and outpatient areas (IC.06.01.01. EP3).
- Screening and surveillance of diseases with pandemic potential (e.g., Ebola, Zika, COVID-19, Mpox)
- Develop alternative techniques to address real and potential exposures (IC.06.01.01. EP1)
- Select and implement the best interventions to minimize adverse processes/outcomes (IC.06.01.01. EP1)
- Evaluate and monitor the results and revise techniques as needed

DEFINITIONS:

Centers for Disease Control and Prevention (CDC) – The nation's leading science-based, data-driven, service organization that protects the public's health which in addition to other departments, houses DHQP and NHSN.

Division of Healthcare Quality Promotion (DHQP) – This organization is a division of the CDC and works to protect patients and healthcare workers through safe healthcare delivery systems in the U.S. Among its other activities, the DHQP oversees NHSN activities.

Healthcare-associated infection: Infection acquired while receiving care in a healthcare facility.

Infection prevention and control committee: A multidisciplinary group that functions as the central decision-making and policymaking body for infection prevention and control in the healthcare setting. Its decisions and policies are guided by data and evidence-based practice.

Pharmaceutical and Therapeutics/Infection Prevention committee: A multidisciplinary group that functions as the central decision-making and policymaking body for infection prevention and control in the healthcare setting. Its decisions and policies are guided by data and evidence-based practice.

Infection prevention and control program: Comprehensive strategy for preventing and controlling infections using a combination of policies, procedures, and actions.

Infection prevention and control risk assessment: A detailed list of potential infectious risks to the healthcare setting that are prioritized to provide direction to the infection prevention and control department.

Infection preventionist: Someone who is qualified through education, training, experience, or certification in infection prevention and control.

Infection surveillance: Systematic method of identifying infections that is used to measure the success of infection prevention and control measures and to meet reporting mandates.

National Healthcare Safety Network (NHSN) – Oversees a national database which is the nation's most widely used healthcare-associated infection tracking system

OVERVIEW:

Infection Prevention and Control at SVMC is important for every decision and plan made within the organization. Infection Prevention is an integral responsibility of all personnel beginning with leadership on through to all staff. A successful program requires cooperation between all departments. The Hospital administration has responsibility to oversee and provide resources for the Infection Prevention Program and to ensure that all hospital personnel including medical staff, volunteers, students and contract personnel, etc. are made aware of their responsibilities related to Infection Prevention.

All personnel, in partnership with medical staff, are responsible for the safety and health of all patients, residents, visitors, and hospital staff while at SVMC. The responsibility may be met by working together to promote safe infection prevention practices, observing all rules, regulations and procedural guidelines, and continually striving to improve the quality of patient care. For those

reasons, SVMC has established an Infection Prevention Program that requires the participation, support and cooperation of all personnel. (IC.06.01.01. EP3)

Each department, in partnership with medical staff, will be responsible and held accountable for its role in SVMC's Infection Prevention Program. Each department will be responsible for reporting any IP concerns to the Manager of Infection Prevention. Each department will be responsible for full and timely cooperation with the Pharmacy & Therapeutics/Infection Prevention and Control Committee (P&T/IPC). Individuals within each department may be given specific assignments or assigned to IP-related committees. When assigned, completion of assignments in a timely and thorough manner is expected. To coordinate infection prevention and control activities, infection prevention management functions are delegated to the Infection Prevention Manager and the P&T/IPC Committee to investigate and follow-up on clinical issues.

The scope of service within this policy includes all departments within the acute care facility and the following outpatient areas: the Distinct Part Skilled Nursing Facility (DP/SNF), Cancer Treatment Center (CTC), Medical Office Building (MOB), Ambulatory Surgery Department (ASD), Wound Care Center, the Urology Center, Outpatient Physical Therapy Center, Urgent Care, Sierra View Community Health Center-Terra Bella, Cardiac Catheterization Laboratory and Surgery Clinic.

POLICY:

1. IP Policy Foundation
    a. Infection Prevention and Control policies are based on recognized guidelines, applicable laws and regulations at the local, state and federal. The policies address measures to prevent the transmission of infections among patients, employees, medical staff, volunteers, visitors, and the general public. Policies have been developed that define surveillance, prevention and control measures in all patient care, support and service areas, and identify methods effective in reducing the risk of transmission of microorganisms, while increasing patient safety.
    b. Policies are reviewed and revised by Infection Prevention and contributing departments at least every three years and as needed. New policies and those policies with major revisions are approved by the P&T/IP Committee. Hospital-wide policies include those that are general, which are followed throughout the hospital, and are located on the SVMC intranet in the Policy Library. Department-specific policies may include policies for tasks or IP measures unique to that particular area. Many of the IP approved practices are integrated into department policies that are kept by the Director/Manager of the department, and Infection Prevention is consulted for input and revisions.
2. Oversight of the Infection Prevention and Control Program (IC.04.01.01. EP1, EP2)

a. Qualified individuals implement the infection prevention program. A full-time Infection Prevention Manager, an Infection Prevention Registered Nurse, Infection Prevention Analyst, and the P&T/IP Committee (including the ID Specialist) oversee the Infection Prevention program. The Infection Prevention Manager reports to the Vice President of Quality & Regulatory Affairs.

b. Employee Health, the Education Department and Infection Prevention collaborate to develop policies and provide education to staff. Policies and educational offerings are created collaboratively with the goal to reduce infections.

c. The P&T/IP Committee assists with the development and approves all Infection Prevention activities and the surveillance program. This approval process considers the following elements:

   i. Criteria used for defining a hospital acquired infection (HAI) and for differentiating them from community-acquired infections. The National Healthcare Safety Network (NHSN) definitions for HAI are utilized.

   ii. Rationale for selecting a specific approach or combination of approaches, and the time frame for using that approach. Targeted surveillance for NHSN and SVMC–specific indicators are used, as described below:

      1. Patient population to be studied
      2. Data collection methods employed
      3. Quality control procedures for ensuring accuracy and completeness of case findings
      4. Assignment or responsibility for data evaluation and follow-up
      5. Method for reporting and follow-up
      6. Reporting of infections to public health as required
      7. Documentation of infections of epidemiological significance among healthcare personnel

3. Risk Assessment (Appendix A) (IC.06.01.01. EP5)

   a. At least once a year, P&T/IP Committee completes a risk assessment, evaluates, revises as necessary, and approves the type and scope of surveillance activities by reviewing the following items:

      i. Data trend analysis generated by surveillance activities during the past year

ii. Effectiveness of prevention and control intervention strategies in reducing the HAI risk

iii. Services instituted, procedures performed, priorities of significant community and world health, and problems identified during the past year

4. Resources for Infection Prevention and Control Program (LD.01.03.01. EP5)

   a. SVMC provides resources for the program through MEDITECH Expanse Live computer services, laboratory services, equipment, supplies and personnel.

5. Healthcare-Associated Infection Surveillance Overview

   a. The SVMC Infection Prevention Program is responsible for monitoring HAIs. Since July 2008, the SVMC Infection Prevention Program has been an active participant in the CDC NHSN program using NHSN infection indicators, definitions, and methodologies for data collection and analysis. Data is entered into the Infection Prevention Database regularly and electronically transmitted into an Infection Prevention Database maintained by NHSN.

   b. Since 2003, a targeted surveillance program for an HAI has been utilized at SVMC. With targeted surveillance, infection prevention outcome objectives are determined, priorities are established, and resources are allocated to the major types of infections and the patient populations at highest risk of acquiring an HAI. Numerators and denominators are clearly established with the focus on procedures that have preventable risk factors that may contribute to the development of an HAI.

   c. In addition to the infection types specified in the targeted surveillance plan, non-targeted infections, single occurrences, and/or outbreaks of an HAI related to any unusual or virulent pathogenic organism are evaluated. The Infection Prevention Manager, Vice President of Patient Care Services, and P&T/IP Committee determine interventions.

6. Definitions for Healthcare-Associated Infections (HAI)

   a. Determination of an HAI depends on evaluation of clinical, laboratory and other diagnostic information gathered on the patient. Consistency in determining HAIs within the healthcare setting is necessary to compare infection rates from one evaluation period to the next. When comparing hospital infection rates to a national infection rate, consistent determination of HAIs from all participating hospitals is essential.

   b. The CDC is the recognized authority for HAI surveillance in the United States. Definitions published by the CDC and NHSN are the standard for use in hospitals. Updated definitions from NHSN are utilized as provided. A hard copy of these definitions

is located in the NHSN binder in the Infection Prevention office or through access to NHSN electronically.

7. Priorities for Healthcare-Associated Infection (HAI) Surveillance

   a. Surgical Site Infections (SSIs) (NPSG.07.01.01): Prevention of surgical site infections is a high priority. CDC (2021) estimates that surgical site infections are associated with nearly 1 million additional inpatient days annually and an estimated annual cost of $3.3 billion. Methods to reduce surgical site infections are well documented in medical literature by medical associations/organizations (e.g., AORN, APIC, ASA). SSIs are monitored, reported, and analyzed on an ongoing basis.

   b. Ventilator Associated Pneumonia (VAP): Prevention of VAP in the Intensive Care Unit (ICU) is a high priority because of high mortality rates, expense associated with prolonged ICU stays, and many preventable factors contributing to these infections. At SVMC, VAP in ICU is monitored on an ongoing basis and reported.

   c. Central Venous Catheter-Associated Blood Stream Infections (CLABSI) (NPSG.07.01.01): Nationally, bloodstream infections associated with central venous catheters are often preventable and have a high mortality rate. It is a high priority to reduce risk factors leading to these infections. Patients in the ICU who develop a BSI are 2-3 times more likely to stay in the hospital an average number of 24 days and/or die (https://www.cdc.gov/clabsi/about/?CDC_AAref_Val=https://www.cdc.gov/HAI/bsi/CLABSI-resources.html). Estimates of added costs attributed to CLABSIs is over $40 million annually. At SVMC, CLABSIs are monitored house-wide and reported on an ongoing basis to P&T/& IP Committee and to the appropriate clinical units.

   d. Catheter-Associated Urinary Tract Infections (CAUTI): Urinary tract infections associated with indwelling urinary catheters have relatively small morbidity and financial consequences. UTIs account for more than 9.5% of infections reported by acute care hospitals. It has been estimated that each year, more than 13,000 deaths are associated with UTIs. At SVMC, house-wide monitoring for CAUTIs in all units will be continued and reported upon.

8. Surveillance Documentation of All Infections

   a. Infection Prevention has created databases for documenting targeted and non-targeted HAIs as a method to track and identify trends. The surveillance fulfills internal requirements for SVMC, California Department of Public Health Services (CDPH), and The Joint Commission (TJC) standard of IP that requires a review for any HAI sentinel event(s) that cause death.

b. Excel spreadsheets (supplemented by MEDITECH Expanse) have been created and contain information about the infection surveillance of many types of infections and may be used to guide the response to any HAI outbreak.

c. Surveillance includes, but is not limited to, surgical procedures, obstetric procedures, catheterization procedures, and antibiotic resistant bacteria (MDROs).

9. Infection Control Reports

a. The SVMC infection prevention process is designed to lower risks and decrease rates or numerical trends of epidemiologically significant infections. Infection prevention reports are presented in a manner that facilitates this process. Infection rates are established using recognized statistical methodology. Histograms and process control charts are utilized when feasible to enhance the identification of infection trends.

b. Results of infection surveillance are reported regularly by Infection Prevention to P&T/IP Committee and documented in the meeting minutes. Minutes are forwarded to the Chief Executive Officer, Vice President of Patient Care Services, Vice President of Quality & Regulatory Affairs, and to the medical staff through various committees. A report of HAI rates is provided regularly by Infection Prevention to the Performance Improvement/Patient Safety (PIPS) Committee, various nursing departments, individual medical staff members, nursing staff, and anyone who may benefit from and provide prevention measures toward decreasing infections. Additional reporting of infection rates, when benchmark rates are exceeded, is managed by Infection Prevention utilizing a team approach of performance improvement processes. NOTE: If infections require immediate intervention strategies, a Statement of Authority allows Infection Prevention to go forth with prevention plans and actions without taking the issues to the P&T/IP Committee.

10. Surveillance Strategies

a. NHSN Indicators: Since July 2008, SVMC has participated in the NHSN system. Infection Prevention collects data using the definitions, methodology and computer software developed by the CDC. The data are used internally to determine HAI rates, and are sent on a regular basis to the CDC for inclusion in the national database.

b. Surgical Site Infection Surveillance Components:

i. All patients who undergo operative procedures are monitored for surgical site infections.

ii. For each patient having surgical procedures, information is collected about the patient's underlying condition. This information includes:

1. American Society of Anesthesiology (ASA) score by assessing variables of age, sex, duration of operation, method of approach
2. Surgical Wound class
3. Whether the operation was performed as an emergency or as a result of trauma
4. If multiple procedures were performed through the same incision

c. Surgical Surveillance:

i. Objectives:

1. Identify HAI trends above NHSN benchmark rates
2. Evaluate procedures, policies, and practices, looking for preventable risk factors when infection trends are identified
3. Reduce infection by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Numerator: Number of patients developing surgical site infection following surgery
3. Denominator: Total number of patients undergoing surgery
4. Stratification of patients by risk factors as recommended by NHSN (utilizing intrinsic patient risk as evidenced by ASA score, wound class, and duration of surgery).

iii. Data Sources:

1. Daily surgery schedule
2. Monthly report of all procedures
3. Daily admission report from the computer data systems
4. Concurrent and/or retrospective chart review by Infection Prevention if there is an occurrence of infection
5. Communication from the surgical nursing staff
6. Post discharge communication is quarterly during the year, from surgeons to Infection Prevention via a follow-up letter

iv. Defining Indicators for Infections:

1. Infections occurring following surgery at SVMC
2. NHSN definition for surgical site infection

v. Follow-up:

1. Reports are provided quarterly to P&T/IPC, participating surgeons, and other committees with a vested interest in these rates
2. When SVMC rates exceed NHSN rates, Infection Prevention makes a determination as to significance
3. Information is shared with Surgical Services and the Performance Improvement/Patient Safety (PIPS) Committee
4. If the infection rate is significant, an evaluation of relevant procedures, policies and practices is undertaken by Surgical Services and Infection Prevention.
5. A report is presented by Infection Prevention to P&T/IPC describing the result of the evaluation
6. If preventable risk factors are identified, an action plan outlining ways to reduce risk is included in this report

d. Ventilator Associated Pneumonia (VAP)

i. Objectives:

1. Compare with the NHSN VAP infection rate
2. Identify trends above the NHSN benchmark and established SVMC rate
3. Evaluate procedures, policies and practices, looking for preventable risk factors when infection trends are identified
4. Maintain "0" rate of VAP
5. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects VAP data on an ongoing basis
2. Reports are provided quarterly to P&T/IPC and appropriate Directors and Clinical Managers
3. Numerator: Number of patients who develop pneumonia following placement on a ventilator

4. Denominator: Number of ventilator days

iii. Data Sources:

1. Monthly number of ventilator days
2. Daily sputum gram stain and culture and sensitivity (C&S) reports from Microbiology Laboratory
3. Daily admission report from computer data system
4. Communication from staff to Infection Prevention
5. Communication from physicians to Infection Prevention
6. Concurrent and/or retrospective chart review

iv. Defining Indicators for Infections:

1. Patient developing pneumonia following placement on ventilator
2. NHSN definitions for pneumonia

v. Follow-up

1. Reports are presented quarterly to the P&T/IP Committee, Clinical Director and Managers for presentation to appropriate staff
2. When SVMC rates exceed NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance
3. If it is determined that the pneumonia rate is significant, evaluation of relevant procedures, policies and practices is undertaken by P&T/IP Committee
4. A report is presented by Infection Prevention to the P&T/IP Committee describing the result of the evaluation.
5. If preventable, risk factors are identified and an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

e. Central Line Associated Blood Stream Infections (CLABSI) (NPSG.07.01.01)

i. Objectives:

1. Identify CLABSI rates above NHSN and SVMC benchmark rates
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis.
2. Reports are provided quarterly to the P&T/IPC and Clinical Directors and Managers.
3. Numerator: Number of episodes of CLABSI infections
4. Denominator: Number of CVC days

iii. Data Sources:

1. Monthly report of number of CVC days
2. Daily microbiology reports of blood, site, gram stain and C&S
3. Concurrent and/or retrospective chart review of patients with CVCs

iv. Defining Indicators for Infection:

1. Patient with CVC
2. NHSN definitions for BSI

v. Follow-up:

1. Reports are presented quarterly to the P&T/ IPC and other groups as needed.
2. When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
3. If it is determined that the infection rate is significant, evaluation of relevant procedures, policies and practices is undertaken by IP and critical care, looking for preventable risk factors.
4. If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation, is included in this report.

f. Catheter-Associated Urinary Tract Infections (CAUTI):

i. Objectives:

1. Benchmark with established SVMC rate and NHSN rate
2. Identify CAUTI rates above NHSN and SVMC benchmark rates
3. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
4. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to the P&T/IPC, Infection Prevention and clinical directors and managers
3. Numerator: Number of episodes of CAUTI in patients
4. Denominator: Number of urinary catheter days in patients.

iii. Data Sources:

1. Daily catheter report generated electronically
2. Daily microbiology reports of urine analysis, urine gram stain and C&S
3. Daily admission reports from the computer data system
4. Communication from nursing staff to Infection Prevention
5. Concurrent and/or retrospective chart review of patients with indwelling urinary catheters

iv. Defining indicators for infection:

1. Patients with indwelling urinary catheter
2. NHSN definitions for CAUTI

v. Follow-up:

1. Reports are presented quarterly to the P&T/IPC and nursing units
2. When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
3. If it is determined that the infection rate is significant, an evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors.
4. A report is presented by infection prevention to the P&T/IPC, describing the result of the evaluation.

vi. If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation, is developed.

11. Additional Surveillance Strategies/Other Indicators – in addition to the NHSN indicators, infection surveillance is performed for the following types of infections:

a. Housewide Bloodstream Infections (BSI):

i. Objectives:

1. Identify BSI rates above SVMC benchmark rates
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to the P&T/IPC and nursing units
3. Numerator: Number of bloodstream infections in SVMC patients
4. Denominator: Number of patient days

iii. Data Sources:

1. Quarterly report of the number of bloodstream infection days from the Infection Prevention Department, Radiology, and quarterly report of the number of admissions from the hospital data system
2. Daily microbiology reports of blood cultures
3. Daily admission reports from the computer data system
4. Communication from nursing staff to Infection Prevention
5. Concurrent and/or retrospective chart review of patients with bloodstream infections

iv. Defining Indicators for Infection:

1. Bloodstream infections will meet the NHSN definition for bloodstream infection

v. Follow-up:

1. Reports are presented quarterly to the P&T/IPC and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance
2. If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IPC
3. An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection

Prevention Department reviews identified infections and assists in investigation.

4. A report is presented by Infection Prevention describing the result of the evaluation
5. If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation

b. MRSA, VRE and *C. difficile* colonization and infections: (NPSG.07.01.01)

i. Objectives:

1. Identify HAI rates above SVMC benchmark rates
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Data is collected on a daily basis
2. Reports are provided quarterly to the P&T/IPC, nursing units, and other committees as necessary
3. Numerator: Number of episodes of HAI
4. Denominator: Number of patient days

iii. Follow-up:

1. Reports are presented quarterly to the P&T/IP Committee and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
2. If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IP Committee.
3. An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.
4. A report is presented by Infection Prevention describing the result of the evaluation.

5. If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

12. Requirements for Surveillance of All Infections:

All patients admitted with an infection, and those acquiring an HAI, will be reviewed by Infection Prevention on a regular basis in order to determine baseline infection rates and identify any outbreaks in the community and the hospital. Patient infections will be categorized by type of infection utilizing ICD-10 codes and provided to infection prevention. The purpose is to reduce all HAIs and develop an action plan if there is a significant increase in infections.

13. Precautions: (IC.04.01.01. EP 3)

Transmission-based precautions to protect against exposure to a suspected or identified pathogen are utilized. Based on the transmission of a specific pathogen, precautions are selected. Contact, droplet, airborne or a combination is used, depending on the pathogen. Standard precautions are always used with all patients. Personal Protective Equipment (PPE) is used specific to the precaution to reduce the risk of infection.

14. Hand Hygiene Compliance: (NPSG.07.01.01)

Infection Prevention monitors compliance with hand hygiene by unannounced direct observation. At least monthly, one or more patient care departments is chosen. Infection Prevention makes observation for opportunities to wash hands with soap and water and/or use alcohol hand rub. Everyone within the department is observed, including visitors. In addition, each patient care department is assigned a specific number of observations per month (based on Leapfrog Group criteria) to be reported to Infection Prevention via Huron on a monthly basis. The opportunity is the denominator, the opportunity taken is the numerator, and a percentage rate is assigned. Rates of compliance are established, documented results shared and recommendations for improvement given. Observations are reported to various committees, directors, managers, physicians, and healthcare personnel.

15. Additional Reports to the Pharmacy and Therapeutics/Infection Control Committee

Infection Prevention and Employee Health are responsible for many other activities to prevent and control infection transmission in the hospital and outpatient areas. The following reports are submitted to the P&T/IP Committee on a regular basis or if a substantial change in occurrence is observed.

a. Influenza Vaccinations: The hospital provides an influenza vaccination to all staff and all licensed independent practitioners. (IC.02.04.01).

i. Education is provided to all staff and licensed independent practitioners about influenza, the vaccine, non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.

ii. Annually, vaccine is provided through Employee Health Services (EHS) during business hours and after hours. For after hours, vaccine is given at Employee Health Services on designated weekends. On designated days, EHS opens earlier to accommodate night shift staff.

iii. There was a 78% vaccination rate in the 2022-2023 influenza season with 22% of all staff declining vaccination (see Table below) as indicated by the signed letter of declination. There was an 85% vaccination rate in the 2023-2024 influenza season with 15% of all staff declining vaccination.

Respiratory Disease Season	Vaccinated (%)	Declined (%)
2022 – 2023	78%	22%
2023 - 2024	85%	15%
2024 - 2025	88%	12%

iv. Improvements in the vaccination rate will be made through the use of education, the requirement that unvaccinated staff wear masks while working, and by making vaccine available frequently by taking the vaccine to the staff as well as continuing the present vaccine program.

v. The goal for the next four years is to increase and maintain vaccine rate at 100% of staff and licensed independent practitioners by working with Employee Health, and Human Resources.

b. Employee Vaccination Health Reports: Report employee compliance annually. A report is provided on a weekly basis during the annual vaccination drive to all departments listing compliance of employees' receipt of seasonal influenza vaccinations or declination of vaccination.

c. Sharps Injuries: A report is provided by Employee Health about the number of needle sticks and safety needle devices available, and provides information about review and trials of prospective safety devices. Employee Health provides the report quarterly.

d. Reportable Infections Reports: Infection Prevention is the liaison between the hospital and local, metropolitan and state public health departments for issues related to infectious diseases. Infection Prevention provides information to the appropriate health department for each reportable infectious disease report that is processed by the hospital laboratory. A

summary of all infections reported to public health agencies by Infection Prevention is provided quarterly to the P&T/IP Committee.

e. Sterilizer Monitoring Reports: A sterilizer monitor report for all steam, ETO, Sterrad and Steris sterilizers used in the hospital is provided quarterly by Surgery and Central Processing.

f. Microbiology Reports: A report from Microbiology about antibiotic resistant organisms and other relevant topics as determined by the P&T/IP Committee and the microbiology lab is provided quarterly.

g. Pharmacy Reports: A report from the Pharmacy providing information about antimicrobial usage and other relevant topics as determined by the Infection Control Committee and the pharmacy is provided quarterly.

h. Dialysis Water Report: A report from Facilities Management about sterility monitoring of dialysis water is provided quarterly.

i. Ventilation Reports: A report from Facilities Management about ventilation in negative-pressure isolation areas and surgery operating rooms is provided at least annually.

16. Additional Infection Prevention Activities

Infection Prevention is responsible for many other activities to prevent and control infection transmission in the hospital and outpatient areas which include:

a. Healthcare Personnel and Public Education: Government regulations, bioterrorism, and unusual microorganisms such as H1N1 influenza, Ebola, Coronavirus (SARS-CoV-2), etc., have greatly increased the need for education and training. Infection Prevention will continue to update and present information when necessary to keep healthcare personnel, volunteers, and the public informed. Annual requirements for healthcare personnel education is maintained in Human Resources.

b. Role as Liaison to Public Health Departments: Infection Prevention is responsible for notifying state, county and local Public Health departments when a reportable disease is identified within SVMC. In addition, IP will assist with concurrent and retrospective chart review as necessary for the health departments in gathering epidemiological information.

c. Input on Purchases: Infection Prevention is consulted regarding the purchase of equipment and medical supplies used for patient care, procedures, sterilization, disinfection and decontamination, and regarding any major change in cleaning products and techniques.

d. Resource and Trouble-Shooting: Infection Prevention has responsibility to respond to questions and concerns about infections, hospital practices, isolation requirements, and incidents of exposure to blood and other potentially infectious body fluids, and other

related topics as requested. In addition, Infection Prevention assists with Employee Health needs when Employee Health is unavailable.

e. Continuing Education and Professional Networking: In order for the Infection Prevention Department staff to remain knowledgeable regarding IC issues, and to keep abreast of current information and resources, ongoing formal and informal education is necessary. Participation in the Association of Professionals in Infection Control and Epidemiology (APIC) on the local and national levels, as well as attending national meetings and educational programs, is an important part of this process.

f. Construction: Infection Prevention has the responsibility to be involved in all hospital renovations and construction. Before any construction or renovation begins, an infection risk assessment of the project is completed. Based on the assessment, an Infection Control Construction Permit is developed and posted. Infection Prevention collaborates with engineering, facilities management, and the Safety Director to ensure a safe environment for patients, personnel, volunteers, and visitors during construction and renovation projects. Monitoring continues on a regular basis during renovations and construction in order to prevent transmission of an infectious disease.

g. Environmental Cleanliness: Working with environmental services, clinical departments, and hospital leadership, the IP Clinical Workgroup was established to better serve the hospital and to meet CMS standards. The IP Clinical Workgroup has many other responsibilities, such as determining needed competencies by staff in infection prevention. Education and training will be an integral part of the EVS new hire process and as needed.

17. Unscheduled Reports

a. Focused Studies: Focused studies and identification of infection prevention measures occurs from data generated from targeted hospital surveillance, government regulations, and the recommendations of recognized experts in Infection Prevention such as APIC and the CDC. Focused studies include retrospective and concurrent chart reviews, literature reviews and surveys of clinical procedures and observations of clinical practices. Infection prevention measures include employee education, revision of policies and procedures when indicated, evaluation and modification of hospital equipment, disinfectants and work practices. Ongoing evaluation and monitoring of infection rates is required to determine the effectiveness of infection prevention measures.

18. Risk Assessment and Prioritization of Goals: (IC.06.01.01. EP1, see Appendix A)

The P&T/IPC, in collaboration with hospital leaders, identifies risks for transmitting and acquiring infections based on the following as discussed below. The Infection Prevention staff in conjunction with the P&T/ IPC will develop a risk assessment at least annually or whenever

significant changes occur in the factors noted below using information from all applicable committees and individuals as appropriate. Consideration will be given for those issues that are high risk, high volume, and problem prone, new techniques related to emerging or reemerging trends and other issues as identified. The Infection Prevention Staff, in collaboration with appropriate staff from other units, will develop action plans to address these issues. (See Appendix A for the risk assessment and the current prioritization list). The factors addressed in the risk assessment include at a minimum:

a. Geographic Location and Community Environment

   Sierra View Medical Center is located in an agricultural community with high rates of farm workers, migrant and foreign workers. In addition, during drought years, construction sites are potential sources of Coccidioidomycosis in the San Joaquin Valley where SVMC is located. Although Coccidioidomycosis is not infectious from person to person, serious infections may result and patients must be monitored and the disease reported. Additionally, SVMC is geographically located near the Porterville Development Center (PDC), serving a large number of developmentally disabled clients on site and in group homes in the area. (Information from: Community Health Assessment Tulare County 2023, https://tchhsa.org/eng/community/community-health-assessment-cha-community-health-improvement-plan-chip/)

b. Characteristics of the Population Served

   SVMC serves a diverse population, with Latinos being the majority, and who have a high incidence of diabetes, hypertension and vascular disease. SVMC also serves a large number of developmentally disabled individuals, as a result of its location.

c. Results of Analysis of Sierra View Medical Center's Infection Prevention, and Control Data

   The surveillance results from surgical procedures, device related infections, communicable disease exposure events and environmental incidents are reviewed for variances.

d. Care, Treatment and Services Provided

   The organization's plan notes the services that are provided. The high volume and/or high-risk services are assessed for surveillance and adaptable measures that can be followed.

e. Employee Health

SVMC provides a safe working environment for employees through the coordination of infection Prevention and Employee Health to identify potentially infectious conditions that may pose a risk for patients and staff.

f. Emergency Preparedness

The organization works continuously to be ready for an internal or external emergency, including, but not limited to, a short or long term influx of infectious patients.

Table of Goals for 2025

Goal #1: Limiting unprotected exposure to pathogens throughout the hospital (NPSG.07.01.01, IC.06.01.01. EP3)

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Improve Hand Hygiene Compliance	Achieve 70% hand hygiene compliance through 2025. Achieve 80% compliance for proper hand hygiene technique	Education Surveillance to monitor compliance On-the-spot reminder when needed Provide regular compliance reports and feedback to leadership and staff Regular reminders for staff, visitors and other HCWs	Monitor hand hygiene of staff with data upload to reporting software (Huron) to generate weekly reports Generate quarterly reports for distribution at committee meetings and hospital physician leadership	Unit Directors, Managers, IPs, HCW and Medical Staff.	Increase Department Hand Hygiene participation and compliance to 70% from a low of 7.7% in 2022. Obtain a realistic report for "no hand hygiene displayed"

Goal #2: Implement evidence-based practices to prevent HAIs due to community acquired MDRO infections in the hospital

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Results**
Implement evidence-based practices to reduce spread of MDROs throughout the hospital (HAIs)	Reduce the incidence of HAI MDROs below1% through 2025	Identify patient on admit or transfer – take appropriate specimen, for laboratory evaluation. Educate staff, patients and families as appropriate to prevent spread. Remind HCW of hand hygiene, standard precautions and contact precautions. Conduct appropriate cleaning and disinfecting of patient's environment; use dedicated equipment Use signage, posters and pamphlets to remind those in contact with patient.	Document and Report on education of staff and patients Monitor hand hygiene and report data for further hand hygiene compliance analysis. Dept. leadership will supervise surveillance to monitor isolation precautions compliance. Report any infractions to directors, managers, etc. for corrective action and on-the-spot advisement	IPs, department directors and managers, staff, medical staff services director.	Observe evaluation and testing of qualified patients within the 72-hour time window. Observe a reduction of HAIs overall, but specifically MRSA

Goal #3: Minimize the risk of infection transmission associated with procedures, the use of medical equipment and devices

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Reduce Central Line-associated Bloodstream Infection (CLABSI) in patients	Reduce incidence of CLABSIs to below current incidence rate (see Expected Result)	Collect and analyze surveillance data. Provide feedback via reports to committees, directors, managers, etc. for distribution to HCW. Provide evidence-based catheter placement checklist for staff. Review current surveillance tool; compare to currently recommended surveillance tools, if necessary, update and implement.	Monitor changes in CLABSI incidence rates of infections Monitor adherence to placement checklist. Report CLABSI rates to Committees quarterly. Conduct annual risk assessment for compliance with evidence-based practices hospital wide. Strive for 100% compliance rate.	IPs, Medical staff, central line insertion staff	Reduce incidence of CLABSIs to below 1% through the end of the fiscal year
Reduce catheter-associated urinary tract infections (CAUTIs) in	Maintain CAUTIs at or below 0.5% (see Expected Result)	Conduct regular surveillance of catheters; provide annual education of	Monitor CAUTIs. Report to P&T IP committee, IP and clinical unit directors	Clinical departments that utilize catheters, physicians, IPs	Reduce incidence of CAUTIs to below 0.5% through the end of the

patients		staff to keep catheter usage at a minimum	and managers		2025 fiscal year
Reduce surgical site infections (SSIs)	Maintain incidence of SSIs below 1% (see Expected Result)	Education of staff involved in surgical procedures upon hire, conduct annual competency reviews, and whenever surgical procedures are added to an individual's job responsibilities. Educate patients and/or patient family about infection prevention after a surgical procedure.	Monitor and report education sign in sheets to support completion of required education. Review nursing care plans for patient education.	Surgical staff, IPs, surgical nursing department, nursing staff and performance improvement.	Maintain incidence of SSIs below 1% through the end of the fiscal year

Goal #4: Limiting unprotected exposure to pathogens throughout the hospital

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Prepare to respond to an influx or risk of influx of infectious patients	Meet 90% or more of the Influx of Infectious Patients Contingency Plan requirements	Provide IP representation on the Emergency Preparedness Team. Provide input on IP issues during emergencies, establish	Perform observation during drills. Report compliance to Hospital Emergency Incident Command System, to Safety Committee,	Infection Prevention Committee	Maintenance and revision of contingency plan policies as needed to be prepared for influx of infectious patients.

		communication with local health dept. Utilize resources of the County Health Department, the State Department, and the Public Health System Maintain and/or revise policies and procedures for influx of patients, outbreaks, emerging infection and bioterrorism.	hospital leadership and P&T IP Committee.		

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- The Joint Commission (2024). Hospital Accreditation Standards Manual. Joint Commission Resources. Oak Brook, IL.
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Cross Reference:

- Influx Of Infectious Patients Contingency Plan
- Surge Capacity Plan

Risk Assessment for the Infection Prevention and Control (IP&C) Program
Annual Infection Control Risk Assessment 2024
Year: 2024_
Organization Name: ____Sierra View Medical Center____
Date of Report: ___Dec. 6, 2024_____

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Geography, Community & Populations served													
Increasing Incidence of TB		2				2					1		5
POTENTIAL HAIs / INFECTIOUS DISEASE													
Surgical Site Infection SSI		2			3						1		6
Ventilator Associated Pneumonia VAP			1		3						1		5

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Central Line-Associated Blood Stream Infection CLABSI			1		3							0	4
Clostridioides difficile Infection CDI		2				2						0	4
Catheter-associated Urinary Tract Infection CAUTI			1			2						0	3
MRSA (Hospital acquired)			1			2						0	3
VRE (Hospital acquired)			1			2						0	3
Exposure - specific infection													
Influenza (Seasonal)	3					2					1		6
Emergency Management - Influx of Infectious		2				2					1		5

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 28 of 32**

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Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Patients													
Infectious Disease Outbreak		2				2					1		5
Ebola Outbreak			1		3						1		5
COVID-19 Outbreak		2				2					1		5
COMMUNICATION													
HAI – Lack of Timely Notification (internal information flow)			1				1					0	2
Employee Illness – Lack of Timely Notification			1				1				1		3
Personnel, lips, Volunteers Surveillance and screening													
Poor Hand Hygiene Compliance		2				2					1		5
Sharps Injury (HCW)		2				2					1		5

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 29 of 32**

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

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Poor TB Screening (Hospital)			1			2						0	3
Poor TB Screening (LIP)		2				2					1		5
Inappropriate Use of Isolation		2				2						0	4
Ineffective Screening of Employees/Contract Staff/LIPs, Volunteers and Students			1				1					0	2
Ineffective Fit Testing (Hospital)			1				1					0	2
Environment of care													
Inappropriate Handling of Biohazard Waste		2			3						1		6
No or Ineffective			1				1					0	2

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Preconstruction IC Planning (ICRA meeting)													
Ineffective Notification or Communication for Applicable Utilities Issues/Shutdowns (HVAC, etc.)			1				1					0	2
Major Biohazard Spill			1			2						0	3
Failure of Appropriate Air Exchange or Air Pressure Monitoring in Isolation Rooms, ORs or Other Critical Environments			1					1				0	2
Improper Cleaning or Disinfection of		2				2					1		5

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 31 of 32**

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Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Environment of Care													
supply storage, instrument & medical device cleaning, disinfection & handling													
Improper Storage or Disposal of Supplies			1			2						0	3
Ineffective Reprocessing of Devices		2			3						1		6
Improper Sterilization (Including Positive Biological Controls) of Supplies and Equipment		2			3							0	5

1. **Probability of the event/condition occurring**: determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, and the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.) are considered when determining this score.

2. **Potential Severity, Risk Level of Failure:** determined by review of historical data and infection surveillance data.
3. **Organization's preparedness to deal with the event/condition**: determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

(Developed by and modified from: K. Arias, M. Patrick, K. Delahanty and S. Odachowski)

SUBJECT: **BLOODBORNE PATHOGEN EXPOSURE PROTOCOL FOR HEALTHCARE WORKERS**	SECTION: **Page 1 of 9**

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

PURPOSE:

To outline the procedure for post bloodborne pathogen exposure and a regimen for safely administering Post Exposure Prophylaxis (PEP) to occupationally exposed healthcare workers (HCW).

POLICY:

All personnel employed by Sierra View Medical Center (SVMC) who have an occupational exposure to blood or other potentially infectious materials are eligible for appropriate treatment as indicated.
This policy is divided into sections as follows:

- Definitions
- Risk of acquiring HIV, Hepatitis B and Hepatitis C after exposure to contaminated blood
- Procedure protocol for Bloodborne Pathogen exposure
- Post Exposure Prophylaxis (PEP) Protocol for exposure to HIV
- Post Exposure Prophylaxis (PEP) Protocol for exposure to Hepatitis B
- Post Exposure Prophylaxis (PEP) Protocol for exposure to Hepatitis C
- Table 1: Guideline for Hepatitis B Post Exposure Prophylaxis

DEFINITIONS:

Health Care Worker (HCW) – Any person in the employment of Sierra View Medical Center for any reason, including volunteers, that is exposed to a patient's blood or other potentially infectious material (OPIM). Contracted workers and physicians will be offered initial treatment per this policy.

"OPIM" – Other potentially infectious material. This includes semen or vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluids or tissue. This does not include urine or saliva.

"PEP" – Post exposure prophylaxis

"EXPOSURES"

1. **Massive exposure**
   a. Transfusion of blood
   b. Injection of blood (> 1ml)
   c. Parenteral exposure to laboratory or research specimens containing high titer of virus.
2. **Definite Parenteral Exposure**
   a. Injection of blood or OPIM (<1 ml)

b. Intramuscular (IM / "deep" / > 3mm) injury produced by a blood or OPIM contaminated needle or instrument.

c. Laceration or similar wound produced by a visible blood/OPIM contaminated instrument, which causes spontaneous bleeding in the HCW.

d. Visible laceration or similar fresh wound inoculated with blood or OPIM.

3. Probable Parenteral Exposure

a. Subcutaneous injury produced by a blood or OPIM contaminated instrument, which does not cause spontaneous bleeding in the HCW.

b. Laceration or similar wound produced by a blood or OPIM contaminated instrument, which does not cause spontaneous bleeding in the HCW.

c. Prior wound or skin lesion visibly contaminated with blood or OPIM.

d. Mucosal membrane inoculation with blood or OPIM, or ingestion thereof.

4. Doubtful Parenteral Exposure

a. Subcutaneous injury with a needle or instrument that is not contaminated with blood or OPIM.

b. Laceration or similar wound produced by a needle or instrument that is not contaminated with blood or OPIM.

5. Non-Parenteral Exposure

a. INTACT skin visibly contaminated with any body fluid.

RISK OF ACQUIRING HIV, HEPATITIS B OR C AFTER EXPOSURE TO CONTAMINATED BLOOD OR OPIM

Human immunodeficiency virus (HIV), the cause of AIDS, can be transmitted to healthcare personnel exposed to blood and other materials that contain the virus. The risk of infection following parenteral needle stick exposure and inoculation of non-intact skin is less than one percent (<1%), but is not zero – it is about 0.3 to 0.4%. The risk can be substantially greater in individual cases. No risk from exposure to normal skin or from other types of exposure has been documented. Other factors (in addition to the route of exposure) may influence transmission risk, such as the titer of virus in the source material, volume of infected material involved, viability of the virus, etc.

There is information suggesting that post exposure prophylaxis (PEP) may reduce the risk for HIV transmission after occupational exposure to HIV infected blood. The triple drug regimen is recommended for occupational exposure associated with the highest risk transmission of HIV. All persons

offered PEP should be prescribed a 28-day course of a 3-drug regimen. Since adherence is critical for PEP efficacy, it is preferable to select regimens that minimize side effects, number of doses per day and the number of pills per dose.

The preferred regimen for otherwise healthy adults is tenofovir disoproxil fumarate (TDF) (300mg) + emtricitibine (FTC) (200 mg) once daily PLUS raltegravir (RAL) (400 mg) twice daily or dolutegravir (DTG) (50 Mg) once daily.

PEP should be initiated promptly, preferably within 1-2 hours post exposure. Although animal studies suggest that PEP probably is not effective when started later than 24-36 hours post exposure, the interval after which there is no benefit from PEP for humans is undefined. Initiating therapy after a longer interval (1-2 weeks) may be considered for the highest risk transmission; even if infection is not prevented, early treatment of acute HIV infection may be beneficial.

RISK OF HEPATITIS B INFECTION IN HEALTHCARE WORKERS

Hepatitis B virus causes liver damage, scarring and cirrhosis. It can be transmitted to healthcare personnel exposed to blood and other materials that contain the virus. The risk of infection following parenteral needle stick exposure and inoculation of non-intact skin depends on the HCW's immune status. HCWs that have received the Hepatitis B vaccine series and have a positive HBsAb have virtually no risk of acquiring the disease. HCWs that do NOT have immunity to Hepatitis B have up to a thirty percent (30%) risk of acquiring the disease. Factors (in addition to the route of exposure) that may influence transmission risk include titer of virus in the source material, volume of infected material involved, viability of the virus, etc.

RISK OF HEPATITIS C INFECTION IN HEALTHCARE WORKERS

Hepatitis C virus causes liver damage, scarring and cirrhosis. It can be transmitted to healthcare personnel exposed to blood and other materials that contain the virus. The risk of infection following parenteral needle stick exposure and inoculation of non-intact skin is approximately three percent (3%). Currently there is no known immunization or PEP that can prevent the acquisition of Hepatitis C after exposure. Factors (in addition to the route of exposure) that may influence transmission risk include titer of virus in the source material, volume of infected material involved, viability of the virus, etc.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES INVOLVED IN ACTIVITIES THAT MAY RESULT IN A BLOODBORNE PATHOGEN EXPOSURE, INCLUDING CONTRACTED EMPLOYEES AND VOLUNTEERS.*

PROCEDURE:

HCW -- IMMEDIATE TREATMENT

(Stop patient care activity as soon as it is safe for the patient.)

A. Wound Care/First Aid

1. Clean wound with soap and water for one minute.
2. Flush mucous membranes with water/saline for at least three minutes.
3. Other wound care as dictated by injury or accident.
4. Seek immediate medical attention at Employee Health Services (7:00a.m. – 3:30pm, Monday-Friday) or the Emergency Dept., if after business hours.

HCW -- RESPONSIBILITIES

1. IMMEDIATELY notify your Department Head/Director or shift Manager.
2. Obtain Employee Exposure Packet located in Employee Health Services or House Supervisor/Staffing Office.
3. Complete the necessary paperwork:
   a. Exposure worksheets – employee
   b. DWC1 (Employee's claim for Workers' Compensation Benefits)
   c. Sharps Injury Log (if applicable)
   d. Consent for HIV testing
4. Seek treatment at the Emergency Department within 24 hours (preferably within one hour).
5. Complete electronic incident report
6. Follow up with Employee Health immediately following medical treatment or during their next available business hours. (Monday-Friday 7:00am-3:30pm)

DEPARTMENT HEAD/MANAGER -- RESPONSIBILITIES

1. Department Head or Manager should notify Employee Health of exposure by calling ext. 6174. If after hours, leave a voice message.
2. Complete paperwork
   a. Source Patient Risk Assessment Questionnaire (if source patient known)

b. Source Patient Consent for HIV test (if source patient known)

c. Check that HCW has completed their paperwork.

If source patient is known, Department Head/Manager will arrange with Employee Health (during office hours Monday-Friday 7:00am-3:30pm) or Patient Registration after hours for IMMEDIATE source patient testing for Hepatitis B (HBsAg), Hepatitis C (HCV-Ab) and HIV, after consent for HIV testing is signed. If source patient refuses HIV testing, the source patient's blood may still be tested for HIV – provided the blood was obtained *prior to* the exposure for other testing purposes.

NOTE: If the source patient has documented HCV-Ab, HBsAg negative results within the last two weeks, these results may be used. If the source patient is documented positive for Hepatitis B, Hepatitis C or HIV, the source patient need not be retested.

3. If source patient is unknown, disregard source patient testing procedure.

4. All forms, completed and unused, are to accompany the HCW to Employee Health (or Emergency Department, if after business hours).

5. All HCW follow-up will be managed by Employee Health Services.

HEALTHCARE PROVIDER-- RESPONSIBILITIES
(Emergency Department physician)

1. Refer to HIV Post Exposure Prophylaxis procedure

2. If the HCW has NOT had a tetanus vaccination in the past five years, then Tetanus prophylaxis is indicated for a cut, laceration or needle puncture. This should be obtained within 48 hours of the injury.

3. Document refusal, if indicated in HCW's record.

4. Obtain HCW blood for HIV, HBsAb and HCV–Ab titers after consent obtained.

EMPLOYEE HEALTH—RESPONSIBILITIES

1. Arrange source patient testing during Employee Health office Hours (Monday-Friday 7:00am-3:30pm

2. Employee Health Services will schedule initial follow-up appointment with designated Healthcare provider and will remind the HCW prior to the time it is due.

3. Contracted worker's will follow up with their employer for follow-up arrangements further instructions per company specific protocol

4. All documentation will be kept in a confidential file maintained by Employee Health Services

POST EXPOSURE PROPHYLAXIS FOR EXPOSURE TO HIV

Post Exposure Prophylaxis (PEP) for exposure to HIV should be initiated within 48 hours after exposure, ideally within one hour.

1. The Healthcare provider will evaluate the significance of the exposure. **Use Figure 1 to determine indications for PEP according to the type of exposure.** If PEP is indicated, it should be started promptly, preferably within 1-2 hours of exposure

   a. If PEP indicated, inform HCW of the risks versus the benefits of the medication. (Chemoprophylaxis). The HCW has the option to decline treatment and continue with serial blood draws.

      NOTE: Pregnancy is a contraindication to the use of these antiretroviral medications, except for zidovudine (ZVD), which can be given during the second and third trimesters.

   b. If PEP indicated and the HCW consents, it is recommended the provider order the following tests:

      - STAT pregnancy test (if applicable)
      - CBC with differential
      - BUN and Creatinine
      - ALT, Amylase, glucose, CPK
      - Urinalysis

2. Order blood work for the HCW:

   a. HBsAb

   b. HCV-Ab

   c. HIV after consent is signed*

   **If the HCW refuses HIV testing, the HCW's blood will be held in the lab for 90 days. The request for holding must be written on the lab slip and the lab notified by phone.*

3. If the HCW is seen after hours in the Emergency Department, return Exposure packet with completed and unused forms to Employee Health Services.

FOLLOW UP CARE

1. The HCW will be referred to a designated physician by Employee Health for follow up treatment. The designated Healthcare Provider will review lab work and re-evaluate exposure risk.

   a. If source patient is HIV positive and the HCW is HIV negative, the provider will determine the course of treatment.

   b. The provider may repeat ALT, BUN, Creatinine and CBC testing at two (2) weeks after initiation of PEP. If any of these are abnormal, further testing will be done as medically indicated.

   c. Repeat HIV testing is recommended at six (6) weeks, three (3) months, and six (6) months.

   d. If HCW is HIV positive on initial testing, refer to primary care physician. If HCW converts to HIV Ab positive during sequential testing, Healthcare Provider will notify the HCW and refer for proper medical follow-up.

POSTEXPOSURE PROPHYLAXIS (PEP) PROTOCOL FOR EXPOSURE TO HEPATITIS B

At provider's discretion and employee consent, Post Exposure Prophylaxis (PEP) for exposure to Hepatitis B should ideally be initiated within one week after exposure.

POSTEXPOSURE PROPHYLAXIS FOR EXPOSURE TO HEPATITIS C

CDC does not recommend postexposure prophylaxis (PEP) for health-care personnel exposed to Hepatitis C virus (HCV). Instead, the source patient in question should be tested for HCV RNA or Hepatitis C antibodies. Baseline testing of the source patient and the health-care personnel should be done as soon as possible (preferably within 48 hours) after the exposure. For health-care workers exposed to a patient testing positive for hepatitis C infection, or whose status remains unknown, management should be guided by CDC's testing algorithm. Healthcare workers who become infected with HCV should be referred for care consistent with current guidelines for evaluation and treatment of all persons with acute or chronic HCV infection.

TABLE 1 GUIDELINE FOR HEPATITIS B POSTEXPOSURE PROPHYLAXIS

Expose Worker HB Vaccination History	HCW HB Immunity (HBsAb)	Source (HbsAg)	Treatment
None	Negative[1] current	High Risk[2] or Positive	HBIG[3] + Hep B vaccine[4]
None	Negative[1] current	Unknown or Negative	Recommend Hep B vaccine[4]
None, or completed series	Positive[5] current	Any status	None recommended
Begun, but not competed series	Negative[1] current	High Risk[2] or Positive	HBIG[3] + complete Hep B Vaccine[4] series
Begun, but not completed series	Negative[1] current	Negative	Complete Hep B vaccine[4] series
Begun, but not completed series	Positive[5] current	High Risk[2] Negative or Positive	Complete Hep B vaccine[4] series
Begun, but not completed series	Positive[5] or negative[1] current	Unknown	Complete Hep B vaccine[4] series
Completed series	Negative[1] current, negative past	High Risk[2] or Positive	HBIG[3] + Hep B booster[6]
Completed series	Negative[1] current, Positive past[5]	High Risk[2] or Positive	Hep B Vaccine booster
Completed series	Negative[1] current	Unknown or Negative	Hep B vaccine booster

Note: If exposed worker is HBsAb negative and has not been positive in the past, the following Hep B tests will be ordered on the exposed worker at six (6) weeks, three (3) months, six (6) months and one (1) year: HbsAg, HbcAb and HBsAb.

[1] Negative is less than 10 IU
[2] High risk includes homosexually or bisexually active men, users of illicit parenteral drugs, clients in institutions for the mentally retarded and household contacts of chronic HBV carriers.
[3] HBIG (Hepatitis B Immune Globulin) is given in an immediate initial dose (0.06ml/kg) if HCW has not had any Hep B vaccine. If HCW refuses vaccine, repeat HBIG in one month.
[4] Hep B vaccine is given in a three dose series of IM injections in the deltoid, at 0, 1 and 6 months. Check for immunity after the third dose.
[5] Positive is 10 or more IU
[6] If HCW has had at least 6 doses of Hep B vaccine and never converted, no more vaccine is indicated. Instead, give HBIG in two doses one month apart.

REFERENCES:

Centers for Disease Control and Prevention. "Immunization of Health Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)". MMWR Vol. 46, No. RR-18. December 26, 1997. Web. Accessed Nov. 29, 2024. https://www.cdc.gov/mmwr/preview/mmwrhtml/00050577.htm

California Code of Regulations, Title 8, §5193, Bloodborne Pathogens. https://www.dir.ca.gov/title8/5193.html

California Health and Safety Code Sections 121130-121140. https://casetext.com/statute/california-codes/california-health-and-safety-code/division-105-communicable-disease-prevention-and-control/part-4-human-immunodeficiency-virus-hiv/chapter-105-repealed-aids-exposure-notification/section-121130-through-121135-repealed

Miller, S. "Occupational Exposure to Bloodborne Pathogens." *APIC Text*. Published 2014. Updated 2020. Accessed 29 November 2024. https://text.apic.org/toc/infection-prevention-for-occupational-health/occupational-exposure-to-bloodborne-pathogens

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SUBJECT:	SECTION:
CODE BLUE / CODE WHITE	***Provision of Care, Treatment and Services (PC)***

PURPOSE:

To define the emergency life support measures to be taken for patients experiencing cardiopulmonary emergencies.

DEFINITIONS:

1. Code Blue: Cardiac/respiratory arrest situation in an adult patient

2. Code White: Cardiac/respiratory arrest situation in a pediatric patient.

1. All hospital employees with direct patient care shall be current in Basic Life Support (BLS) and shall administer Basic life Support to a patient in an arrest situation unless there is an order in the patient's medical record that they or their decision-maker request a Do Not Resuscitate/Comfort Measures.

2. All Clinical Patient Care Providers will participate on the Code Blue Team as outlined in this policy.

3. RNs qualified to work in Emergency Department (ED), Intensive Care Unit (ICU), Telemetry, Clinical Decision (Observation), Labor and Delivery, Interventional Radiology, Cardiac Catheterization Lab, and Surgical Services units shall hold a current Advanced Cardiac Life Support (ACLS) provider card.

4. Clinical Pharmacists and Respiratory Therapists (RT) shall hold a current ACLS provider card.

5. ED RNs, Pediatric Area RNs, and RTs shall hold a current Pediatric Advanced Life Support (PALS) provider card.

    a. All other clinical RNs, LVNs, CNAs, and NAs will complete the annual Code Blue competency.

    b. All licensed clinical care providers will read and verbalize understanding of Code Blue/Code White Form and documentation guideline.

AFFECTED PERSONNEL/AREAS: *ALL CLINICAL STAFF/PATIENT CARE AREAS*

EQUIPMENT:

- Crash Cart with medications / Back Board/ bag-valve-mask with oxygen source and/or an Oxygen tank
- Monitor / Defibrillator / AED
- Code Blue/ Code White Form
- Code Blue/ Code White Evaluation Form

PROCEDURE:

A. Initiation of Code Blue / Code White in the Hospital (licensed staff, all others respond per direction of the RN).

1. **Discovery Person/First (1st) Responder**, upon discovery of an arrest situation will:

   a. Activate the Code Blue/Code White Team.

      - Push the Code Blue button in the patient room where possible.
      - When no Code Button is available, dial 55 and state "CODE BLUE" for an adult patient. For a pediatric patient, state "CODE WHITE."
      - Give location of unit and room number.

2. **Switchboard** will announce the code overhead according to the Overhead Paging policy, and then call the ED to ensure the ED responds to all CODE BLUE/CODE WHITE calls.

3. **1st Responder** will:

   a. Remain with the patient and begin CPR using mouth to mask device or bag-valve-mask with high oxygen source delivery, and/or

   b. Provide hands-only CPR if neither of these are immediately available

   c. Provide report of patient condition/time found to patient's assigned RN or Code Team Leader

4. **2nd Responder** will:

   a. Bring the Crash Cart to the room/location and assist with placement of the backboard

b. Assess the patient to determine if adequate CPR is being performed

c. Provide/attach the bag-valve-mask to the O_2 source if not done

d. Allow RT to take over the bag-valve-mask upon their arrival

e. Take over compressions when relieved of bag-valve-mask

5. **3rd responder** will:

a. Attach monitor pads to patient and turn machine "ON"

b. Check that suction is working correctly

c. Ensure that patient has IV access x 2, preferably with two large bore IV catheters

d. Hang Normal Saline IV Fluid without additives

6. **Recorder** will:

a. Begin documentation using *Code Blue/Code White Form*

b. Monitor patient's vital signs including Pulse Oximetry ($SaPO_2$)

c. Ensure patient's chart is available at the scene

B. Initiation of Code Blue / Code White Outside of the Main Hospital:

1. Staff in outpatient locations on campus, such as Ambulatory Surgical Department (ASD), Cancer Treatment Center (CTC), Dialysis Center, Laboratory (LAB), Urology Department, Wound Healing Department, Mobile Imaging Trailers off the immediate hospital campus, and Medical Plaza Building will dial 9-911 and then initiate CPR as first responder when a cardiopulmonary emergency situation occurs. Notify the Emergency Department about pending arrival of patient from their location.

Mobile Imaging Trailers on campus will initiate a Code Blue/White.

C. Code Blue Team Members and Responsibilities:

1. CODE TEAM LEADER:

a. ED Charge Nurse/designee is the Code Team Leader until a responding physician is available, for all first floor codes and CODE WHITE/pediatric codes

b. ICU Charge Nurse/designee is the Code Team Leader until a responding physician is available, for all CODE BLUE/adult codes on floors 2, 3 and 4

2. Responsibilities of Code Team Leader:

a. Assess CPR effectiveness

- Make necessary suggestions for improvement, if indicated
- Rotate staff providing compressions as needed to ensure adequate compressions are delivered throughout the code

b. Interpret EKG patterns via crash cart monitor/defibrillator

c. Direct code interventions based on EKG rhythm interpretations and patient assessment/responses to interventions using ACLS / PALS guidelines.

d. Oversee reviewing and labeling of code strips

- Place number at lower right corner of each strip, if necessary
- Give patient's rhythm strips to patient's assigned RN

e. Direct staff to collect patient's vital signs data at appropriate intervals and report to Recorder

f. Keep Recorder apprised of all interventions and patient responses

g. When physician arrives:

- Update with report of patient diagnosis, history, current status, assessments / interventions, patient responses
- Assist as needed

3. RECORDER – Licensed staff not providing compressions, ventilations, medications; (typically this is the patient's assigned RN):

a. Report time when code began to Code Team Leader

b. Ensure complete and accurate documentation of the event using *Code Blue/Code White Form* - record times and dosages of medications administered during code

c. Ensure *Code Blue/Code White Form* has all appropriate signatures at end of code

d. Ensure complete and accurate documentation of *Code Blue/Code White Evaluation Form* at end of code

e. Communicate time of next dose of medication as directed by code leader.

4. IV / MEDICATION NURSE:

a. Observe for presence of a patent IV site, start second IV line of Normal Saline (NS) at rate to keep vein open (TKO) or as instructed

b. Prepare and administer medications as ordered by Code Team Leader

c. Announce administration of drugs, with dosages and routes, to the recorder

5. COMPRESSOR – BLS Certified Employee

a. Provide chest compressions

b. Place backboard under the patient as soon as possible

6. VENTILATOR – Primarily the Respiratory Care Practitioner , may be any BLS provider in rotation to ensure adequate ventilations over time

a. Ventilate patient using bag-valve-mask device attached to supplemental oxygen

b. Make necessary adjustments to head position and mask to assure adequate chest expansion

c. Assist with endotracheal tube (ETT) or laryngeal mask (LMA) intubations, and announce tube size and placement location to Recorder as appropriate

d. Ensure proper taping and securement of the ETT/LMA

e. Assure suction equipment is available and suction as necessary

7. PRIMARY CARE NURSE –

a. Provide patient's chart and information to the Code Team Leader, including patient's condition prior to arrest and other pertinent recent history

b. Inform attending physician and family members of patient's condition

c. Perform other duties as assigned by Code Team Leader.

d. Mount patient's rhythm strips and place in their chart under tab labeled "STRIPS". (Make sure strips are in numerical /chronological order)

8. SUPERVISING RN – Unit Director and/or Clinical Manager, Charge Nurse/Resource Nurse, Administrative/House Supervisor: *NOTE: In the absence of any above mentioned personnel, Code Team Leader will fill in and provide data to proper personnel on their arrival.*

a. **Responsible to attend all codes**.

b. The following duties may be accomplished through delegation:

- Ensuring proper recording/documentation of Code Blue/Code White Form and Code Blue/Code White Evaluation Form
- Notification of the family
- Controlling staff traffic in the room
- Controlling visitors
- Supplying medications as needed
- Ensuring patient privacy, etc.
- Ensure names and signatures lines on the Code Blue/Code White Form are completed
- Ensure accurate completion of Code Blue/Code White Form in conjunction with Recorder (Original white copy is placed in patient chart, canary copy is sent or faxed to Pharmacy)
- Ensure Code Blue/Code White Form goes to the clinical manager of the unit

9. ADDITIONAL RESPONDERS:

a. Radiology Tech – as assigned to unit

b. Laboratory Tech – as assigned to unit

c. Respiratory Therapist – as assigned to unit

d. Security – for vertical transportation and as requested for crowd control

10. ADDITIONAL RESPONDERS – During normal working hours:

    a. Department Director/Manager/Nursing Supervisor

    b. Chaplain/Chaplain Assistant

    c. Case Manager – as assigned by unit

    d. Pharmacist – as assigned by unit

D. Documentation:

1. The patient's Primary Care RN is responsible for completion and disposition of an Occurrence

2. For other documentation needs, refer to *Code Blue/Code White Form DOCUMENTATION GUIDELINE*

E. Lucas device procedure during a code blue:
Note: BLS and ACLS resuscitation responses should be initiated as soon as the condition is recognized, including activating a "Code Blue" .This includes, but is not limited to, early chest compressions, early defibrillation, airway management, and other appropriate resuscitative measures. The use of a mechanical cardiopulmonary resuscitation device must never delay standard resuscitation following American Heart Association guidelines. Trained staff will be responsible for placing and operating the device on patients, in collaboration with the Code Team leader.

1. Lucas device may be used by clinical staff with competency on device (Appendix A reference guide)
2. This device will be stored in ED/ICU and must be plugged in at all times when not in use OR ensure that batteries are fully charged at all times.
3. Staff will follow the Instructions for Use
4. After use and as needed the device will be cleaned according to "Medical Equipment Cleaning and Disinfection/Identification of Clean Equipment". (Appendix B)

Indications for consideration of use of the mechanical chest compression devices include:

- Confirmed cardiac arrest
- Plan for extracorporeal membranous oxygenation cannulation
- Plan for transport to cardiac catheterization lab
- Expected prolonged resuscitation
- Code Team discretion (usually due to multiple consecutive code blues, Lucas puck should not be removed)
- COVID-19 presumed patients in cardiac arrest

Contraindications to use of the use of mechanical chest compression devices include:

- If it is not possible to position the LUCAS device safely or correctly on the patient's chest. Do not attempt placement on patients who are very large or very small or have abnormal chest shape

-Too small patient: if the LUCAS device alerts with 3 fast signals when lowering the suction cup, and you cannot enter the PAUSE mode or ACTIVE mode.

- Too large patient: if you cannot lock the upper part of the LUCAS device to the back plate without compressing the patient's chest

- Patients suffering from traumatic cardiac arrest or with obvious signs of traumatic chest injury
- Code Team discretion
- Patients with Ventricular Assist Devices (VADs)

REFERENCES:

- American Heart Association Program Administration Manual (2020). Retrieved on 08-11-2021 from https://cpr.heart.org/pam/course-information

- *LUCAS - Chest Compression System*. (n.d.). https://www.lucas-cpr.com/

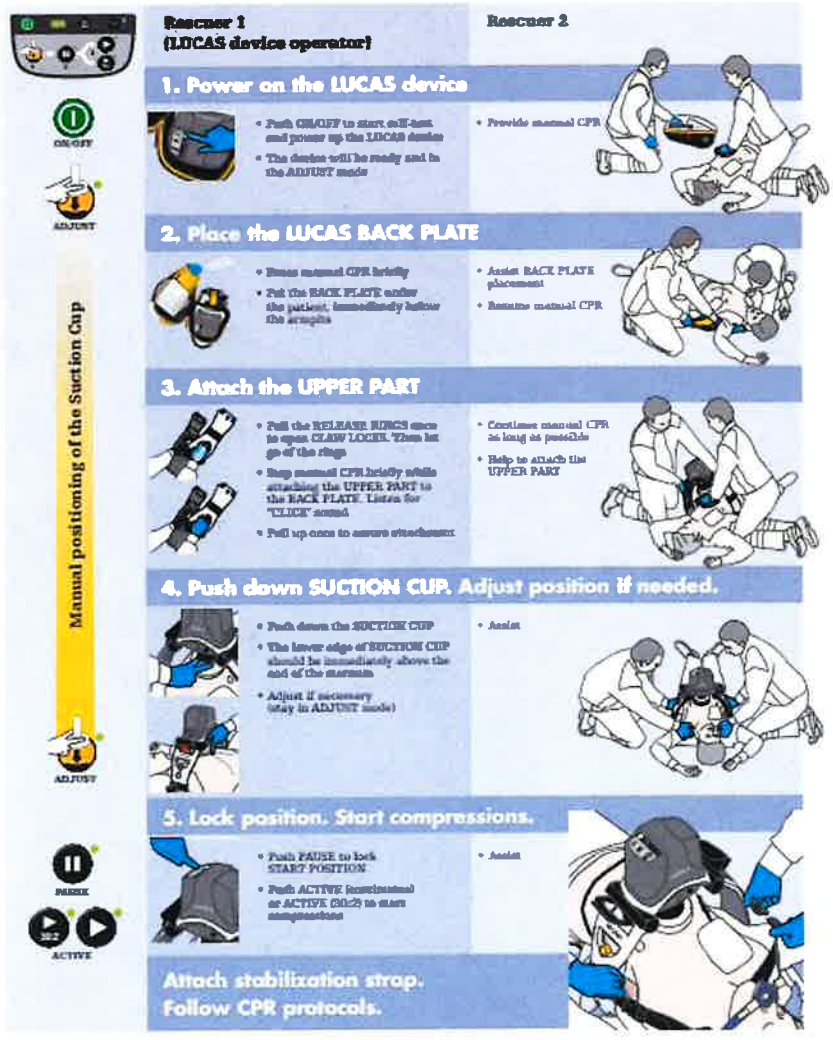
- The Joint Commission (2020). Hospital accreditation standards. PC 02.01.11. Joint Commission Resources. Oak Brook, IL.

Appendix A

stryker

LUCAS® 3 Chest Compression System

Quick reference guide



www.physio-control.com/LUCAS

Appendix B

6 Care after use and preparation for next use

6.1 Optional: Send and receive data after the event

The LUCAS Chest Compression System captures data of the device status and use, and can be configured to meet local protocols. The data can be transmitted using Bluetooth or Wifi.

Push the TRANSMIT data key to send device data and receive new configurations.

To transmit:

1. Make sure the LUCAS device is powered OFF
2. Push the TRANSMIT data key

Caution – radio frequency
Radio frequency communications can affect other medical electrical equipment.

For more information, please refer to Stryker data management programs, or contact your local Stryker representative.

6.2 Preparation for next use

Do the following after each use of the LUCAS Chest Compression System:

1. Remove the Suction Cup *(refer to section 6.4)*.
2. If necessary, remove and clean the Patient Straps and the Stabilization Strap separately *(refer to section 6.3 and 6.5)*.
3. Clean the device and let it dry *(refer to section 6.3)*.
4. Replace the used Battery with a fully charged Battery in the battery slot in the hood.
5. Mount a new Suction Cup.
6. Attach the Patient Straps again, if they are removed.
7. Attach the support leg straps of the LUCAS Stabilization Strap again, if they are removed.
8. Pack the device into the Carrying Case:
   - Put the Upper Part in the Carrying Case with the DC input placed downward.

     Note: Putting the LUCAS device in this position makes it possible to charge the device through the Carrying Case charger access port and to check Battery charge status through the Carrying Case top window.
   - Put the external Power Supply (optional) in the compartment between the LUCAS support legs.
   - Put a spare (optional) charged LUCAS Battery in the compartment between the LUCAS support legs.
   - Extra Suction Cups can be put in the compartment between the support legs.
   - Put the neck strap of the Stabilization Strap between the support legs.
   - Slide the Back Plate into the Carrying Case cover lid compartment.
   - Put the Instructions for Use in the transparent pocket.
9. Close the Carrying Case.

Do routine checks weekly and after each use *(refer to the maintenance section, chapter 7)*.

Appendix B Continued

6.3 Cleaning routines

Clean all surfaces and straps with a soft cloth and warm water with a mild cleaning agent or disinfectant agent, e.g.

- 70% isopropyl alcohol solution
- 45% isopropyl alcohol with added detergent
- Quaternary ammonium compound
- 10% bleach
- Peracetic (peroxide) acid solutions

Follow the handling instructions from the manufacturer of the disinfectant.

Caution – liquid
Do not immerse the LUCAS Chest Compression System in liquid. The device can be damaged if liquid enters the hood.

Allow the device to dry before you pack it into the Carrying Case.

Caution – contamination
Clean the device between each use to reduce the risk of contamination.

6.4 Remove and install the Suction Cup

- Pull the Suction Cup off the black mounting tube.
- Discard the Suction Cup as biohazardous waste.
- Bend a new Suction Cup onto the black mounting tube.
- Make sure the Suction Cup is safely attached on the mounting tube.

6.5 Remove and attach the Patient Straps

Remove:

1. Open the Patient Straps and pull them out from the metal rings on the LUCAS support legs.

Clean according to 6.3.

Install:

2. Thread the Patient Straps through the metal holder on the LUCAS support legs.
3. Fold the Patient Strap so that the symbol is visible.
4. Press the strap parts firmly together.

Appendix B Continued

30

6.6 Remove and attach the Stabilization Strap

Remove the Support leg straps, which is a part of the Stabilization Strap, by opening the buckles.

Clean the Stabilization Strap according to 6.3.

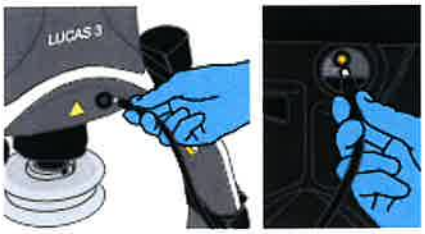
Install according to 4.3.

6.7 Remove and recharge the Battery

1. Replace the Battery with a fully charged one.
2. Recharge the used Battery for future use.

You can charge the LUCAS Battery in two ways:

- In the external LUCAS Battery Charger
  - put the Battery in the slot of the Battery Charger,
  - connect the Battery Charger power cord to the mains wall outlet.
- Installed in the LUCAS device:
  - put the Battery in the slot of the hood of the LUCAS device.
  - connect the Power Supply/Car Power Cable to the DC input on the side of the LUCAS device. This is possible also when the LUCAS device is inside the Carrying Case through the charger port access,
  - connect the Power Supply to the mains wall outlet.



During charge, 3 green LEDs will show a "running" light.

Caution – keep Battery installed
The Battery must always be installed for the LUCAS device to be able to operate, also when powered by the external Power Supply.

WARNING – USE ONLY APPROVED ACCESSORIES
Use only Jolife-approved accessories with the LUCAS Chest Compression System. The LUCAS device may not operate correctly if you use accessories that are not approved. Use only LUCAS Batteries and the LUCAS Power Supply that are designed for the LUCAS device. If you use other batteries or Power Supply you can cause permanent damage to the LUCAS device. This also voids the warranty.

SUBJECT:	SECTION:
CRASH CARTS --EXCHANGING, RESTOCKING, SECURITY AND VERIFICATION	***Medication Management (MM)*** **Page 1 of 9**

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

PURPOSE:

To ensure that a standardized and completely supplied crash cart for all patient care and surrounding areas, with no lapse of time between use, will be available at designated areas throughout the hospital.

POLICY:

Carts which can accommodate adult, pediatric and neonatal patients are maintained in accordance with current ACLS and PALS recommendations and are available for use in designated patient care areas. Once used, these carts are replaced with newly supplied and verified back-up carts located in the Central Processing Department (CPD).

Four (4) Adult Crash Carts, one (1) Pediatric Crash Cart exchangeable and two (2) Neonatal Crash Carts fully stocked and verified (sealed) are maintained in CPD and are available to exchange for used carts 24-hours per day.

Pediatric Resuscitation System – Broselow/Hinkle pediatric carts are located in areas where pediatric patients are potentially treated.

Additional medication trays and medical supplies are available 24-hours per day to accommodate additional needs. Procedures are outlined to address exchanging, restocking, security and verification (sealed) of the contents of Crash Carts.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF; PHARMACY; NURSING; RESPIRATORY THERAPY, CENTRAL STERILE PROCESSING*

PROCEDURE:

EXCHANGE PROCEDURE (Exchangeable Carts)

1.. A licensed Nurse from the department/unit/treatment area (where the Code Blue occurred) is "*responsible for delegating and ensuring*" that a fully stocked Crash Cart from CPD is obtained as soon as possible after the termination of the Code Blue situation. **The used cart shall NOT be removed from the area until a new cart is available** (see *"Exchange Procedure).*

Exchange Procedure When CPD is Open:

a. Upon cessation of the code, the medication nurse for the code will remove the blue lock provided in the medication tray of the crash cart and use it to lock the opened medication drawer back into the cart. Central Processing Department will then be notified that a replacement cart is required. The CPD Technician will bring a new crash cart to the code area and remove the secured crash cart to be processed.

b. Used carts will be retrieved by CPD or brought to CPD for restocking, and then taken to the pharmacy to have the blue lock broken and the medication drawer removed by a

licensed pharmacy staff member. Pharmacy personnel will visually inspect the medication drawer of the cart for cleanliness and will wipe clean if necessary. A pharmacist, intern pharmacist or pharmacy technician will then load a new medication tray into the crash cart and secure the medication drawer with a red lock, with proper documentation. Intern pharmacists and pharmacy technicians performing these restocking duties must do so under the direct supervision and control of a registered pharmacist.

c. After the used medication drawer has been removed, replaced with a new sealed medication tray and locked into the cart with a red lock. Pharmacy will notifyCPD to come to pharmacy to retrieve the newly stocked and locked carts.

Exchange Procedure When CPD is Closed:

a. Upon cessation of the code, the Med Nurse for the code will remove the blue lock provided in the medication tray of the crash cart and use it to lock the opened medication drawer back into the cart. The number of the lock will be recorded on the log in the binder with appropriate notations in the comment section.

b. The Night Administrative Supervisor will then obtain a newly supplied exchange cart from CPD and transport it to the patient care area where the code situation has terminated. **The used cart shall remain in the area until a new cart is available**

c. Once a newly supplied exchange cart has been delivered to the patient care area where the code has terminated, the Night Administrative Supervisor will transport the used cart to the decontamination area of the CPD and ensure it is behind locked doors. The cart is not to be left outside in the hallway.

d. When CPD staff arrive in the morning, they will clean and restock the cart and transport the used cart to pharmacy for processing.

e. In the event that exchange cart supply is exhausted when CPD is closed, the Night Administrative Supervisor will call the on call CPD technician and the on call pharmacist for processing of a new exchange cart.

DEFIBRILLATORS AND EQUIPMENT LOCATED ON TOP OF THE CART:

1. Defibrillators and all equipment located on the top of the Crash Cart will remain in their assigned area to be transferred to the new exchange cart upon arrival.

2. Defibrillators will be checked daily throughout the hospital utilizing the "Crash Cart/Defibrillator Checklist." Defibrillators in the ASD, Imaging, Wound Healing Department, OR, and Cath Lab will be checked daily when the unit is open.

3. Defibrillators will be **UNPLUGGED** from the electrical outlet when tested in order to check the "Charge" status of the battery.

MEDICATION TRAYS AND SUPPLIES

1. The Adult, Neonatal and Pediatric Crash Carts will contain a Medication Tray that is prepared by Pharmacy, and contains a checklist that includes the name of the medication, strength, dispensing unit, and quantity. All medications contained within the Medication Tray will be consistent with medications used in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS).

2. The checklist will identify the "First Medication to Expire" and the "Expiration Date" of that item.

3. Medications placed in the tray will have at least 2 months dating prior to expiration (subject to market availability).

4. The trays will be verified by a Registered Pharmacist (see *"Emergency Medication Crash Cart List" form*).

5. Non-Pharmaceutical Crash Cart supplies will be replenished by CPD based upon the items and quantities listed on the Crash Cart Contents List, kept in CPD.

LOCATION OF ADULT CRASH CARTS:

- OB/OR Suite – 4th Floor
- Family Birthing Center – 4th Floor
- Pediatrics - 3rd Floor
- 3 South Medical/Surgical – 3rd Floor
- 3 West Medical/Surgical – 3rd Floor
- 3 East Medical/Surgical – 3rd Floor
- Intensive Care Unit (2 carts) – 2nd Floor
- Telemetry Unit – 2nd Floor
- Operating Room– 2nd Floor
- Post-Anesthesia Care Unit – 2nd Floor
- Flex Care Unit – 2nd Floor
- Emergency Department (3 carts) – 1st Floor

- Sub-Acute Unit – 1st Floor
- Radiology Department – Special Procedures
- Radiology Department – MRI Suite
- Radiology Department – CT Suite
- Cardiac Cath Lab (2 carts)
- Central/Sterile Processing (8 carts) – 1st Floor
- Ambulatory Surgery Department (ASD)

LOCATION OF BROSELOW/HINKLE PEDIATRIC CRASH CART

- Emergency Room 2 carts
- 3 North Medical/Surgical
- Pediatrics
- PACU/Surgery
- Radiology –Interventional Radiology
- Radiology – General Procedures
- Central/Sterile Processing – 2 cart
-

LOCATION OF NEONATAL CRASH CART

- NICU (2 carts)
- Central/Sterile Processing– 1st Floor
- ER 1st Floor

INSPECTION PROCEDURE:

Daily Inspection

1. The nurse will assure that:

a. The defibrillator is plugged into the RED electrical outlet and charged.

b. Test the defibrillator daily. UNPLUG before testing.

Charge to the joules indicated on the machine.

c. When charged, the energy is to be discharged and the delivered energy on the screen should match the set amount.

d. If the delivered energy does not match the setting or there is any other problem in the operation, notify Plant Operations immediately and take the unit out of service.

e. If the test is within limits, then the defibrillator is to be plugged back into the red emergency wall outlet.

f. The initials of the staff nurse performing the check will document that this is completed.

2. Check the contents on top of the crash carts, assuring none of the supplies are compromised or expired.

3. Check the oxygen cylinder for adequate content (no less than 1500 psi) and performance of regulator. Notify Plant Operations of any problems or for a replacement if necessary. The initials of the staff nurse will be documented on the Crash Cart Integrity Check List.

4. If applicable, check the portable suction pump for proper operation.

5. Make sure that the top of the Crash Cart is clean and organized and ready for use.

6. Make sure the contents of the Crash Cart are secure by verifying tamper-evident seals are locked and that the lock number corresponds to the number recorded on the log. ***If the lock is broken, the cart is NOT to be used.*** Exchange the Crash Cart in accordance with the "Exchange Procedure" of this policy.

7. Sign the Crash Cart Integrity Check List that is attached to the Crash Cart.

8. Only licensed personnel may complete and sign the Crash Cart Integrity Check List.

Monthly Inspection

1. A pharmacist, intern pharmacist or pharmacy technician will check the contents of the medication trays for dating during the Monthly Unit Area Inspections. Intern pharmacists and pharmacy technicians performing the monthly checks must do so under the direct supervision and control of a registered pharmacist.

2. Any irregularities discovered in the monthly inspections must be reported to the Director of Pharmacy and the Chief Executive Officer (CEO) within 24 hours.

3. Trays with contents that outdate within the upcoming month will be removed and replaced with a tray with at least two (2) months dating. The pharmacist, intern pharmacist or pharmacy technician will re-certify the medication drawer according to procedure.

Quarterly Inspection

1. The Central Processing Department will check every non medication item on each Crash Cart throughout the hospital on a monthly basis. A log with expiration dates will be maintained by the CPD staff.

2. All carts will be restocked according to the Crash Cart Contents List, periodically reviewed and updated by the Code Blue Committee.

REFERENCES:

- California Code of Regulations. 22 CCR § 70263. March 2021.

CROSS REFERENCES:

- Crash Carts Tray Checklist Adult
- Crash Cart Tray Checklist Neonatal
- Crash Cart Tray Checklist Pediatric

ATTACHMENT A: CRASH CART TRAY CHECK LIST (ADULT)
REVISED 2-27-147/13/16

Sierra View Medical Center
Adult Emergency Medication "Crash Cart" List

Medication Name	Strength	Dispensing Unit	Quantity	Exp. Date
Adenosine	3 mg/ml	2 ml vial	5	
Amiodarone	50 mg/ml	3 ml Amp	4	
Atropine Sulfate	0.1 mg/ml	10 ml PFS	3	
Calcium chloride	100 mg/ml	10 ml PFS	1	
Calcium Gluconate	100 mg/ml	10 ml vial	3	
Dextrose 50%	0.5 gm/ml	50 ml PFS	2	
Dopamine drip in D5W	1.6 mg/ml	250 ml PMB	1	
Epinephrine	1 mg/ml (1:1,000)	1 ml Amp	2	
Epinephrine	0.1 mg/ml (1: 10,000)	10 ml PFS	10	
Flumazenil	0.1 mg/ml	10 ml vial	1	
Lidocaine	20 mg/ml	5 ml PFS	4	
Lidocaine drip in D5W	4 mg/ml	250 ml PMB	1	
Magnesium Sulfate	0.5 gm/ml	2 ml vial	2	
Metoprolol	1 mg/ml	5 ml Amp	3	
Naloxone	1 mg/ml	2 ml Amp	2	
Phenylephrine HCl	10 mg/ml	1 ml vial	2	
Procainamide	100 mg/ml	10 ml PFS	2	
Sodium Bicarbonate	1 mEq/ml	50 ml PFS	2	
Vasopressin	20 units/ml	1 ml vial	2	

First Medication to Expire:		**Expiration Date:**	

Tray Prepared by Technician (Initials):		**Date Prepared/Time:**	

Tray Checked by Pharmacist (Initials):	

ATTACHMENT A: (Continued)
Sierra View Medical Center
Pediatric Emergency Medication "Crash Cart" List

Medication Name	Strength	Dispensing Unit	Quantity	Exp. Date
Adenosine	3 mg/ml	2 ml vial	5	
Amiodarone	50 mg/ml	3 ml Amp	4	
Atropine Sulfate	0.1 mg/ml	10 ml PFS	3	
Calcium chloride	100 mg/ml	10 ml PFS	1	
Dextrose 10%	0.1 gm/ml	1000 ml	1	
Dextrose 25%- Pediatric	0.25 gm/ml	10 ml PFS	1	
Dextrose 50%	0.5 gm/ml	50 ml PFS	2	
Dobutamine drip in D5W	2000 mcg/ml	250 ml PMB	1	
Dopamine drip in D5W	1.6 mg/ml	250 ml PMB	1	
Epinephrine	1 mg/ml (1:1,000)	1 ml Amp	2	
Epinephrine	0.1 mg/ml (1: 10,000)	10 ml PFS	4	
Flumazenil	0.1 mg/ml	10 ml vial	1	
Lidocaine	20 mg/ml	5 ml PFS	4	
Lidocaine drip in D5W	4 mg/ml	500 ml PMB	1	
Magnesium Sulfate	40 mg/ml	50 ml PMB	2	
Naloxone	0.4 mg/ml	1 ml vial	2	
Naloxone	1 mg/ml	2 ml Amp	2	
Procainamide	100 mg/ml	10 ml PFS	2	
Sodium Bicarbonate	1 mEq/ml	50 ml PFS	2	
Sodium Bicarbonate- Pediatric	0.5 mEq/ml	10 ml PFS	1	

First Medication to Expire:		**Expiration Date:**	

Tray Prepared by Technician (Initials):		**Date Prepared/Time:**	

Tray Checked by Pharmacist (Initials):	

ATTACHMENT A: (Continued)
Sierra View Medical Center

Newborn Emergency Medication "Crash Cart" List

Medication Name	Strength	Dispensing Unit	Quantity	Exp. Date
Dextrose	10%	500 ml	1	
Epinephrine	0.1 mg/ml (1:10,000)	10 ml PFS	2	
Naloxone HCl	0.4 mg/ml	1 ml Amp	2	
Normal saline	0.9%	250 ml	2	
Normal saline (flush)	0.9%	10 ml	5	
Sodium bicarbonate	4.2%	10 ml PFS	2	
Sterile water for injection		50 ml	2	

First Medication to Expire:		**Expiration Date:**	

Tray Prepared By Technician (Initials):		**Date Prepared/Time:**	

Tray Checked By Pharmacist (Initials):	

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

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

PURPOSE:

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

DEFINITIONS:

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

2. Intravesical instillation - Administration into the bladder

POLICY:

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

AFFECTED PERSONNEL/AREAS: *NURSING, PHARMACY*

EQUIPMENT:

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

PROCEDURE:

A. Intra-operative antineoplastic order

The licensed practitioner will:

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

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

3. SVMC Pharmacy will purchase the compounded Mitomycin if unable to compound due to state regulations. For procedures to be done in OR's the Main Pharmacy cannot compound without a USP 797/800 compliant space. Supplier must be registered with CA Board of Pharmacy.

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

C. Intravesical Instillation:

The registered nurse assisting the medical doctor will:

1. Don personal protective equipment (PPE).

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

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

4. Attach antineoplastic precautions label to the catheter drainage bag/tubing.

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

1. Don personal protective equipment (PPE).

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

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

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

E. Care of the patient who has received intravesical instillation of mitomycin:

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

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

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

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

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

REFERENCES:

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

CROSS REFERENCES:

- STERILE HAZARDOUS DRUG HANDLING Policy

SUBJECT: **TABLO SET UP, TREATMENT, AND POST DEVICE CARE**	SECTION: **Page 1 of 6**

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

PURPOSE:
To provide guidelines for Tablo system use

POLICY:
Guidelines for Tablo dialysis system set-up and initiation of therapy and post treatment

AFFECTED PERSONNEL/AREAS:
DIALYSIS RN'S, CRITICAL CARE RN'S, BIO MED TECHNITION, CHT'S

PROCEDURE:

Set-up and treatment Initiation:

1. Gather patient and device supplies.
2. Confirm valid, current patient dialysis order in medical record
3. Power up the Tablo System from the back of the touchscreen.
4. Connect Tablo to water source and set up drain. Enter water source on Tablo
5. Enter the patient prescription
    a. Insert the patient key that includes the appropriate dialysis prescription, **OR**
    b. Enter the machine settings and prescription information directly on the device.
6. Follow the instructions on the Tablo touchscreen to verify the patient identification and prescription data.
    a. Verify system prescription data with current, valid order in medical record
    b. Review the supplies checklist on the Tablo screen
7. Perform and document a complete patient assessment prior to initiation of treatment
    a. Adjust the treatment settings in Tablo to appropriately monitor treatment performance and patient vital signs.
8. Set up the system following the steps on the touchscreen prompts
    a. Prepare and connect dialysis jugs
    b. Place Cartridge
    c. Clamp, spike and hang saline bag
    d. Attach red and blue dialyzer lines from the Cartridge to the dialyzer,
    e. Attach new and used dialysate connectors to dialyzer
    f. Clip in dialyzer to Tablo Console
    g. Unclamp saline and start prime
9. Obtain pre-treatment vitals (Weight, Temp)
10. Enter fluid removal goal if not using weights.
11. Perform water and dialysate tests
    a. Collect a chlorine water sample (incoming water) using the spout on the front of Tablo. Complete chlorine testing
    b. Take dialysis fluid sample for dialysate temperature and conductivity testing. Take sample for pH testing if applicable.

   c. Verify all testing results are within acceptable range
12. Prepare the vascular access for treatment
13. Discard prime fluid
14. Make connections to the patient access lines and unclamp red and blue patient lines of the Cartridge blood tubing set
15. Ensure all connections are secure including patient arterial and venous line connections.
16. Make sure air has been properly flushed out of the venous needle line or the venous catheter line.
17. Make sure that venous and arterial patient line connections are always visible for inspection and are not covered by sheets, blankets, or tape.
18. Initiate treatment following the Tablo touchscreen prompts.

End Treatment Return Blood

1. Perform hand hygiene and apply PPE
2. Ensure there is a minimum of 300mL of NS available
3. When treatment has completed, select tab that say "Begin Blood Return"
4. Clamp arterial access
5. Perform rinse back process
6. Upon completion of rinse back user will be prompted to check vital signs
   a. Deliver saline bolus if needed
7. Follow onscreen instructions to clamp all remaining clamps
8. Tap the tab that states Disconnect

Machine Breakdown

1. Follow onscreen instructions to disengage the cartridge, dialyzer and saline bag
2. Dispose in biohazard bag
3. Disconnect the dialysate caps from straws
4. After every treatment, thoroughly wipe all exposed surfaces of the Tablo system including the Touchscreen and blood pressure (BP) tubing (BP cuff will be patient issued, disposable), using one of the manufacturers approved disinfectants
   a. PDI Bleach Sani Wipes
   b. Household bleach mixture 1:10
5. Let device complete rinse if possible
   a. If end of day rinse must be completed prior to disinfection process
6. At end of day put device into the appropriate disinfection process (Heat or Chem)

End Treatment Discard Blood

1. Choose Pause Treatment at the bottom of the touchscreen
2. Choose End Treatment

3. Choose Discard Blood
4. Follow onscreen instructions to disconnect patient (steps 4-19 above)

General post-treatment cleaning

A. After every treatment, thoroughly wipe all exposed surfaces of the System including the Touchscreen and blood pressure (BP) tubing (BP cuff will be patient issued, disposable), using one of the manufacturers approved disinfectants:
    a. PDI Super Sani Cloth Germicidal Wipes (Do NOT use for C. Diff patients).
    b. PDI Super Sani Bleach Germicidal (C. Diff patients only).
B. At the end of treatment, perform hand hygiene, don clean gloves and clean all surfaces without visible blood with low level disinfection for visible blood:
    a. Perform hand hygiene, don PPE, wipe up minor blood spill with absorbent towel, and discard in biohazardous container.
C. In the event blood and/or saline is observed on the Venous and/or Arterial Pressure Sensors, the Console should be wiped down with an appropriate cleaning agent (see item A. a-b above), removed from service, and contact biomed for servicing. Call 1-844-MY TABLO to log the issue.

Post Treatment Rinse

A. The rinse cycle is completed at the end of each day, after all treatments are complete, prior to powering off the system.
    a. The Tablo console will default to initiate an optional rinse cycle between treatments.
    b. The nurse may skip this rinse cycle if they wish to proceed with the next treatment by choosing *Get Started* on the Home Screen.
    c. Complete the Rinse Cycle prior to powering off the system.

Disinfect Cycles

A. Heat and Full Chem cycles will be logged

CYCLE	DURATION	SCOPE	ADDITIONAL KEY POINTS
HEAT (2.5-3h)	Heat 60 minutes Regular Cool 90-120 min. Optional Quick Cool (optional) ~ 30 min.	High heat to all areas of the device except for the RO	• Good for up to 72 hours, if no treatments performed • Best for use after last treatment of the day
FULL CHEM (6-9h)	Chem infusion ~ 25 min. Chem recirculation ~ 80 min. Rinse ~ 3.5 hr. Heat 2 hr. Regular Cool ~ 90 min Optional Quick Cool ~ 30 min	Minncare chemical treatment to all areas of water treatment and dialysis components	• Minncare residual test required • Must be performed at least every 7 days
QUICK CHEM (1h 15)	Chem infusion 45 min Rinse ~ 30 min	Minncare chemical treatment to top portion only (patient contacting)	• No heat cycle required • Minncare residual test required • Best for use with isolation or unknown status patients • Does not replace the need to perform Full Chem weekly

Heat Disinfect

A. Complete daily at the end of day.
   a. From the *Home screen*, choose the maintenance tab.
   b. From the *DISINFECT tab*, choose the *Heat* button.
   c. Choose the *Start Heat* button.
   d. Choose *Yes* to confirm you want to start heat.

Full Chem Disinfect using MinnCare HD

A. The Full Chem disinfection cycle will infuse chemical disinfectant into the system and circulate it throughout, including reverse osmosis membranes.
   a. This serves to both disinfect and descale the pertinent components of the fluidic pathway
   b. After a dwell period, the chemical disinfectant is rinsed out, followed by a Heat disinfect cycle.

B. Required weekly to disinfect and descale the system.
C. Prepare Minncare per manufacturer instructions.
    a. Don protective equipment as required by the manufacturer
D. If using a new chemical bottle place on a flat surface and remove and discard the chemical bottle cap.
    a. Place the insert with the straw onto bottle. Only use an insert with straw provided by Outset.
    b. Screw the insert with straw tightly onto bottle for storage or for immediate use
E. From the Home screen, choose the maintenance icon
    a. From the *DISINFECT tab*, choose the *FULL CHEM* button.
    b. Choose the *Start Full Chem* button.
F. Set the disinfectant behind the Touchscreen and unscrew the top.
G. Remove the red cap from the Console by pulling it straight up.
    a. Press the red cap onto the disinfectant.
    b. Prepare for the Full Chem by priming the system.
    c. When prompted, remove the red cap from the disinfectant and place it back on its port.
    d. Close and store the disinfectant
H. Once the Full Chem is finished, complete Minncare residual test. If the user gets a positive result for the absence of disinfectant, perform a 25-minute rinse and recheck.

Quick Chem Disinfect using MinnCare HD

A. The Quick Chem disinfection cycle will infuse chemical disinfectant into the portion of the fluid path which is in contact with the patient's spent dialysate.
    a. It does not disinfect or descale the water filtration system, nor does it reset the weekly timer for the required Full Chem.
    b. Completed after treatment with a patient in isolation status or with unknown isolation status before using the device for a subsequent treatment on another patient.
    c. May NOT be used to replace required weekly Full Chem Disinfect
B. Prepare Minncare per manufacturer instructions.
C. Don protective equipment as required by the manufacturer
D. Place the new chemical bottle on a flat surface and remove and discard the chemical bottle cap.
    a. Place the insert with the straw onto bottle. Only use an insert with straw provided by Outset.
    b. Screw the insert with straw tightly onto bottle for storage or for immediate use
E. From the Home screen, touch the wrench.
    a.
    b. From the *DISINFECT tab*, touch the *QUICK* button.
    c. Touch the *Start Quick Chem button*.

F. Set the disinfectant behind the Touchscreen and unscrew the top.
G. Remove the red cap from the Console by pulling it straight up.
    a. Press the red cap onto the disinfectant.
    b. Prepare for the Quick Chem by priming the system.
    c. When prompted, remove the red cap from the disinfectant and place it back on its port.
    d. Close and store the disinfectant
I. Once the Quick Chem finishes, complete Minncare residual test. If the user gets a positive result for the absence of disinfectant, perform a 25 minute rinse and recheck.

Water testing after Full or Quick Chem

A. Clean the bottom port on the upper door (new dialysate sample port) with alcohol and allow to dry
B. Collect a dialysis fluid sample with a syringe
C. Using a Minncare HD residual test strip, test the water sample
D. Choose *PASS* or *FAIL* on the Tablo screen
    a. If the water test fails, perform a Tablo Rinse and repeat the water test again.
    b. If the water test fails a second time, repeat the Tablo rinse. Repeat the water test again.
    c. If the test fails a third time, remove the device from service until biomed services the device. Notify biomed. Log the failure and biomed notification

References

- Nissenson, A.R., & Fine, R.A. (2017). *Handbook of Dialysis Therapy* (5th ed). Philadelphia, PA: Elsevier.
- Outset Medical. (2019). Tablo hemodialysis system user manual, PN-0004205 Rev. 08. San Jose, Ca: Outset Medical.

SUBJECT: **TUBERCULOSIS CONTROL PLAN**	SECTION: **Page 1 of 28**

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

PURPOSE:

The Tuberculosis Control Plan (TCP) integrates Centers for Disease Control and Prevention (CDC) evidence-based research and guidelines across all entities and provides Sierra View Medical Center (SVMC) staff a comprehensive plan for the early detection, management, isolation and treatment of persons with active tuberculosis (TB). Adherence to the policies and procedures addressed in this TB Control Plan will assist in reducing the risk of exposure to patients, visitors and staff within the Sierra View Medical Center (SVMC) environment. This Tuberculosis Control Plan includes:

TB CONTROL PLAN – TABLE OF CONTENTS

POLICY:

Sierra View Medical Center (SVMC) is committed to providing a safe and healthful work environment for our staff, caregivers, and patients. In pursuit of this endeavor, the following TCP is provided to minimize or eliminate occupational exposure to TB in accordance with the corrected and updated 2005 CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities. It is the intent of SVMC to comply with California Code of Regulations Title 8, Section 5144, Subchapter 7 concerning respiratory protective equipment and OSHA Standard 29 CFR 1910.139 concerning respiratory protection for Mycobacterium tuberculosis (MTB).

AFFECTED AREAS/PERSONNEL: *ALL HEALTHCARE WORKERS*

SECTION I - RESPONSIBILITY FOR THE TB INFECTION PREVENTION PROGRAM

A. The fundamentals of a TB Control Plan should consist of administrative controls, environmental controls, and a respiratory protection program.

1. Administrative Controls: These are management measures that are intended to reduce the risk of exposure to persons with infectious TB and include:

- Assigning someone the responsibility for TB infection control in the health care setting;
- Conducting a TB risk assessment of the setting;
- Developing and implementing a written TB infection-control plan;
- Ensuring the availability of recommended laboratory processing, testing, and reporting of results;
- Implementing effective work practices for managing patients who may have TB disease;
- Ensuring proper cleaning, sterilization, or disinfection of equipment that might be contaminated (e.g., endoscopes);
- Educating, training, and counseling health care personnel, patients, and visitors about TB infection and TB disease;
- Screening, testing, and evaluating personnel who are at risk for exposure to TB disease. Early identification, isolation, and treatment of persons with TB, (e.g., provide and practice early patient screening in the Emergency Department, to identify potentially infectious patients, and prevent employee exposures).
- Using posters and signs to remind patients and staff of proper cough etiquette (covering mouth when coughing) respiratory hygiene; and
- Coordinating efforts between local or state health departments and high risk healthcare and congregate settings.

2. Environmental Controls: The use of environmental controls to reduce the concentration and prevent the spread of infectious droplet nuclei.

    - Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation (e.g., hoods, tents, or booths) diluting and removing contaminated air by using general ventilation.
    - Secondary environmental controls consist of controlling airflow to prevent contamination of air in areas adjacent to the source airborne infection isolation (AIIR) rooms; and cleaning the air by correctly using high efficiency particulate air (HEPA) filtration.

3. Respiratory-Protection Controls: Consists of the use of personal protective equipment in situations that pose a high risk of exposure to TB disease.

    - Implementing a respiratory protection program;
    - Training healthcare personnel on respiratory protection; and
    - Educating patients on respiratory hygiene and the importance of cough etiquette procedures.

B. The Tuberculosis Control Plan was developed and approved by the Administrative staff and the Board of Directors, who have ultimate responsibility for the development of programs that create a safe work environment for the employees.

The Infection Prevention and Control Committee has the authority for implementation and ongoing evaluation of the TB Control Plan. Leadership is responsible for monitoring compliance with the plan. All employees are expected to follow the policies and procedures contained in the TB Plan.

SECTION II – RISK ASSESSMENT

Risk assessment includes:

A. Analysis of the number of infectious TB patients admitted to the facility and each area in the facility
B. Analysis of Healthcare Worker (HCW) Tuberculin Skin Test (TST) conversion and possible patient-to-patient TB transmission.
C. Analysis of the management of infectious TB patients in the hospital, drug susceptibility patterns, and adequacy of treatment of TB patients.
D. Analysis of relevant current epidemiological information for the geographic area (locally, statewide and nationally)

SECTION III - PROTOCOL FOR EARLY DETECTION

In order to protect healthcare workers, patients and visitors from exposure to tuberculosis, patients (across all SVMC entities) with known or suspected infectious tuberculosis will be promptly screened and identified. Control measures will be employed in accordance with this policy and local, state, and federal regulations. *See other SVMC entity-specific policies as appropriate.*

Characteristics of TB:

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as:

A. Signs and symptoms of active TB:
    1. Productive, persistent cough of 3 weeks (or longer) duration (unclear etiology)
    2. Purulent bloody sputum/phlegm from deep inside the lungs (hemoptysis)
    3. Night sweats
    4. Pleuritic chest pain
    5. Unexplained weight loss
    6. Loss of appetite (anorexia)
    7. Easy fatigability
    8. Fever of unknown origin

Symptoms of TB disease in other parts of the body depend on the area affected.

B. Certain groups experience disease and infection rates in excess of the general population. These groups include:

1. Persons with certain comorbid medical conditions: diabetes, cancer, and HIV infection alter the immune system's ability to fight TB

2. Babies and young children with weak immune systems

3. Geographic disparities:

    a. Foreign-born persons from high prevalence countries (see listed reference)
    b. Medically underserved low-income populations, including high risk minority, African American, Hispanics, Native Americans and Southeast Asians
    c. Certain other populations that have been identified locally as having an increased prevalence of TB

4. Close contacts with known infectious TB cases

5. Persons with alcohol use disorder and intravenous drug users

6. Residents of high-risk congregated settings:

    a. Long-term care facilities (e.g., correctional facilities, skilled nursing)
    b. Individuals experiencing homelessness

C. Medical Risk Factors:

1. Persons with HIV infection
2. Silicosis
3. Abnormal chest radiograph showing fibrotic lesions
4. Prolonged corticosteroid therapy
5. Organ transplants
6. Immuno-suppressive therapy
7. Hematologic and reticuloendothelial diseases
8. End-stage renal disease
9. Intestinal by-pass
10. Post-gastrectomy
11. Chronic malabsorption syndromes
12. Carcinomas of the oropharynx and upper GI tract
13. Ten percent (10%) or more below ideal bodyweight

SECTION IV - SCREENING AND DIAGNOSIS

Diagnostic measures/assessment should be initiated on any person with suspected TB. The nursing staff shall notify the primary physician/hospitalist of any symptoms suggestive of TB upon initial patient assessment.

A. Diagnostic measures may include:

1. History and physical examination
2. Tuberculin Skin Test (TST)
3. Blood Assay for Mycobacterium tuberculosis (BAMT); Interferon Gama Release Assay (IGRA) or QuantiFERON-TB Gold test
4. Chest X-Ray
5. AFB sputum smear and culture
6. Others as prescribed

B. Tuberculin Skin test (TST): *See TST – ADMINISTRATION AND INTERPRETATION OF TB SKIN TEST POLICY*

1. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.
2. Test may be given to employees, healthcare providers, and patients. Patient results will be entered into the medical record.

3. Two-step TST Testing is used for new employees

C. Notification of the Nursing Unit and Infection Prevention Department

1. In addition to notifying the nursing unit, the Infection Prevention Department shall be notified (ext. 3781; Fax at 791-3819) by any person on the healthcare team in a timely manner of any suspect or confirmed TB diagnosis.

2. Notification can be accomplish by:

    a. The **nursing units** should notify Infection Prevention **ASAP** when placing a patient in Airborne Precautions
    b. **Physicians** can notify the nursing units/IP Department
    c. The interpreting **radiologist** (or Imaging designee) shall be responsible for immediately notifying attending imaging staff, who will inform the nurse and Infection Prevention of any abnormal radiological findings suggestive of TB
    d. The **laboratory** will notify the nursing unit, physician and Infection Prevention of any **positive** results of in-patient AFB smears, cultures or TST as soon as possible.
    e. **Pharmacy** should notify the Infection Prevention Department when a patient has been placed on a new regimen of TB medications.

SECTION V - MANAGEMENT AND ISOLATION OF PATIENTS WITH POSSIBLE TUBERCULOSIS

A. Decision to place in Airborne Precautions (See Figure 1)

1. Signs and symptoms suggestive of TB may include:

    a. Productive, persistent cough 3 weeks duration (unclear etiology)
    b. Purulent or bloody sputum (hemoptysis)
    c. Night sweats
    d. Pleuritic chest pain
    e. Unexplained weight loss
    f. Loss of appetite (anorexia)
    g. Easy fatigability
    h. Fever of unknown origin
    i. Abnormalities (i.e., cavitation) in the chest X-Ray including apical and posterior segments of the upper lobe, in the superior segments of the lower lobe or diffuse nodular infiltrates

2. Any patient with signs and symptoms suggestive of TB, **and** any of the following circumstances will be considered suspect for TB and placed into Airborne Precautions as soon as possible:

    a. There is an order for sputum for AFB's
    b. The physician writes "R/O suspect or confirmed TB"

3. The physician, infectious disease physicians, nurse, nursing supervisor or infection preventionist shall have the authority to implement Airborne Isolation Precautions when signs and symptoms are suggestive of TB (suspected or confirmed). The physician and Infection Prevention Team should be consulted as part of the decision making process.

B. Airborne Precautions (Airborne Infection Isolation Room (AIIR)

When a patient is placed in Airborne Precautions, the following should take place:

1. Assure the room is negative pressure or has a HEPA filter at bedside.
2. An Airborne Precautions sign (caddy as needed) shall be placed on the door to the patient's room.

3. The door will remain closed, except when entering or leaving the room
4. A National Institute for Occupational Safety and Health (NIOSH) approved **respirator masks or Powered Air Purifying Respirator (PAPR)** should be donned by **all** staff (i.e., nursing, physicians, EVS, Lab, RT, Imaging, etc.) upon entering the room.

C. Airborne Infection Isolation Room (AIIR) Location

Designated Airborne Infection Isolation Rooms (AIIR) appropriate for the placement of patients with known or suspected TB are located in the following areas:

1. **Main Hospital:**
    a. Telemetry Department - Room 260
    b. Medical Surgical Department – Room 360
2. If a room is not a designated AIIR, it may be able to be adapted with an appropriately placed HEPA filter.

D. Inpatients with known or suspected TB:

1. Patient must be placed in Airborne Infection Isolation room (AIIR) or have a HEPA filter unit placed at bedside.
2. Patients on treatment for infectious TB who are re-admitted to SVMC shall be placed in the above designated room until infectiousness is ruled out.
3. Notify the Infection Prevention Department as soon as possible (Infection Prevention Department 3781).
4. Within 24 hours of diagnosis or strong suspicion of an active TB case, notification of the Tulare County TB Office must be done. The IP Team will initiate this process.
5. Adherence to Airborne Precautions/etiquette compliance by the staff and patient is mandatory.
6. Any incident of noncompliance with Airborne Precautions protocol shall be reported to the area Clinical Director/Manager.
7. The physician shall be notified if the patient will not comply with Airborne Precaution protocols.
8. The physician and/or nurse will provide the following education to the patient in respiratory precautions:
    a. Transmission of TB
    b. Reasons for respiratory precautions and importance of compliance
    c. Precautions, such as covering the mouth and nose with tissues when coughing or sneezing
    d. Importance of staying inside the patient's room

e. Specific instructions for transportation to areas outside the patient's room

SECTION VI - OTHER CIRCUMSTANCES

A. Patient Movement to other locations:

1. A patient in Airborne Precautions shall not be routinely transported to other locations for a procedure/test unless it is deemed medically essential (and cannot be done in the patient's room).
2. If a patient in Airborne Precautions must be transported outside the patient's room for a medically essential procedure, the patient shall wear a surgical mask during the transfer and procedure. The mask should be changed if it is no longer effective (i.e., wet or soiled). If use of a mask is not possible during the procedure, the receiving department should use Airborne Precautions. Patient should be placed in a single room with a HEPA-filter. Staff should don an N-95 respirator or (PAPR) and follow other Standard Precautions (gown, face shield/goggles, gloves) if further exposure to body fluids is anticipated. Room should be exhausted for one hour (door closed) after the procedure with the HEPA-filter on.
3. If the patient requires mechanical ventilation, a HEPA-filter must be used on the expiratory side of the resuscitation bag or ventilator circuit. Portable ventilators are ***not*** equipped with closed circuit capability, therefore should not be used in transport of active TB ventilated patients.
4. The minimum respirator is a fitting face-piece respirator and must be selected from those approved by CDC/National Institute for Occupational Safety and Health (NIOSH) under Title 42 CFR, Part 84. It must meet one of the following specifications:
   - Non-powered air-purifying respirators (N-95)
   - Powered air-purifying respirators (PAPRs) with high-efficiency filters; or
5. Outside the patient room, during transport within the hospital or clinics, the employee does not need respiratory protection because the patient is wearing a surgical mask.
6. Staff should make **all** attempts to schedule the procedure at a time when it can be performed rapidly, when the patient is in a single room, and when waiting areas are less crowded (i.e., end of day).

B. Outpatients with known or suspected TB

1. Facility staff should be notified by physician's office staff in **advance** regarding a possible TB patient arrival.
2. Patient should be instructed to wear a mask upon entering the facility and practice appropriate respiratory etiquette (i.e., use tissues while coughing, proper disposal, etc.).
3. Place patient in a room with a HEPA filter. If not readily available, patient is to wear a mask until placed in an appropriate room.

4. When appropriate, schedule suspect TB patients at times to avoid contact with immunocompromised patients

C. Aerosol-generating (high hazard, cough-inducing) procedures (i.e., bronchoscopy, airway surgeries, intubation/extubation, non-invasive positive pressure ventilation (e.g., CPAP, BIPAP, open Suctioning of tracheostomy or endotracheal tube)

1. Minimize such procedures when possible.
2. Use the HEPA units for aerosol-generating procedures.
3. HCWs should utilize "Enhanced Airborne Precautions" during the procedure (i.e., N-95 respirator mask/PAPR, goggles/face shield, gloves and gown).
4. Following the procedure, confine the patient to the room or enclosure until coughing subsides or until patient is discharged. Have patient use tissues to contain any secretions.
5. Allow at least 1 hour following the procedure before placing another patient in the procedure room.
6. Document precautions taken on the patient record, including area of recovery.

D. During Emergency Department Care

1. The patient shall wear a surgical mask when being transported via emergency medical services (EMS) if TB is suspected or confirmed. Staff should be alerted to a possible TB patient.
2. The suspect patient should be provided supplies for respiratory etiquette (mask, tissues and hand sanitizer) and instructed on respiratory hygiene. This process should begin in the waiting room. The patient should be separated from other patients as soon as possible.
3. The patient should be placed in a private room with HEPA filtration. Airborne Precautions should be implemented.
4. A mask should be worn at all times by the patient, until sufficient arrangements are made. The mask should be changed as necessary (i.e., when wet or soiled).
5. The patient should be processed as quickly as possible through the Emergency Department.

E. Operating Room (OR):

1. Elective operative procedures shall be deferred, if possible, until TB is no longer infectious.
2. OR procedures that must be done shall be completed with the door closed and traffic minimized.
3. If possible, procedures shall be performed at the end of the day.
4. A bacterial filter shall be placed on the endotracheal tube and/or expiratory side of the anesthesia breathing circuit.

5. OR personnel shall wear an N-95 respirator mask instead of a surgical mask during the procedure.
6. HEPA filtration should **not** be used during the operative procedure due to disruptions of normal air flow.
7. HEPA filtration will be required for air scrubbing the environment post-operation after the patient has been removed from the OR suite. Note: The HEPA unit must be disinfected prior to entry into the operating room.
8. Allow the HEPA-filter unit to run for at least 60 minutes after the patient has vacated the room.
9. Recovery shall be in an individual room meeting ventilation requirements.

F. PPD Positive Obstetric Patients

1. Obstetric patients and their newborns will be provided quality effective care that meets the requirements for effective management of TB.
2. Positive PPD skin test obstetric patients should have a documented chest radiograph in their medical records to verify disease status.
3. Asymptomatic PPD positive obstetrics patients **with** a documented x-ray within the last year do not require any additional precautions related to TB upon admission
4. Asymptomatic PPD positive obstetrics patients **without** a documented chest x-ray within the last year will require a chest x-ray as soon as possible after delivery. They (as well as the infants) will not require any additional precautions related to TB upon admission until the status of the x-ray is determined.

5. **Symptomatic positive PPD** patients will require Airborne Precautions:
    a. Separation may be necessary:
        1) Mothers who are too ill to care for their infants or who need higher levels of care.
        2) Neonates at higher risk for severe illness (e.g., preterm infants, infants with underlying medical conditions, infants needing higher levels of care).
    b. If the neonate remains in the mother's room, measures that can be taken to minimize the risk of transmission from a mother with symptomatic TB to her neonate include:
        1) Mothers should wear a mask and practice hand hygiene during all contact with their neonates. **Note**: Plastic infant face shields are not recommended and masks should **not** be placed on neonates or children younger than 2 years of age.

6. If an obstetric patient is undergoing active treatment for TB, the staff will contact the Infection Prevention Department. The Infection Prevention Department will communicate with the Tulare County TB Office. A determination will be made regarding the patient's current infectious status. Precautions will be taken if necessary. The Birth Center will notify the Infection Prevention Department when the patient is discharged. The Infection Prevention Department will notify Tulare County of the discharge.

SECTION VII - ENGINEERING CONTROLS

A. Ventilation
   1. Local exhaust ventilation
      a. Air from ventilation devices in the patient room is directly exhausted to the outside of the building, away from air intake vents.
      b. Precaution rooms and rooms used for treatment have a minimum of twelve (12) air exchanges per hour. Air is exhausted to the outside and not recirculated.

B. Negative Pressure Rooms (AIIR)

   1. Monitoring
      a. Negative airflow pressure rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

C. HEPA Filtration

A HEPA air filtration unit is a portable device used to "clean" the air of a non-negative pressure patient room or area by creating high efficiency particulate air filtration (removal of respirable particles).

   1. Installation of Unit

      a. Call Engineering when a HEPA unit is needed in a patient room.
      b. Engineering staff will install the unit in required area as per nursing staff and use appropriate particulate respirator and other protective equipment, as required due to patient condition.

   2. Monitoring

Negative airflow pressure check is conducted by engineering. AIIR rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

3. Unit Removal

Upon notification from nursing that the unit is no longer necessary:

a. Engineering will be called to remove the HEPA unit.
b. HEPA unit will remain "ON" in the patient's room (to scrub the air) for at least one (1) hour, prior to being removed by Engineering (necessary only if patient had infectious TB).
c. Unit will be cleaned by Environmental Services staff.
d. Intake filter will be removed and cleaned in a non-common open area by Bio-med every 3 months.
e. Unit will be stored by Engineering.

4. Maintenance Procedure

a. HEPA filters are to be properly installed, tested, and maintained per manufacturer's instructions. HCW will maintain documentation in the patient's record indicating the time that the unit was used.
b. Filters are to be installed to prevent leakage between filter segments and between the filter bed and its frame.
c. A pressure sensing device in the filter system will determine the need for filter replacement. Changes will take place per manufacturer's recommendations by Engineering.
d. Installation should allow for maintenance without contaminating the delivery system or area served.
e. Engineering personnel are adequately trained on the installation and maintenance procedures. Respiratory protection is worn during maintenance and testing.

SECTION VIII - DISCHARGE PLANNING

A. Discontinuance of Airborne Precautions:

1. The following persons are authorized to discontinue isolation:
   a. Attending physician
   b. Infection Preventionist
2. Isolation may be discontinued if the patient is:
   a. On effective therapy (usually four TB drugs)

b. 3 daily consecutive sputum smears for AFB are rare or negative
c. With permission of Tulare County Health Department
d. When patients are found not to have infectious TB

B. TB Inpatient Notification/Discharge Planning:

Every health care provider who provides treatment for a patient with active tuberculosis must promptly report to the local health officer each diagnosis or suspected diagnosis of active TB. Also reportable are instances when the patient discontinues treatment for active TB.

A healthcare facility cannot discharge a person who is known or reasonably suspected to have active TB until after the discharge plan for the patient is approved by a Tulare County Public Health Official.

To comply with the above regulations, the Infection Prevention Department will be the overall coordinator for the reporting process. Problems or concerns should be directed to the Infection Prevention Department. However, a team approach should be used to facilitate the initial reporting mechanism and discharge planning process between the facility and the Tulare County Health and Human Services Agency (TCHHSA) TB Office. Nursing, the patient's physician, Case Management and the Infection Prevention Practitioner will collaborate to expedite the communication of information necessary to report TB cases and to obtain approval for the patient's discharge plan.

1. Within **24 hours** of diagnosis or strong suspicion of an active TB case (i.e. patient with symptoms suggestive of TB, positive chest radiograph with positive PPD or AFB smear), notification of the Tulare County TB Office must be done. Nursing staff or the patient's physician shall notify the IP Nurse to initiate this process.

2. When the Infection Preventionist receives notice of the patient actual or suspected diagnosis, the completed TB Suspect Case Report will be faxed or input in CalREDIE by the IP.

3. The Infection Preventionist and staff will communicate with Tulare County TB Office as necessary, to facilitate patient treatment/progress. Documentation of any communication shall be recorded in the patient's medical record.

4. As soon as a projected discharge date is known and at **least one day prior to discharge,** the Tuberculosis Discharge Treatment Plan will be completed and faxed to the Tulare County TB Office by IP.

5. Notification of approval of the discharge plan will be sent from the Tulare County TB Office within approximately 24 to 48 hours after the plan was submitted as above. **The patient may not be discharged prior to receiving approval of the TB discharge plan.** If the patient

refuses to wait for the facility to receive the approved discharge plan form from the Health Department, the patient must sign out AMA and the TCHHSA TB Office must be informed immediately by hospital staff.

6. For medically necessary transfers to other acute care hospitals or correctional institutions, notification of the Tulare County TB Health Officer should be done ASAP. Document in the patient's medical record that the transfer was reported and to whom it was reported. The TB discharge plan will need to be completed.

SECTION IX - RESPIRATORY PROTECTION OF EMPLOYEES/FIT-TESTING

7. All employees are required to be fit-tested by Employee Health Services (EHS).
8. for a NIOSH-approved N-95 respirator mask.
9. Must seal the mask around the nose and mouth.

10. The mask must be "seal checked" for an effective seal each time before entry into an Airborne Precautions room. To do so, blow forcefully into the mask as it expands. The wearer should not feel air escaping around the edges of the mask.

11. As with any disposable mask, N-95 respirator shall be removed and disposed of immediately after a single use.

12. If the employee fails the N-95 fit test, they must wear a Powered Air Purifying Respirator (PAPR).

SECTION X - EVALUATION OF CONVERSIONS/TRANSMISSION

A. Exposure to TB in a HCW (See APPENDIX D: Employee Health Policy *Tuberculosis screening Program* and Employee Screening Form)

1. A contact investigation among other HCWs, patients, and visitors after a confirmed exposure to active TB will be initiated by Infection Prevention and Employee Health.
2. The Infectious Disease Department Chair will also be consulted.
3. Employee Health and Infection Prevention will follow current CDC recommended guidelines for exposure of employees (i.e., baseline TST and follow up at 8 - 10 weeks).
4. An employee exposure line list will be developed. Any employee converting to positive will be managed by Employee Health. Appropriate measures will be implemented based on each individual case.
5. Previous positive TST employees will be evaluated for symptoms and will be recommended for a chest x-ray.
6. The Tulare County Office will be notified for community contact investigation and consultation as required.

7. Investigation will be performed to determine the cause of transmission.
8. An evaluation of the TB exposure/TB Control Plan and processes will be conducted, with possible opportunities for improvement to be developed and recommendations implemented.
9. Summary of findings and recommendations will be presented to the Infection Prevention Committee.

B. Patient-to-Patient/Visitor TB Transmission

1. Surveillance will be conducted by Infection Prevention to determine any additional cases of TB transmission related to other patients and visitors.
2. Potential patient/visitor (as possible) exposures will be identified and the primary physician will be notified for recommended follow-up.
3. Tulare County TB Office will be notified as necessary.

C. Exposure Follow-up for Unrecognized TB at Time of Hospitalization

1. Investigation will be conducted to determine areas and persons potentially exposed.
2. All persons exposed shall be handled as above in A and B.

SECTION XI – DEFINITIONS/VOCABULARY

Acid-fast bacilli (AFB) - Bacteria that retain certain dyes after being washed in an acid solution. Most acid-fast organisms are mycobacteria. When AFB are seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be suspected; however, the diagnosis of TB is not confirmed until a culture is grown and identified as M. tuberculosis.

Active TB - TB bacteria are dividing and multiplying within an affected individual's body, causing tissue and organ damage. A person with active TB is likely to be or soon become symptomatic.

Aerosol - The droplet nuclei that are expelled by an infectious person (e.g., by coughing or sneezing); these droplet nuclei can remain suspended in the air and can transmit M. tuberculosis to other persons.

Anergy - The inability of an individual to react to skin-test antigens (even if the person is infected with the organisms tested) because of immunosuppression.

Bacille Calmette-Guérin (BCG) – The only vaccine currently used to prevent tuberculosis. It was developed by the French scientists Albert Calmette and Camille Guérin at the Institute Pasteur, Lille, between 1907 and 1921. It is a living, attenuated (weakened) variant of the bovine tubercle bacillus.

Bronchoscopy - Examination of the airways by means of a flexible or rigid tube. Modern instruments are fiber-optic and highly flexible and they enable specimens to be obtained from the lung by aspiration, washing, brushing and biopsy.

Cavity, pulmonary - A necrotic tuberculous lesion which communicates with the airways, enabling tubercle bacilli to enter the sputum and to be coughed out.

Cluster - Two or more PPD skin-test conversions occurring within a 3-month period among HCWs in a specific area or occupational group, and epidemiologic evidence suggests occupational (hospital acquired) transmission.

Culture - The process whereby bacteriological specimens are grown in an incubator. In the case of tuberculosis, this can take weeks.

Droplet nuclei - Microscopic particles (i.e., 1-5 mm in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets produced by an infectious TB patient can carry tubercle bacilli and can remain suspended in the air for prolonged periods of time and be carried on normal air currents in the room.

Ethambutol - One of the first-line anti-tuberculosis drugs, given during the first 2 months of therapy. Care is required in its use as it can cause visual disturbance (blurred and red/green color disturbance) and irreversible eye damage. Patients should be told that if they experience any visual disturbance they should stop taking the drug and seek medical advice.

Ethionamide - A drug used to treat cases of drug resistant tuberculosis.

Exposure -- The condition of being subjected to something (e.g. infectious agents) that could have a harmful effect. A person exposed to M. tuberculosis does not necessarily become infected.

First line drugs - Active, drug-sensitive TB disease is treated with a standard six-month course of four antimicrobial drugs: Isoniazid, Rifampicin, Pyrazinamide and Ethambutol. These are referred to as first line drugs for treating TB.

Fluoroquinolones - A class of antibiotics used to treat drug-resistant tuberculosis and some diseases caused by environmental mycobacteria. Examples include ofloxacin, ciprofloxacin and moxafloxacin.

Haemoptysis **(or Hemoptysis)** - Expectoration (coughing up) of blood or of blood-stained spit from the bronchi, larynx, trachea, or lungs.

Health Disparity - a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

Healthcare Worker (HWC) - Those working for the agency that care directly for patients/clients.

Immunosuppressed - A condition in which the immune system is not functioning normally (e.g., severe cellular immunosuppression resulting from HIV infection or immunosuppressive therapy). Immunosuppressed persons are at greatly increased risk for developing active TB after they have been infected with M. tuberculosis. No data are available regarding whether these persons are also at increased risk for infection with M. tuberculosis after they have been exposed to the organism.

Incubation period - The interval between infection and the development of clinically evident disease.

Isoniazid - A synthetic agent and one of the first line anti-tuberculosis drugs. It is particularly effective against actively replicating bacilli in the lung cavities. It is also used for preventive therapy in those with latent tuberculosis.

Latent tuberculosis - A term applied to the status of those infected with the tubercle bacillus but remaining healthy. It is assumed that the tubercle bacilli are in some dormant or resting 'persister' state.

Miliary tuberculosis - A form of disseminated tuberculosis occurring in patients with relatively good immune responses. The lesions are millet-seed sized granulomas (Latin: milium – a millet seed) that are easily seen on chest radiographs and, sometimes, on the retina by use of an ophthalmoscope. Miliary lesions differ from those of cryptogenic disseminated tuberculosis.

Multidrug-resistant TB (MDR TB) – TB disease caused by bacteria resistant to two of the most important medicines: INH and RIF.

Mycobacterium - The genus of bacteria which includes the tubercle and leprosy bacilli and the environmental mycobacteria. The name means 'fungus bacteria', in allusion to the mould-like pellicles they form on liquid culture media.

M. tuberculosis complex -- A group of closely related mycobacterial species that can cause active TB (e.g. M. tuberculosis, M. bovis, and M. africanum); most TB in the United States is caused by M. tuberculosis.

Negative Pressure - An isolation room used for infectious patients from which the air is constantly being extracted to result in slight negative pressure in the room compared with the outside corridor. Any bacteria coughed by the patient will then be extracted through a filter system rather than blowing into the corridor.

Percutaneous - The route of administration through or via the skin.

Prevalence - Prevalence is a measurement of all individuals affected by the disease at a particular time. This is distinct from incidence, which is a measurement of the number of new individuals who contract a disease during a particular period of time.

Positive PPD reaction - A reaction to the purified protein derivative (PPD) - tuberculin skin test that suggests the person tested is infected with M. tuberculosis. The person interpreting the skin-test reaction determines whether it is positive on the basis of the size of the induration and the medical history and risk factors of the person being tested.

Pulmonary tuberculosis - Tuberculosis of the lung. The most common form of tuberculosis. Pulmonary TB is the only form of TB that may be infectious.

Purified Protein Derivative (PPD) - A derivative of tuberculin prepared by harvesting precipitated proteins. It is less likely to give non-specific reactions than unpurified tuberculin.

Purified protein derivative (PPD) - tuberculin - A purified tuberculin preparation that was developed in the 1930s and that was derived from old tuberculin. The standard Mantoux test uses 0.1 ml of PPD standardized to 5 tuberculin units.

Rifampicin (Rifampin in the USA) - A member of a class of antibiotics termed the rifamycins, it is the most powerful of the first-line anti-tuberculosis drugs. It has the unique property of killing very slowly, replicating bacilli that persist in lesions.

Smear positive/smear negative - Smear positive means that bacteria can be seen when a sample of sputum is specially stained and examined under a microscope. It usually indicates an infectious patient. Smear negative means that the bacteria could not be seen in a specimen. It may mean that disease is absent or that bacteria are too few to be seen.

Sputum – Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear; part of the sputum can also be used to do a culture.

TB blood test – A test that uses a blood sample to find out if you are infected with TB bacteria. The test measures the response to TB proteins when they are mixed with a small amount of blood. Examples of these TB blood tests include QuantiFERON®-TB Gold In-tube (QFT-GIT).

Tuberculosis - A chronic infectious disease caused by the closely related species *Mycobacterium tuberculosis, M. bovis,* and *M. africanum*.

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CROSS REFERENCES:

- TST- Administration and Interpretation of TB Skin Test

APPENDIX A

Fit Testing Procedure

1. Assignment of Responsibility- Employee Health Services.

2. Identify those HCWs to be fit-tested.

3. Select respirator- NIOSH-approved (minimum N- 95).

4. Instruct each HCW to abstain from eating, drinking, and chewing gum for a minimum of 15 minutes prior to being fit-tested.

5. HCW to fill out questionnaire/medical evaluation entitled, "Mandatory Information for those Employees Selected to use a Respirator" to determine the employee ability to use a respirator (see attachment). Evaluate the employee potential health problems that might limit the employee's ability to wear a respirator during performance of normal job duties. (Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used and the medical status of the employee.)

6. Fit-tester to review and determine HCW's ability to be fit-tested and wear N-95 in the clinical setting. If questionnaire results indicate health concerns and inability to wear respirator safely, do not continue with fit-testing. (Refer if needed, as designated by EHS.)

7. Describe to the employee the limitation of the respirator and the consequences for not wearing it correctly.

    A. Limitations:

        i) Respirator face-seal: leakage is not necessarily 100%.
        ii) Lack of fit-checking each time used may increase risk of leakage.
        iii) Qualitative tests rely on the subjective response of the HCW being fit-tested.
        iv) Considerations of hygiene, damage, and breathing resistance all are factors in its use.

    B. Consequences:

        i) Risk of exposure to *M. tuberculosis*.

8. Train the healthcare worker on:

    A. How the N-95 respirator is to be applied to the face and how to adjust it.
    B. How to inspect the integrity (physical damage or soil) of the N-95 respirator.
    C. How to fit-check with each use.
    D. How to maintain the N-95 respirator (protect from elements.)
    E. How to store the N-95 respirator (clean, convenient, sanitary area, if it is to be reused due to shortage.)

F. When to dispose of the N-95 respirator (damaged or noticeable breathing resistance.)
G. How to dispose of the N-95 respirator (regular trash.)
H. How to obtain additional respirators.
I. To return for fit-testing if the employee has facial changes (through weight loss/gain, medical conditions, facial surgery, etc.) or if there are any questions. Training can recur annually or as needed.
J. Fit-testing and N-95 respirators are at no cost to the employee.

9. Inform the HCW of the ingredients of the fit-test solution and that they will be exposed to a fine mist.

10. Qualitatively (saccharin) fit-test an appropriate size respirator to the HCW following the instructions of the manufacturer's fit-test kit.

11. Allow the healthcare worker to practice how it should be worn.

12. If the HCW cannot be fitted with the available respirators, assign HCW to use (PAPR)
13. Maintain documentation of fit-testing in personnel file.

APPENDIX C: FIT TESTING RECORD FOR RESPIRATOR USERS

SIERRA VIEW MEDICAL CENTER

Fit Testing Record for Respirator Users

Employee: _____ **Job Title:** _____

Department: _____ **Extension:**_____ **Date of Birth:** _____

Description of condition requiring RPE use:

_____

Since your last fit test, has a physician diagnosed you with any major conditions that would interfere with your ability to use a respirator?

Yes / No

Employee signature: _____

Fit Testing Record

☐ **PE Manufacturer:** 3M 1860 **R / S Model Number:** 1860 (N95)
NIOSH Approval #: TC-84A-0006
Face-piece Type and Size: Regular / Small

☐ **PE Manufacturer:** Alpha Pro Tech **Model Number:** 695 (N95)
NIOSH Approval #: TC-84A-0457
Face-piece Type and Size: Regular

☐ **PE Manufacturer:** _____ **Model Number:** _____ (N95)
NIOSH Approval #:_____
Face-piece Type and Size: Regular / _____

Medical Restriction Noted by Physician? Yes / No

Odor Detection Adequate? Yes / No

Date Fit Tested: _____ **Qualitative Analysis:** X

Pass / Fail Comments: _____

_____
Signature of Fit Tester

ehs→ EHS FORMS → Current EHS forms Revised 2009

APPENDIX D: TUBERCULOSIS SCREENING PROGRAM AND EMPLOYEE TB SCREENING FORM

1. General Information

   A. Participation in the MTB screening program is mandatory initially for all, and for HCWs annually thereafter.

   B. PPD skin tests are available to employees at no cost.

   C. Determination shall be made concerning any medical condition or treatment that leads to severely impaired cell-mediated immunity, thereby affecting the reading of a PPD skin test.

   D. An employee shall be counseled regarding the meaning of a PPD skin test result.

   E. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.

   F. PPD Positive Interpretation (definition):

      i) A reaction of ≥ 5 mm is classified as positive in:

         - Persons with HIV infection or risk factors for HIV infection with unknown HIV status.
         - Persons who have had recent contact with persons with active TB
         - Persons who have abnormal chest radiographs consistent with old healed TB

      ii) A reaction of ≥ 10 is classified as positive in all persons who do not meet any of the criteria above but who have other risk factors for TB including:

         - High-Risk Groups

            a) Intravenous drug users known to be HIV seronegative
            b) Persons with other medical conditions that have been reported to increase the risk of progressing from latent TB infection to active TB, including silicosis, gastrectomy, jejuno-ileal bypass surgery, being 10% or more below ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and other immunosuppressive therapy, some hematologic disorder (e.g. leukemia and lymphomas), and other malignancies.

- High-Prevalence Groups
  a) Foreign-born persons from high prevalence countries in Asia, Africa and Latin America
  b) Persons from medically underserved low income populations
  c) Persons from high-risk populations in their communities, as determined by local public health authorities

iii) Induration of ≥ 15 mm increase within a 2-year period is classified as positive for persons who do not meet any of the above criteria.

iv) Recent converters are defined on the basis of both induration and age:
- ≥ 10 mm increase within a 2-year period is classified as positive for persons < 35 years of age
- ≥ 15 mm increase within a 2-year period is classified as positive for persons ≥ 35 years of age
- ≥ 5 mm increase under certain circumstance (see "i" above).

2. New Healthcare Workers and PPD Skin Testing:

A. Healthcare workers with no documented evidence of PPD skin testing or those with history of BCG vaccine or those new healthcare workers who have documentation of a PPD (-) status, yet the documentation is greater than 12 months:

i) New healthcare workers with undocumented history of PPD testing or (PPD-more than 12 months ago) or treatment with BCG shall be tested upon hire using the two-step tuberculin skin testing method. If the first tuberculin test is negative, a second 5-TU shall be administered 1-3 weeks later. A positive second result probably indicates boosting from a past infection or prior BCG vaccination. Persons having a boosted reaction should be classified as a reactor, not a converter. If the second result is negative, the person is probably uninfected and a positive reaction to subsequent tests indicates a true tuberculin skin-test conversion.

ii) Use intermediate strength PPD 5 TU/0.1cc intradermal in the forearm.

B. PPD Positive New Healthcare Workers

i) Known PPD (+) new healthcare workers with professionally documented previous positive reaction or TB infection/treatment, or both, are exempt from further PPD screening and shall be evaluated by symptom review and risk evaluation using the employee screening form. Obtain chest x-ray if indicated.

ii) New healthcare workers with a history of possible significant previous reaction which is undocumented should be: 1) <u>strongly</u> encouraged to obtain documentation of previous (+) as many people are unclear on their medical

history/testing, 2) probed to describe the "positive" test (i.e. where was it given, what did it look like, who told you it was positive, what was the follow-up?), 3) considered for skin testing if answers to questions in 2) clearly indicate that the HCW does not know their PPD history, 4) if unable to obtain documentation of skin test, then obtain chest x-ray at the hospital's provider of employee health services, 5) if the chest x-ray is clear, consider the employee cleared for patient care activities. If the chest x-ray is abnormal, employee health services provider will evaluate for further follow-up/clearance for work. All new healthcare workers who react or convert to PPD (+) will need to be evaluated by chest x-ray and should be medically evaluated for further treatment and clearance for work.

3. Annual Healthcare Worker Evaluation for Clinical Employees:

   All employees must have a PPD skin test annually (unless already documented positive). If the HCW converts their skin test to a (+), assess for symptoms of TB and refer to hospital's provider of employee health services for chest x-ray, further medical evaluation, treatment if indicated, and clearance for work:

4. TB Exposure Incident:

   A. Definition- An exposure incident is defined as any unprotected exposure to a patient/client with a (+) AFB smear, which results in identification as MTB, or if clinical diagnosis of MTB is confirmed by the health department.

   B. Follow-up- Administer PPD skin testing to non-reactors at time of exposure and at 8-10 weeks after the exposure.

      i) If the skin test is negative, the healthcare worker shall revert to annual skin testing schedule.
      ii) If the skin test is positive, refer to PPD converter section above and work with the health department for proper follow-up.

   C. Investigate the exposure incident for transmission risks, need for further education, procedural changes, and further employee contacts/exposures.

APPENDIX E: CLIENT/FAMILY EDUCATION MATERIAL

1. Healthcare workers from SVMC are practicing **Airborne Precautions** until deemed unnecessary. SVMC is dedicated to protecting the health and safety of its employees. The healthcare workers entering the patient's room will wear a special mask called a respirator at all times. The reason for these **Airborne Precautions is that the patient has been diagnosed with or has symptoms/diagnostic test results indicating suspicion of active tuberculosis:**

   ☐ The patient has been diagnosed by a physician as having clinical signs/symptoms of active tuberculosis.

- ☐ The health department has determined that the patient has or is suspicious for having active tuberculosis.
- ☐ One of the laboratory tests done by the hospital indicates that they may have active tuberculosis (+ AFB sputum test).

2. You may contact the Tulare County Department of Health Services if you have additional questions. They will be involved with following up on contacts and exposed individuals. You may also contact your primary care physician.

3. Active pulmonary/laryngeal TB is carried in airborne particles, or droplet nuclei, that can be generated when persons who have pulmonary or laryngeal TB sneeze, cough, speak, or sing. The particles are tiny, and normal air currents can keep them airborne for prolonged periods of time. Infection occurs when a susceptible person inhales droplet nuclei containing the TB bacteria.

4. It is important that you take your anti-TB medicines exactly as prescribed.

5. Visitors in the home- the Health Department will determine when it is safe for you to have visitors in the home.

6. Do not leave your home until deemed safe by the health department. If you must go to a doctor's appointment or the Health Department, wear a regular mask until you are no longer considered infectious.

7. While at home, always use tissues to cover your mouth and nose when coughing or sneezing. Take any other precautions that the Health Department has instructed you in.

APPENDIX F: TUBERCULOSIS DISCHARGE TREATMENT PLAN

Tulare County
Health & Human Services Agency
Public Health Branch
Tuberculosis Program

TUBERCULOSIS DISCHARGE TREATMENT PLAN

☐ In Patient ☐ Out Patient

*Prior to anticipated discharge…*Complete this form in entirety and FAX to Tulare County TB Control Program: 559-713-3720

Patient Name	Date of Birth	Facility

PART I: DISCHARGE INFORMATION

Anticipated Discharge Date:	Discharge to: ☐ Home ☐ Jail/Prison ☐ Skilled Nursing Facility ☐ Other (specify) ☐ Shelter			
Discharge Address: STREET CITY	ZIP CODE	COUNTY	PHONE NUMBER	
People In Household?	Children Under 4?	Any Immunocompromised Individuals?		
Name Of Medical Provider After Discharge	Pager Number	Phone Number	Fax Number	
Meds to last until appointment ☐ YES ☐ NO	Follow Up Appointment Date:	Time:	SPECIAL INSTRUCTIONS:	

PART II: DISCHARGE MEDICATIONS/TREATMENT PLAN (Complete upon discharge)

CURRENT BACTERIOLOGY: Include all negative and positive				DISCHARGE MEDICATIONS	Weight:	
DATE (Month/Day/Year)	SOURCE	SMEAR +/-	CULTURE +/-	Medication	Daily Doses In Mgms	Start Date
				ISONIAZID		
				RIFAMPIN		
				PYRAZINAMIDE		
				ETHAMUTOL		
				B6		
				OTHER		
				OTHER		
				OTHER		

INCLUDE DATES OF UNSUCCESSFUL SPUTUM COLLECTION ATTEMPTS:( )( )( )( )( )( )( )( )( )( )( )

Current CXR Report: Date: ☐ Stable ☐ Improved ☐ Worse Describe:	D.O.T. Recommended? ☐ YES ☐ NO START DATE: DOT Legal Order Required? ☐ YES ☐ NO DOT to occur where? ☐ Clinic ☐ Home ☐ Worksite Other?

PHN Home Assessment Received? ☐ Yes ☐ No Reviewed? ☐ Yes ☐ No	COMPLETED BY:	PHONE #	FAX #	DATE

PART III: HEALTH DEPARTMENT REVIEW

Discharge Approved: ☐ Yes ☐ No Problems Identified: ______

Actions Required Prior to Discharge: ______

Authorized By: ______ Date: ______
NAME OF HEALTH OFFICER/DESIGNEE

Policy 40-25___ (Jan 2018) Page 1 of

Tulare County
Health & Human Services Agency
Public Health Branch
Tuberculosis Program

TUBERCULOSIS DISCHARGE TREATMENT PLAN

Discharge of a Suspected or Confirmed Tuberculosis Patient

As of January 1, 1994, California State Health and Safety Codes mandate that patients suspected of or confirmed as having TB may not be discharged or transferred without prior Health Department approval. To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria. (See Below)

Tuberculosis Control Program (TBC) Response Plan

For Weekday Discharge- Non Holiday: Monday – Thursday 8:am – 5:00pm. Upon a receipt of a completed discharge request form, TB staff will provide a response within 24 hours. To expedite your request, please include all laboratory and/or radiology reports.

TBC staff will review the request and notify the submitter of approval, or will inform the submitter if additional information or action is required prior to discharge approval. If a home evaluation is needed to determine if the environment is suitable for discharge, the TBC staff will make a home visit within (1) working day notification.

Holiday and Weekend Discharge

If you anticipate a discharge on a weekend or holiday, please contact the TB Control Program immediately. For discharge planned Friday through Sunday, a completed form must be received no later than 5pm on Wednesday. For holiday discharge, a completed form must be received no later than 5pm on the second preceding business day.

Discharge Criteria

Approval of patient discharge is dependent upon compliance of the discharge treatment plan meeting the guidelines included below. Final approval for discharge is granted by the Health Officer after receipt and review of the discharge plan. Forms must be filled out in entirety to avoid delay in approval.

1. Home with no at risk individual(s) in the home:
   - Patient is on appropriate drug regimen
   - Patient is clinically stable
   - Patient deemed an acceptable candidate for home isolation
2. Home with high risk individual(s) in the home who have not been exposed:
   - Patient is on appropriate drug regimen >1 week
   - Patient is clinically stable
   - Patient deemed an acceptable candidate for home isolation
   - Contact(s) considered for or placed on prophylaxis
3. High Risk Setting:
   - Patient is on appropriate drug regimen >2 weeks
   - Patient clinically improving
   - Three consecutive negative AFB smears

In all instances, an accurately completed Discharge Treatment Plan must be submitted at least 24 hours prior to consideration for approval for discharge. If these criteria cannot be satisfied, discharge cannot be approved and the patient **MUST** be held until the next business day for appropriate arrangements to be made.

Contact Information: TB Coordinator, (559) 685-5715 - Fax TB Program (559) 713-3720

SUBJECT: **UNANNOUNCED REGULATORY SURVEYS**	SECTION: *Leadership (LD)* **Page 1 of 4**

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

PURPOSE:

- To define the steps to be taken when unannounced regulatory surveys occur.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to remain in regulatory compliance at all times. Unannounced surveys can affect schedules and organizational operations if not planned. The purpose of this policy is to define the organization's orderly and professional response to an unannounced regulatory survey.

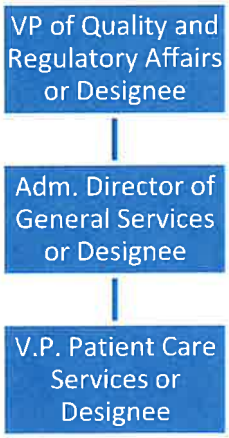
AFFECTED AREAS/PERSONNEL: *ALL*

PROCEDURE:

STAGE I – NOTIFICATION

1. The **Survey Coordinator** (VP of Quality and Regulatory Affairs), or designee, will check the **Joint Commission** website daily for important communications. Regulatory surveys occur every three years and can occur any time after the 18-month mid-point Periodic Performance Review (PPR) is submitted. Beginning in the 18-month window, the website will be checked daily by 0730 for official notification that a survey team has been deployed to SVMC and is due any time that day. The **Survey Coordinator, or designee,** will activate the notification of key Administrative and Leadership personnel.

2. In the event a survey team arrives on the premise prior to normal business hours and before official credentials can be verified from the Joint Commission website, the Nursing House Supervisor will have Security escort the Survey Team to the Board Room and activate the following call schedule:



3. Each of the above will be responsible for activating a call schedule of identified members of the Leadership Team and Elected Medical Staff Leaders responsible for identified survey activities.

STAGE II – SURVEY DOCUMENT GATHERING

1. The **Accreditation and Regulatory Coordinator** will be responsible for maintaining a complete set of up to date documents that could be requested by surveyors at the time of an unannounced survey. These manuals can be retrieved by any person designated to have access to the office. These documents are to be kept in physical copy (in binder) as well as in electronic thumb drive for ease of use by surveyors.

   These manuals are as follows (for CMS/CDPH/and TJC surveys):

   a. Licensure and Certifications

      - A copy of all hospital current licensure and certifications
      - Program flexes
      - Documents specified on the "survey entrance list of documents" provided by each specific regulatory/accreditation entity

   b. Bylaws

      - Board of Directors
      - Medical Staff

   c. Organization Structure

      - Organizational Chart
      - Medical Staff Chain of Command and Committee Structure

   d. Organizational Hard Copy of Policy and Procedures as requested or listed on the survey entrance lists

   e. Organizational Performance Improvement

      - Current Dashboards

- Current External Reports
- Most recent Patient Satisfaction Report
- Completed FMEAs

f. Current Census and Surgery Schedule as of 1630 the previous day

These manuals will be labeled and placed in a position that anyone designated can remove these manuals and proceed to the designated survey command center room while other data is gathered. These manuals will provide the survey team with enough **information** to begin planning the survey schedule. The following documents will be brought to the Board Room by the appropriate Director upon arrival:

Upon completion of their initial data review, the Survey Team will meet with the VP of Quality and Regulatory Affairs, or designee, and members of Senior Management and provide the organization with the planned survey schedule.

STAGE III – THE SURVEY

1. Upon receipt of the Survey Team's proposed schedule, the proposed survey schedule will be emailed to all Directors and Managers by the Administrative Assistant while the surveyors are escorted to their first survey location by designated escorts and scribes.

2. Dietary/Catering will be contacted and meals requested as appropriate by the Accreditation and Regulatory Coordinator

3. An overhead announcement will be delivered to hospital operator and shall be as follows for TJC surveys:

   "***Sierra View Medical Center is proud to welcome the Joint Commission on Healthcare Accreditation and the California Department of Health Services to our facility*** for our ***triennial inspection. Please welcome them as you see them in your areas."***

   This announcement will serve to alert hospital personnel throughout the facility that surveyors are present.

4. The designated escorts and scribe team will continue to coordinate schedules and escorts throughout the facility over the length of the survey and inform the survey Command Center of planned survey activity, findings, and requested documentation by the surveyors.

5. Directors and Managers will be expected to adjust their schedules over the survey period to be present from 0700 to 1630 to ensure the orderly operation of their departments and assistance to their staff during periods when surveyors may be present.

STAGE IV – THE EXIT CONFERENCE

The Survey Team will meet with members of Senior Management, Board of Directors, Medical Staff Leadership, Directors, and Managers, as designated, to discuss the outcome of the survey. Upon official receipt of survey findings, the Leadership Team will meet to discuss:

- Immediate Impact on Organization
- Press Releases
- Corrective Action Planning as needed

STAGE V – ONGOING SURVEY PREPAREDNESS

A summary of the issues identified will be completed by the VP of Quality and Regulatory Affairs during the unannounced survey, for discussion and implementation into ongoing preparedness for future unannounced survey activity.

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

The monthly **February 25, 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 5:00 p.m.

Directors Present: **LOMELI, MARTINEZ, KASHYAP**

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Jeffery Hudson, VPPCS/CNO/DIO, Ron Wheaton, VP of Professional Service, Tracy Canales, VP of Human Resources and Marketing, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor DeShazo, Director of Marketing and Community Services, Cindy Gomez, Compliance Privacy Officer, Alex Reed-Krase, Legal Counsel and Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

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

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:01 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

2. Quality Division Update – Quality Report

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

Closed Session Items C and E were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman 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 provided by Chief of Staff Sandhu.
Information Only; No Action Taken.

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 Director KASHYAP, 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 Yes
MARTINEZ Yes
LOMELI Yes

2. Compliance Report – Quarter 2

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

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

IV. Public Comments

None

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda

attached to the file copy of these Minutes). It was moved by Director KASHYAP, seconded by Director MARTINEZ, and carried to approve the Consent Agenda. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director MARTINEZ and seconded by Director KASHYAP to approve the January 28, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

VII. Business Items

A. January 2025 Financials

Craig McDonald, CFO presented the Financials for January 2025. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Director KASHYAP, seconded by Director MARTINEZ and carried to approve the January 2025 Financials as presented. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

B. Board Self Evaluation and Goals
Recommended Action: Information Only: No Action Taken

C. President/CEO Contract

Following review and discussion, it was moved by Director KASHYAP and seconded by Director MARTINEZ to defer this item to the following meeting. The motion carried and the vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

VIII. CEO Report

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

IX. Announcements:

A. Regular Board of Directors Meeting – March 25, 2025 at 5:00 p.m.

Closed Session: Board adjourned Open Session at 6:30 p.m., reconvening in Closed Session at 6:34 p.m. to discuss the following items.

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).

X. Closed Session: Chairman LOMELI adjourned Open Session at 6:23 p.m., reconvening in Closed Session at 6:28 p.m.

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (2 Items). Estimated date of Disclosure: January 1, 2027

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 (2 Items).

XI. Open Session: Chairman LOMELI adjourned Closed Session at 7:10 p.m., reconvening in Open Session at 7:11 p.m.

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

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C. 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 7:11 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

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FINANCIAL PACKAGE
February 2025

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
February 2025

Statistic	Feb-25 Actual	Feb-25 Budget	Feb-25 Over/ (Under)	Feb-25 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) Feb-24	% Change
Utilization											
SNF Patient Days											
Total	-	56	(56)	-100.0%	127	450	(323)	-71.8%	450	(323)	-71.8%
Medi-Cal	-	56	(56)	-100.0%	127	448	(321)	-71.7%	450	(323)	-71.8%
Sub-Acute Patient Days											
Total	829	970	(141)	-14.5%	7,891	7,757	134	1.7%	7,757	134	1.7%
Medi-Cal	415	879	(464)	-52.8%	3,948	6,630	(2,682)	-40.5%	6,636	(2,688)	-40.5%
Acute Patient Days	1,559	1,648	(89)	-5.4%	13,238	13,181	57	0.4%	13,351	(113)	-0.8%
Acute Discharges	406	427	(21)	-4.9%	3,538	3,415	123	3.6%	3,466	72	2.1%
Medicare	175	169	6	3.3%	1,402	1,328	74	5.6%	1,347	55	4.1%
Medi-Cal	195	204	(9)	-4.3%	1,679	1,687	(8)	-0.5%	1,712	(33)	-1.9%
Contract	34	52	(18)	-34.4%	435	376	59	15.7%	383	52	13.6%
Other	2	2	0	8.0%	22	23	(1)	-6.0%	24	(2)	-8.3%
Average Length of Stay	3.84	3.86	(0.02)	-0.5%	3.74	3.86	(0.12)	-3.1%	3.85	(0.11)	-2.9%
Newborn Patient Days											
Medi-Cal	148	161	(13)	-8.1%	1,229	1,280	(51)	-4.0%	1,377	(148)	-10.7%
Other	23	31	(8)	-25.8%	291	257	34	13.1%	232	59	25.4%
Total	171	192	(21)	-10.9%	1,520	1,537	(17)	-1.1%	1,609	(89)	-5.5%
Total Deliveries	92	99	(7)	-7.1%	793	792	1	0.1%	820	(27)	-3.3%
Medi-Cal %	89.13%	83.43%	5.70%	6.8%	81.76%	83.43%	-1.67%	-2.0%	85.17%	-3.41%	-4.0%
Case Mix Index											
Medicare	1.5476	1.6368	(0.0892)	-5.4%	1.6128	1.6368	(0.0240)	-1.5%	1.6181	(0.0053)	-0.3%
Medi-Cal	1.0980	1.1975	(0.0995)	-8.3%	1.1986	1.1975	0.0011	0.1%	1.2027	(0.0041)	-0.3%
Overall	1.3041	1.3724	(0.0683)	-5.0%	1.3667	1.3724	(0.0057)	-0.4%	1.3729	(0.0062)	-0.5%
Ancillary Services											
Inpatient											
Surgery Minutes	7,088	8,224	(1,136)	-13.8%	60,777	65,791	(5,014)	-7.6%	65,816	(5,039)	-7.7%
Surgery Cases	83	94	(11)	-11.5%	727	750	(23)	-3.1%	749	(22)	-2.9%
Imaging Procedures	1,289	1,404	(115)	-8.2%	12,064	11,234	830	7.4%	11,264	800	7.1%
Outpatient											
Surgery Minutes	13,401	12,775	626	4.9%	109,190	102,201	6,989	6.8%	95,135	14,055	14.8%
Surgery Cases	166	204	(38)	-18.5%	1,500	1,630	(130)	-8.0%	1,594	(94)	-5.9%
Endoscopy Procedures	190	192	(2)	-0.8%	1,461	1,532	(71)	-4.6%	1,454	7	0.5%
Imaging Procedures	3,796	3,886	(90)	-2.3%	32,609	31,086	1,523	4.9%	31,148	1,461	4.7%
MRI Procedures	300	302	(2)	-0.6%	2,406	2,413	(7)	-0.3%	2,408	(2)	-0.1%
CT Procedures	1,058	1,237	(179)	-14.5%	9,792	9,895	(103)	-1.0%	9,853	(61)	-0.6%
Ultrasound Procedures	1,217	1,244	(27)	-2.1%	10,408	9,949	459	4.6%	9,959	449	4.5%
Lab Tests	32,247	32,140	107	0.3%	251,149	257,121	(5,972)	-2.3%	252,955	(1,806)	-0.7%
Dialysis	3	6	(3)	-52.6%	27	51	(24)	-46.7%	30	(3)	-10.0%

Sierra View Medical Center
Financial Statistics Summary Report
February 2025

	Feb-25				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) Feb-24	% Change
Cancer Treatment Center											
Chemo Treatments	1,898	1,924	(26)	-1.3%	15,199	15,390	(191)	-1.2%	12,883	2,316	18.0%
Radiation Treatments	1,963	1,836	127	6.9%	14,704	14,686	18	0.1%	14,416	288	2.0%
Cardiac Cath Lab											
Cath Lab IP Procedures	12	11	1	6.7%	100	90	10	11.1%	100	-	0.0%
Cath Lab OP Procedures	16	30	(14)	-46.5%	263	239	24	9.9%	232	31	13.4%
Total Cardiac Cath Lab	28	41	(13)	-32.0%	363	329	34	10.2%	332	31	9.3%
Outpatient Visits											
Emergency	3,285	3,415	(130)	-3.8%	27,597	27,317	280	1.0%	27,500	97	0.4%
Total Outpatient	13,728	13,994	(266)	-1.9%	111,418	111,954	(536)	-0.5%	106,570	4,848	4.5%
Staffing											
Paid FTE's	887.62	855.00	32.62	3.8%	872.13	855.00	17.13	2.0%	856	16.20	1.9%
Productive FTE's	761.29	734.21	27.08	3.7%	746.61	734.21	12.40	1.7%	735	11.94	1.6%
Paid FTE's/AOB	5.20	4.50	0.70	15.6%	5.16	4.88	0.27	5.6%	5	0.12	2.5%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,998	10,552	446	4.2%	11,241	10,552	689	6.5%	10,611	630	5.9%
Cost/Adj.Patient Day	2,986	2,557	429	16.8%	2,805	2,623	181	6.9%	2,669	135	5.1%
Revenue/Adj. Discharge	53,265	53,065	199	0.4%	54,529	53,065	1,464	2.8%	53,010	1,519	2.9%
Cost/Adj. Discharge	14,462	12,861	1,601	12.4%	13,604	13,191	413	3.1%	13,335	270	2.0%
Adj. Discharge	986	1,057	(71)	-6.7%	8,472	8,459	13	0.1%	8,306	166	2.0%
Net Op. Gain/(Loss) %	-1.51%	-1.87%	0.35%	-19.0%	-2.29%	-1.87%	-0.42%	22.4%	-5.94%	3.65%	-61.5%
Net Op. Gain/(Loss) $	(212,845)	(249,496)	36,651	-14.7%	(2,576,917)	(4,790,368)	2,213,451	-46.2%	(6,207,683)	3,630,766	-58.5%
Gross Days in Accts Rec.	85.87	95.03	(9.16)	-9.6%	85.87	95.03	(9.16)	-9.6%	94.81	(8.95)	-9.4%
Net Days in Accts. Rec.	42.75	57.75	(15.00)	-26.0%	42.75	57.75	(15.00)	-26.0%	57.30	(14.56)	-25.4%

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

	FEB 2025	JAN 2025
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 15,830,636	$ 16,818,418
SHORT-TERM INVESTMENTS	93,740	1,333,176
ASSETS LIMITED AS TO USE	3,561,044	3,085,080
PATIENT ACCOUNTS RECEIVABLE	167,095,206	162,310,970
LESS UNCOLLECTIBLES	(20,639,684)	(16,263,133)
CONTRACTUAL ALLOWANCES	(126,354,247)	(127,666,011)
OTHER RECEIVABLES	27,244,148	25,233,274
INVENTORIES	4,579,619	4,446,092
PREPAID EXPENSES AND DEPOSITS	2,990,827	3,206,660
LEASE RECEIVABLE - CURRENT	303,872	303,872
TOTAL CURRENT ASSETS	74,705,161	72,808,398
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	31,917,314	31,837,518
LONG-TERM INVESTMENTS	136,655,661	134,652,017
PROPERTY, PLANT AND EQUIPMENT, NET	73,059,199	73,150,516
INTANGIBLE RIGHT OF USE ASSETS	327,287	339,308
SBITA RIGHT OF USE ASSETS	4,097,994	2,193,204
LEASE RECEIVABLE - LT	867,533	893,716
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,342,695	1,363,675
TOTAL ASSETS	$ 323,222,845	$ 317,488,351

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

	FEB 2025	JAN 2025
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 231,175	$ 115,588
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,466,865	1,551,431
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	5,966,400	5,832,376
ACCRUED PAYROLL AND RELATED COSTS	6,838,755	6,678,290
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	6,118,761	3,321,777
LEASE LIABILITY - CURRENT	136,899	138,613
SBITA LIABILITY - CURRENT	1,706,184	1,113,638
TOTAL CURRENT LIABILITIES	26,700,039	22,986,712
SELF-INSURANCE RESERVES	2,123,530	2,126,435
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,286,405	2,338,362
LEASE LIABILITY - LT	213,822	224,008
SBITA LIABILITY - LT	2,621,303	1,244,293
DEFERRED INFLOW - LEASES	1,104,657	1,131,175
TOTAL LIABILITIES	68,324,754	63,325,984
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	6,512,580	5,776,857
TOTAL LIABILITIES AND FUND BALANCE	$ 323,222,845	$ 317,488,351

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

FEB 2025 ACTUAL	FEB 2025 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
4,847,171	5,253,784	406,613	(8)%	INPATIENT - NURSING	42,914,155	42,030,272	(883,883)	2%
16,858,203	17,396,289	538,086	(3)%	INPATIENT - ANCILLARY	150,609,922	139,170,318	(11,439,604)	8%
21,705,374	22,650,073	944,699	(4)%	TOTAL INPATIENT REVENUE	193,524,077	181,200,590	(12,323,487)	7%
30,839,398	33,463,072	2,623,674	(8)%	OUTPATIENT - ANCILLARY	268,454,628	267,704,573	(750,055)	0%
52,544,772	56,113,145	3,568,373	(6)%	TOTAL PATIENT REVENUE	461,978,705	448,905,163	(13,073,542)	3%
				DEDUCTIONS FROM REVENUE				
(12,250,557)	(18,243,309)	(5,992,752)	(33)%	MEDICARE	(134,731,994)	(145,946,472)	(11,214,478)	(8)%
(15,155,657)	(18,032,202)	(2,876,545)	(16)%	MEDI-CAL	(141,852,841)	(144,257,616)	(2,404,775)	(2)%
(6,103,282)	(6,660,852)	(557,570)	(8)%	OTHER/CHARITY	(55,841,544)	(53,286,816)	2,554,728	5%
(238,909)	(9,556)	229,353	2,400%	DISCOUNTS & ALLOWANCES	(13,815,907)	(76,448)	13,739,459	17,972%
(5,423,113)	(499,610)	4,923,503	986%	BAD DEBTS	(7,713,669)	(3,996,880)	3,716,789	93%
(39,171,518)	(43,445,529)	(4,274,012)	(10)%	TOTAL DEDUCTIONS	(353,955,954)	(347,564,232)	6,391,722	2%
13,373,254	12,667,616	(705,638)	6%	NET SERVICE REVENUE	108,022,751	101,340,931	(6,681,820)	7%
680,254	682,481	2,227	0%	OTHER OPERATING REVENUE	4,658,312	5,459,854	801,542	(15)%
14,053,508	13,350,097	(703,411)	5%	TOTAL OPERATING REVENUE	112,681,063	106,800,785	(5,880,278)	6%
				***** OPERATING EXPENSE *****				
5,317,599	5,365,602	(48,003)	(1)%	SALARIES	45,049,700	44,204,146	845,554	2%
586,477	650,148	(63,671)	(10)%	S&W PTO	5,022,693	5,385,242	(362,549)	(7)%
862,768	1,457,327	(594,560)	(41)%	EMPLOYEE BENEFITS	11,188,216	11,687,368	(499,152)	(4)%
2,351,087	1,398,895	952,192	68%	PROFESSIONAL FEES	14,309,409	11,318,832	2,990,577	26%
922,400	852,325	70,075	8%	PURCHASED SERVICES	6,839,886	6,672,963	166,923	3%
2,261,281	2,026,604	234,677	12%	SUPPLIES & EXPENSES	16,699,019	16,241,901	457,118	3%
268,074	265,788	2,286	1%	MAINTENANCE & REPAIRS	2,038,700	2,196,344	(157,644)	(7)%
206,711	277,064	(70,353)	(25)%	UTILITIES	2,193,845	2,216,512	(22,668)	(1)%
42,427	19,601	22,826	117%	RENT/LEASE	284,765	156,832	127,933	82%
136,494	121,228	15,266	13%	INSURANCE	985,369	969,824	15,545	2%
912,222	856,110	56,112	7%	DEPRECIATION/AMORTIZATION	7,575,437	7,970,154	(394,718)	(5)%
398,815	308,901	89,914	29%	OTHER EXPENSE	2,859,662	2,571,035	288,627	11%
0	0	0	0%	IMPAIRED COSTS	211,281	0	211,281	
14,266,353	13,599,593	666,760	5%	TOTAL OPERATING EXPENSE	115,257,980	111,591,153	3,666,827	3%
(212,845)	(249,496)	(36,651)	(15)%	NET GAIN/(LOSS) FROM OPERATIONS	(2,576,916)	(4,790,368)	(2,213,452)	(46)%
138,253	138,253	0	0%	DISTRICT TAXES	1,106,024	1,106,024	0	0%
353,477	343,454	(10,023)	3%	INVESTMENTS INCOME	3,058,764	2,747,635	(311,129)	11%
29,964	54,011	24,047	(45)%	OTHER NON OPERATING INCOME	2,668,769	432,084	(2,236,685)	518%
(91,916)	(80,572)	11,344	14%	INTEREST EXPENSE	(629,453)	(644,585)	(15,132)	(2)%
(20,980)	(36,952)	(15,972)	(43)%	NON-OPERATING EXPENSE	(313,550)	(295,623)	17,927	6%
408,799	418,194	9,395	(2)%	TOTAL NON-OPERATING INCOME	5,890,553	3,345,535	(2,545,018)	76%
195,954	168,698	(27,256)	16%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	3,313,636	(1,444,833)	(4,758,469)	(329)%
539,769	100,000	(439,769)	440%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	3,198,944	800,000	(2,398,944)	300%
735,723	268,698	(467,025)	174%	NET GAIN/(LOSS)	6,512,580	(644,833)	(7,157,413)	(1,110)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
02/28/25

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(212,845)	(2,576,916)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	912,222	7,575,437
Provision for bad debts	4,376,551	(2,906,591)
Change in assets and liabilities:		
Patient accounts receivable, net	(6,096,002)	6,620,309
Other receivables	(2,010,874)	(8,993,965)
Inventories	(133,527)	(288,967)
Prepaid expenses and deposits	215,833	(669,423)
Advance refunding of bonds payable, net	20,980	167,837
Accounts payable and accrued expenses	134,025	(357,193)
Deferred inflows - leases	(26,518)	(119,259)
Accrued payroll and related costs	160,465	(1,721,064)
Estimated third-party payor settlements	2,796,984	2,461,816
Self-insurance reserves	(2,905)	(65,470)
Total adjustments	347,234	1,703,467
Net cash provided by (used in) operating activities	134,389	(873,449)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	1,106,024
Noncapital grants and contributions, net of other expenses	(17,904)	(37,889)
Net cash provided by (used in) noncapital financing activities	120,349	1,068,135
Cash flows from capital and related financing activities:		
Purchase of capital assets	(808,884)	(3,693,358)
Proceeds from sale of assets	-	3,255,420
Proceeds from lease receivable, net	26,183	121,486
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,397)	(1,490,646)
Net change in notes payable and lease liability	(31,700)	(748,043)
Net changes in assets limited as to use	(555,760)	955,785
Net cash provided by (used in) capital and related financing activities	(1,371,558)	(5,654,356)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(1,463,875)	(4,721,356)
Investment income	353,477	3,058,764
Net cash provided by (used in) investing activities	(1,110,398)	(1,662,592)
Net increase (decrease) in cash and cash equivalents:	(2,227,218)	(7,122,262)
Cash and cash equivalents at beginning of month/year	18,151,594	23,046,638
Cash and cash equivalents at end of month	15,924,376	15,924,376

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
February 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Mar-24	11,275,398	3,178,205	14,453,603
Apr-24	13,314,378	6,920,700	20,235,078
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
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**

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

February 2025 Summary of Other Activity:

4,472,514	Anthem Blue Cross Rate Range IGT YCY23
574,112	M-Cal IP DSH 12/24 - 01/25
3,006,393	M-Care Cost Report Tentative Settlement FY24
282,258	Miscellaneous
8,335,277	02/25 Total Other Activity