Kaweah Delta
MORE THAN MEDICINE. LIFE.

April 23, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Kaweah Delta Support Services Building - 520 West Mineral King – Granite Conference Room – 4th floor beginning at 4:00PM. Due to the maximum capacity allowed in this room per CDC social distancing guidelines, members of the public are requested to attend the meeting via GoTo meeting - https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings or you can also dial in 669-224-3412 Access Code: 468-246-165.

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors at 4:00PM (location and GoTo information above).

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Board of Directors meeting at 4:01PM pursuant to Health and Safety Code 1461 and 32155, Government Code 54956.9(d)(2).

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors meeting at 4:30PM (location and GoTo information above).

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: cmoccio@kdhcd.org, or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
www.kaweahdelta.org

KAWEAH DELTA HEALTH CARE DISTRICT - BOARD OF DIRECTORS MEETING

Kaweah Delta Medical Center / Support Services Building
520 West Mineral King – Granite Conference Room (4th floor)

Join from your computer, tablet or smartphone
https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings
or Dial In: 669-224-3412 / Access Code: 468-246-165

Monday April 26, 2021

OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   - 4.1. **Approval of closed meeting minutes** – March 22, 2021.
   - *4.2.* **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **–** *Ben Cripps, Chief Compliance Officer and Rachele Berglund, Legal Counsel*
   - 4.3. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD Chief of Staff*
   - 4.4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, MD Chief of Staff*

   Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

   Action Requested – Approval of the April 26, 2021 closed meeting agenda.
5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**
2. **APPROVAL OF CLOSED MEETING MINUTES** – March 22, 2021.

   Recommended Action: Approval of the closed meeting minutes from March 22, 2021.
3. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case

   Ben Cripps, Chief Compliance Officer and Rachele Berglund, Legal Counsel
4. **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155

   Byron Mendenhall, MD Chief of Staff
5. **QUALITY ASSURANCE -** Pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Byron Mendenhall, MD Chief of Staff
6. **ADJOURN**

OPEN MEETING AGENDA {4:30PM}

Join from your computer, tablet or smartphone

https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings

or Dial In: 669-224-3412 / Access Code: 468-246-165

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after Board discussion. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the March 16 and March 22, 2021 open minutes.

   Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

   Action Requested – Approval of the open meeting minutes – March 16 and March 22, 2021 open board of directors meeting minutes.

6. **CREDENTIALS** - Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

Byron Mendenhall, MD Chief of Staff

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the MEC, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff be approved or reappointed (as applicable), as attached, to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files.

7. **CHIEF OF STAFF REPORT** – Report relative to current Medical Staff events and issues.

Byron Mendenhall, MD Chief of Staff

8. **QUALITY – STROKE PROGRAM** - A review of key quality measures, and quality improvement projects related to the care of the stroke population.

Cheryl Smit, Stroke Program Manager and Sean Oldroyd, MD, Stroke Program Medical Director

9. **CONSENT CALENDAR -** *All matters under the Consent Calendar will be approved by one motion, unless a Board member requests separate action on a specific item.*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the April 26, 2021 Consent Calendar.

9.1. REPORTS

A. Maternal Child Health
B. Physician Recruitment

9.2. POLICIES – Administrative

A. Sentinel Event & Adverse Event Response and Reporting – AP87 **Revised**
B. Weapons Brought Into the District – AP180 **Revised**
C. Census Saturation Plan – AP114 **Reviewed**
D. Computer Security – AP28 **Reviewed**

9.3. Approval of rejection of claim of Dan Lovell, Mattew Lovell, Jennifer Lovell, Janna Martinez vs. Kaweah Delta Health Care District.

9.4. Approval of the Kaweah Delta Health Care District Graduate Medical Education diplomas certifying that the Kaweah Delta Health Care District duties for each residency has been fulfilled.

	Start Date	Graduation Date
Anesthesiology		
Caitlin Cammarano, DO	6/19/2017	6/20/2021
Michael D. Green, MD	6/19/2017	6/20/2021
Emergency Medicine		
Albert Wong Aparicio, MD	6/18/2018	6/20/2021
Benjamin Villarreal Camacho, MD	6/18/2018	6/20/2021
Patsy Chenpanas, MD	6/18/2018	6/20/2021
Hector Guerrero, MD	6/18/2018	6/20/2021
Nicole Reiko Guillen, MD	6/18/2018	6/20/2021
Josue Juan Guzman, MD	6/18/2018	6/20/2021
Travis Helm, MD	6/18/2018	6/20/2021
Priscilla Anne Henson, MD	6/18/2018	6/20/2021
Theresa Joy Yeon Jung Kim, MD	6/18/2018	6/20/2021
Carli Marie Nichta, MD	6/18/2018	6/20/2021
Stephanie Marie Songey, DO	6/18/2018	6/20/2021
Jeff Christian Wells, MD	6/18/2018	6/20/2021
Dane Alexander Zappa, DO	6/18/2018	6/20/2021
Family Medicine		
Lakai Monee Banks-Dean, MD	6/18/2018	6/20/2021
Ann-Gelle Shanice Carter, MD	6/18/2018	6/20/2021
Faiza Nawaz, MD	6/18/2018	8/29/2021
Daniel Proctor, MD	6/18/2018	6/20/2021
Mara G. SantaMaria, MD	6/18/2018	6/20/2021
Linh Nguyen Tran, MD	6/18/2018	6/20/2021
Jason Kuan Kit Wong, DO	6/18/2018	6/20/2021
Psychiatry		
Setare Eslami, MD	6/19/2017	6/20/2021
Rubina M. Faizy, MD	6/19/2017	6/20/2021
Christine Ann Le, DO	6/19/2017	6/20/2021
Vahig S. Manugian, DO	6/19/2017	6/20/2021
Juan Roberto Sosa, MD	6/19/2017	6/20/2021
Jessica Noelle Ming Uno, MD, MA	6/19/2017	6/21/2020
Surgery		
Geoffrey Christopher Darby, MD	6/18/2018	6/20/2021
Kenny Derkang Lee, MD	6/22/2016	6/20/2021
John Rockwell Popovich, MD	6/22/2015	6/16/2021
Lucas Cale Toho, MD	6/20/2016	6/20/2021
Lucas Cale Toho, MD	6/22/2015	06/19/2016

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY MARCH 16, 2021, AT 4:00PM, IN THE KAWEAH DELTA MEDICAL CENTER SUPPORT SERVICES BUILDING 520 WEST MINERAL KING AVENUE – GME CONFERENCE ROOM – 5TH FLOOR, VISALIA AND VIA GOTO MEETING DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; A. Banerjee, VP & Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Rosie Gonzalez, recording

The meeting was called to order at 4:04PM by Director Francis.

Director Francis entertained a motion to approvee the agenda.

MMSC (Havard Mirviss/Gipson) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

2020/2021 ANNUAL OPERATING & CAPITAL BUDGET AND FINANCIALS – Review of the annual operating & capital budget and strategies and the most current fiscal year financial results (copy attached to the original of these minutes and considered a part thereof).

INVESTMENT REPORT – Semi-annual review of the Kaweah Delta Health Care District Investment Report (copy attached to the original of these minutes and considered a part thereof) - *Jennifer Stockton, Director of Finance*

MMSC (Havard Mirviss/Olmos) to approve the semi-annual investment report and approval of the investment policy (and any changes proposed) as well as the delegation of authority contained within the policy. *Vote: Yes – Havard Mirviss, Olmos, Rodriguez, and Francis* – Abstained - Gipson

ADJOURN - Meeting was adjourned at 6:00PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY MARCH 22, 2021, AT 330PM, IN SUPPORT SERVICES BUILDING 5TH FLOOR GRADUATE MEDICAL EDUCATION CONFERENCE ROOM (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Cindy Moccio, recording

The meeting was called to order at 3:30PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

MMSC (Havard Mirviss/Gipson) to approve the open agenda. . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

CLOSED AGENDA – 3:31PM

- **APPROVAL OF CLOSED MEETING MINUTES** – February 22, 2021.
- **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION** - Pursuant to Government Code 54956.9(d)(1) – Valdovinos v. Kaweah Delta Health Care District / Tulare County Superior Court Case VCU279423 **-** *Richard Salinas, Legal Counsel and Alexandra Bennett, Director of Risk Management*
- **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 - *Monica Manga, MD Vice Chief of Staff*
- **QUALITY ASSURANCE -** Pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee. - *Monica Manga, MD Vice Chief of Staff*

MMSC (Gipson/Olmos) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 3:31PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY MARCH 22, 2021, AT 4:00PM, IN SUPPORT SERVICES BUILDING 5TH FLOOR GRADUATE MEDICAL EDUCATION CONFERENCE ROOM (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Cindy Moccio, recording

The meeting was called to order at 4:00PM by Director Francis.

Director Francis asked for approval of the agenda.

MMSC (Havard Mirviss/Olmos) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: Approval of closed minutes from February 22, 2021.

OPEN MINUTES – Request approval of the meeting minutes February 22, 2021.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Gipson/Havard Mirviss) Approval of the open meeting minutes February 22, 2021. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

RECOGNITIONS – Director Lynn Havard Mirviss

- Presentation of Resolution 2123 to Robert E. Pierce, in recognition of as the Service Excellence recipient – March 2021.
- Presentation of Resolution 2124 to Nancy Allain, retiring from Kaweah Delta after 19 years of service.
- Presentation of Resolution 2126 to Rebecca Wright, ACR Compliance Coordinator, retiring from Kaweah Delta after 31 years of service.

CREDENTIALING – Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Director Francis requested a motion for the approval of the credentials report {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Olmos/Havard Mirviss) Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the Executive Committee of the Medical Staff, for all of the medical staff

scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff, excluding Emergency Medicine Providers as highlighted on Exhibit A (copy attached to the original of these minutes and considered a part thereof), be approved or reappointed (as applicable), to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF OF STAFF REPORT – Report from Monica Manga, MD – Vice Chief of Staff

- Doctors Day is March 30th.

REVISED KAWEAH DELTA ANNUAL PHYSICIAN RECRUITMENT PLAN – Review and discussion of the proposed revision to the Kaweah Delta Physician Recruitment Plan approved by the Board of Directors on September 28, 2020 - revised to include outpatient pulmonology {copy attached to the original of these minutes and considered a part thereof} - *Marc Mertz, VP & Chief Strategy Officer and Brittany Taylor – Director of Physician Recruitment & Relations*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Gipson/Havard Mirviss) Having reviewed and analyzed the Provider Needs Assessment conducted by Sg2 in 2020, which includes a specific list of the needed physician specialties for 2020 and 2021 in communities served by the District "Needed Physician Specialties," the Board hereby finds that it will be in the best interests of the public health of the communities served by the District to have the District provide appropriate assistance in order to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. Therefore, the Board authorizes the District to provide the types of assistance authorized by Cal. Health & Safety Code §32121.3, to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

QUALITY – RAPID RESPONSE / CODE BLUE QUALITY COMMITTEE REPORT - A review of key quality measures, analysis and actions associated with patients with rapid response team initiation and code blue response {copy attached to the original of these minutes and considered a part thereof} - *Kassie Waters, RN, MPH, Director of Cardiovascular Critical Care.*

STRATGIC PLANNING – HIGH PERFORMING OUT PATIENT (OP) NETWORK – Review of the Kaweah Delta strategic plan initiative – High Performing OP Network including a review of the metrics and strategies/tactics {copy attached to the original of these minutes and considered a part thereof} - *Ryan Gates, Vice President of Population Health and Jessica Rodriguez, Director of Outpatient Clinic Network*

CONSENT CALENDAR – Director Francis entertained a motion to approve the consent calendar (copy attached to the original of these minutes and considered a part thereof).

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Gipson) to approve the consent calendar. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ORGANIZATIONAL REBRANDING INITIATIVE – Review and discussion of rebranding initiative as reviewed by the Marketing and Community Relations Committee on November 17, 2020 and approved by the Board November 23, 2020 (copy attached to the original of these minutes and considered a part thereof) - *Gary Herbst, CEO and Marc Mertz, Vice President and Chief Strategy Officer*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Olmos/Gipson) To authorize management to proceed with the immediate implementation of an organizational rebranding initiative.

- *The legal name of the organization will remain as **Kaweah Delta Health Care District**.*
- *The core brand name ("Doing Business As") will be **Kaweah Health**, to be applied consistently throughout the organization.*
- *The **Kaweah Health** naming convention to be applied to individual facilities.*
- *The facility name, as reflected on the California Department of Public Health (CDPH) Consolidated General Acute Care Hospital License, will be changed from Kaweah Delta Medical Center to **Kaweah Health Medical Center** effective May 1, 2021.*

This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF EXECUTIVE OFFICER REPORT – Report relative to current events and issues - Gary Herbst, Chief Executive Officer

- The number of COVID patients is slowly declining and we are now in the mid 30 range.
- April 5th we will see our first patient at the Tulare Health Clinic.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- No Report.

ADJOURN - Meeting was adjourned at 5:50PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

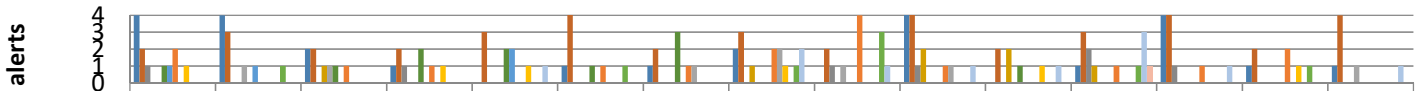
Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

Stroke Program Dashboard 2019-2020

	Bench-marks	2019 Totals	2020 Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov
Grouping of Stroke Patients													
Ischemic		*460*	39	42	38	23	28	32	31	29	34	27	24
Hemorrhagic		*98*	8	6	5	7	6	4	4	8	7	8	14
TIA (in-patient and observation)		*344*	33	44	29	24	21	13	27	20	16	24	19
Transfers to Higher Level of Care (Ischemic)		*27*	1	2	3	3	2	6	1	3	4	3	5
Transfers to Higher Level of Care (Hemorrhagic)		*17*	1	1	1	1	1	0	2	1	6	6	2
TOTAL NUMBER OF PATIENTS		*946*	82	95	72	58	58	55	65	61	67	68	64
Total # of Pts who rec'd Alteplase (Admitted/Transferred)		*65*	8	6	4	2	2	4	4	0	4	3	4
% of Alteplase - Inpatient & Transfers		*13%*	20%	14%	10%	8%	7%	11%	13%	0%	11%	10%	14%
% Appropriate vital sign monitoring post Alteplase	90%	*68%*	75%	75%	100%	100%	100%	75%	75%	NA	75%	88%	100%
Rate of hemorrhagic complications for Alteplase pts	0%	*0%*	0%	0%	0%	0%	0%	0%	0%	NA	0%	0%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	*54%*	100%	NA	0%	100%	NA	100%	0%	50%	100%	100%	100%
% Appropriate stroke order set used (In-Patient)	90%	*93%*	95%	97%	99%	97%	96%	92%	90%	98%	91%	95%	91%
% Appropriate stroke order set used (ED)	90%	*90%*	94%	92%	88%	89%	98%	90%	82%	89%	88%	80%	93%
STK-1 VTE (GWTG, TJC)	85%	*99%*	100%	100%	95%	100%	91%	85%	85%	92%	96%	90%	88%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	*99%*	100%	100%	100%	100%	100%	100%	97%	97%	97%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	*96%*	100%	89%	100%	100%	100%	75%	80%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	*80%*	100%	100%	100%	NA	NA	100%	100%	NA	NA	50%	NA
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	*99%*	92%	93%	97%	100%	96%	92%	96%	96%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	*98%*	100%	98%	100%	100%	97%	100%	96%	100%	100%	93%	100%
STK-8 Stroke Education (GWTG, TJC)	75%	*94%*	93%	97%	94%	100%	96%	88%	85%	100%	100%	100%	91%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	*100%*	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	*94%*	85%	85%	91%	90%	77%	81%	97%	97%	72%	85%	90%
% Smoking Cessation (GWTG)	85%	*99%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	*94%*	91%	84%	96%	100%	90%	90%	91%	100%	97%	90%	92%
Intensive Statin Therapy (GWTG)	75%	*90%*	94%	91%	88%	88%	97%	94%	91%	79%	93%	93%	100%
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	*96%*	100%	80%	NA	100%	100%	100%	67%	NA	100%	100%	NA
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	*97%*	100%	86%	100%	100%	100%	100%	100%	NA	100%	100%	80%
% NIHSS Reported (GWTG)	75%	*98%*	100%	93%	92%	100%	96%	94%	92%	96%	90%	100%	96%
Ischemic ALOS/GMLOS excess	<1.0	*NA*	1.45	1.67	2.2	0.18	0.49	1.68	0.91	0.18	1.23	0.53	3.94
Hemorrhagic ALOS/GMLOS excess	<1.0	*NA*	1.63	0.43	3.74	0.49	3.53	17.98	1.42	6.11	5.01	-1.66	0.62
Ischemic Mortality O/E Ratio (Midas)	<1.0	*NA*	0.74	0.88	0.61	0	0	0.74	0	0.8	0.7	0.8	1.9

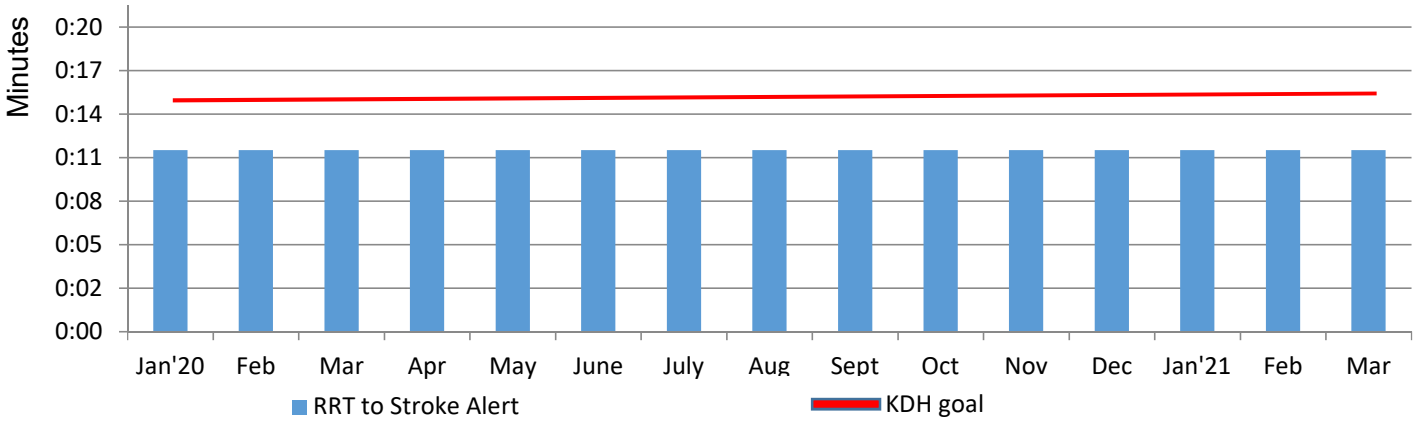
2020-2021
In-House Stroke Alert Dashboard

Stroke Alert Location



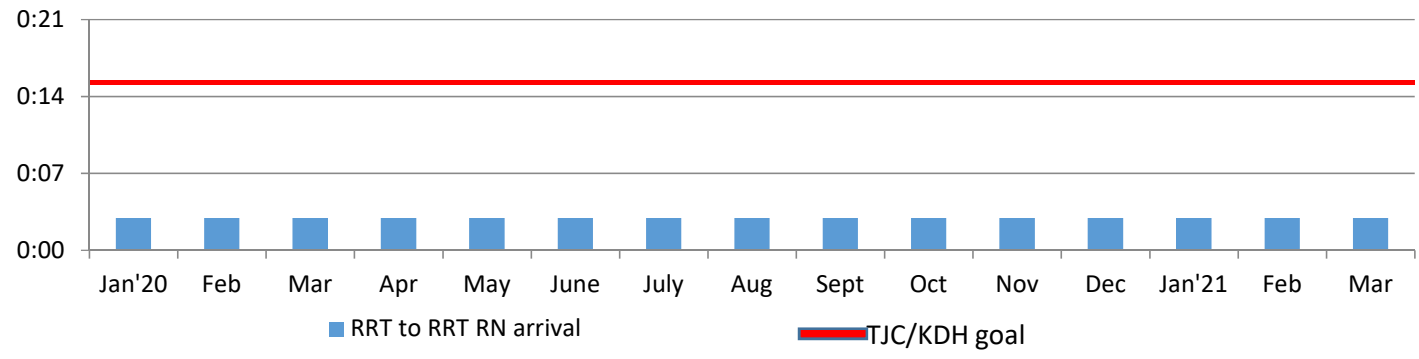
	Jan'20	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'21	Feb	Mar
3W	4	4	2	1		1	1	2		5		1	4	1	1
4S	2	3	2	2	3	9	2	3	2	6	2	3	6	2	4
2S	1			1					1	1		2	1		
3S			1					1		2	2	1			
Cath Lab		1	1						1						1
CVICU	1		1	2	2	1	3				1				
ICU	1	1			2										
4N	2		1	1		1	1	2	4	1		1	1	2	
3N							1	2		1					
4T	1			1	1			1			1			1	
PACU															
2N		1				1		1	3			1		1	
5T					1			2	1	1	1	3	1		1
BP												1			

RRT to Stroke Alert



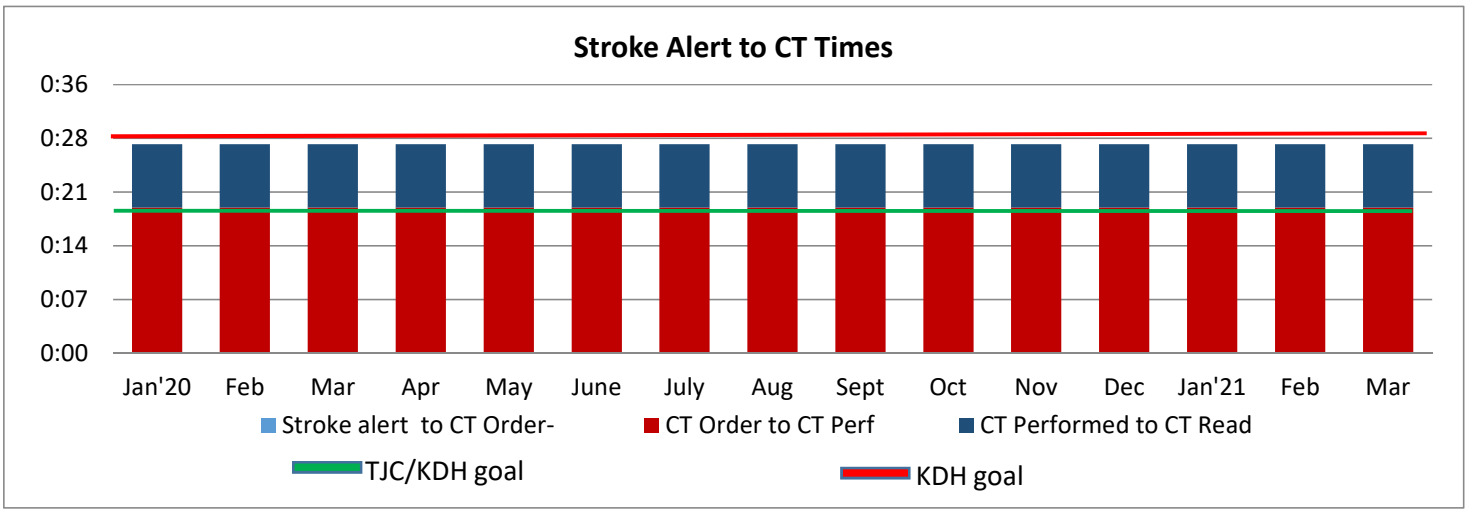
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

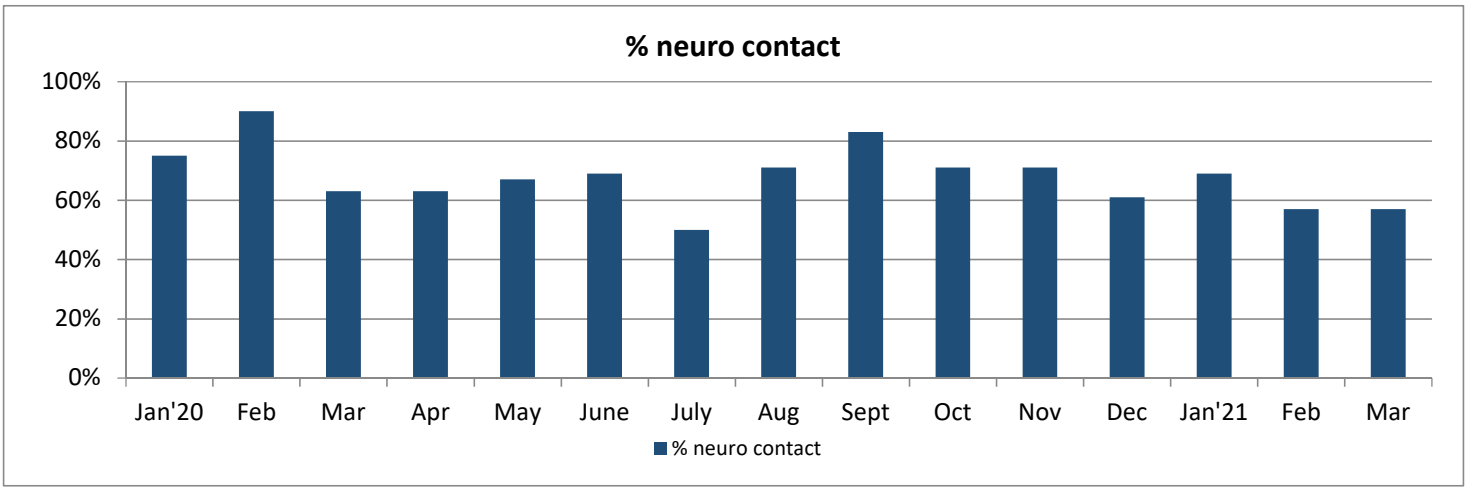


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

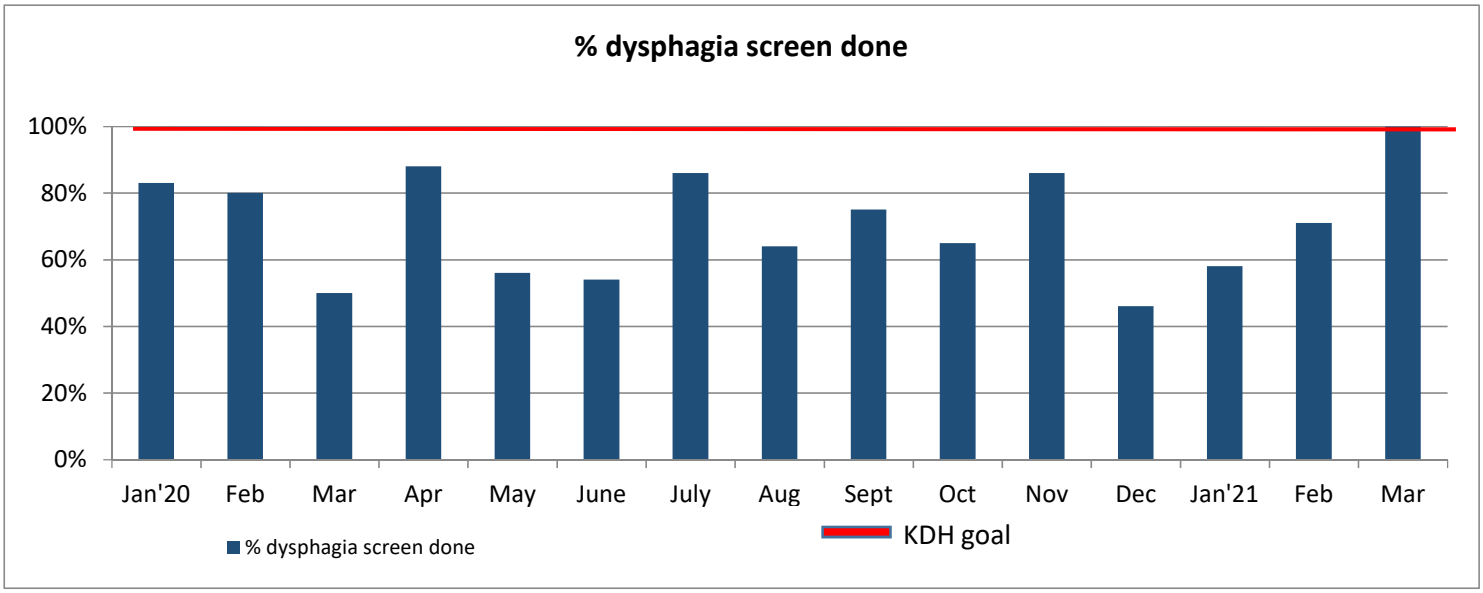
2020-2021
In-House Stroke Alert Dashboard



TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**



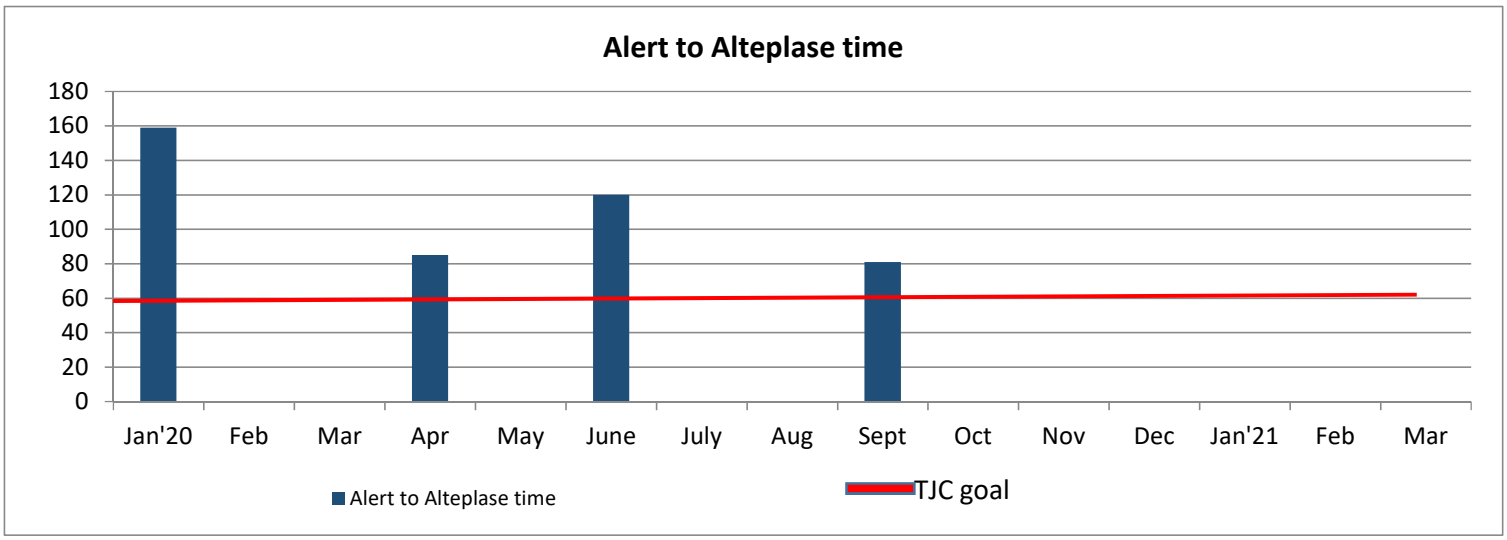
Neurology consultation should occur on all in-house stroke alerts.



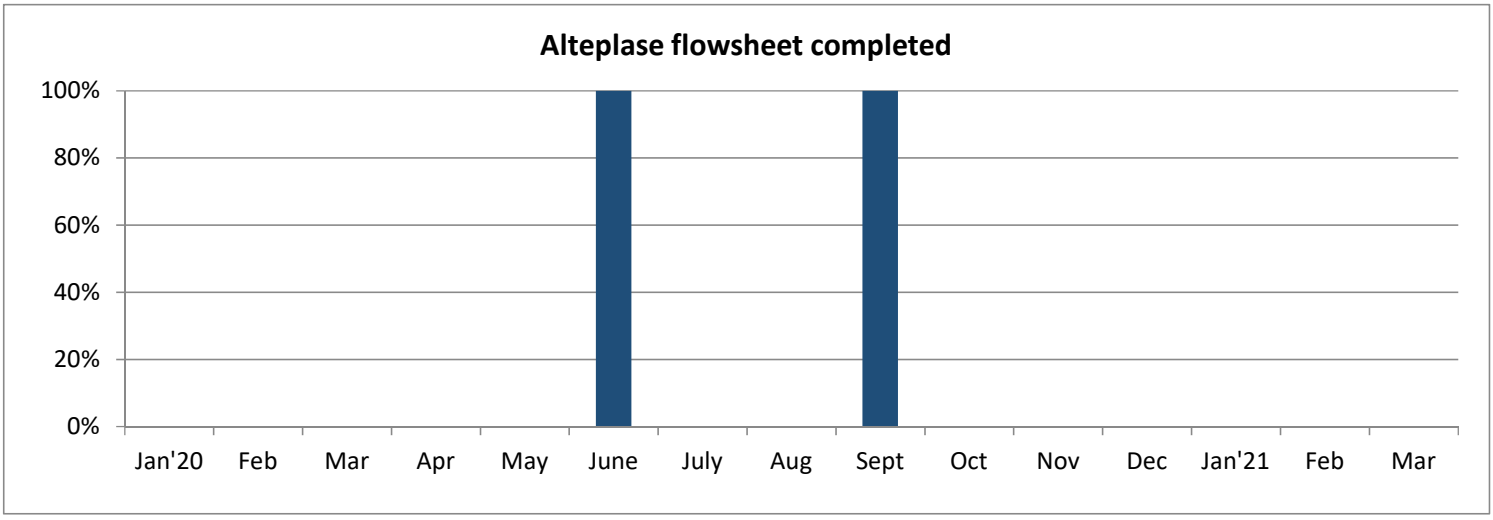
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

2020-2021

In-House Stroke Alert Dashboard

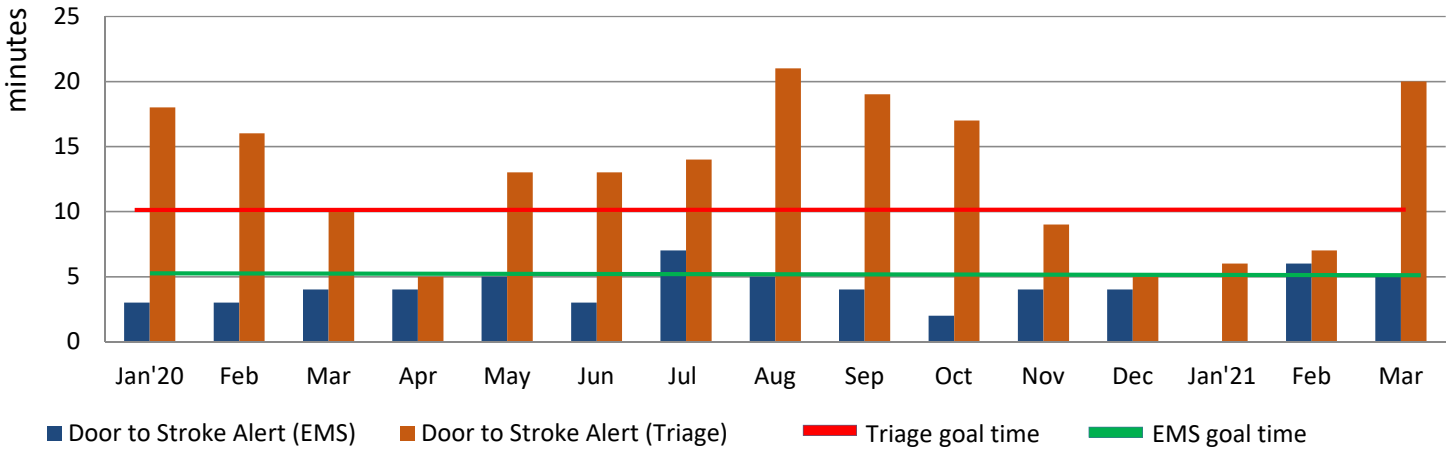


ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms



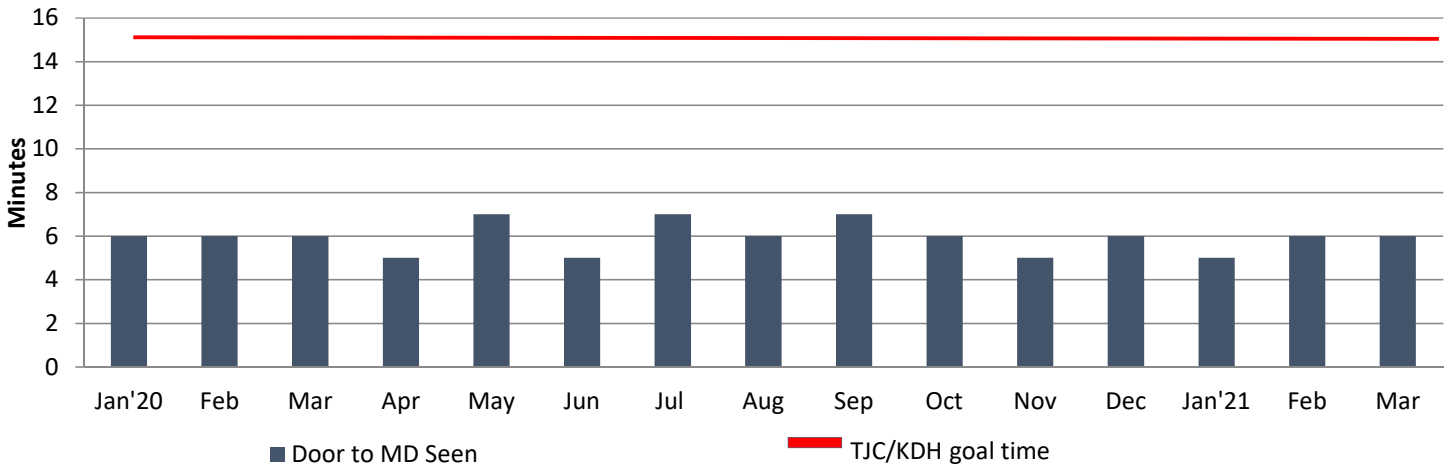
2020-2021 Stroke Alert Dashboard

Door to Stroke Alert (median times)



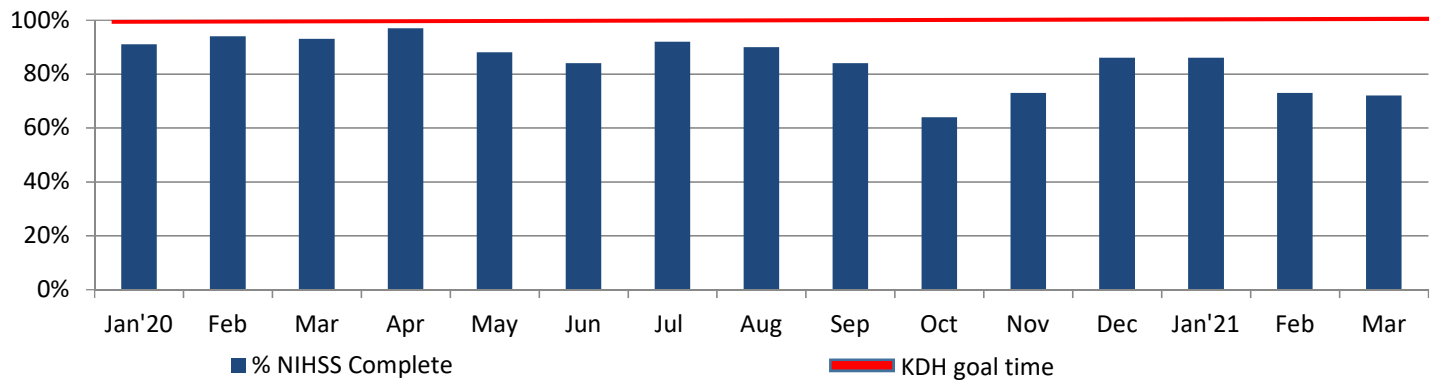
Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.

Door to MD Seen (median time)



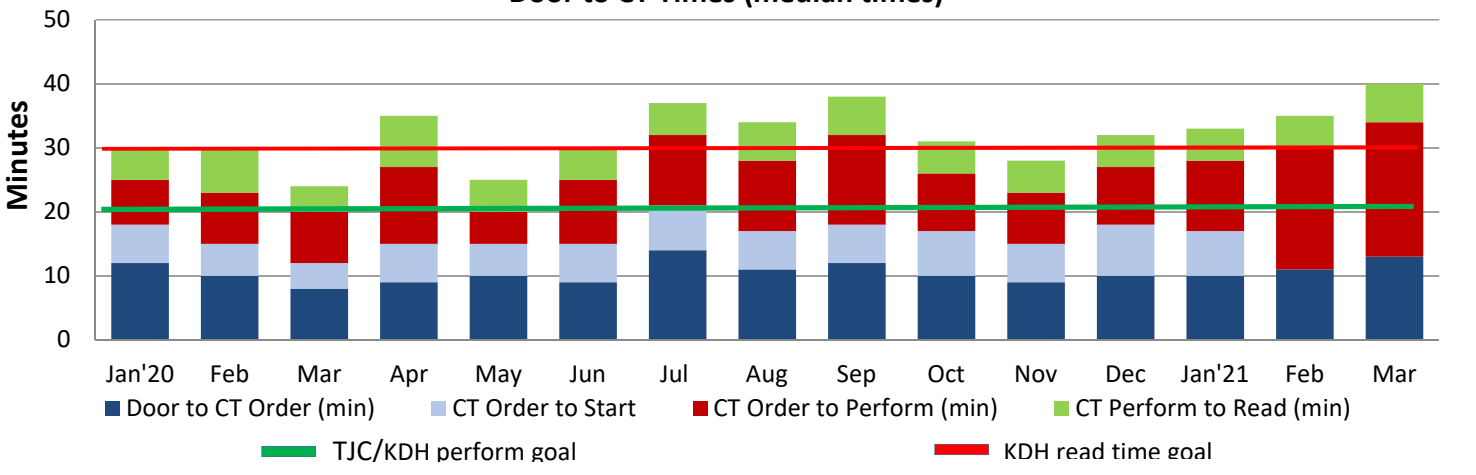
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.

% NIHSS Complete

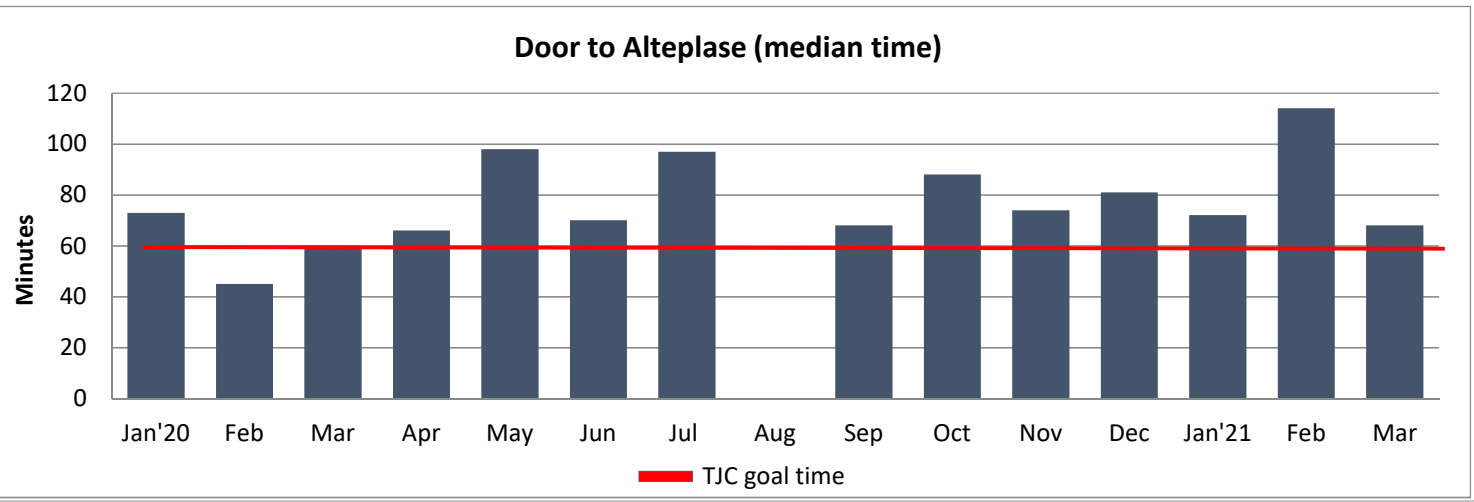


The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician.

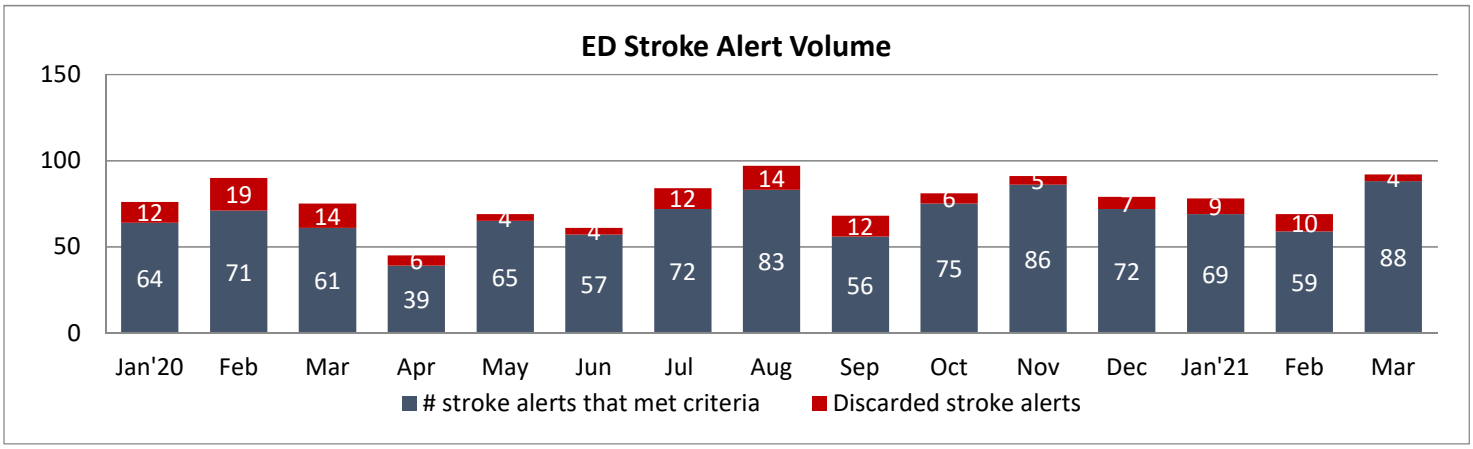
2020-2021 Stroke Alert Dashboard



CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse. **Feb 2021 removed CT start time metric.



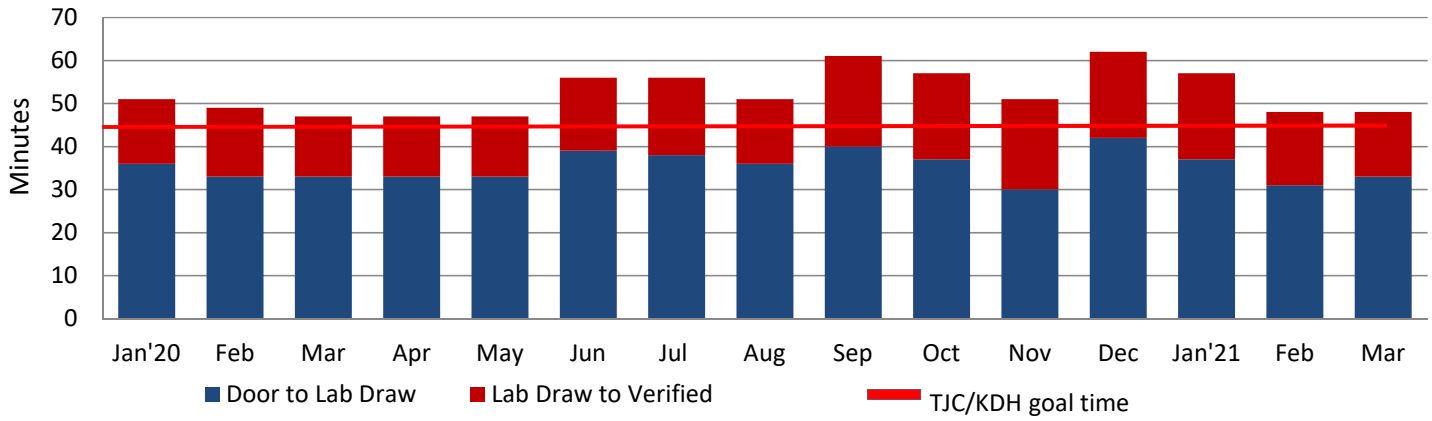
The data in this graph includes all Alteplase patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, continued changes to the stroke alert process have been made.



Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

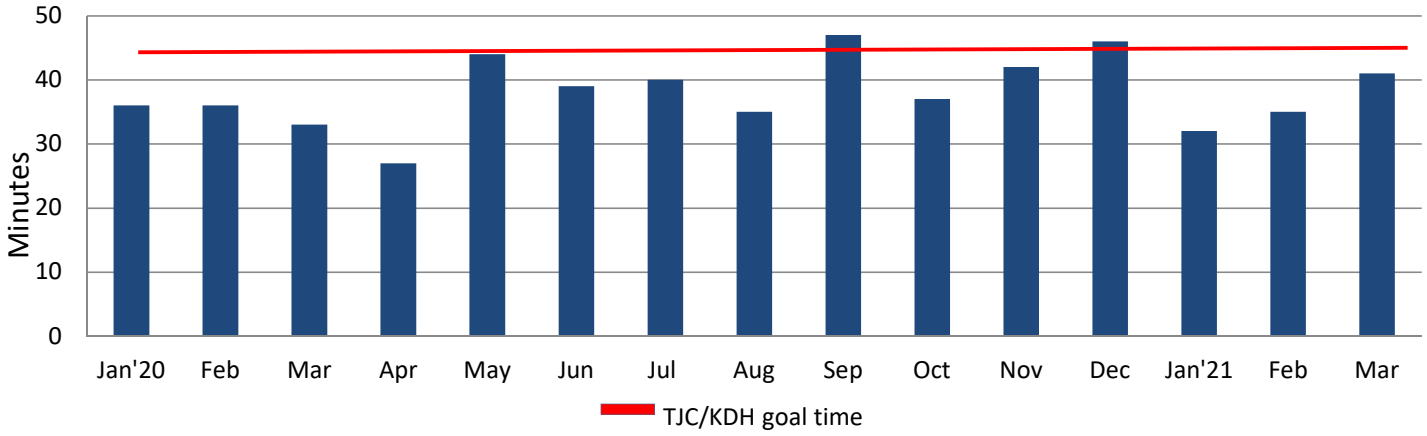
2020-2021 Stroke Alert Dashboard

Door to Lab Time (median times)



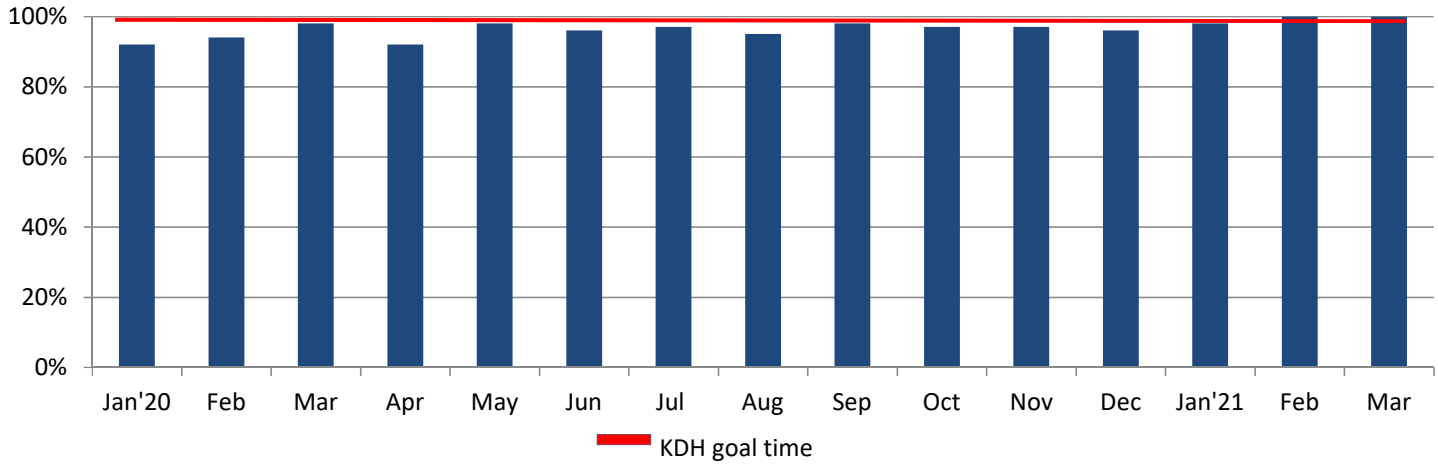
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab lable makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)



TJC expectation is that EKGs are completed within 45 minutes of arrival.

% Dysphagia screen completed when ordered



Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

Kaweah Delta Health Care District
Annual Report to the Board of Directors

Maternal Child Health

Tracie Sherman MSN, RNC-OB, NE-BC
Director Maternal Child Health
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Ph. 624-5338
April 2021

Summary Issue/Service Considered

- Seek opportunities to grow volumes in Labor and Delivery, Post-Partum, Labor Triage, NICU, and Pediatrics.
- Continue to recruit to and develop the Laborist Program.
- Continue to lower Gestational Age in the Neonatal Intensive Care Unit (NICU).
- Continue to seek opportunities to decrease labor and supply costs.
- Continue to increase exclusive breast-feeding rates for new moms.

Quality/Performance Improvement Data

- HCAHPS Scores for overall patient satisfaction for Fiscal Year 2021 for Postpartum and Labor & Delivery were 79.1%. This surpassed the organizational goal of 76.5
- The exclusive breast-feeding rate for 2020 was 60%. This is above the Joint Commission benchmark of 52%. This is an increase of 6%
- The Postpartum Unit continues to focus on increasing Exclusive Breastfeeding. This year a Breastfeeding Bundle was implemented. The bundle included adjusting lactation staff schedules to improve our ability to assist new mothers 7 days a week with breast-feeding. We have shifted half of the lactation staff hours to be spent on the Labor & Delivery, Labor Triage and Antenatal Units to increase the focus on education and commitment prior to delivery. This has allowed patients to have a lactation counselor to be present for the first feeding with is crucial to successful breastfeeding. A new survey was developed and is handed out to our mothers asking them what their feeding preference for their baby was on admission, whether or not they met their goals and why or why not? This has given us valuable information related to when and why patients are failing to achieve exclusive breastfeeding of their babies. We will continue to use feeding orders to help increase collaboration with our physician staff when a mother decides to formula feed. In collaboration with the Information Technology (IT) Department, we now have a report to that shows us exactly when a patient fails to meet their goal of exclusive breastfeeding and who was caring for the patient at that time. This allows us to follow up and coach or make improvements where indicated. We have started a new Breast is Best Committee. This includes members of all areas of MCH as well as leaders and physicians. This committee reviews the patients who did not meet their goals. Subsequently, their nurse and physician come to the meeting to discuss the barriers that caused their patient not to meet their goal of exclusive breastfeeding. These actions have caused our current breastfeeding rates to improve to 60% for 2020
- The Neonatal Intensive Care Unit (NICU) continues to participate in the California Perinatal Quality Care Collaborative (CPQCC). The NICU has had zero Ventilator Associated

Pneumonia (VAP) and one Central Line Associated Blood Stream Infection (CLABSI) for 2020. NICU continues to hire new nursing staff and develop them with the new core curriculum for all NICU and Respiratory Therapists working in the NICU. This education is focused on the care of Very Low Birth Weight (VLBW) Babies. We have been successful in our ability to keep more VLBW babies in our NICU and keeping them in our community. We have been successful in keeping babies as low as 26 weeks gestation weighing 800 grams, for the duration of their care through discharge. The NICU Staff are growing in their abilities to care for these tiny patients every day.

- The Neonatologists along with NICU Leadership have begun to meet with our Maternal Fetal Medicine Physicians on a regular basis to discuss our high-risk patients and their impending births. This allows us to meet with our patients prior to delivery to make a plan and address the special needs for their situation. This is an integral part of patient safety to ensure that everyone involved in the care of the mother and baby are included in the development of the plan of care prior to birth and after delivery.
- Labor and Delivery continues to participate in the California Maternal Quality Care Collaborative (CMQCC) Program to develop policies and procedures to minimize non-medically indicated (elective) deliveries before 39 weeks gestation, also known as Early Elective Deliveries (EED). We achieved an EED rate of zero for 2020.The current benchmark for this measure is Zero. We continue to monitor administration of Antenatal Steroids for patients between 24-34 weeks gestation who are at risk for pre-term delivery where we are 100% compliant for 2020. Primary C-Section Rates for Low Risk Pregnancies is another area we continue working on and are at 26.4% for 2020, the state target is 24%. Nitrous Oxide is a new service, introduced to Kaweah Delta Labor & Delivery as another tool available for patients to help them cope with the discomfort and pain of labor. Shortly after implementation, we were forced to remove Nitrous Therapy due to the COVID Pandemic. We have since resumed the practice since COVID has declined in our community.
- We have also developed the Early Recovery After C-section (ERAC) Program. This is similar to the Early Recovery After Surgery (ERAS) Program, which was implemented in the Main Operating Rooms for orthopedic and gastrointestinal surgeries. Order sets have been created and approved by the Obstetric Department. This program will be implemented in the next few months. ERAC is proven to improve the healing process and reduce postoperative infections.
- Maternal Child Leadership and nurse educators are collaborating with Graduate Medical Education to bring Advanced Life Support in Obstetrics (ALSO) to Kaweah Delta. This is a course certification much like Advance Cardiac Life Support (ACLS) except it is specific to Obstetric Patients. This is a wonderful way to increase staff and physician knowledge and support of our high-risk pregnant patients in the organization.
- Pediatrics is at zero for Central Line Associated Blood Stream Infections (CLABSI) and Catheter Associated Urinary Tract Infections (CAUTI). Pediatrics had three non-injury patient falls in 2020, with the last one being in March 2020. Collaboration between the Pediatric Nursing Department and the Pediatric Hospitalist Physicians has led to the implementation of a very robust Pediatric Rapid Response Team (RRT). This team responds to all Pediatric RRT's in the hospital including the Emergency Department. A Pediatric Code White/RRT Policy has been developed and implemented. The whole Pediatric Department in collaboration with the Emergency Department staff, physicians, educators and leaders are responsible for making this happen for the betterment and safety of our pediatric patients in all areas.
- All areas of Maternal Child Health worked diligently on all initiatives related to the COVID 19 Pandemic in our hospital and on our units. Units and staffing resources were very impacted. An enormous amount work was done to ensure that the most up to date safety measures and best practices were in place for patients and staff. Our patient population had very different and specialized needs and requirements specifically related to COVID 19. Labor and Delivery started testing patients for COVID on the unit in July, 2020. In December, the organization began testing all admitted patients and Maternal Child Division implemented the

same practice. In total, we have tested 2175 pregnant mothers and had 188 positive since July 2020. The Pediatric Unit was relocated off the Pediatric Floor to the Mother Baby Unit to increase bed availability related to the COVID Surge. The Pediatric Patients and staff were relocated for almost the entire pandemic with the exception of 3 weeks between surges. They recently moved back to the Pediatric Floor in March 2021. In December 2020, the Neonatal Intensive Care Unit (NICU) was also relocated during the Pandemic. They moved to the previous step-down NICU on Labor & Delivery and to the Mother Baby Nursery to allow adult patients to be placed on the 6th Tower for add bed space. The NICU move made it necessary to limit our capacity to 10 NICU babies at a time. This resulted in some transfers of babies to Valley Children's Hospital to create beds here at Kaweah Delta for urgent admissions. Collaboration occurred between the Neonatologists and Pediatric Hospitalist group to transfer babies that were appropriate for down grading the level of care, to our Pediatric Service when pediatric census allowed. This required an extremely high level of surveillance and involvement of nursing and physician leadership every shift, every day. The goal was to safely keep as many babies as possible here close to home. When it was necessary to transfer a baby for bed space, we made every effort to send the patient who had the shortest length of stay left, so as to cause the least amount of disruption and hardship on the families traveling to be with their baby. The NICU moved back to the sixth Tower in February 2021. We are very proud of the contributions made by our teams to the organizational efforts, goals and outcomes during the COVID Pandemic.

Policy, Strategic or Tactical Issues

- Valley Children's' Medical Group continues to provide Maternal Fetal Medicine Services for our patients as well as Pediatric Hospitalist and Neonatology Services. All Pediatric Hospitalist positions are now filled. All Neonatologist positions are filled. We are no longer using Neonatal Nurse Practitioners (NNP) in the NICU. We staff 24/7 with on-site neonatologists.
- The Laborist Program was implemented on March 16, 2019. This program will and has improved patient safety for all Obstetrical Patients in the hospital. The goal of this program is to provide 24/7 on site Obstetric Physician coverage. We continue to recruit for this program. Currently we are able to staff night shift and 24-hour weekend coverage on site. Day shifts are covered with off-site providers. However, progress is being made, in that recently, we have been able to staff 2 days shifts per week on-site as well.
- The New 23 Bed NICU Unit was complete and occupied in April 2020. This unit is a wonderful addition for our patients and staff.
- Nitrous Oxide Gas for pain management has been implemented. This is widely used in labor and delivery units across the nation, and is a very safe less invasive alternative for those patients who are not candidates or do not desire an epidural for pain relief and do not want narcotics.

Recommendations/Next Steps

- Continue to encourage Shared Governance and Unit Based Councils, as well as participation in our Comprehensive Unit Based Safety Programs (CUSP). Implement the Just Culture Program throughout our Departments. These initiatives have continued with minor interruption during the COVID Pandemic. Staff are engaged and invested in these committees as a way to work together for the good of our patients and to improve workflows.
- Collaborate with Marketing to promote our Labor Triage Unit, our NICU and Maternal Fetal Medicine Program, Laborist Program and Pediatric Departments. Marketing has been very instrumental in communicating with our community during the COVID Pandemic.

- Continue to collaborate with our Emergency Department Colleagues to improve pediatric care and outcomes. There was much collaboration with the Emergency Department over the last year to improve care for pediatric patients in the hospital.
- Collaborate with Marketing and Physicians' offices to promote breastfeeding as the most beneficial and preferred way to feed your baby, as well as informing the public about breastfeeding classes offered.
- Carefully and thoughtfully, evaluate our visiting policy. We have learned many things about how our patients have improved and recovered with fewer visitors during the COVID Pandemic. We want to open back up while retaining the positive outcomes we've seen and still provide our patients all the support they need from family members visiting.
- Support new Obstetrician's and Pediatricians practicing at Kaweah Delta. Continue to recruit Obstetricians to the Kaweah Delta Clinic to increase those participating in our Laborist Program and increase on site coverage in the daytime hours.
- Continue to hire and fill all nursing vacancies in the Maternal Child Health areas. We will continue to over-hire to address the staffing issues related to employees on Leaves of Absence. We will continue the mentor program and roll out to all Maternal Child Health Units as a way to address nurse retention. Maternal Child Health has endured many staffing challenges due to the COVID Pandemic. However, we have been able to reduce the use of contract labor in MCH areas significantly.

Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve.
- Financial Performance Key Takeaways:
    1. Fiscal Year 2021 contribution margin at $12.8 million, substantially lower than prior years, primarily due to declines in supplemental government funding and lower volumes.
    2. COVID had an effect on volumes for some Service Lines.
    3. Expense controls were key in maintaining substantial contribution margin.
    4. Neonatology was particularly impacted by substantially reduced supplemental funds and 500 fewer Medi-Cal days.
- Patient Cases were down 11% overall.
- Indirect costs were up 5%.
- Direct Costs were down by 13% overall. This was no small feat. Much effort was put into controlling and decreasing direct costs making it possible to stay within our operational budgets.
- Direct Costs/Case were down by 2%
- The Maternal Child Health Division will continue to work to develop financially responsible, realistic budgets, continue to be productive while maintaining excellent outcomes and experiences for the patients we serve.

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Summary

FY2021 Annualized

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
14,600	$50,667,435	$37,867,950	$12,799,485	($4,290,389)
▼ -11%	▼ -15%	▼ -13%	▼ -22%	▼ -2320%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS BY SERVICE LINE - FY 2021

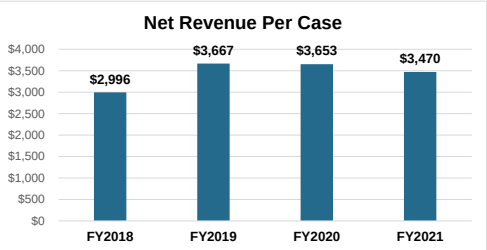
*Annualized

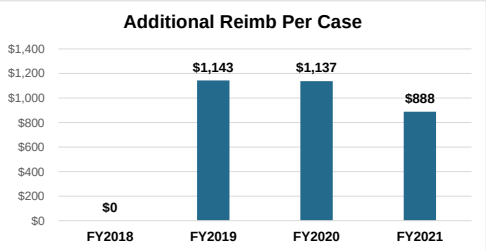
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
OB/Delivery	4,277	$26,329,527	$16,463,580	$9,865,947	$1,521,195
Normal Newborns	2,547	$3,930,666	$2,109,981	$1,820,685	$735,692
Other OB	267	$1,880,940	$1,078,245	$802,695	$329,268
Pediatrics	251	$2,915,520	$1,945,359	$970,161	$148,178
Neonatology	1,803	$14,791,419	$14,284,419	$507,000	($4,776,152)
OP Obstetrics	5,456	$819,363	$1,986,366	($1,167,003)	($2,248,569)
Maternal Child Health Total	14,600	$50,667,435	$37,867,950	$12,799,485	($4,290,389)

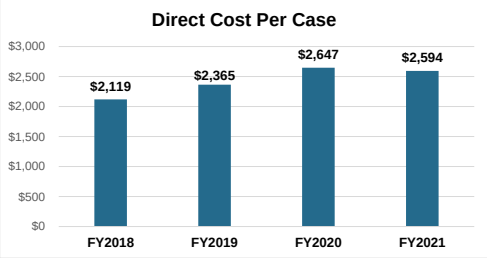
METRICS SUMMARY - 4 YEAR TREND

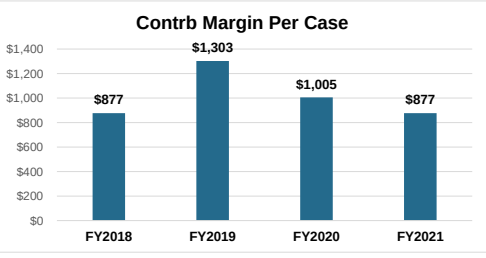
METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	18,347	17,560	16,360	14,600	▼ -11%	
Net Revenue	$54,973,475	$64,395,476	$59,755,810	$50,667,435	▼ -15%	
Direct Cost	$38,883,772	$41,522,518	$43,310,956	$37,867,950	▼ -13%	
Additional Reimb	$2,801,040	$20,076,448	$18,603,723	$12,971,334	▼ -30%	
Contribution Margin	$16,089,703	$22,872,958	$16,444,854	$12,799,485	▼ -22%	
Indirect Cost	$15,077,399	$15,461,669	$16,251,566	$17,089,874	▲ 5%	
Net Income	$1,012,304	$7,411,289	$193,288	($4,290,389)	▼ -2320%	
Net Revenue Per Case	$2,996	$3,667	$3,653	$3,470	▼ -5%	
Additional Reimb Per Case		$1,143	$1,137	$888	▼ -22%	
Direct Cost Per Case	$2,119	$2,365	$2,647	$2,594	▼ -2%	
Contrb Margin Per Case	$877	$1,303	$1,005	$877	▼ -13%	
CM w/o Add Reim Per Case		$159	($132)	($12)	▲ 91%	

GRAPHS









Notes:
Source: Inpatient and Outpatient Service Line Reports
Selection Criteria Inpatient and Outpatient Data: ServiceLine IN (OB/Delivery, Normal Newborn, Neonatology, Pediatrics (age 0-18), Other OB and OP Obstetrics)

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient OB/Delivery Service Line

FY2021 Annualized

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,277	$26,329,527	$16,463,580	$9,865,947	$1,521,195
▼ -4%	▼ -9%	▼ -9%	▼ -9%	▼ -38%

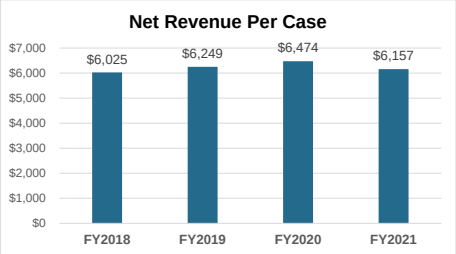
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

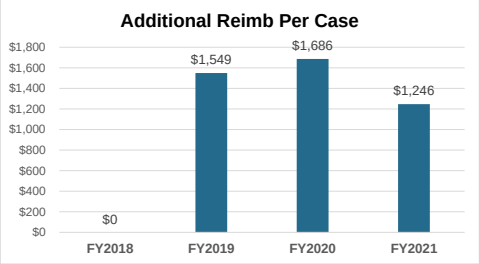
METRICS SUMMARY - 4 YEAR TREND

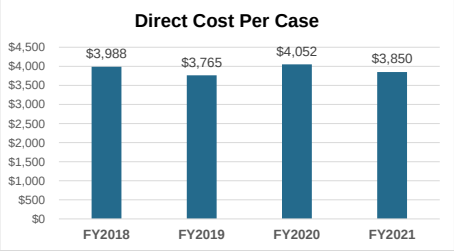
*Annualized

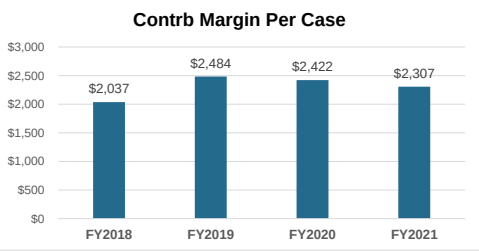
METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	4,627	4,730	4,467	4,277 ▼	-4%	
Patient Days	9,414	9,920	9,126	8,703 ▼	-5%	
ALOS	2.03	2.10	2.04	2.04 ▶	0%	
Net Revenue	$27,878,640	$29,558,832	$28,919,300	$26,329,527 ▼	-9%	
Additional Reimb	$923,481	$7,327,846	$7,532,090	$5,329,626 ▼	-29%	
Direct Cost	$18,451,982	$17,808,945	$18,102,187	$16,463,580 ▼	-9%	
Contribution Margin	$9,426,658	$11,749,887	$10,817,113	$9,865,947 ▼	-9%	
Indirect Cost	$7,970,334	$7,555,980	$8,369,256	$8,344,752 ▶	0%	
Net Income	$1,456,324	$4,193,907	$2,447,857	$1,521,195 ▼	-38%	
Net Revenue Per Case	$6,025	$6,249	$6,474	$6,157 ▼	-5%	
Additional Reimb Per Case		$1,549	$1,686	$1,246 ▼	-26%	
Direct Cost Per Case	$3,988	$3,765	$4,052	$3,850 ▼	-5%	
Contrb Margin Per Case	$2,037	$2,484	$2,422	$2,307 ▼	-5%	
CM w/o Add Reim Per Case		$935	$735	$1,061 ▲	44%	

PER CASE TRENDED GRAPHS









KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient OB/Delivery Service Line

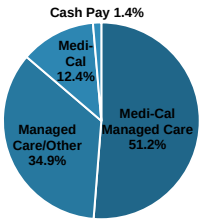
FY2021 Annualized

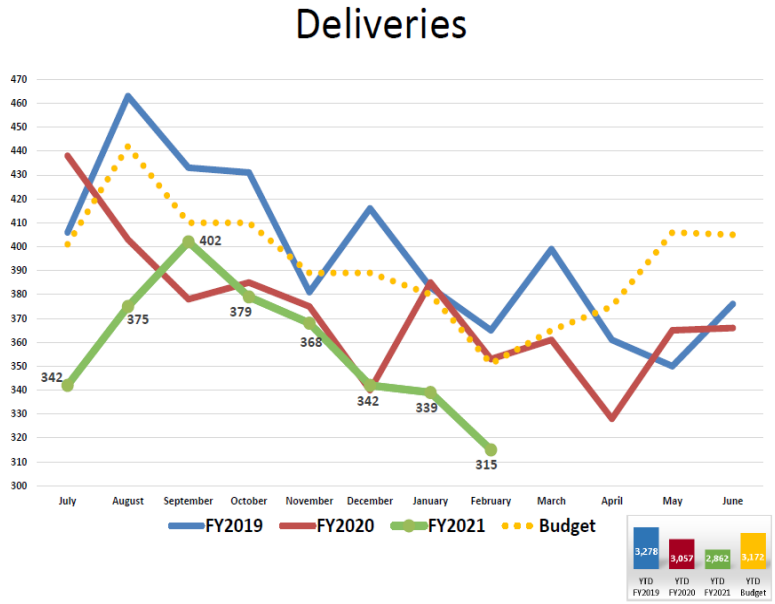
KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	46.2%	48.0%	47.8%	51.2%
Managed Care/Other	36.6%	35.8%	37.4%	34.9%
Medi-Cal	16.4%	15.5%	14.1%	12.4%
Cash Pay	0.4%	0.3%	0.5%	1.4%

FY 2021 PAYOR MIX





Notes:
Source: Inpatient Service Line Report
Selection Criteria: ServiceLine = OB/Delivery

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient Normal Newborns Service Line

FY2021 Annualized

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

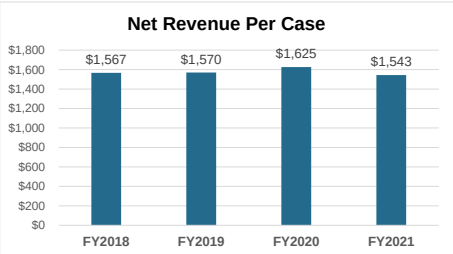
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,547	$3,930,666	$2,109,981	$1,820,685	$735,692
▼ -16%	▼ -20%	▼ -26%	▼ -12%	▼ -4%

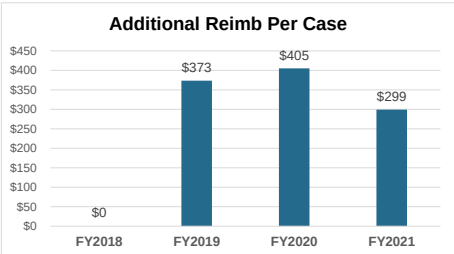
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

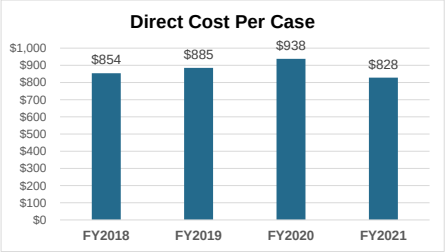
METRICS SUMMARY - 4 YEAR TREND

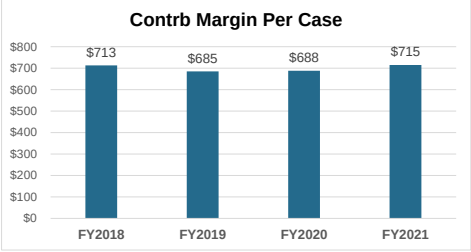
METRIC	FY2018	FY2019	FY2020	*Annualized FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	3,021	3,382	3,024	2,547	▼ -16%	
Patient Days	4,665	5,063	4,330	3,513	▼ -19%	
ALOS	1.54	1.50	1.43	1.38	▼ -4%	
Net Revenue	$4,732,995	$5,309,883	$4,915,484	$3,930,666	▼ -20%	
Additional Reimb	$173,773	$1,263,146	$1,225,086	$762,224	▼ -38%	
Direct Cost	$2,579,660	$2,993,080	$2,835,546	$2,109,981	▼ -26%	
Contribution Margin	$2,153,335	$2,316,803	$2,079,938	$1,820,685	▼ -12%	
Indirect Cost	$1,077,212	$1,310,512	$1,312,475	$1,084,994	▼ -17%	
Net Income	$1,076,123	$1,006,291	$767,463	$735,692	▼ -4%	
Net Revenue Per Case	$1,567	$1,570	$1,625	$1,543	▼ -5%	
Additional Reimb Per Case		$373	$405	$299	▼ -26%	
Direct Cost Per Case	$854	$885	$938	$828	▼ -12%	
Contrb Margin Per Case	$713	$685	$688	$715	▲ 4%	
CM w/o Add Reim Per Case		$312	$283	$416	▲ 47%	

PER CASE TRENDED GRAPHS









KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient Normal Newborns Service Line

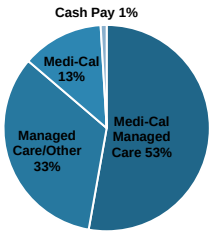
FY2021 Annualized

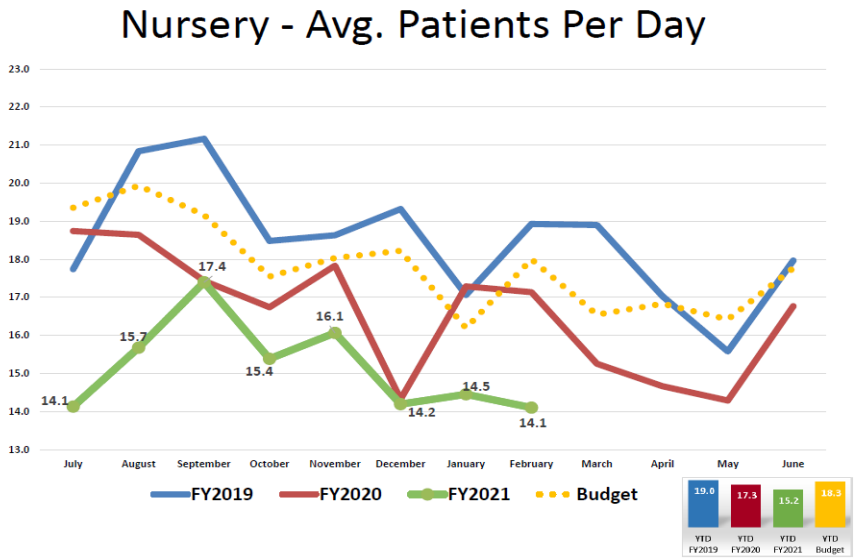
KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	46%	48%	47%	53%
Managed Care/Other	36%	36%	37%	33%
Medi-Cal	17%	16%	15%	13%
Cash Pay	1%	1%	1%	1%

FY 2021 Payer Mix





Notes:
Source: Inpatient Service Line Report
Selection Criteria: ServiceLine = Normal Newborn

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient Neonatology Service Line

FY2021 Annualized

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

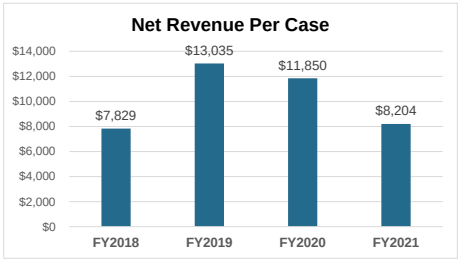
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,803	$14,791,419	$14,284,419	$507,000	($4,776,152)
▲ 18%	▼ -19%	▼ -8%	▼ -81%	▼ -418%

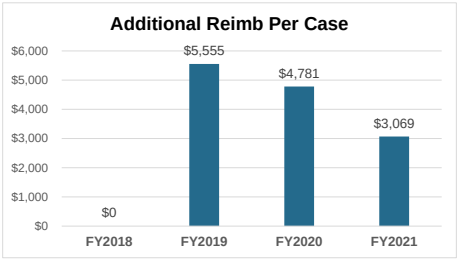
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

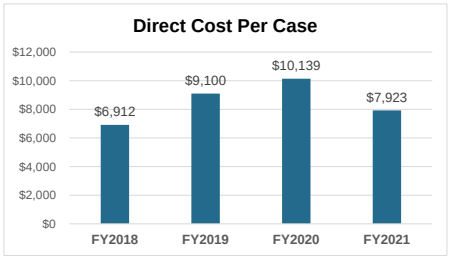
METRICS SUMMARY - 4 YEAR TREND

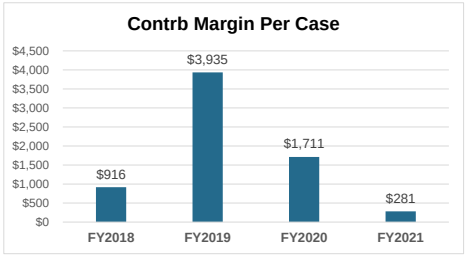
METRIC	FY2018	FY2019	FY2020	FY2021 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,739	1,511	1,533	1,803 ▲	18%	
Patient Days	6,948	7,368	6,653	7,061 ▲	6%	
ALOS	4.00	4.88	4.34	3.92 ▼	-10%	
Net Revenue	$13,614,267	$19,695,391	$18,165,387	$14,791,419 ▼	-19%	
Additional Reimb	$1,250,699	$8,393,815	$7,329,981	$5,533,790 ▼	-25%	
Direct Cost	$12,020,793	$13,750,247	$15,542,515	$14,284,419 ▼	-8%	
Contribution Margin	$1,593,474	$5,945,144	$2,622,872	$507,000 ▼	-81%	
Indirect Cost	$3,581,367	$3,419,861	$3,544,154	$5,283,152 ▲	49%	
Net Income	($1,987,893)	$2,525,283	($921,282)	($4,776,152) ▼	-418%	
Net Revenue Per Case	$7,829	$13,035	$11,850	$8,204 ▼	-31%	
Additional Reimb Per Case		$5,555	$4,781	$3,069 ▼	-36%	
Direct Cost Per Case	$6,912	$9,100	$10,139	$7,923 ▼	-22%	
Contrb Margin Per Case	$916	$3,935	$1,711	$281 ▼	-84%	
CM w/o Add Reim Per Case		($1,621)	($3,071)	($2,788) ▲	9%	

PER CASE TRENDED GRAPHS









KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient Neonatology Service Line

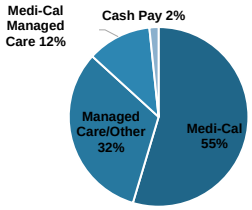
FY2021 Annualized

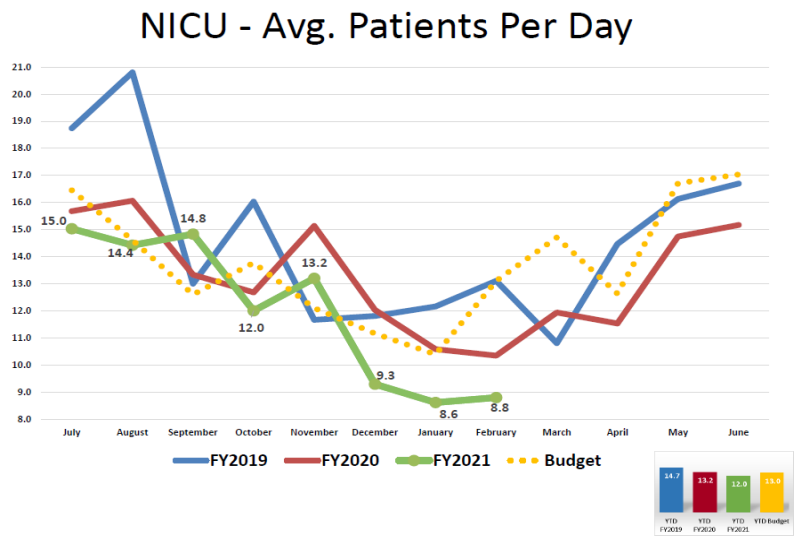
KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal	24%	59%	53%	55%
Managed Care/Other	30%	30%	35%	32%
Medi-Cal Managed Care	46%	11%	11%	12%
Cash Pay	0%	1%	1%	2%

FY 2021 Payer Mix





Notes:
Source: Inpatient Service Line Report
Selection Criteria: Entity = Neonatology

KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Maternal Child Health Services - Inpatient Pediatrics (Age < 19)

Exludes Normal Newborn, OB/Delivery, Other OB and Neonatology Service Lines

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

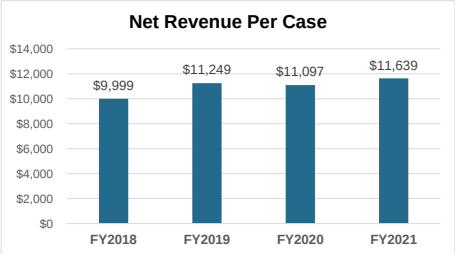
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
251	$2,915,520	$1,945,359	$970,161	$148,178
-42%	-39%	-38%	-41%	-55%

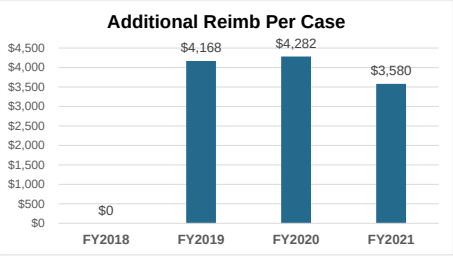
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

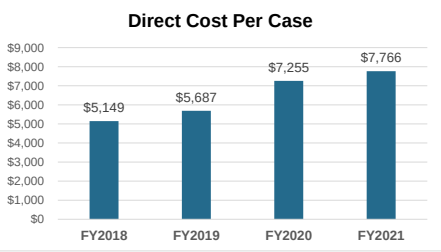
METRICS SUMMARY - 4 YEAR TREND

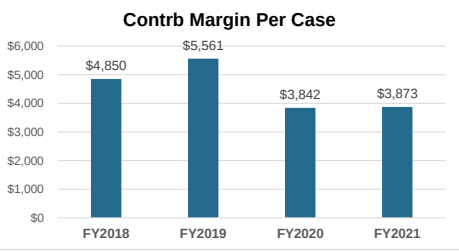
METRIC	FY2018	FY2019	FY2020	FY2021 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	548	539	430	251	▼ -42%	
Patient Days	1,416	1,266	1,033	872	▼ -16%	
ALOS	2.58	2.35	2.40	3.48	▲ 45%	
Net Revenue	$5,479,311	$6,062,993	$4,771,656	$2,915,520	▼ -39%	
Additional Reimb	$310,662	$2,246,769	$1,841,207	$896,826	▼ -51%	
Direct Cost	$2,821,577	$3,065,453	$3,119,621	$1,945,359	▼ -38%	
Contribution Margin	$2,657,734	$2,997,540	$1,652,035	$970,161	▼ -41%	
Indirect Cost	$1,127,583	$1,462,489	$1,326,015	$821,984	▼ -38%	
Net Income	$1,530,151	$1,535,051	$326,020	$148,178	▼ -55%	
Net Revenue Per Case	$9,999	$11,249	$11,097	$11,639	▲ 5%	
Additional Reimb Per Case		$4,168	$4,282	$3,580	▼ -16%	
Direct Cost Per Case	$5,149	$5,687	$7,255	$7,766	▲ 7%	
Contrb Margin Per Case	$4,850	$5,561	$3,842	$3,873	▲ 1%	
CM w/o Add Reim Per Case		$1,393	($440)	$293	▲ 167%	

PER CASE TRENDED GRAPHS









KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Maternal Child Health Services - Inpatient Pediatrics (Age < 19)

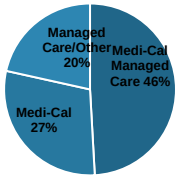
Exludes Normal Newborn, OB/Delivery, Other OB and Neonatology Service Lines

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	54%	49%	45%	46%
Medi-Cal	22%	31%	27%	27%
Managed Care/Other	21%	18%	26%	20%

FY 2021 Payer Mix



Notes:
Source: Inpatient Service Line Report
Selection Criteria : Pediatric Patients Ages 0-18, KDMC campus only, excluding the following Service Lines: OB/Delivery, Other OB, Normal Newborn, Neonatology.

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Inpatient Other OB Service Line

FY2021 Annualized

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
267	$1,880,940	$1,078,245	$802,695	$329,268
▼ -9%	▼ -9%	▼ -7%	▼ -12%	▼ -24%

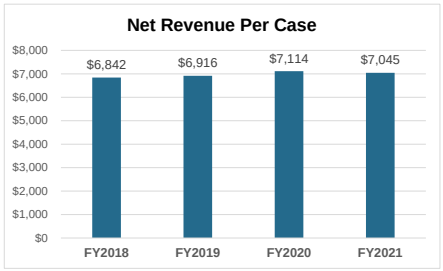
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

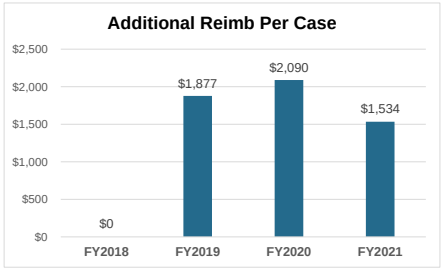
METRICS SUMMARY - 4 YEAR TREND

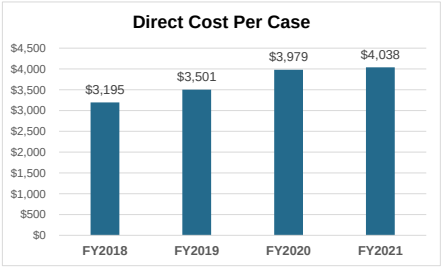
*Annualized

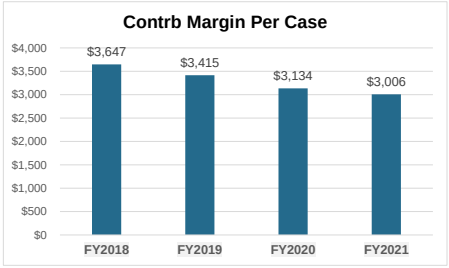
METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	320	417	292	267	▼ -9%	
Patient Days	716	982	687	690	▶ 0%	
ALOS	2.2	2.4	2.4	2.6	▲ 10%	
Net Revenue	$2,189,499	$2,884,169	$2,077,235	$1,880,940	▼ -9%	
Additional Reimb	$83,144	$782,872	$610,146	$409,598	▼ -33%	
Direct Cost	$1,022,544	$1,459,941	$1,161,992	$1,078,245	▼ -7%	
Contribution Margin	$1,166,955	$1,424,228	$915,243	$802,695	▼ -12%	
Indirect Cost	$404,319	$581,690	$480,677	$473,427	▼ -2%	
Net Income	$762,636	$842,538	$434,566	$329,268	▼ -24%	
Net Revenue Per Case	$6,842	$6,916	$7,114	$7,045	▼ -1%	
Additional Reimb Per Case		$1,877	$2,090	$1,534	▼ -27%	
Direct Cost Per Case	$3,195	$3,501	$3,979	$4,038	▲ 1%	
Contrb Margin Per Case	$3,647	$3,415	$3,134	$3,006	▼ -4%	
CM w/o Add Reim Per Case		$1,538	$1,045	$1,472	▲ 41%	

PER CASE TRENDED GRAPHS





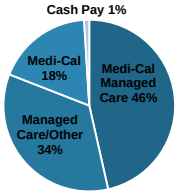




PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	55%	56%	60%	46%
Managed Care/Other	22%	25%	23%	34%
Medi-Cal	22%	18%	15%	18%
Cash Pay	1%	1%	2%	1%

FY 2021 PAYOR MIX



Notes:
Source: Inpatient Service Line Reports
Selection Criteria: ServiceLine = OTHER OB

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Outpatient Obstetrics Service Line

FY2021 Annualized

KEY METRICS - FY 2021 Eight Months Ended February 28, 2021 Annualized

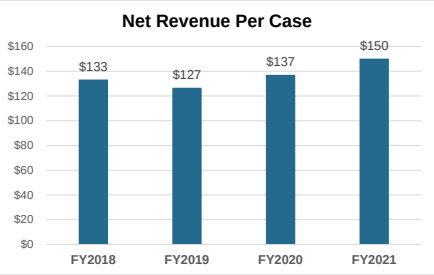
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
5,456	$819,363	$1,986,366	($1,167,003)	($2,248,569)
▼ -18%	▼ -10%	▼ -22%	▲ 29%	▲ 21%

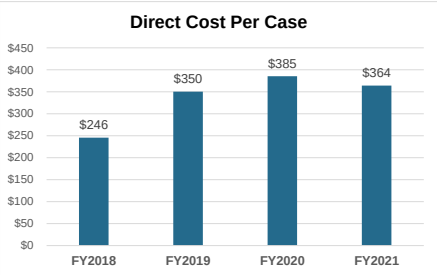
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

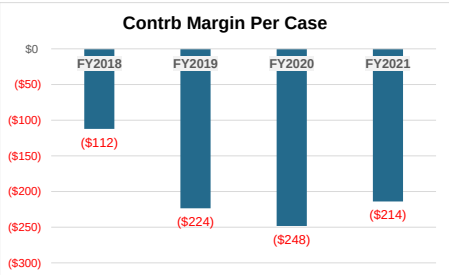
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	8,092	6,981	6,614	5,456	▼ -18%	
Net Revenue	$1,078,763	$884,208	$906,748	$819,363	▼ -10%	
Direct Cost	$1,987,216	$2,444,852	$2,549,095	$1,986,366	▼ -22%	
Contribution Margin	($908,453)	($1,560,644)	($1,642,347)	($1,167,003)	▲ 29%	
Indirect Cost	$916,584	$1,131,137	$1,218,989	$1,081,566	▼ -11%	
Net Income	($1,825,037)	($2,691,781)	($2,861,336)	($2,248,569)	▲ 21%	
Net Revenue Per Case	$133	$127	$137	$150	▲ 10%	
Direct Cost Per Case	$246	$350	$385	$364	▼ -6%	
Contrb Margin Per Case	($112)	($224)	($248)	($214)	▲ 14%	

PER CASE TRENDED GRAPHS



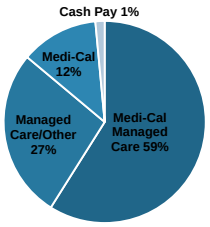


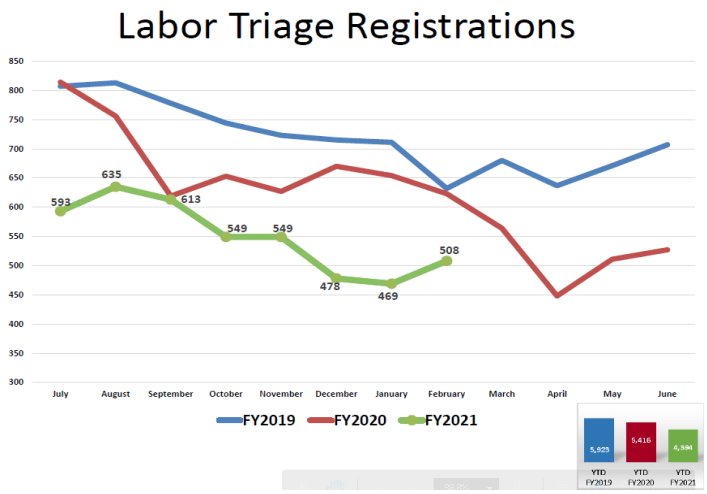


PAYER MIX - 4 YEAR TREND (Vists)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	55%	61%	57%	59%
Managed Care/Other	22%	23%	25%	27%
Medi-Cal	22%	16%	17%	12%
Cash Pay	1%	0%	0%	1%

FY 2021 PAYOR MIX





Notes:
Source: Outpatient Service Line Reports
Selection Criteria : ServiceLine = OP Obstetrics

Kaweah Delta Physician Recruitment and Relations
Medical Staff Recruitment Report - April 2021

Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations - btaylor@kdhcd.org - (559)624-2899

Date prepared: 4/23/2021

Central Valley Critical Care Medicine	
Intensivist (1- Part-Time; 1 - Full-Time)	2

Delta Doctors Inc.	
OB/Gyn	1

Kaweah Delta Faculty Medical Group	
Family Medicine Associate Program Director	1
Family Medicine Core Faculty	2

Key Medical Associates	
Internal Medicine/Family Medicine	2

Oak Creek Anesthesia	
General Anesthesia	3
Certified Registered Nurse Anesthetist	3

Other Recruitment	
Neurology	1
Orthopedic Surgery (Trauma)	1
Pulmonology	1

Valley Children's Health Care	
Maternal Fetal Medicine	2

Visalia Medical Clinic (Kaweah Delta Medical Foundation)	
Dermatology	2
Family Medicine	4
Internal Medicine	1
Gastroenterology	2
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Radiology - Diagnostic	1
Rheumatology	1
Urology	3

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Colorectal Surgery	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Ota, M.D.	Kyle	08/21	Current KD General Surgery resident	Offer accepted; Start Date: 8/2/2021
Anesthesia	Oak Creek Anesthesia	Eslahpazir, M.D.	Benjamin	TBD	CompHealth - 4/9/21	Currently under review
CRNA	Oak Creek Anesthesia	Baldwin	Joy	TBD	Direct - 4/15/21	Currently under review
CRNA	Oak Creek Anesthesia	Hester	Joshua	TBD	Director - 4/13/21	Currently under review
CRNA	Oak Creek Anesthesia	McGarrity	John	TBD	Direct - 3/19/21	Currently under review
CRNA	Oak Creek Anesthesia	Mosley	Katarzyna	05/21	Direct - 3/29/21	Currently under review
CRNA	Oak Creek Anesthesia	Yrjanson	Sable	TBD	Direct - 3/22/21	Currently under review
Diagnostic Radiology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Dalle, D.O.	John	TBD	Merritt Hawkins - 2/26/21	Site Visit: 4/1/21; Offer pending
Diagnostic Radiology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Murillo, M.D.	Horacio	TBD	Merritt Hawkins - 3/4/21	Currently under review
Dermatology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Chu, M.D.	Thomas	08/21	Curative - 2/24/21	Site Visit: 4/6/21; Offer pending
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Hsueh, D.O.	Marion	09/21	Direct referral	Site Visit: 3/23/21; Offer accepted
Family Medicine	Key Medical Associates	Fernandez, M.D.	Rogelio	04/21	Direct referral	Offer accepted; Start Date: 4/19/21

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Family Medicine	Visalia Family Practice	Suleymanova, M.D.	Violetta	TBD	Direct -4/21/20 UCSF Fresno Career Fair	Offer accepted; Start Date: 4/19/21
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Bassali, M.D.	Mariam	08/21	Referred by Dr. Martinez - 10/14/20	Site Visit: 3/10/21; offer extended
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Rangel-Orozco, M.D.	Daniela	08/22	Kaweah Delta Resident	Currently under review
Hospitalist	Central Valley Critical Care Medicine	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site Visit: 10/7/20; Offer accepted
Hospitalist	Central Valley Critical Care Medicine	Reed, M.D.	Jennifer	08/21	Vista Staffing - 1/18/21	Offer accepted
Intensivist	Central Valley Critical Care Medicine	Dierksheide, M.D.	Julie	08/21	Vista Staffing - 4/15/21	Offer accepted
Intensivist	Central Valley Critical Care Medicine	Hansen, M.D.	Diana	TBD	Vista Staffing - 2/25/21	Offer accepted
Intensivist	Central Valley Critical Care Medicine	John, D.O.	Avinaj	08/21	Vista Staffing - 10/25/19	Site visit: 12/13/19; Offer accepted
Intensivist	Central Valley Critical Care Medicine	Akinjero, M.D.	Akintunde	08/21	Vista Staffing - 10/20/20	Virtual Interview: 11/30/20 Offer accepted
Internal Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Sadiqi, M.D.	Rauf	08/21	Direct - 3/23/21	Currently under review
Neonatology	Valley Children's	Singh, M.D.	Himanshu	08/22	Valley Children's - 3/31/21	Site Visit: 4/19/2021
Orthopedic Surgery - Hand	Visalia Medical Clinic (Kaweah Delta Medical Foundation)/ Orthopaedic Associates	Tomooka, D.O.	Beren	08/21	Direct referral	Phone Interview: 12/2/20; Site Visit: 3/12/21; Offer extended
Otolaryngology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Nguyen, D.O.	Cang	07/22	Curative - 3/15/21	Site Visit: 5/18/21
Palliative Medicine	Independent	Grandhe, M.D.	Sundeep	08/21	Direct -12/7/20	Virtual Interview: 12/28/20; Offer accepted; Start Date: 9/1/21

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Urology APP	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Dhanoa	Kirat	06/21	Direct	Virtual Interview: 3/17/21; Offer accepted
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patel, M.D.	Neil	06/21	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20; Part-Time; Tentative Start Date: 7/01/2021

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP87	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Sentinel Event and Adverse Event Response and Reporting	

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

PURPOSE:

This Policy describes the multidisciplinary framework in which Kaweah Delta (KD) and its organized Medical Staff identifies and responds to all Sentinel Events/Adverse Events (SE/AE) occurring within the organization. KD's response encompasses the identification, investigation, and action plan to reduce risks, implement process improvements, monitor the effectiveness of those improvements, and the appropriate reporting of Events consistent with The Joint Commission (TJC) and all applicable regulatory mandates.

Kaweah Delta recognizes that the commitment to Quality and Patient Safety is everyone's responsibility, and that this accountability begins at the unit level where individual unit staff and leadership play a critical role in the delivery of quality care and patient safety. Staff and leadership in every department should call the Risk Management Department to notify of a potential Sentinel or Adverse Event as soon as possible after an event is identified.

The Risk Management (RM) Director shall coordinate all investigations, Root Cause Analysis (RCAs), Plans of Correction, Action Plans and monitoring activities. The RM Director will coordinate with the Chief Executive Officer (CEO), Chief ~~Medical~~Quality Officer (C~~M~~QO), Chief Medical Officer (CMO), Chief Compliance Officer, and any other appropriate Vice President (VP) to ensure the timely and complete compliance with all required notification(s) to California Department of Public Health (CDPH) or Center for Medicare and Medicaid Services (CMS). The RM Director will coordinate with the CEO, C~~QM~~O, CMO, or the appropriate VP to ensure the written Plan of Correction report is completed and received by CDPH.

DEFINITIONS:

For purposes of this policy, Sentinel Events and Adverse Events shall be considered as one: Sentinel Event/Adverse Event (SE/AE).

I. **Sentinel Event (SE)** – is a term used by The Joint Commission to describe "a Patient Safety Event" that reaches a patient and results in any of the following:

- a) Death
- b) Permanent harm

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c) Severe temporary harm and intervention required to sustain life

Reporting of Sentinel Events to The Joint Commission is strongly encouraged, but not required. (Attachment C)

~~I.~~II. **Adverse Events (AE)** – The list of CDPH reportable adverse events is defined by California Health and Safety Code Section 1279.1. These Adverse Events encompass "Sentinel Events" as well as other delineated (and reportable) situations as well as National Quality Forum's "never events." (See Attachment B).

~~II. For purposes of this policy, Sentinel Events and Adverse Events shall be considered as one: Sentinel Event/Adverse Event (SE/AE).~~

~~I~~III. **Near-Miss** – ~~a~~Any process variation that did not affect an outcome, but for which a recurrence carries a significant chance of serious adverse outcome. Such a "near-miss" falls within the scope of the definition of a SE, but outside of the scope of those Events that are subject to review by TJC under its SE Policy.

~~II.~~IV. **Quality Concern –** Events, errors, or situations that are either corrected before a patient is harmed, or that represent an opportunity to identify and correct flaws that jeopardize patient safety. They do not rise to the level of ~~Sentinel/Adverse~~SE/AE or near-miss events, and are managed by the RM department utilizing the Focused Review process.

V. **Focused Review –** A process ~~similar to an RCA,~~ to evaluate Quality Concerns that hold less potential for severity and harm than would be appropriate for an RCA. In the absence of extenuating circumstances, Focused Reviews are conducted by Unit or Service Line leadership utilizing the KD standardized process and documentation. ~~(Attachment C)~~ RM staff shall serve as a resource to this process on an as needed basis. Focused Reviews are an integral part of KD's Patient Safety and Quality Improvement program.

~~III.~~VI. **Center for Medicare and Medicaid Services (CMS)** – Federal agency responsible for enforcement of Medicare and Medicaid regulations.

~~A. CMS requires a report within 24 hours of any deaths associated with the use of restraints~~ (Attachment D).

~~IV.~~VII. **Case Review Committee (CRC)** – A multidisciplinary team composed of:

~~Chief Executive Officer,~~

- Chief Executive Officer (CEO)
- Chief Quality Officer (CQO) or Chief Medical Officer (CMO)
- Chief Compliance Officer (CCO)
- Chief of Staff or designee (Chair), if Applicable,

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- Medical Staff Clinical Department Chair, if Applicable, ~~Chief Medical Officer (CMO),~~
- Chief Nursing Officer (CNO), in events involving nursing
- ~~Chief Operating Officer (COO)~~
- Vice President of area in which event occurred, as available
- Medical Director of Quality/Patient Safety, as available
- Director of Risk Management (RM) ~~Director~~
- Director of Quality ~~&/~~Patient Safety~~,~~
- Director of area where SE/AE occurred
- Others may be asked to participate as appropriate

~~A quorum for taking action by the CRC shall require at least two Medical Staff members and at least two Administrative members.~~

~~V.~~VIII. **Root Cause Analysis and Actions (RCA2)** – Root-Cause Analysis (RCA) – Root cause analysis is a comprehensive systematic analysis for identifying the factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily, but not exclusively, on systems and processes, rather than individual performance. The analysis identifies changes that could be made in systems and processes through redesign o~~f~~r development of new systems or processes that will improve the level of performance and reduce the risk of particular serious adverse event occurring in the future. Root Cause Analysis is an integral part of KD's Patient Safety and Quality Improvement program.

PROCESS for Sentinel/Adverse events and near-misses ~~:~~ (Attachment A):

~~**(see Algorithm, Attachment A):**~~

A. When an event that is potentially a Sentinel/Adverse or near-miss occurs or is discovered, staff will immediately notify the ~~RM Director or RM staff member on call.~~Risk Management Department (624-2340) or RM staff member on call through the House Supervisor.

B. Upon notification of the event, the Risk Management Department will immediately perform an initial assessment to determine the following:

~~A.~~1. The immediate safety of any patients, staff or other persons who are or may be at risk.

~~B.~~2. ~~Whether the event in question may require the convening of the CRC. If this is thought to be the case, the RM Director will notify the CMO to confirm this determination. Upon confirmation, the COS & CEO shall be notified in a timely manner. Those events, in which there is no question as to the fact that a SE/AE or near-miss has occurred as determined by the RM Director in consultation with the CMO, will not require the convening of a CRC. In these situations,~~ ~~t~~The RM Director or designee shall proceed directly to initiate a~~n~~ CRC meeting~~.~~ ~~RCA~~ as described in Section C~~,~~ below.

~~C.~~3. RM will then complete their investigation.

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~~D.~~C. The ~~convening of the CRC will be the responsibility of the RM Director or designee with assistance as required from the Chief Medical Quality Officer, the Medical Director of Quality & Patient Safety, or their designee's, and will occur~~Risk Management Director or designee will convene a CRC within 72 hours.

~~C.~~D. The CRC ~~responsibility is to consider~~will review the event in question and determine:

~~A.~~1. If the event is a Sentinel/Adverse~~,~~ or near-miss;~~,~~

~~B.~~2. If the event requires reporting to either CDPH and/or TJC;~~,~~

~~C.~~3. If the event ~~does NOT~~ require~~s~~ a~~n~~ RCA, ~~and~~ or if an alternate action is appropriate; and

~~D.~~4. If any immediate actions prior to the RCA are required.

E. If the event is deemed reportable, the RM Director or designee will ensure that such reporting is done in compliance with KD policy and all applicable regulatory and statutory requirements as well as~~,~~ notify the CEO, CC~~O~~O, and CNO.

F. Upon determination that a Sentinel/Adverse event has occurred, the RM Director shall conduct a RCA using methodology consistent with current TJC standards unless the CRC determines that an alternate action is appropriate. ~~To create a safe environment, intended attendees at RCA's are exclusively those individuals that were directly involved in the event. In unusual circumstances, and at the discretion of the RM Director, other participants, including managers and/or Directors may be included only if their participation is of clear value. Staff involved in the event will make every effort to attend the RCA.~~ Directors shall also ensure to the best of their ability that their involved staffs are available to attend the RCA, if their participation is needed. Leadership will be responsible for ensuring that support services for any involved individual ~~needing them~~ are available. Patients and/or families may also be interviewed to gather information for the RCA, as appropriate.

G. The RM Director (or designee) in collaboration with the patient's physician, Chief of Staff (or designee) will ensure that~~-~~ an apology is offered and notice of the SE/AE is given to the patient involved, or the party responsible for the patient, of the nature of the Event by the time the initial report is made to CDPH. A notation that this notice has occurred shall be placed in the patient's medical record. If process changes were implemented ~~as a result~~because of a preventable SE/AE, the patient/family will be informed of those changes. An apology or notice are not required for near-miss events or quality concerns.

H. While the focus of SE~~s~~/AE~~s~~ is about improving patient care, KD may also waive costs to the patient or a third party payer for costs directly related to the SE/AE. This will be reviewed on a case-by-case basis, and will be done in compliance with all applicable regulatory standards. ~~-~~

I. The patient or the party responsible for the patient shall not be provided with a copy of the CDPH report. The CDPH report will not be placed in the patient's medical record, and no reference that a report to CDPH has been made should be included in the medical record.

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~~VI.~~I. The RCA shall be conducted and produce an Action Plan within 20 days of the initial meeting that includes a detailed review of what transpired prior to, during, and immediately following the event.

The RCA will:

A. Focus on systems and processes related to event;
B. Identify changes that could be made in the systems and processes which would reduce to prevent future occurrences:
C. Develop a detailed written Action Plan for each of the opportunities identified, and will:
    1. Identify the key accountable staff position (usually a Director) for ensuring changes are implemented,
    2. A date for action implementation or completion,
    3. How the department will monitor the effectiveness of such changes, including the accountable staff person and target dates for reporting;
    4. When necessary~~If possible~~, include references from relevant literature for "best practices" used in the RCA and the development of the Action Plan.
D. All documentation related to RCAs, Focused Reviews, Action Plans, CDPH Plans of Correction, and monitoring activities involving clinical practice or conduct by members of the Medical or Advanced Practice Provider staff will be maintained exclusively as confidential Medical Staff documents so as to be protected by California Evidence Code, Section 1157.
E. The RM Director, C~~M~~QO, and the Medical Director of Quality/Patient Safety are responsible for reporting finalized RCAs and Action Plans to the following committees as appropriate for approval:

- The Patient Safety Committee;
- Professional Staff Quality Committee (Prostaff)~~staff~~
- Medical Staff issues will be referred to the appropriate medical staff committee/department for follow-up prior to being referred on to the Medical Executive Committee.
- Quality Council

F. Board of Directors Organizational Learning: Every attempt will be made to use "teaching moments" and disseminate the "lesson learned" from these events to all appropriate areas of our organization. Department and unit meetings, in-service discussions, Grand Rounds, conferences, newsletters and other venues will be used in this effort to be sure that we collectively learn from, improve, and prevent similar occurrences in the future.

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

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REFERENCES:

The Joint Commission Perspectives, December 2020, Volume 40, Issue 12
The Joint Commission Perspectives, June 2020, Volume 40, Issue 6
CHA Consent Manual, 2020, Chapter 19
National Quality Forum, 2011,
https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx

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Attachment A

Process

Suspected Sentinel/Adverse Event ➡ CRC --- If SE/AE confirmed ➡ RCA* (except HAPI)

Suspected Near-miss ➡ CRC--- If near-miss confirmed: ➡ RCA*

Quality Concern ➡ Focused Review

*unless CRC determines that an alternate action is appropriate

Attachment B

SPECIFIC DEFINITION OF SENTINEL/ADVERSE EVENT IN LAW

I. *California Health and Safety Code 1279.1*

1279.1. (b) For purposes of this section, "adverse event" includes any of the following:

(1) **Surgical events**, including the following:

(A) **Surgery performed on a wrong body part** that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

(B) **Surgery performed on the wrong patient.**

(C) **The wrong surgical procedure performed on a patient**, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

(D) **Retention of a foreign object in a patient after surgery or other procedure**, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(E) **Death during or up to 24 hours after induction of anesthesia after surgery** of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(2) **Product or device events**, including the following:

(A) **Patient death or serious disability associated with the use of a contaminated drug, device, or biologic** provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

(B) **Patient death or serious disability associated with the use or function of a device** in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

(C) **Patient death or serious disability associated with intravascular air embolism** that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(3) **Patient protection events**, including the following:

(A) An infant discharged to the wrong person. Attachment I

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(B) Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.

(C) **A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility** due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

(4) **Care management events**, including the following:

(A) **A patient death or serious disability associated with a medication error**, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

(B) A patient death or serious disability associated with hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

(C) **Maternal death or serious disability associated with labor or delivery** in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

(D) **Patient death or serious disability directly related to hypoglycemia**, the onset of which occurs while the patient is being cared for in a health facility.

(E) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

(F) **A Stage 3 or 4 ulcer**, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

(G) **A patient death or serious disability due to spinal manipulative therapy** performed at the health facility.

(5) **Environmental events**, including the following:

(A) **A patient death or serious disability associated with an electric shock** while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

(B) **Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.**

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(C) **A patient death or serious disability associated with a burn** incurred from any source while being cared for in a health facility.
(D) **A patient death associated with a fall** while being cared for in a health facility.
(E) **A patient death or serious disability associated with the use of restraints or bedrails** while being cared for in a health facility. See Attachment D.

(6) **Criminal events**, including the following:
(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
(B) The abduction of a patient of any age.
(C) **The sexual assault on a patient** within or on the grounds of a health facility.
(D) **The death or significant injury of a patient or staff member resulting from a physical assault** that occurs within or on the grounds of a facility.

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.
(c) The facility shall inform the patient or the party responsible for the patient ofthe adverse event by the time the report is made.
(d) "Serious disability" means a physical or mental impairment that substantiallylimits one or more of the major life activities of an individual, or the loss of bodilyfunction, if the impairment or loss lasts more than seven days or is still present at thetime of discharge from an inpatient health care facility, or the loss of a body part.

~~*Title 22, Division 5, Chapter 12, Article 5, Section 79787*~~
~~(c) Events constituting an unusual occurrence shall include, but not be limited to:~~
~~(1) Poisonings.~~
~~(2) Fires or explosions.~~
~~(3) Death of an inmate-patient, employee, or visitor because of unnatural causes.~~
~~(4) Sexual acts involving inmate-patients who are minors, nonconsenting adults, or persons incapable of consent.~~
~~(5) Physical assaults on inmate-patients, employees, or visitors.~~
~~(6) All suspected criminal acts involving inmate-patients, employees, or visitors.~~
~~(7) All suspected incidents of physical or sexual abuse to an inmate-patient.~~
~~(8) Unexplained or illicit disappearance or loss of an inmate-patient or inmate-patient remains.~~
~~(9) Disruption of services of the licensed correctional treatment center.~~

Attachment C

Definition of Sentinel Event – The Joint Commission

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A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital§
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient‖
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the hospital. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm
- Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (e.g., skull fracture, subdural or intracranial hemorrhage) or internal (e.g., rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

~~A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:~~

- ~~Death~~
- ~~Permanent harm~~
- ~~Severe temporary harm~~

~~An event is also considered sentinel if it is one of the following:~~

- ~~Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)~~
- ~~Unanticipated death of a full-term infant n Discharge of an infant to the wrong family~~
- ~~Abduction of any patient receiving care, treatment, and services~~

- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or
- severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products
  having major blood group incompatibilities (ABO, Rh, other blood groups)
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure‡
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong region or >25% above the planned dose.

Sentinel FALL EVENT: Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (for example, skull, fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury; or a patient with coagulopathy who receives blood products as a result of the fall; death or permanent harm as a result of injuries sustained form the fall (not from physiologic events causing the fall)

REVISED Definitions for Abuse or AssaultEFINITIONS:

- Sexual abuse/assault of any [patient/client] while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization*
- Sexual abuse/assault of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to [patients/clients]*
- Physical assault of any [patient/client] (leading to death, permanent harm, or severe temporary harm) while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization.
- Physical assault (leading to death, permanent harm, or severe temporary harm) of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to [patients/clients]
- Homicide of any [patient/client] while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization
- Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to [patients/clients]

** Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact, including oral, vaginal, or anal penetration or fondling of the individual's sex organ(s) by another individual.*

One or more of the following must be present to determine that it is a sentinel event:
**Any staff-witnessed sexual contact as described above*

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**Admission by the perpetrator that sexual contact, as described above, occurred on the premises*
**Sufficient clinical evidence obtained by the health care organization to support allegations of unconsented sexual contact*

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Attachment C Attachment I REPORTING REQUIREMENTS UNDER STATE LAW

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California Health and Safety Code – Pertaining to General Acute Care Hospitals

1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(b) Omitted – see definitions of adverse/sentinel events per Health and Safety Code in previous section.

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(c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

(e) Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in Section 70737 of Title 22 of the California Code of Regulations. The department shall review Section 70737 of Title 22 of the California Code of Regulations requiring hospitals to report "unusual occurrences" and consider amending the section to enhance the clarity and specificity of this hospital reporting requirement.

1279.2. (a) (1) In any case in which the department receives a report from a facility pursuant to Section 1279.1, or a written or oral complaint involving a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250, that indicates an ongoing threat of imminent danger of death or serious bodily harm, the department shall make an onsite inspection or investigation within 48 hours or two business days, whichever is greater, of the receipt of the report or complaint and shall complete that investigation within 45 days.

(2) Until the department has determined by onsite inspection that the adverse event has been resolved, the department shall, not less than once a year, conduct an unannounced inspection of any health facility that has reported an adverse event pursuant to Section 1279.1.

(b) In any case in which the department is able to determine from the information available to it that there is no threat of imminent danger of death or serious bodily harm to that patient or other patients, the department shall complete an investigation of the report within 45 days.

(c) The department shall notify the complainant and licensee in writing of the department's determination as a result of an inspection or report.

(d) For purposes of this section, "complaint" means any oral or written notice to the department, other than a report from the health facility, of an alleged violation of applicable requirements of state or federal law or an allegation of facts that might constitute a violation of applicable requirements of state or federal law.

(e) The costs of administering and implementing this section shall be paid from funds derived from existing licensing fees paid by general acute care hospitals, acute psychiatric hospitals, and special hospitals.

(f) In enforcing this section and Sections 1279 and 1279.1, the department shall take into account the special circumstances of small and rural hospitals, as defined in Section 124840, in order to protect the quality of patient care in those hospitals.

(g) In preparing the staffing and systems analysis required pursuant to Section 1266, the department shall also report regarding the number and timeliness of investigations of adverse events initiated in response to reports of adverse events.

Title 22, Division 5, Chapter 12, Article 5, Section 79787– Pertaining to Correctional Treatment Centers

(a) Reportable communicable diseases shall be reported to the local health officer and all unusual occurrences shall be reported to the Department by the licensed correctional treatment center within twenty four (24) hours, either by telephone with written confirmation or by telephone facsimile (FAX).

(b) The reporting of communicable diseases and outbreaks shall be in conformance with Sections 2500, 2502, 2503 and 2504 of Title 17, California Code of Regulations.

(c) Omitted – see definitions of adverse/sentinel events per Health and Safety Code in previous section.

(d) The licensed correctional treatment center shall furnish other pertinent information related to such occurrences as the local health officer or the Department shall require.

(e) All reports required in this Section shall be retained on file by the licensed correctional treatment center for three (3) years.

(f) Every fire or explosion that occurs in or on the premises shall be additionally reported immediately to the local fire authority, or in the areas not having an organized fire service, to the State Fire Marshal.

(g) The local health officer of the county to which an inmate patient is to be released shall be notified at least one day in advance before an inmate patient on any tuberculosis medication is released from the correctional facility.

Definition of Sentinel Event – The Joint Commission

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

An event is also considered sentinel if it is one of the following:

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- ~~Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)~~
- ~~Unanticipated death of a full-term infant n Discharge of an infant to the wrong family~~
- ~~Abduction of any patient receiving care, treatment, and services~~
- ~~Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or~~
- ~~severe temporary harm to the patient~~
- ~~Hemolytic transfusion reaction involving administration of blood or blood products~~
  ~~having major blood group incompatibilities (ABO, Rh, other blood groups)~~
- ~~Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the~~
  ~~hospital†~~
- ~~Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital~~
- ~~Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure‡~~
- ~~Unintended retention of a foreign object in a patient after an invasive procedure, including surgery~~
- ~~Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)~~
- ~~Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong region or >25% above the planned dose.~~

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~~Attachment C~~

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Kaweah Delta HEALTH CARE DISTRICT

FOCUSED REVIEW

Patient Name:

Date of Admission:

Acct #:

Safety Event ID#: Event Date:

Brief Description of Event:

A. Intended Process Flow

- What is the intended process flow according to policy & procedure, protocol, guideline?
- Were there any steps in the process that did not occur as intended? Yes ☐ No ☐

B. Communication

- To what degree was the communication among participants adequate for this situation?
- What communication barriers exist?

Please explain:

C. Human Factors

- Did any of the following human factors contribute to the event: Boredom, failure to follow P&P, fatigue, inability to focus on task, inattentional blindness, personal problems, lack of complex critical thinking skills, rushing to complete task, trust.

Please explain:

D. People

- Did staffing factor into the event? Yes ☐ No ☐
- Was staff properly qualified and competent? Yes ☐ No ☐
- How can orientation/training be revised to reduce the risk of such events?

Please explain:

E. Equipment & Environment

- Was this the appropriate physical environment for the processes being carried out? Were there any equipment failures? Unknown ☐
- Was available technology used as intended? Yes ☐ No ☐
- What systems are in place to identify this environmental risk? N/A

If no, please explain
F. Action Plan:
G. Measures of Success:

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Attachment D

REPORTING REQUIREMENTS RELATED TO RESTRAINT OR SECLUSION

~~There are several state and federal reporting requirements potentially implicated when an adverse event occurs to a patient who is, or has been, in restraints or seclusion. These reporting requirements are described below. One incident can easily lead to multiple reports being required. The reporting requirements related to the Safe Medical Devices Act, adverse event reporting, and unusual occurrences should be reviewed and all necessary reports should be made in the event of an adverse event involving restraint or seclusion.~~

CMS Death Reporting and Recording Requirements

REPORTING REQUIREMENTS

Hospitals must report the following deaths associated with the use of seclusion or restraint to the Centers for Medicare & Medicaid Services (CMS) Regional Office no later than the close of business on the next business day following knowledge of the patient's death. The following events must be reported:

1. Each death that occurs while a patient is in restraint or seclusion, except for deaths subject to the "Documentation Requirement~~,~~", ~~page 19.16.~~
2. Each death that occurs within 24 hours after the patient was removed from restraint or seclusion (whether or not the hospital believes that the use of restraint or seclusion contributed to the patient's death), except for deaths subject to the "Documentation Requirement~~,~~" ~~page 19.16.~~
3. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

This requirement applies to deaths that occur in any unit of the hospital, including an ICU or critical care unit. ~~However, critical access hospitals are required to report to CMS only if they have a psychiatric or rehabilitative distinct part unit. (Critical access hospitals may be required to report an adverse event related to restraints or seclusion under another reporting requirement described in this chapter.)~~

DOCUMENTATION REQUIREMENT

When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff does not need to notify CMS of a patient death by the next business day.

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The date and time of the report to CMS must be documented in the patient's medical record.

~~[42 C.F.R. Section 482.13(g)]~~

~~**B. Electronic Reporting Form**~~

Hospitals must report to the CMS Regional Office electronically using Form CMS-10455, "Report of a Hospital Death Associated with the Use of Restraint or Seclusion." ~~Reporting by email, fax or phone is not acceptable. To start the electronic reporting process, go to https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjlw2WAzto8J.~~

~~The hospital submits the form electronically when all information has been entered. It will automatically be sent to the appropriate Regional Office. A confirmation page containing the date and time the form was submitted will display on the hospital's computer screen. A copy of the submitted form can be downloaded, saved, or printed.~~

~~Hospitals with questions about the reporting requirement may send an email to QSOG_Hospital@cms.hhs.gov. A CMS memo on the reporting process and a link to an instructional video may be found at www.cms.gov/files/ document/qso-20-04-hospital-cah-dpu-revised.pdf.~~

~~*DOCUMENTATION REQUIREMENT*~~

~~When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff does not need to notify CMS of a patient death by the next business day. Instead, hospital staff must record the following information in an internal log or other system:~~

- ~~The patient's name,~~
- ~~The patient's date of birth,~~
- ~~The patient's date of death,~~
- ~~The name of attending physician or other LIP who is responsible for the care of the patient,~~
- ~~The patient's medical records number, and~~
- ~~The patient's primary diagnosis(es).~~

~~Each entry must be made not later than seven days after the date of death. An entry must be made for:~~

- ~~Any death that occurs while a patient is in restraints as described above.~~
- ~~Any death that occurs within 24 hours after a patient has been removed from restraints as described above.~~

~~The log or other system must be made available in either written or electronic form to CMS immediately upon request.~~

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The date and time of the log entry must be documented in the patient's medical record.

C. CMS Response

CMS will use the information reported by the hospital to:

- Authorize an onsite investigation (complaint survey) of the hospital by CDPH, which is the state survey agency for CMS, and
- Inform the federally-mandated protection and advocacy entity, which in California is Disability Rights California (DRC). DRC's role and responsibilities are described in VII. "Mental Health Advocacy Programs," page 16.10.

FDA Restraint Reportings

FDA regulates restraint devices as it regulates other medical devices. Thus, hospitals and other device user facilities must report incidents involving restraints that have or may have caused or contributed to the serious injury or death of a patient.

For purposes of this reporting law, it should be noted that the FDA uses a different definition of restraint than does the Centers for Medicare & Medicaid Services Conditions of Participation or California law. The FDA defines a "protective restraint" as:

> a device, including but not limited to a wristlet, anklet, vest, mitt, straight jacket, body/limb holder, or other type of strap, that is intended for medical purposes and that limits the patient's movements to the extent necessary for treatment, examination, or protection of the patient or others [21 C.F.R. Section 880.6760].

Whereas the CMS definition of restraint could include a geri-chair, a tray table, a side rail, a sheet, or even a staff member holding a patient, the FDA definition does not. Therefore, this reporting requirement is somewhat more narrow than the CMS reporting requirement for deaths associated with seclusion or restraints discussed under XII. "Reporting Requirements Related to Restraint or Seclusion," page 19.16.

Required Policies and Procedures

Hospitals must develop and implement written policies and procedures that provide for the following:

- Timely and effective identification, communication and evaluation of events that may be subject to medical device reporting requirements;
- A standardized review process/procedure for determining when an event meets the criteria for reporting to the FDA; and
- Timely transmission of complete medical device reports to the FDA and/or the device manufacturer.

The policies and procedures must also include documentation and record keeping requirements as described under "Required Documentation," below, including information that was evaluated to determine if an event was reportable [21 C.F.R. Section 803.17].

REQUIRED DOCUMENTATION

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Facilities must establish and maintain medical device reporting (MDR) event files. MDR event files must be prominently identified as such and filed to facilitate timely access. The files may be written or electronic, and may incorporate references to other information, such as medical records or engineering reports, in lieu of copying and maintaining duplicates in this file. MDR event files must include the following:

- Information related to adverse events, including all documentation of the hospital's deliberations and decision-making processes used to determine if a device-related death, serious injury or malfunction was or was not reportable under this part; and
- Copies of all Safe Medical Devices Act forms and other information related to the event that was submitted to the FDA or manufacturer.

MDR event files must be retained for two years following an adverse event. Hospitals must permit FDA employees to access, copy and verify the records noted above [21 C.F.R. Sections 803.13, 803.17 and 803.18].

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F. Request From FDA For Additional Information

The FDA may determine that protection of the public health requires additional or clarifying information for the medical device reports submitted to the FDA under this law. In these instances, and in cases when the additional information is beyond the scope of FDA reporting forms or is not readily accessible, the agency will notify the reporting entity in writing of the additional information that is required.

Any request from the FDA must state the reason or purpose for which the information is being requested, specify the due date for submitting the information and clearly identify the reported event. All verbal requests will be confirmed in writing by the FDA. [21 C.F.R. Section 803.15]

G. Device Tracking

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Device manufacturers and distributors are required to develop formal schemes for tracking specified ("tracked") medical devices [21 U.S.C. Section 360i(e)]. Hospitals, licensed practitioners, retail pharmacists and other types of device user facilities are considered "final distributors" [21 C.F.R. Section 821.3].
Under the regulations, a final distributor must provide the manufacturer with specified information at the time that it purchases a tracked device [21 C.F.R. Section 821.30(a)] and at the time that a tracked device is implanted in or provided to a patient [21 C.F.R. Section 821.30(b)].

At the time that the device is implanted in or provided to the patient, the hospital must provide to the device manufacturer the following information:

- The name and address of the final distributor (i.e., the hospital itself).
- The unique device identifier (UDI), lot number, batch number, model number or serial number of the device, or other identifier used by the manufacturer to track the device.
- The name, address, telephone number and Social Security number (if available) of the patient receiving the device unless not released by the patient *(see "Patient Confidentiality Rights," page 19.14)*.
- The date the device was provided to the patient or for use in the patient.

- The name, mailing address and telephone number of the prescribing physician.
- The name, mailing address and telephone number of the physician regularly following the patient if different from the prescribing physician.
- When applicable, the date the device was explanted, and the name, mailing address and telephone number of the explanting physician, the date of the patient's death, or the date the device was returned to the manufacturer, permanently retired from use or otherwise permanently disposed of.

[21 C.F.R. Section 821.30(b)]

PATIENT CONFIDENTIALITY RIGHTS

A patient receiving a device subject to tracking may refuse to release, or refuse permission to release, his or her name, address, telephone number and Social Security number, or other identifying information for the purpose of tracking [21 CFR Section 821.55]. FDA guidance states that hospitals must document the refusal and the forwarding of such documentation back to the device manufacturer.

DEVICE TRACKING RECORDS

Hospitals must permit FDA employees to access, copy and verify device tracking records, as well as all other records and information related to the events and persons identified in such records [21 C.F.R. Section 821.50]. In addition, hospitals must make any records required to be kept by the device tracking law available to the manufacturer of the tracked device for audit upon written request by an authorized representative of the manufacturer [21 C.F.R. Section 821.30(d)].

Device tracking records must be maintained for the useful life of the tracked device. The useful life of a device is the time a device is in use or in distribution for use. A record may be retired if the person maintaining the record becomes aware that the device is no longer in use, has been explanted, returned to the manufacturer or the patient has died. [21 C.F.R. Section 821.60]

Records required to be kept by the device tracking law must be kept in a centralized point [21 C.F.R. Section 821.50].

Attachment E

List of National Quality Forum Serious Reportable Events (aka SRE or "Never Events")

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

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Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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Attachment F: REPORTING REQUIREMENTS UNDER STATE LAW

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California Health and Safety Code – Pertaining to General Acute Care Hospitals

1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

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Kaweah Delta Health Care District

Administrative Manual

Policy Number: AP180	**Date Created: 12/01/2009**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Weapons Brought Into The District	

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

PURPOSE:

Kaweah Delta is committed to the safety and wellbeing of our employees, physician staff, volunteers, patients, and visitors.

DEFINITION:

A weapon is defined as any firearm, knife, chemical spray or device that can cause bodily harm or injury.

Examples of weapons include, but are not limited to:

- Firearms
- Edged weapons (Swords, Knives)
- Generally pocket knives and multi-tools are not considered weapons; however, extreme caution should be taken in their presence. Any edged weapon with a blade length of over 3 inches will be considered a weapon and will be stored in the safe.
- Striking implements (Batons, Clubs)
- Missile throwing objects (slingshots, bow/arrows)
- Explosives
- Incendiary devices
- Any other object deemed to be inherently dangerous to ~~Sentara~~ patients, staff, visitors, contractors, or vendors.

POLICY:

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I. Weapons are ~~never~~ not permitted on Kaweah Delta ~~Health Care District property~~properties.

II. Weapons that are discovered after arrival should be returned to the owner's vehicle or turned in to Security for safekeeping.

EMPLOYEE EXCEPTION:

Understanding that our employee workforce is our greatest resource and that we have a shared value to keep our employees safe, Kaweah Delta will permit employees to carry mace/pepper spray and stun gun/taser electroshock self-defense devices tools when coming to and leaving work.

Employees who choose to carry approved personal self-defense tools while coming to and going from work may bring such items on-site. However, it is a violation of company policy, to openly display, carry or inappropriately refer to possession in a threatening or disruptive manner while performing work responsibilities or interacting with co-workers or customers.

STORAGE:
Employees are responsible for ensuring that self-defense tools are stored properly where patients and the public cannot access the property. (concerned that units do not have the secured storage capacity for self-defense tools)

Department employees and support staff assigned to work in the Emergency Department and the Mental Health Hospital are not permitted to enter the patient care areas/units with these self-defense tools. Property must be secured before stepping onto the patient care area.

DISCLAIMER:
Employees are liable for the cost of property damage, cleanup, or injuries resulting from an accidental discharge, negligent or willful use while on duty.

AEROSOL WARNING:
Pepper spray is a chemical compound that irritates the eyes to cause tears, pain and temporary blindness (inflammatory effects cause eye to close). An accidental discharge of pepper spray inside our facilities can travel through the HVAC (heating, ventilation and air conditioning) system and contaminate the environment.

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

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Commented [MM1]: Can we be more prescriptive on this? Do they have to be stored in a locked draw/cabinet, for example?
Commented [LM2]: Suggest change the word "floors" when referring to location – "patient care area" or "patient care unit"
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April 26, 2021

Sent via Certified Mail
No. 70121010000301264789
Return Receipt Required

Ken M. Fitzgerald
4236 W. Mineral King Ave.
Visalia, CA 93291

RE: Notice of Rejection of Claim of Dan Lovell, Matthew Lovell, Jennifer Lovell, Janna Martinez vs. Kaweah Delta Health Care District

Notice is hereby given that the claim, which you presented to the Board of Directors of the Kaweah Delta Health Care District on April 2, 2021, was rejected on its merits by the Board of Directors on April 26, 2021

WARNING

Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6. You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Garth Gipson
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

Appendix D

Policy Submission Summary

Manual Name: Medical Staff			**Date: 4/9/21**
Support Staff Name:			
Routed to:			**Approved By: (Name/Committee – Date)**
☐ **Department Director** ☐ **Medical Director** *(if applicable)* ☐ **Medical Staff Department** *(if applicable)* ☐ **Patient Care Policy** *(if applicable)* ☐ **Pharmacy & Therapeutics** *(if applicable)* ☐ **Interdisciplinary Practice Council** *(if applicable)* ☐ **Credentials Committee** *(if applicable)* ☐ **Executive Team** *(if applicable)* ☒ **Medical Executive Committee** *(if applicable)* ☒ **Board of Directors**			
Policy/Procedure Title	**#**	**Status** (New, Revised, Reviewed, Deleted)	**Name and Phone # of person who wrote the new policy or revised an existing policy**
Code of Conduct for Medical Staff & Advanced Practice Providers	MS 47	Revised	Teresa Boyce x2365
Impaired Practitioner Policy	MS 40	Revised	Teresa Boyce x2365
Practitioner Health Policy	MS 49	Reviewed	

Policy Number: MS 47	Date Created: 03/26/2021
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Code of Conduct For Medical Staff & Advanced Practice Providers

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

Purpose:

The purpose of this policy is to encourage behavior that promotes a culture of safety, quality and respect.

A high standard of professional behavior, ethics and integrity are expected of individual Medical Staff and Advanced Practice Staff (collectively, Practitioners) at Kaweah Delta Health Care District (KDHCD). The Code of Conduct is a statement of the ideals and guidelines for professional behavior of Practitioners in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, and others they may encounter.

Policy:

Practitioners have a responsibility for the welfare of their patients, along with a responsibility to maintain their own professional and personal well-being. Each Practitioner is expected to treat all fellow colleagues, hospital staff, students, patients and others with courtesy and respect.

When a practitioner is found to have fallen short of these expectations, the Medical Staff supports tiered, non-confrontational intervention strategies focused on restoring trust, placing accountability on, and rehabilitating the offending Practitioner. However, the safeguarding of patient care and safety is paramount, and the Medical Staff will enforce this policy with disciplinary measures whenever necessary.

I. DEFINITIONS

A. “Appropriate behavior” includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under the bylaws.

B. “Inappropriate behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated

inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as disruptive behavior.

C. "Disruptive behavior" means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

D. "Harassment" means conduct toward others based on but not limited to their race, religious creed, color, national origin, physical or mental disability, marital status, sex, age, sexual orientation, or veteran status; which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

E. "Sexual harassment" means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidating or otherwise hostile work environment.

F. "Practitioner" means physicians or advanced practice providers that have been granted membership and/or privileges at Kaweah Delta by the Board of Directors.

II. TYPES OF CONDUCT

A. "Ethical behavior" includes behavior that demonstrates adherence to Medical Staff Bylaws, Rules and Regulations, Policies, KDHCD's behavior standards and State and Federal laws.

B. "Unethical Behavior" includes behavior that is unprofessional and or illegal.

~~A.~~C. Appropriate Behavior.

Examples of appropriate behavior include, but are not limited to the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient's care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approaches to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner;
- Professional comments to any professional, managerial, supervisory, or administrative staff of members of the board of Directors about patient care or safety provided by others;
- Active participation in medical staff and hospital meetings.

~~B.~~D. Inappropriate Behavior

Inappropriate behavior by Practitioners is prohibited. Examples of inappropriate behavior include, but are not limited to the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Lack of cooperation without good cause;
- Refusal to return phone calls, pages, or other messages concerning patient care;
- Condescending language; and degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

~~C.~~E. Disruptive Behavior

Disruptive behavior by Practitioners is prohibited. Examples of disruptive behavior include, but are not limited to the following:

- Physically threatening language directed an anyone in the hospital including physicians, nurses, other Practitioners or any hospital employee, administrator, or member of the Board of Directors, patients, their families, and visitors;
- Physical contact with another individual that is threatening, unwelcome, or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution or retaliation;
- Sexual harassment;
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation;
- Behavior that disrupts patient care, hospital operations, and/or meetings of the Medical Staff, Medical Staff Committees, or hospital.

F. Unethical Behavior

Examples of unethical behavior include, but are not limited to the following:

- Fraudulent Billing Practices
- Theft or destruction of hospital property, including diversion of drugs or supplies
- Violation of patient privacy laws; and
- Knowingly providing false information

III. PROCEDURE

A. Delegation by Chief of Staff

At the discretion of the Chief of Staff (or Vice Chief if the Chief of Staff is the subject of the complaint), the duties here assigned to the Chief of Staff can be delegated to a designee. Designees may be the Chief Medical Officer, other Medical Staff Officers, or Department Chairs/Vice Chairs.

B. Initiation of Complaints

Complaints about a Practitioner regarding allegedly inappropriate or disruptive behavior are encouraged to be entered into the event reporting system or conveyed to the Peer Review Coordinator (PRC). Information should include the following:

1. Date, time and location of the behavior;
2. A factual description of the behavior;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or other persons who were involved in or witnessed the incident;
5. The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care of safety, hospital personnel or operations; and
6. Any action taken to intervene in or remedy the incident, including names of those intervening.

The complainant will be provided a written acknowledgement of receipt of the complaint.

C. Processing Behavioral Event Reports

The process whereby the event report is processed is as follows (see attached flow chart):

1. Incident report is submitted through MIDAS or directly to the PRC. Midas reports involving physicians are immediately routed to the Medical Staff PRC. (VP of HR is also notified on all Hostile Work Environment or Harassment incidents. If the incident ~~is an~~involves alleged abuse, or an illegal activity ~~abuse allegation,~~ Risk Management is also informed.).
2. The PRC does an initial screening and reports result of inquiry to Chief of Staff.
3. Minor incidents are tracked and trended, with follow up/educational call or email to physician, at the discretion of the Chief of Staff.
4. Significant incidents are sent to PRC for detailed Case Review. Results are reported to the Chief of Staff (COS).. The following action may be taken as determined by the Chief of Staff:
    a. Prompt Collegial Intervention by COS, or Designee;
    b. Forward to Department Chair for Collegial Intervention;
    c. Forward to Behavior Committee (which consists of COS, VCOS, PCOS, Secretary Treasurer)
        i. Letter will be sent to practitioner containing a synopsis of the event, asking for practitioner's view of the event with a response expected within 30 days

ii. Incident and response letter discussed at subsequent Behavior Committee
iii. Action may include:
1. Dismiss as unfounded or if unable to authenticate;
2. Track and Trend;
3. 1:1 conversation with practitioner and COS or other officer;
4. Request for additional information;
5. Educational letter to physician.
iv. Three (3) incidents in a rolling 12 months require action
1. Behavior Committee meets with and advises practitioner that recurring behavior must cease or corrective action will be initiated. This "final warning" shall be sent to the offending Practitioner in writing.
2. FPPE Developed by Department Chair

d. Track and Trend
e. Forward to MEC for further action per bylaws; Options include, but are not limited to:
i. Referral to Well Being Committee
ii. Professional Conduct Agreement
iii. Requirement to attend continuing education course or program at practitioner's expense
iv. Initiate formal investigation

Reports alleging a Practitioner has engaged in illegal activity will be immediately subjected to an inquiry by the Chief of Staff or designee and forwarded to the Medical Executive Committee for review.

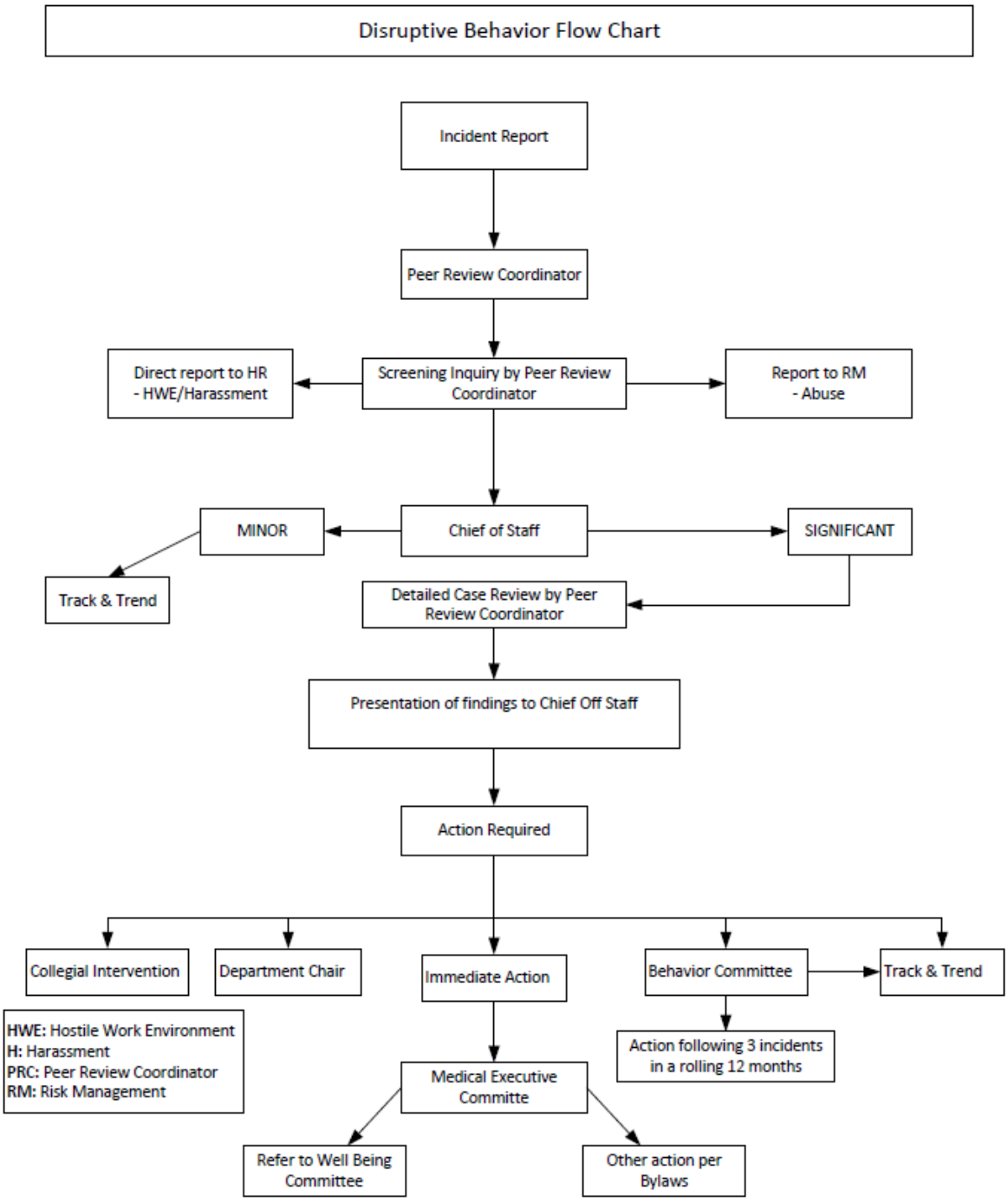
Formal corrective action, such as a summary suspension of clinical privilege, may be warranted if ~~a single~~one or more ~~-~~incidents of disruptive behavior ~~or repeated incidents of disruptive behavior constitute an~~presents a risk of imminent danger to the health or safety of any individual~~ or individuals, the offending practitioner may be summarily suspended, per the Medical Staff Bylaws. The medical staff member shall have all of the due process~~. In the event of corrective action, the Practitioner is entitled to the procedural rights set forth in the ~~medical~~ Medical ~~staff~~ Staff ~~bylaws~~Bylaws.

D. In the event of inconsistencies between this policy and the Medical Staff Bylaws, the Medical Staff Bylaws will prevail.

References:
Kaweah Delta Medical Staff Bylaws

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new

techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."


Disruptive Behavior Flow Chart
Incident Report
Peer Review Coordinator
Direct report to HR - HWE/Harassment
Screening Inquiry by Peer Review Coordinator
Report to RM - Abuse
MINOR
Chief of Staff
SIGNIFICANT
Track & Trend
Detailed Case Review by Peer Review Coordinator
Presentation of findings to Chief Off Staff
Action Required
Collegial Intervention
Department Chair
Immediate Action
Behavior Committee
Track & Trend
HWE: Hostile Work Environment
H: Harassment
PRC: Peer Review Coordinator
RM: Risk Management
Action following 3 incidents in a rolling 12 months
Medical Executive Committe
Refer to Well Being Committee
Other action per Bylaws

Policy Number: MS 40	**Date Created: 03/26/2021**
Document Owner: April McKee (Medical Staff Svcs Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration); Medical Executive Committee; Boyce, Teresa; McKee, April; Moccio, Cindy	

Impaired Practitioner Policy

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

I. **Purpose:** Substance abuse can adversely impact patient care and workplace safety. Use and abuse of alcohol or controlled substances may impair the ability of a medical staff member and advanced practice provider (collectively, Practitioner) to provide services and may endanger the individual, his or her co-workers, patients and the public. This policy is developed to provide for patient safety and to help eliminate the problem of workplace substance abuse.

II. **Policy:** It is the medical staff's policy to continuously strive toward preventing Practitioners from providing patient care services while impaired and toward maintaining a work environment free from illegal drug use and abuse of other substances. It is also the medical staff's policy that the integrity, well being, confidentiality, and professional activity and personal privacy of the Practitioner under review be protected to the extent permitted by law.

III. **Applicability of Policy:** This policy applies to all Practitioners holding membership or privileges at Kaweah Delta Health Care District (KDHCD).

IV. **Definitions:**

A. Controlled substance – Any and all chemical substances or drugs listed in any controlled substances acts or regulations applicable under any federal, state or local laws. Where these laws are conflicting (e.g. medical marijuana) legal counsel will render an opinion regarding the legality of use of such substances by practitioners.

B. Illegal drug – Any controlled substance the possession of which is illegal under any federal, state or local laws. Where these laws are conflicting (e.g.: medical marijuana) legal counsel will determine the legality of such substances.

C. Drug or alcohol test – Any test administered to determine the presence or absence of a chemical or drug in a person's urine or blood. Testing should be done by a reputable laboratory with a definitive testing modality and NOT a screening test, which may be unreliable. When warranted by the circumstances, a Practitioner may be required to submit hair or nail samples for drug or alcohol testing.

D. Under the influence – A condition that impairs or may impair a Practitioner's ability to provide medical services in a safe and productive manner and/or may adversely affect his or her safety or that of patients or other Practitioners. This must be shown to be reasonably present at the time of occurrence.

E. Screening Physical Exam – An immediate thorough exam that includes, as appropriate, bedside point-of-care (POC) testing [blood glucose, ethanol breathalyzer, EKG, etc] mini-mental status exam, neurological exam, GCS, and/or toxidrome evaluations.

F. Chief of Staff Designee or Designee – Any Officer of the Medical Staff: Vice Chief of Staff, Past Chief of Staff or Secretary/Treasurer; The Chief Medical Officer may be asked on a case by case basis to act as a Chief of Staff Designee in the absence of all Officers of the Medical Staff.

V. Prohibited Actions:

The following are prohibited while engaging in activities related to patient care at any KDHCD facilities:

1. Possessing, consuming, or being under the influence of alcohol or illegal drugs.

2. Exhibiting physical or mental impairment likely to adversely affect patient care or workplace safety.

3. Distribution, sale, or purchase of controlled substances or illegal drugs while on KDHCD property, even if the illegal drug itself is not actually possessed on KDHCD premises.

4. Use or being under the influence of other substances that cause an altered psycho physiological state, where there is any possibility such use may impair the Practitioner's ability to safely provide medical services to patients or may adversely affect their safety or patient safety and care or the safety of other individuals.

5. Diversion or ~~theft of an~~stealing any medications, including controlled substances, from KDHCD.

Procedure:

I. REPORTING OF SUSPECTED IMPAIRMENT

Evidence of possible impairment includes altered mental state, slurred speech, impaired balance, smell of alcohol, unsteady gait, lack of focus, shaking hands, vision impairment, problems communicating, observed possession use, or diversion of alcohol, controlled substances or illegal drugs, or failure to comply with protocols for documenting use of controlled substances or other drugs.

Whenever a hospital staff member observes evidence of possible impairment by a Practitioner while on hospital premises, the staff member must immediately inform his or her supervisor who shall inform the CEO or Designee. The CEO or Designee shall immediately inform the Chief of Staff /Designee.

Whenever a Practitioner observes evidence of possible impairment of another Practitioner, he or she must immediately inform the Chief of Staff or Designee.

Whenever the Chief of Staff or Designee receives a report of possible impairment, he or she must promptly conduct or supervise the administration of a Screening Physical Exam of the Practitioner. The purpose of the preliminary evaluation is to determine whether drug or alcohol testing is warranted.

If any follow up inquiry or investigation by the Medical Staff or Hospital administration identifies facts suggesting or establishing that a Practitioner has violated this policy, that information must be reported to the Medical Executive Committee for consideration of initiating a formal investigation and/or imposing disciplinary action, if warranted.

The Medical Staff will consider whether any mandatory reports to applicable licensing boards under Budiness and Professions Code sections 805 and 805.1 are triggered by any events and follow-up inquiries conducted under this policy. If mandatory reports are not required, the Chief of Staff and/or Medical Executive Committee may consider whether to submit a voluntary report to the applicable licensing board about the possible or confirmed impairment of a Practitioner.

II. SUBSTANCE ABUSE TESTING FOR REASONABLE CAUSE

A. Situations When Drug or Alcohol Testing is Required. A Practitioner is required to submit to drug or alcohol testing under any of the following circumstances:

1. When there is a reasonable suspicion that the Practitioner is under the influence of alcohol, controlled substance or illegal drugs while engaging in activities related to patient care at a KDHCD facilities. "Reasonable suspicion" includes but is not limited to incidents in which the Practitioner:

   a. Is observed using alcohol, controlled ~~substances,or~~substances, or illegal drugs while engaging in activities related to patient care at a KDHCD facilities;

   b. Is in an apparent state of physical impairment as determined by an immediate Screening Exam.

   c. Is in an impaired mental state, as determined by the immediate Screening Physical Exam.

   d. Exhibits marked changes in behavior that are not otherwise explainable, as determined by an immediate Screening Physical Exam.

   e. Is involved in one or more incidents raising serious concerns about his or her work performance or delivery of patient care that is not explained by the immediate Screening Physical Exam.

   f. Any suspected or actual violation of this policy. Examples include MIDAS event reports; concerns from colleagues or staff regarding usage or diversion; medication and/or narcotic documentation discrepancy trends.

2. When a Practitioner is suspected to be in possession of alcohol, a controlled substance or an illegal drug in violation of this policy, or when alcoholic beverages, controlled substances or illegal drugs are found on KDHCD premises under the control of Practitioner (e.g., locker or desk);

3. When a Practitioner has suspicious patterns or discrepancies in any medication and/or narcotic ~~administration report~~documentation;

4. As required by Well-Being Committee contract.

B. If testing for reasonable cause is indicated:

1. Both the person reporting the event and Chief of Staff/Designee will complete an Occurrence Report.

2. If deemed warranted by the Screening Physical Exam, the Chief of Staff or Designee will escort the Practitioner to the Medical Staff conference room to submit to a POC test. In this situation, the Practitioner must submit to the POC test within two (2) hours.

3. The Chief of Staff or Designee will obtain from the Practitioner the Consent for Drug and/or Alcohol Testing (Attachment A), including an authorization for release of medical information. Refusal to submit to drug or alcohol testing or to execute the Consent form will be cause for summary suspension of clinical privileges.

4. The Chief of Staff or Designee shall ask the Practitioner if he or she is taking any medication prescribed or recommended by a health care professional and will note on the Consent form any prescribed medication so specified. If the test reveals the presence of a medication prescribed for the Practitioner, he or she will not be subject to discipline unless the levels of

the medication show abuse. Even if the Practitioner is not abusing a prescribed medication, the medication may make the individual unfit to attend to patients as determined by the Screening Physical Exam. If so, the Practitioner will not be disciplined, but may be required to refrain from attending to patients while under the influence of the medication.

5. The Chief of Staff or Designee will contact the KDHCD house supervisor to obtain the phone number for Mineral King Lab mobile services, after which he or she will contact the service to come to a location designated by the Chief of Staff or Designee, where a urine or blood sample will be obtained to test for the suspected substance following the chain of custody for specimens. The Chief of Staff or Designee will directly observe the collection of all samples.

6. A confidential number, as assigned by the Medical Staff Services Director/designee, will be used for all samples and for reporting the results.

7. The Practitioner submitting the specimen will validate the chain of custody process through signature on the chain of custody form (Attachment B) and initials on the sealed specimen.

8. The same specimen will then be transported by Adventist Health phlebotomist to the Adventist Health Toxicology in Tulare, CA for testing, with the chain of custody being followed.

9. The Medical Staff Services Director shall maintain the confidential documentation of the incident for the Chief of Staff or Designee and CEO or Designee to review.

10. The original test results and the Reasonable Cause for testing form(s) will be forwarded to the Medical Staff Services Director for review by the Chief of Staff or Designee and the Well-Being Committee.

E. If the POC testing for substance use and/or the Screening Physical Exam indicate impairment at the time of providing care to patients, the Practitioner's privileges will be summarily suspended pursuant to the Medical Staff Bylaws, pending the test results from Adventist Health Toxicology. The responsibility for care of the Practitioner's hospitalized patients will be assigned to another Practitioner with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a covering Practitioner.

F. Arrangements for safe transportation home will be made for the Practitioner.

G. If the test results are negative, the Practitioner will be advised through the Well-Being Committee of the need for further evaluation of other medical or mental health issues.

H. A positive alcohol and/or drug test result indicating abuse of a prescribed medication may result in the continuation of a summary suspension. The Medical Executive Committee will meet to consider continuing the summary suspension within the timelines specified in the Medical Staff bylaws.

The Practitioner will be referred to the Well-Being Committee.

ATTACHMENT A

CONSENT TO DRUG AND/OR ALCOHOL TESTING AND

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I voluntarily agree to submit to a comprehensive drug and alcohol testing and analysis to be administered by an outside, independent laboratory.

I understand that the testing is voluntary on my part, that I may refuse to submit to testing , and that such refusal may be grounds for disciplinary action, including summary suspension of my clinical priileges.

I hereby authorize the testing facility to disclose the results of the evaluation and tests, including and related analyses and/or reports of testing to the KDHCD Chief of Staff via the Medical Staff Services Director for use in connection with the consideration of whether I am fit to practice and my continued qualification for Medical Staff membership and clinical privileges by the Chief of Staff and Medical Executive Committee. I authorize the Chief of Staff to release this information to the Medical Executive Committee and ny Ad Hoc Committee that may be formed in connection with this pupose. I also authorize the Chief of Staff to release this information to the Chair of KDHC Medical Staff Well-Being Committee…

I understand that the information obtained will be maintained confidentially and will not be released to anyone else or used for any other purpose unless required by law, governmental agencies, or subpoena.

My consent and authorization shall expire oneyears from the date of this consent and authorization.

I have signed this consent and authorization voluntarily, and I understand that I have a right to receive a copy upon my request.

_____ _____

Signature Date

_____

Printed Name

ATTACHMENT B

LABORATORY
LEGAL CHAIN OF CUSTODY FORM

Identification Band Verified: YES☐ NO☐
Specimen Type: ☐ Urine Blood☐ Both☐
Test Requested: Urine Drug Screen☐ ☐ Blood Alcohol Other: Specify☐☐

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Place a tamper proof evidence seal over the lid and down the sides of the specimen container.

Date and sign. Do all of the above in front of the practitioner.

Name:_____ Date Collected:_____

Time Collected: _____

Collection Witnessed By:_____

Policy Submission Summary

Manual Name: Patient Care Manual	**Date: 3/16/21**
Support Staff Name: Kathie Allred	
☐ **Department Director**	**N/A**
☐ **Medical Director** *(if applicable)*	
☐ **Medical Staff Department** *(if applicable)*	
☒ **Patient Care Policy** *(if applicable)*	**03/16/21**
☒ **Pharmacy & Therapeutics** *(if applicable)*	
☐ **Interdisciplinary Practice** *(if applicable)*	**If appropriate**
☐ **Executive Team** *(if applicable)*	**N/A**
☒ **Medical Executive Committee** *(if applicable)*	

Policy/Procedure Title	**#**	**Status** (New, Revised, Reviewed w/no Revision, Deleted)	**Name and Phone # of person who wrote the new policy or revised an existing policy**
IV Therapy: Care of Implanted Port	PC-SP.117	Revised	Emma Mozier x2825
COVID-19 Vaccine Administration	PC-SP.124	Revised	Gabby Robles x2749 Emma Mozier x20825
Previous Title: Chemotherapy: Hypersensitivity Infusion Reaction **New Title:** Chemotherapy: Hypersensitivity Infusion Reaction	PC-SP.118	Revised	Emma Mozier x2825 Brittany Roper x5290
Glucommander Intravenous and Subcutaneous Glycemic Management - Adult	PC.256	Revised	Mary Laufer x5224
Previous Title: Code Blue/White **New Title:** Code Blue	PC.189	Revised	Kassie Waters x2466 Jeanette Callison
Death: Pronouncement of Death by RN	PC.99	Revised	Mary Laufer x5224
IV Therapy: Adult Parenteral Nutrition	PC.01	Revised	Kari Knudsen x2196
C. difficile Testing Criteria	PC.255	Revised	Shawn Elkin, x2174

Standardized Procedure Number: PC-SP.117	Date Created: No Date Set Date Approved: Not Approved Yet
Approvers: Interdisciplinary Practice Committee; Medical Executive Committee; Patient Care Policy Approval Committee; Pharmacy and Therapeutics; Standardized Procedures Approval Committee	
IV Therapy: Care of Implanted Port	

I. PROCEDURE

A. FUNCTION:

Port flushing with normal saline and heparin locking are used to maintain patency and ~~T~~to decrease/prevent the incidence of Persistent Withdrawal Occlusion (PWO) and thrombus formation. Cathflo Activase is used to restore function of a partially occluded or occluded central venous access device.

B. CIRCUMSTANCES UNDER WHICH RN MAY PERFORM FUNCTION

1. SETTING:

Registered nurses (RNs) may perform for inpatients at ~~-~~ Kaweah Delta Health Care District (KDHCD) including Skilled Nursing, Subacute and Acute Rehabilitation.~~-~~ RNs in outpatient areas include: outpatient imaging, ~~Transitional Care Services (TCS), Rehabilitation, Sub Acute,~~ SRCC Radiation Oncology, and the Emergency Department.

2. SUPERVISION:

Performed under the direction of a Licensed Independent Practitioner (LIP) ~~Provider~~ with Medical Staff Privileges at KDHCD

3. PATIENT CONDITIONS:

Adult patient with an implanted port ~~that is saline locked~~

4. OTHER:

EXCLUSION CRITERIA:

Patients with the following are to be excluded from the use of heparin:

- Less than 18 years of age
- Allergy to heparin and heparin derivatives

- Allergy to porcine (pork) containing products
- History of Heparin Induced Thrombocytopenia (HIT)
- A port with continuous solution infusing through it does not require a heparin flush. ~~Continuous intravenous infusion through the implanted port~~

Patients with the following are to be excluded from the use of Cathflo Activase:

- Less than 18 years of age
- Allergy to Alteplase

II. PROTOCOL

A. DEFINITIONS:

- **Adult:** 18 years of age or older
- **Implanted Port:** ~~central~~ Central vascular access device that is implanted subcutaneously.
- **Persistent Withdrawal Occlusion (PWO):** ~~fluids~~ Fluids can be flushed or infused without resistance, but blood cannot be withdrawn.
- **Thrombus:** ~~clot~~ Clot composed of fibrin and blood cells that attach to a vessel. A thrombus may grow to surround the implanted port and obstruct the vessel and/or device.
- **HIT (heparin induced thrombocytopenia):** Occurs within the first 4-10 days after heparin exposure. HIT is suspected when a decrease in the thrombocyte count by 50% from the baseline count is observed.

B. DATA BASE:

1. SUBJECTIVE DATA BASE:

The Registered Nurse (RN) ~~will~~ reviews and informs the licensed independent provider (LIP) of any actual or potential complications associated with saline, heparin, and Cathflo Activase instillation.
~~N/A~~

2. OBJECTIVE DATA BASE:

Evaluate appropriateness for saline and heparin flush to maintain catheter patency.

- If the patient has an accessed implanted port and does not meet the exclusion criteria, the RN ~~is to~~ orders saline and heparin flush per standardized procedure.

Evaluate appropriateness for Cathflo Activase to restore catheter patency.

- Inability to withdraw blood or sluggish blood return
- Sluggish blood flow (less than 3 ml in 3 seconds)
- Inability to flush or infuse medications

C. DIAGNOSIS:

Patients requiring implanted port maintenance and/or restoration.
~~N/A~~

D. PLAN:

1. Treatment

a. Verify patient has an accessed implanted port.

b. Assess patient for exclusion criteria.

c. In the electronic medical record (EMR), the RN ~~will~~ orders the powerplan: "Standardized Procedure: IV Therapy – Care of the Implanted Port, ADULT" per standardized procedure. Orders include the following:

1) Normal Saline (0.9%) flush 10 ml to implanted port every 12 hours.
2) Normal Saline (0.9%) flush 20 ml using push-stop method followed by heparin flush to implanted port prn after medication administration and blood sampling.
3) Heparin flush 5 ml (100 units/1 ml) to implanted port PRN after medication administration, blood sampling, and prior to de-accessing.
4) Cathflo Activase 2 mg IV PRN to instill in each clotted or sluggish lumen for 30 to 120 minutes. May repeat X 1 PRN to non-functioning lumen.

d. During downtime procedures, the RN may initiate written orders for normal saline, heparin, and/or Cathflo Activase as outlined above.

~~b.~~2. Patient Condition Requiring Physician Consultation

~~c.~~a. Assess for the occurrence of HIT and report symptoms to the LIP.

b. Report to the LIP any of the following assessment findings to the implanted port site: redness, swelling, warmth, pain/tenderness, and/or drainage.

~~d.~~3. Education: Patient and/or family

~~e.~~a. Educate the patient and/or family members of the purpose of the medications being administered. ~~normal saline and heparin flushing to maintain catheter patency~~.

~~Educate the patient family members of the purpose of Cathflo Activase to restore catheter function.~~

4. Follow Up

~~f.~~a. If Cathflo Activase is unsuccessful in restoring catheter function to implanted port after ~~2~~ two doses, inform the LIP.

~~1. The RN will write an order for saline flush in the physician's orders and sign their name in the following manner: "*Normal Saline (0.9%) flush 10 ml to implanted port every 12 hours.* Name of RN, Title, per standardized procedure"~~

~~2. "*Normal Saline (0.9%) flush 20 ml using push-stop method followed by heparin flush to implanted port prn after medication administration and blood sampling.* Name of RN, Title, per standardized procedure"~~

~~3. The RN will write an order for heparin flush in the physician's orders and sign their name in the following manner: "*Heparin flush 5 ml (100 units/1 ml) to implanted port PRN after medication administration, blood sampling, and prior to de-accessing"* Name of RN, Title, per standardized procedure".~~

~~4. Assess for the occurrence of HIT and report symptoms to physician.~~

~~5. Patient condition requiring physician consultation~~

~~6. Education: Patient and family function of cen~~

~~7. Follow up~~

E. RECORD KEEPING:

1. Document all interventions, ~~and~~ outcomes, and any follow up made to the LIP.

2. Document assessment findings associated with an allergy to heparin and/or the occurrence of HIT.

a) If the patient develops ~~physician diagnosed~~ HIT, the RN ~~will~~ immediately discontinues the heparin orders in the EMR ~~the heparin orders~~ per standardized procedure~~:~~.

3. Written orders are entered in the following manner: "Discontinue Heparin flush" now per standardized procedure.
4. sign their name in the following manner: "*Discontinue Heparin flush now, per standardized procedure*"
1. Name of RN, Title, per standardized procedure".

III. REQUIREMENTS FOR RN:

A. EDUCATION:

Education and competency of the standardized procedure will be evaluated by the department manager or designee during initial clinical orientation. performed annually.

B. EXPERIENCE/TRAINING

Current California Registered Nurse License

C. INITIAL AND CONTINUING EVALUATION:

1. Initial competency will beis initiated during clinical orientation, including completion of a. A computer-based learning module. will be completed. Performance-based competency may be required at the unit level by the department manager or designee during clinical orientation.
2. Continuing evaluation will beis completedrequired annually via computer-based learning modulemodule completion. Performance-based competency may be required at the unit level.
Education and competency demonstration of the standardized procedure will occur during orientation for newly RN hires.

CONTINUING EVALUATION:
Education and competency of the standardized procedure will be performed annually.

IV. DEVELOPMENT AND APPROVAL:

A. METHOD:

Developed and approved by authorized representative of administration, medicine, pharmacy, and nursing.

B. REVIEW SCHEDULE:

The standardized procedure shall be reviewed at least every three years or sooner if there is a change in practice or if indicated by Quality and Patient Safety.

C. DEVELOPED BY:

Sabrina Sanchez, PhD, RN, AOCNS, OCN

Ellen Woods, BSN, RN, OCN

REVISED BY:
Sabrina Orique, PhD, RN, AOCNS, OCN
Brittany Roper, BSN, RN, OCN

D. APPROVAL:
Refer to AP38 for approval process.

References:

Arch, P. (2007). Port Navigation: Let the Journey Begin. Clinical Journal of Oncology Nursing, 11(4), p. 485-488.

Centers for Disease Control and Prevention (CDC). (2011). Basic Infection Control and Prevention Plan for Outpatient Oncology Settings. Retrieved 12/31/13 from http://www.cdc.gov/HAI/settings/outpatient/basic-infection-control-prevention-plan-2011/

Infusion Nurses Society (INS). (2016). Infusion Therapy Standards of Practice (5th ed.). Journal of Infusion Nursing.

Medcomp®. (2012). Power Injectable Implantable Infusion Port: Instructions for Use. Retrieved 12/31/13 from http://www.medcompnet.com/products/ports/dignity_ct_ports.html#ifu

Standardized Procedure Number: PC-SP.124	Date Created: No Date Set Date Approved: Not Approved Yet
Approvers: Interdisciplinary Practice Committee; Medical Executive Committee; Patient Care Policy Approval Committee; Pharmacy and Therapeutics; Standardized Procedures Approval Committee	
COVID-19 Vaccine Administration	

I. PROCEDURE

A. FUNCTION:

Appropriately, qualified personnel may administer the COVID-19 vaccine to Health Care Personnel (HCP) that meet Kaweah Delta Pharmacy and Therapeutics (P&T) approved organizational use criteria specific to the COVID-19 vaccine to be administered and are agreeable to receiving the vaccine.

B. CIRCUMSTANCES UNDER WHICH RN MAY PERFORM FUNCTION:

1. SETTING:
Kaweah Delta Medical Center or alternate locations on the Acute Care Hospital consolidated license.

2. SUPERVISION:
RN may independently perform the function with Practitioner available for supervision in person or by telephone.

3. PATIENT CONDITIONS:
HCP that meet the Kaweah Delta P&T approved organizational use criteria specific to the vaccine to be administered and are agreeable to receiving the vaccine.

4. OTHER
Exclusion Criteria: As described in the Kaweah Delta P&T Approved COVID-19 organizational use criteria.

II. PROTOCOL

A. DEFINITIONS:

1. **Health Care Personnel (HCP)** – paid and unpaid persons serving in a Kaweah Delta healthcare setting who have the ***potential for direct or indirect exposure*** to patients or infectious materials.

    a. For clarity, HCP includes the following individuals that meet the definition outlined in procedure II A. 1*:*

        (1) Kaweah Delta employees; Kaweah Delta Medical Staff and Advanced Practice Providers; Kaweah Delta Medical Foundation Practitioners; and individuals working in a Kaweah Delta or acute care setting through a Kaweah Delta contracted service in accordance with the organization's vaccine prioritization and distribution list.

B. DATA BASE:

1. SUBJECTIVE DATA BASE:
N/A

2. OBJECTIVE DATA BASE:
N/A

C. DIAGNOSIS:
N/A

D. PLAN:

1. Treatment

    a. The HCP will be screened for the following:

        (1) Previous severe reaction to any ingredient of the vaccine or severe allergic reaction after a previous dose of the vaccine.

        (2) Confirmation that the Kaweah Delta P&T approved organizational use criteria specific to the COVID-19 vaccine to be administered are met.

    b. If the HCP meets the criteria and agrees to receive the vaccine, the Registered Nurse (RN) may administer the COVID-19 vaccine.

        (1) After screening, the RN may delegate administration of the COVID-19 vaccine to a Licensed Vocational Nurse (LVN) or other personnel authorized to administer medications.

c. Prior to administration, prepare the COVID-19 vaccine in accordance with applicable organizational Policy and Procedures and any instructions specific to the medication to be administered.

d. Administer the COVID-19 vaccine in the dose, frequency and route of administration specific to the vaccine being administered

e. Advise the HCP to remain seated in the vicinity of vaccine administration for a minimum of 30 minutes post vaccine-administration for persons with a history of anaphylaxis (due to any cause) or a minimum of 15 minutes for all other persons so that appropriate measures can be taken to manage any adverse reactions that arise.

2. HCP conditions requiring Practitioner consultation

a. HCPs with clinical considerations described in the COVID-19 Vaccine Screening Questionnaire that warrant further discussion with the Standardized Procedures' designated Supervising Practitioner(s) prior to vaccine administration.

b. HCPs that experience an unexpected reaction during the timeframe that intervenes between vaccine and administration and the HCP leaving the site of vaccine administration.

c. Activation of the Rapid Response System or other emergency response if needed in accordance with organizational policy and procedures.

3. Education

a. To support efficiency and the optimal customer experience, the "Fact Sheet for Recipients and Caregivers" specific to the COVID-10 vaccine being administered was provided to the HCP for review prior to scheduling the vaccination appointment. In the event this information was not provided or accessible, ensure it is provided for HCP review prior to COVID-19 vaccine administration.

b. Prior to COVID-19 vaccine administration, provide to the HCP any other required information such as the Vaccine Information Statement (VIS). *At the time of SP development and approval, a VIS has not been made available nor is their*

language in the Emergency Use Authorization indicating this is a requirement.

c. When indicated, reinforce the importance of completing the COVID-19 vaccination series and the recommended timeframe for the 2nd dose of the series. Provide after-care instructions to include information for dealing with common side effects, information about when to seek medical attention and when to notify their healthcare provider about concerns that arise following vaccination.

E. RECORD KEEPING:

1. Prior to scheduling their appointment for vaccine administration, the HCP is provided information consistent with the “Fact Sheet for Recipients and Caregivers” including:

   a. The COVID-19 vaccine they will be receiving is a vaccine that is considered an unapproved drug that is authorized for use under an FDA Emergency Use Authorization.

   b. They have an option to accept for refuse the COVID-19 vaccine.

   c. The significant known and potential risks and benefits of the COVID-19 vaccine, and the extent to which such risks and benefits are unknown.

   d. Information about available alternative vaccines and the risks and benefits of those alternatives.

   e. Place an order for the COVID-19 vaccine to be administered; taking care to select the specific vaccine intended for administration. Use the order modifier “Per Standardized Procedure” when placing the order.

   f. Document COVID-19 vaccine administration in accordance with applicable organizational Policy and Procedures and any other required vaccine administration documentation that are specified in the COVID-19 Vaccination Program Provider Agreement.

III. REQUIREMENTS FOR REGISTERED NURSES

A. EDUCATION:

Education and demonstration of competency will be evaluated by the Employee Health Manager or designee prior to functioning under this SP.

B. EXPERIENCE/TRAINING:

1. Current California Registered Nurse License.

2. Current basic life support (BLS) certification.

C. INITIAL AND CONTINUING EVALUATION:

Competency evaluation will be performed prior to functioning under this SP, annually, and as appropriate.

IV. DEVELOPMENT AND APPROVAL

A. METHOD:

Developed and approved by authorized representatives of administration, medicine, and nursing.

B. REVIEW SCHEDULE:

Reviewed at least every three years or sooner if there is a change in practice or if indicated by Employee Health.

C. DEVELOPED BY:

Emma Mozier, MSN, RN, CNML, Director of Med-Surg Services
Lacey Jensen, RN, MN, CPHIMS, Director of Clinical Informatics
Mary Laufer, DNP, RN, NE-BC, Director of Nursing Practice
Chris Lawry-Hawkins, MA, RN, PHN, NE-BC, Director of Clinical Education
Rheta Silvas, PharmD, Assistant Director of Pharmacy
Gloria Simonetti, RN-CCM, GCM, Employee Health Services Manager

D. APPROVAL

Per Administrative Policy, AP38.

REFERENCES:

Centers for Disease Control and Prevention (CDC), Interim Considerations for COVID-19 Vaccination of Healthcare Personnel and Long-Term Care Facility Residents last reviewed: December 3, 2020. Retrieved 12/10/2020 from:

https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19/clinical-considerations.html

Centers for Disease Control and Prevention (CDC), Interim Considerations: Preparing for the Potential Management of Anaphylaxis at COVID-19 Vaccination Sites Summary. December 22, 2020. Retrieved 12/29/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/allergic-reaction.html

Standardized Procedure Number: PC-SP.118	Date Created: 11/21/2014 Date Approved: Not Approved Yet
Approvers: Interdisciplinary Practice Committee; Medical Executive Committee; Patient Care Policy Approval Committee; Patient Care Policy Committee; Pharmacy and Therapeutics	
Chemotherapy: Hypersensitivity Infusion Reaction for Chemotherapy and Immunotherapy	

I. PROCEDURE

A. FUNCTION:

To ensure prompt recognition and management of hypersensitivity reactions or anaphylaxis secondary to chemotherapy and/or ~~biotherapy~~ immunotherapy administration.

B. CIRCUMSTANCES UNDER WHICH RN MAY PERFORM FUNCTION

1. SETTING:

Kaweah Delta Health Care District (KDHCD) Inpatient Oncology (3S)

2. SUPERVISION:

Performed under the direction of a Licensed Provider with Medical Staff Privileges at KDHCD

3. PATIENT CONDITIONS:

Adult patient receiving chemotherapy and/or ~~biotherapy~~ immunotherapy agents

4. OTHER:

None

II. PROTOCOL

A. DEFINITIONS:

Hypersensitivity reaction: immunologic response to a foreign substance or antigen.

Anaphylactic reaction: acute, severe inflammatory response that is sudden and systematic, caused by the release of chemicals triggering a hypersensitivity reaction event.

Adult: ≥ 18 years of age

Chemotherapy hypersensitivity reactions usually occur within one hour of drug administration, but may occur hours later depending on the agent given. Patients may display features of anaphylactic (antibody mediated) or anaphylactoid (non-antibody mediated) reactions. Hypersensitivity reactions can occur with initial doses and/or a patient's repeated exposure to the particular drug. Chemotherapy drug classes most often associated with these types of reactions are the TAXANES, PLATINUM DERIVATIVES, and the MONOCLONAL ANTIBODIES. ~~Severity of symptoms requiring treatment are divided into grades:~~

Grading criteria with severity of symptoms:

Grade 1: signs or symptoms such as transient flushing or rash, mild itching, mild anxiety, and/or mild disorientation.

Grade 2: signs or symptoms such as infusion-related fever, rash, arthralgia, mild dyspnea, dizziness, headache, agitation, intense itching, chest discomfort, abdominal discomfort, lower back pain, rigors and/or mild hypotension.

Grade 3: signs and symptoms such as severe arthralgia, rash covering 30% of the body with intense or widespread itching, symptomatic bronchospasm with or without urticaria, moderate/severe hypotension (SBP < 90), angioedema, shortness of breath with stridor, respiratory distress at rest, severe disorientation, and/or severe hallucinations.

Grade 4: life threatening signs and symptoms such as severe cardiac or respiratory compromise requiring emergent intervention.

Risk factors for hypersensitivity reaction include:

- Treatment with an agent from one of the following classes:
  - Taxanes
  - Platinum Derivatives
  - Monoclonal Antibodies
- ~~Reaction to particular agent, or an agent within the same class, during a previous infusion~~ Previous infusion reaction
- Medications given by IV route, as compared to oral, intramuscular or subcutaneous routes
- History of asthma or allergies

B. DATA BASE

1. SUBJECTIVE DATA BASE:

Prior to chemotherapy/biotherapy administration, review patient allergy history and other associated risk factors for hypersensitivity reaction including previous exposure to chemotherapy/~~biotherapy~~immunotherapy.

2. **OBJECTIVE DATA BASE:**

Obtain and record baseline vital signs including baseline pulse oximetry.

C. DIAGNOSIS:

Patients receiving medications (chemotherapy or immunotherapy) with risk for a hypersensitivity reaction ~~A medical condition requiring treatment with chemotherapy or biotherapy agents.~~

D. PLAN

~~1.~~ Perform initial risk assessment and review patient's allergy history

~~2.~~1. ~~Obtain baseline vital signs.~~

~~3.~~2. Administer prescribed chemotherapy/immunotherapy, including prophylactic pre-medications ~~prior to chemotherapy/biotherapy administration~~.

~~4.~~3. Educate the patient about hypersensitivity and instruct the patient/family to report hypersensitivity symptoms immediately. Document education in the medical record.

~~5.~~4. Ensure that emergency equipment is readily available.

~~6.~~5. ~~-~~Assemble emergency equipment at the bedside:

~~7.~~a. Oxygen equipment

~~8.~~b. Primed and locked 1L of 0.9% sodium chloride or dextrose-5% water, depending on compatibility with medication being administered. These fluids should be the primary line connected to the patient's IV site and the medication administered using the IV y-site.

~~9.~~c. "Chemotherapy~~/Biotherapy hypersensitivity~~ Reaction Infusion ~~k~~ Kit" ~~-~~available in Pyxis and will contain the following:

~~a.~~i. One vial of diphenhydramine 50 mg/ml (1 ml)
~~b.~~ii. One act-o-vial of methylprednisolone 125 mg (2 ml)
~~c.~~iii. Two vials of famotidine 10 mg/ml (2 ml)
~~d.~~iv. One vial Epinephrine (1:1000) 1 mg/1 ml (30 ml)
~~e.~~v. One unit dose of Albuterol 2.5 mg/3 ml solution
~~f.~~vi. Ten 3 ml luer-lok syringes with attached 20g by 1 1/2 needle
~~g.~~vii. Ten 10 ml prefilled 0.9% sodium chloride syringes
~~h.~~viii. Ten ~~Alcohol~~ alcohol swabs
~~i.~~ix. Medication Labels

~~10.~~6. **In the event of a hypersensitivity/anaphylactic reaction, perform the following actions:**

a. Grade the reaction (see section A)
~~a.~~b. For Grade 1, 2, 3, and 4 reactions, **STOP** chemotherapy or ~~/biotherapy~~ immunotherapy infusion.
~~b.~~c. Assess patient's airway, breathing, circulation, cognitive function, and skin changes.
~~c.~~d. Treat the patient according to the following:

Grade Level	Treatment Approach
Grade 1	• Stop infusion • Observe patient for reaction progression • If patient improves symptomatically, may resume infusion at 50% of previous rate and titrate by 25% every 30 min to 100% of original rate.
Grade 2	• Stop infusion • Place patient in recumbent position • **Diphenhydramine** 25 mg IVP x 1 • **Methylprednisolone** 125 mg IVP x 1 • After recovery, may resume infusion at 50% of previous rate and titrate by 25% every 30 min to 100% of original rate.
Grade 3 and 4	• Stop infusion • CALL CODE BLUE OR RAPID RESPONSE (RRT) • Place patient in recumbent position • **Epinephrine** (1:1000) 0.3 mg IM x 1, may repeat in 5 min x 1 if symptoms unresolved • **Diphenhydramine** 50 mg IVP x 1 (*give 25 mg IVP x 1 if 25 mg dose was given for grade 2 reaction*) • **Famotidine** 40mg IVP x 1 (dilute in 5-10 ml~~s~~ normal saline give over 2 to 3 minutes) • **Methylprednisolone** 125 mg IVP x 1 (do not given an additional dose if 125mg dose was given for grade 2 reaction) • **Albuterol** 2.5 mg via nebulizer x 1 • **Normal Saline 0.9%** 1L IV at wide open rate (maintain SBP > 100 mm/Hg) • Oxygen starting at 2L/min and titrated prn dyspnea to maintain SpO_2 > 90% • Notify ~~Oncologist of~~ordering practitioner ~~patient status~~

~~d.~~e. Continuous monitoring of vital signs until symptoms resolve.
~~e.~~f. Continuous oxygen saturation level until symptoms resolve.

E. RECORD KEEPING:

1. Document all of the following in the electronic medical record:

   a. Pre-infusion assessment
   b. Infusion rate at the time of onset of symptoms and course of progression
   c. Grade of reaction
   d. Interventions, timing, and patient response to treatment
   e. Time of symptom resolution
   f. Once patient is stabilized, the nurse will ~~enter/write a complete~~ order ~~for~~ all medications administered (including the dose, route, and time)~~,~~ per standardized procedure~~, registered nurse signature.~~.

III. REQUIREMENTS FOR RN:

A. EDUCATION:

Current California Registered Nurse License

B. EXPERIENCE & TRAINING:

Basic Life Support (BLS) competency

C. INITIAL & CONTINUING EVALUATION:

Education and demonstration of standardized procedure competency evaluated by the clinical educator, advanced practice nurse, or designee during initial and annual competency validation.

IV. DEVELOPMENT AND APPROVAL:

A. METHOD:

Developed and approved by authorized representatives of medicine, pharmacy, and nursing.

B. REVIEW SCHEDULE:

Reviewed at least every three years or sooner if there is a change in practice or if indicated by Quality & Patient Safety.

C. DEVELOPED & REVISED BY:

Developed by:

Clint Brown PharmD.
Sabrina Orique, ~~MSN~~PhD, RN, CNS, OCN

Revised by:
Brittany Roper, BSN, RN, OCN

D. Per Administrative Policy, AP38.

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Policy Number: PC.256	Date Created: No Date Set
Document Owner: Kathie Allred (Clinical Education Prg Coord)	Date Approved: Not Approved Yet
Approvers: Medical Executive Committee, Patient Care Policy Approval Committee, Patient Care Policy Committee, Pharmacy and Therapeutics	

Glucommander Intravenous and Subcutaneous Glycemic Management - Adult

Policy:

Administration of insulin for glycemic control will follow safe and consistent standards of care utilizing an integrated glycemic management system (Glucommander™). Glucommander™ will be the primary mechanism for insulin management for adult patients requiring glycemic control at the Main Campus and West Campus Rehab facilities.

I. Definitions:

A. Glucommander™ Enterprise Software (Glucommander™) is used to assist healthcare professionals in the calculation of glucose and insulin dosing for attaining blood glucose (BG) in target range for patients on intravenous (IV) infusion and subcutaneous (SubQ) insulin dosing. Access to this software system is integrated within the current Electronic Medical Record (EMR).

B. Glucommander™ Dashboard provides a list of all patients on IV and SubQ insulin treatment with Glucommander ™ and provides a countdown timer indicating when the next BG is due.

C. Glucoview™ displays IV Glucommander™ patients on a visual display monitor located at each unit. Patients on Glucommander™ are identified in a HIPPA compliant manner.

D. Glucosurveillance™ is a display view within the Glucommander™ system of inpatients that have 2 blood glucose results greater than 180 mg/dL in a 24 hour period.

E. Multiplier is a required element of the Glucommander™ physician order.
   1. The multiplier is used to approximate a patient's insulin sensitivity. It will automatically adjust based on the patient's BG entries.
   2. For IV administration, a lower multiplier indicates an increased sensitivity to insulin.
   3. For SubQ administration, the selected multiplier will be used to approximate the patient's total daily dose of insulin based on the entered weight.

F. Target Range is a required element of the Glucommander™ physician order and represents the desired patient's blood glucose target.

II. Patient Type:

A. Any adult patient requiring glycemic management via administration of IV or SubQ insulin will be potential candidates for Glucommander™.
B. Patients with an HbA1c value of less than 6.5 may not require treatment with subcutaneous insulin.
C. For patients admitted with an existing SubQ insulin pump please refer to PC.243 Subcutaneous Insulin Pump.

III. Exceptions:

A. An order for a single dose of short or long acting insulin does not require Glucommander™ utilization
B. Emergency Department patients who have not been admitted should not be started on Glucommander.
C. Glucommander™ **will not be utilized** in the following patient care areas:
    1. Pediatrics and Neonatal Intensive Care Unit
    2. South Campus
    3. Outpatient Surgery
    4. Mental Health
    5. Intraoperative Areas (OR)
    6. Ante/Post-Partum Units (for SubQ only)
D. Glucommander™ should not be utilized for indications not related to glycemic management.
E. Patients refusing glucose checks or insulin management.

IV. Contraindications

A. Terminal patients with a life expectancy of less than 48 hours.
B. Severe insulin resistance as indicated in patients receiving more than 500 units/hour of insulin.
C. Known allergy to insulin

V. Procedure:

A. Glucommander™ will be initiated subsequent to an order by a licensed independent practitioner (LIP) authorized to prescribe within the facility.
B. Orders for Glucommander ™ must utilize the organizational approved Glucommander order sets.
C. Any oral anti-diabetic medications and any previous insulin orders should be discontinued prior to initiation of Glucommander™.
D. After the initial transcription of the order elements into the Glucommander ™ system by the Registered Nurse (RN) receiving the order, a second RN will perform an independent double check to verify the inputted order elements have been correctly entered into the Glucommander™ system.
E. The Registered Nurses (RN) or Licensed Vocational Nurse (LVN) will monitor the patient's response to the insulin therapy by utilizing the hospital owned and maintained blood glucose point of care (POC) testing machine to check blood glucoses as directed by the glycemic management system.
F. Doses of insulin will be administered by the RN or LVN as directed by the glycemic management system.

1. No medical decision should be based solely on the recommended guidance provided by this software program.
   - RN's are to contact the prescriber to clarify any recommendation provided by Glucommander™ that may require additional clinical evaluation before proceeding.

G. Recommendations from Glucommander™ for transition to home insulin therapy at the time of discharge are provided by selecting the Transition to Home button in Glucommander™.
   - These recommendations should be considered along with any previous oral medications or insulin regimens that may have been discontinued prior to Glucommander™ initiation.

VI. Management of Hypoglycemia and Hyperglycemia

A. For any instances of hypoglycemia (where POC - BG is less than ~~<~~70 mg/dL) the RN will follow corrective therapy recommendations as directed by the Standardized Procedure, PC-SP.113 Hypoglycemia, Adult: Administration of Dextrose or Glucagon ~~by Glucommander ™~~ to correct the blood glucose level.

B. For instances of hyperglycemia while on Glucommander, refer to power plan for threshold to contact ~~where POC-BG is greater than 500 mg/dL~~ the LIP ~~will be contacted~~ for further orders

VII. Documentation:

A. Nurse documentation of the following will occur in Glucommander™ and electronic medication administration record (EMR).
   1. Point of Care (POC) BG
   2. Insulin doses
   3. Administration of ~~D50W~~hypoglycemia treatment

B. Alternately, access to the Glucommander™ dashboard may be utilized by selecting the appropriate link in the EMR and will display patient specific information as listed above.
   - Electronic flowsheets in the critical care setting and paper flowsheets in the step-down intensive care unit will continue to display insulin doses and POC BG results.

VIII. Downtime Procedure:

A. In the event of a system downtime, Glucommander™ downtime forms can be accessed in the following locations:
   1. Downtime Forms Box
   2. Accessible on e-forms

B. The RN should follow the directions on the downtime form to continue insulin therapy and document on the downtime form as directed.

C. Management of hypoglycemic events during downtime may follow the Standardized Procedure, PC-SP.113 Hypoglycemia, Adult: Administration of Dextrose or Glucagon.

D. In the event of a prolonged electronic health record downtime, permission to access the Glucommander™ site directly will be evaluated and passwords granted at the discretion of the Information Systems Support (ISS) Department.

IX. Education:

A. Nursing staff will receive education related to diabetes management and complete a Glucommander™ software management training course prior to managing patients via the glycemic management system. Demonstration of competency will be evaluated by the Department Manager or designee during initial clinical orientation.

References:

Glucommander ™ Enterprise Software User Manual V3.1. Glytec. Aug 31, 2015.

Glucommander ™Best Practices. Glytec. May 17, 2019.

American Diabetes Association. Diabetes care in the hospital. Sec 14. In Standards of Medical Care in Diabetes – 2017. *Diabetes Care* 2017 Jan;40(Suppl.1):S120-S127.

Related Documents:

Hypoglycemia Identification & Treatment of, Adult: Collection of Point of Care Glucose & Administration of Dextrose or Glucagon, PC-SP.113.

Glucose Monitoring System, Freestyle Precision Pro, PC-00052.

Critical Value Reporting Procedure, LG-00006.

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

Policy Number: PC.189	Date Created: 10/29/2019
Document Owner: Kathie Allred (Clinical Education Prg Coord)	Date Approved: Not Approved Yet
Approvers: Medical Executive Committee; Patient Care Policy Approval Committee; Patient Care Policy Committee; Pharmacy and Therapeutics	

Code Blue

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

Policy: ~~Staff who hold a current Basic Life Support (BLS) for Health Care Provider (HCP) card or HeartSaver AED (HSAED) card will immediately render Basic Life Support to any individual within the district who is found to be without a pulse and/or non-breathing. Staff will follow guidelines established by the American Heart Association related to C, A, B (circulation, airway, breathing). After the arrival of Code Team or Emergency Medical Services (EMS) if applicable, care of the patient will be turned over to professionals qualified to provide a higher level of care (e.g. Advanced Cardiac Life Support/Pediatric Advanced Life Support).~~

~~**The pharmacist will respond to each code blue/white called in the acute Medical Center. The pharmacist may draw up and prepare all medications as ordered by the licensed independent practitioner. In patient care areas that do not call a code blue/white the nurse will draw up code medications under the direction of the licensed independent practitioner or ACLS prepared practitioner.**~~

Definition: ~~*Code Blue* - The KDHCD designation for cardiac or respiratory arrest in need of immediate resuscitation to preserve life.~~

~~*Code White* – The KDHCD designation for cardiac or respiratory arrest in need of immediate resuscitation to an individual 13 years or under.~~

~~*Crash Cart/Emergency cart* – All crash carts and emergency carts will be standardized. All crash/emergency carts will be secured in a manner consistent per hospital policy. (refer to Patient Care Manual Policy PC.144 "Medication: Security in Patient Care Areas"). Carts are not to be used for storage or as a medication mixing station.~~

~~*Main Hospital Campus* - The Kaweah Delta Hospital building located at 400 W. Mineral King. Emergency situations involving cardiac or respiratory arrest within the main campus will require a 44 call.~~

~~*Satellite Units* - All other sites outside of the main hospital campus are considered satellite units. Satellite areas will require a 9-911 call for cardiac or respiratory arrest situations.~~

In those areas defined as the Main Campus where the defibrillators have both paddle and Automatic External Defibrillator (AED) capabilities, defibrillator paddles are to be utilized as the primary form of defibrillation.

Procedure:

I. First Responder

A. Any district staff member witnessing an individual who is experiencing cardiac and/or respiratory arrest will immediately call for help either verbally and/or by dialing “44” within the main campus or “9-911” in satellite areas using any in-house telephone. The operator will page the code team.

B. Stay with patient.

C. Prepare for resuscitation efforts by:

1. (in bed) removing pillow, lower head of bed utilizing “quick drop” release; If specialty bed is being used, put in resuscitation mode, lower side rails and raise bed

2. (out of bed) safely assist patient to ground or flat surface.

3. expose chest area;

4. begin BLS (CPR) if competent.

5. maintain patient’s privacy.

II. Second Responder

A. Deliver Crash Cart or Emergency Cart to the scene:

1. If applicable, turn AED on follow all voice prompts.

B. When Crash Cart/Emergency Cart arrives at scene:

1. If in bed, slide compression board under the thoracic spine;

2. Place All-in-One (with ECG) defibrillator pads (per instructions) and change cardiac defibrillator/monitor to “Lead II” or “Pads”. Ensure correct cord is attached to defibrillator/monitor)

3. Units using regular defibrillator pads, place pads per instructions and add the 3 EKG leads (white to right, black to left, red to left lateral chest).

C. Assist with chest compression if indicated,

1. If RT not on scene, assist with attaching resuscitation bag to O_2;

III. Code White – In the case of a Code White outside of Pediatrics, Pediatrics is responsible for sending a PALS certified nurse (unless the code white is being called on a neonate on the Mother-Baby unit) and the Pediatric Hospitalist to the in-house code and as requested by the Emergency Department.

a. Pediatric resuscitation will be guided by Pediatric Advanced Life Support (PALS), and American Heart Association principles.

b. The Broselow Cart will be brought to the code.

c. Resuscitation medication dosing will be weight-based.

d. In the event the actual weight of the child is unknown, the Broselow tape will be used to determine the approximate weight and appropriate equipment.

- To establish the approximate weight, the patient will be measured from the top of the head to the bottom of the heel. The approximate weight will be based on where the heel lands, e.g. if the patient measures in the red range to 9 kg then the approximate weight is 9 kg.

E. Once the weight of the patient is known the Pediatric Emergency standard pediatric reference binder will be used for medication dosing.

IV. Role Responsibilities

A. Registered Nurse- Bedside Nurse

1. Confirm that the patient is without a pulse and/or non-breathing.

2. Continue CPR as appropriate. Continue to provide BLS care.

3. Assess cardiac rhythm and determine if pulseless ventricular tachycardia or ventricular fibrillation exists.

a. If yes and manual defibrillator is available, deliver immediate defibrillation.

b. Resume CPR. Reassess for pulse, respiration, and heart rhythm every 5 cycles of CPR or after 2 full minutes of CPR.

c. If unit has AED instead of manual defibrillator, AED will identify if shock is advised. Follow voice prompts to defibrillate and then immediately resume CPR for 2 minutes. If no shock advised, continue CPR, rechecking for return of

spontaneous circulation every 2 minutes following BLS guidelines, until code team or EMS arrives.

4. Initiate IV access as necessary.

5. Provide background and situation information as code team arrives.

B. ACLS ICU RN (Rapid Response Nurse or ICU Team Lead)

1. Responds to all in-house codes, except ED, OR, and NICU (unless specifically requested).

a. Interprets cardiac rhythm and initiates appropriate ACLS protocol until a physician arrives.
b. Assess patency of IV and initiation of IO as needed.

c. Verify adequate compressions and ventilations are performed.

d. Directs rescue efforts until physician arrives. All others responding without a designated role, will be dismissed.

e. Collaborates with attending RN to assure appropriate patient interventions

f. If resuscitation successful, accompanies patient during transport to the ICU.

g. Works in collaboration with responding physician in the coordination and direction of rescue.

h. Reviews and reconciles documentation on the resuscitation report and forward to pharmacy, PI, and the medical record

C. Nurse Manager, Charge Nurse, Team Leader

1. Assure the following:

a. Notification of the attending physician.

b. Crowd control outside the room.

c. privacy of the patient;

d. notification of family, or care of family by Patient & Family Services;

D. Nurse Supervisor

1. Assures proper documentation on the resuscitation report including the code critique.

E. Responding Physician (ED or Intensivist physician) is in charge of the Code until the attending physician arrives. Residents with Intensivist will perform duties upon the instruction of the Intensivist.

1. Physician (ED MD, Intensivist and Pediatric Hospitalist (for Code White)

a. The Intensivist and ED physician will respond to all in-house Code Blue. The Pediatric Hospitalist and ED physician will respond to Code White events unless:

(1) primary physician or other qualified physician is at bedside and does not request assistance from ED MD, Intensivist or Pediatric Hospitalist;

(2) cannot abandon current critical patient(s) in their care in the ED, ICU or NICU.

1. PALS (Pediatric Advanced Life Support) Pediatric RN

a. Responds to all in-house code white,

b. Interprets cardiac rhythm and initiates appropriate PALS until a physician arrives.

c. Assess patency of IV and initiation of IO as needed.

d. Verify adequate compressions and ventilations are performed.

e. Directs rescue efforts until physician arrives.

f. Collaborates with attending RN to assure appropriate patient interventions

g. If resuscitation successful, PALS Certified RN accompanies patient during transport to the appropriate level of care in the hospital, or until transport team from tertiary facility arrives to transport patient.

h. Works in collaboration with responding physician in the coordination and direction of rescue.

i. Reviews and assists with documentation on the resuscitation report.

2. Respiratory Care Practitioner

a. Establishes patent airway.

b. Ventilates patient via resuscitation bag using 100% O_2

c. Post intubation, verifies proper tube placement by

(1) observing $ETCO_2$ detector

(2) initiate continuous capnography (if available)

(3) auscultating bilateral breath sounds

(4) observing chest excursion during ventilation.

3. Pharmacist

a. Brings additional resuscitation medications.

b. Prepares medications.

4. Phlebotomist

a. Draws and labels all specimens/samples.

b. Transports specimens to lab for STAT resulting.

5. Other Trained Staff (Patient Transport)

a. Performs chest compression as needed.

b. Assists, as necessary, within scope of practice.

F. Radioactive Patient

1. Patient should be bagged only. Mouth-to-mouth breathing assistance should be avoided if at all possible.

2. Face protection should be used by those at risk for splash exposure to saliva, respiratory sections or vomitus. Universal precautions should be employed as usual.

3. If time permits, portable shields may be used.

4. Personnel assisting in procedures should maintain the maximum distance consistent with effective care.

5. After situation is resolved, staff should dispose of gowns, gloves, etc. in the disposable container of the patient's room. Equipment

such as defibrillators, etc. should be checked for contamination by the Radiation Safety Officer before they are removed from the room, unless they need to accompany the patient when transferred. Personnel should perform thorough hand washing.

6. The radiation safety officer should be contacted when the patient is transferred. Transfer to a higher level acuity should be performed regardless of whether the patient has been removed from "radiation precautions", if immediately indicated.

G. Discontinuation of a Code Blue OR Code White

After resuscitation efforts have been initiated, Code Blue or Code White efforts may only be terminated by the physician in charge or by EMS staff if physician is not available.

V. Crash Cart/Emergency Cart Replacement/Inventory

A. Central Logistics shall inventory, and maintain all District crash and emergency carts to ensure standardization and readiness. This is to include full cart exchanges of all on campus crash carts and full tray exchanges for off campus crash carts and emergency carts as needed.

1. Specific Central Logistics staff will be assigned to inventory carts. Each cart will be assigned a specific day of each month to be inventoried ensuring a 30-day inventory rotation.

2. A pharmacist/or designee is responsible for opening and inspecting emergency drug supplies no less frequently than every 30 days.

B. Main Hospital Procedure:

1. Following a code, nursing staff will contact Central Logistics and request a cart exchange. The used drug tray will be locked with a color coded lock to indicate that it is incomplete.

2. Central Logistics staff will transport a ready cart from Central Logistics to Pharmacy. Pharmacy staff will place the drug tray in the designated cart drawer and secure the medication-containing drawer(s) with an approved, numbered lock, with documentation of lock number on crash cart log. The date and name of the 1st medication to expire shall be placed on the medication-containing drawer(s) of the crash cart.

3. Central Logistics staff will transport completed cart to requesting unit within 30 minutes of the initial nursing staff contact.

4. Upon arrival on the unit, staff will remove defibrillator, defibrillator pads, and notebook, from the top of the used cart and place onto

the incoming cart. The compression board attached to the used cart will remain with the cart. Respiratory equipment utilized during the code will be sealed in a bag and left on the used crash cart. This equipment will be taken off the unit with the used cart.

5. Central Logistics will transport used cart to Pharmacy for removal of the drug tray.

6. Central Logistics will transport used cart to Sterile Processing and deliver Respiratory equipment to Sterile Processing staff for reprocessing. This equipment will be signed in on the Sterile Processing Log.

7. Central Logistics will return used cart to their department, where it will be cleaned with an approved germicidal agent.

8. Central Logistics staff will inventory and restock cart drawers per the Crash Cart Inventory form. Any product labeled to expire within 45 days of inventory will be replaced. Cart drawers will be secured with an approved lock, and cart will be stored in Central Logistics. Pharmacy is responsible for securing medication-containing drawer(s) with an approved lock. The date and the name of the first medication to expire shall be placed on the medication-containing drawer(s) of the crash cart.

9. All completed crash cart inventories will be documented on the Crash Cart Log located in Central Logistics.

Instances of crash cart drawer locks being broken during non-code situations should be communicated to Central Logistics and the Director of the area. Nursing staff will advise Central Logistics which drawer(s) are unlocked. Central Logistics staff will deliver the appropriate sealed drawer tray(s), exchange and lock the drawer(s). Unlocked drug drawers (drawer #3 of the adult crash cart; drawer #1 of the neonatal crash cart) should be reported to Pharmacy and the Director.

C. Satellite Unit Procedure

1. Following a code, nursing staff will contact Central Logistics to request a full tray exchange on the emergency or crash cart. If a separate supply of emergency medications are stocked on the unit and have been used during the code, nursing will notify Pharmacy to re-stock the medications.

2. Central Logistics will transport the full tray to the unit by the end of the next business day.

~~VII. Exceptions/Special Considerations~~

~~A. If Code Blue or White occurs in (Main campus) Cafeteria, Main Lobby, Admitting, Physical Therapy, basement near E107, Blue Room or Lab, first floor hallways near PBX or in the Main Elevator, District staff member witnessing event shall dial "44" and the Emergency Department will respond with their crash cart. First staff member that identifies a code situation will begin resuscitation efforts.~~

~~B. Neonatal crash carts do not contain a back board, oxygen tank, ambu bag or a defibrillator/monitor.~~

~~VIII. Resuscitation Forms/Sheets~~

~~A. Complete entire form including both sides (Press firmly to assure legible copies).~~

~~B. Nurse Manager or Nursing Supervisor is responsible for assuring completion of form.~~

~~C. Copies are distributed post-code as follows:~~

~~1. White copy - patient chart~~

~~2. Yellow copy – Pharmacy~~

~~3. Pink copy – Performance Improvement Department~~

~~**Related Documents:**~~
~~None~~

~~**References:**~~
~~None~~

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

Policy: Staff who hold a current Basic Life Support (BLS) for Health Care Provider (HCP) card or HeartSaver AED (HSAED) card will immediately render Basic Life Support to any individual within the district who is found to be without a pulse and/or non-breathing. Staff will follow guidelines established by the American Heart Association related to initiation of Cardio Pulmonary Resuscitation (CPR). After the arrival of Code Team or Emergency Medical Services (EMS) if applicable, care of the patient will be turned over to professionals qualified to provide a higher level of care (e.g. Advanced Cardiac Life Support).

The pharmacist will respond to each code blue called in the acute Medical Center. The pharmacist may draw up and prepare all medications as ordered by the licensed independent practitioner. In patient care areas that do not call a code blue the nurse will draw up code medications under the direction of the licensed independent practitioner or ACLS prepared practitioner.

Definition: *Code Blue* - The KDHCD designation for cardiac or respiratory arrest in need of immediate resuscitation to preserve life.

Crash Cart/Emergency cart – All crash carts and emergency carts will be standardized. All crash/emergency carts will be secured in a manner consistent per hospital policy. (refer to Patient Care Manual Policy PC.144 "Medication: Security in Patient Care Areas"). Carts are not to be used for storage or as a medication mixing station.

Main Hospital Campus - The Kaweah Delta Hospital building located at 400 W. Mineral King. Emergency situations involving cardiac or respiratory arrest within the main campus will require a 44 call.

Satellite Units - All other sites outside of the main hospital campus are considered satellite units. Satellite areas will require a 9-911 call for cardiac or respiratory arrest situations.

Procedure:

I. First Responder

A. Any district staff member witnessing an individual who is experiencing cardiac and/or respiratory arrest will immediately call for help either verbally and/or by dialing “44” within the main campus or “9-911” in satellite areas using any in-house telephone. The operator will page the code team.

B. Stay with patient.

C. Prepare for resuscitation efforts by:

1. (in bed) removing pillow, lower head of bed utilizing “quick drop” release; If specialty bed is being used, put in resuscitation mode, lower side rails and raise bed

2. (out of bed) safely assist patient to ground or flat surface.

3. expose chest area;

4. begin BLS (CPR) if competent.

5. maintain patient’s privacy.

II. Second Responder

A. Deliver Crash Cart or Emergency Cart to the scene:

1. If applicable, turn AED on and follow all voice prompts.

B. When Crash Cart/Emergency Cart arrives at scene:

1. If in bed, slide compression board under the thoracic spine;

2. Place All-in-One (with ECG) defibrillator pads (per instructions) and change cardiac defibrillator/monitor to “Lead II” or “Pads”. Ensure correct cord is attached to defibrillator/monitor)

3. Units using regular defibrillator pads, place pads per instructions and add the 3 EKG leads (white to right, black to left, red to left lateral chest).

C. Assist with chest compression if indicated,

1. If Respiratory Therapist is not on scene, assist with attaching resuscitation bag to O_2.

III. Role Responsibilities

A. Registered Nurse/designee as appropriate~~- Bedside Nurse~~

1. Confirm that the patient is without a pulse and/or non-breathing.

2. Continue CPR as appropriate. Continue to provide BLS care.

3. Assess cardiac rhythm and determine if pulseless ventricular tachycardia or ventricular fibrillation exists.

a. If yes and manual defibrillator is available, deliver immediate defibrillation.

b. Resume CPR. Reassess for pulse, respiration, and heart rhythm every 5 cycles of CPR or after 2 full minutes of CPR.

c. If unit has AED instead of manual defibrillator, AED will identify if shock is advised. Follow voice prompts to defibrillate and then immediately resume CPR for 2 minutes. If no shock advised, continue CPR, rechecking for return of spontaneous circulation every 2 minutes following BLS guidelines, until code team or EMS arrives.

4. Initiate IV access as necessary.

5. Provide background and situation information as code team arrives.

A. ACLS ICU RN (Rapid Response Nurse or ICU Team Lead or designee)

1. Responds to all in-house codes, except ED, OR, and NICU (unless specifically requested).

a. Interprets cardiac rhythm and initiates appropriate ACLS protocol until a physician arrives.
b. Assess patency of IV and initiation of IO as needed.

c. Verify adequate compressions and ventilations are performed.

d. Directs rescue efforts until physician arrives. All others responding without a designated role, will be dismissed.

e. Collaborates with attending RN to assure appropriate patient interventions

f. If resuscitation successful, accompanies patient during transport to critical care.

g. Works in collaboration with responding physician in the coordination and direction of rescue.

h. Reviews and reconciles documentation on the resuscitation report and forward to pharmacy, PI, and the medical record

C. Nurse Manager, Charge Nurse, Team Leader

1. Assure the following:

a. Notification of the attending physician.

b. Crowd control outside the room.

c. privacy of the patient;

d. notification of family, or care of family by Patient & Family Services;

D. Nurse Supervisor

1. Assures proper documentation on the resuscitation report including the code critique.

E. Responding Physician (ED or Intensivist physician) is in charge of the Code until the attending physician arrives and is relieved of duties related

to the code. Residents with Intensivist will perform duties upon the instruction of the Intensivist.

1. Physician (ED ~~MD~~, Intensivist)

   a. The Intensivist and/or ED physician will respond to all in-house Code Blues unless:

      (1) the primary physician or other qualified physician is at bedside and does not request assistance from ED ~~MD~~physician or Intensivist;

      (2) cannot abandon current critical patient(s) in their care in the ED or ICU.

2. Respiratory Care Practitioner

   a. Establishes patent airway.

   b. Ventilates patient via resuscitation bag using high flow ~~100%~~ O_2

   c. Post intubation, verifies proper tube placement by

      (1) observing $ETCO_2$ detector

      (2) initiating continuous capnography (if available)

      (3) auscultating bilateral breath sounds

      (4) observing chest excursion during ventilation.

3. Pharmacist

   a. Brings additional resuscitation medications.

   b. Prepares medications.

   ~~b.~~c. Provides dosing and administration instructions for ordered medications as~~n~~ needed.

4. Phlebotomist

   a. Draws and labels all specimens/samples.

   b. Transports specimens to lab for STAT resulting.

5. Other Trained Staff (Patient Transport)

   a. Performs chest compression as needed.

b. Assists, as necessary, within scope of practice.

F. Radioactive Patient

1. Patient should be bagged only. Mouth-to-mouth breathing assistance should be avoided if at all possible.

2. Face protection should be used by those at risk for splash exposure to saliva, respiratory sections or vomitus. Universal precautions should be employed as usual.

3. If time permits, portable shields may be used.

4. Personnel assisting in procedures should maintain the maximum distance consistent with effective care.

5. After situation is resolved, staff should dispose of all personal protective equipment (PPE) ~~gowns, gloves, etc.~~ in the appropriate disposable container located in the ~~of the~~ patient's room. Equipment such as defibrillators, etc. should be checked for contamination by the Radiation Safety Officer before they are removed from the room, unless they need to accompany the patient when transferred. Personnel should perform thorough hand washing.

6. The radiation safety officer should be contacted when the patient is transferred. Transfer to a higher level acuity should be performed regardless of whether the patient has been removed from "radiation precautions"~~,~~ if immediately indicated.

G. Discontinuation of a Code Blue

After resuscitation efforts have been initiated, Code Blue efforts may only be terminated by the physician in charge or by EMS staff if physician is not available.

IV. Crash Cart/Emergency Cart Replacement/Inventory

A. Central Logistics shall inventory, and maintain all District crash and emergency carts to ensure standardization and readiness. This is to include full cart exchanges of all on campus crash carts and full tray exchanges for off campus crash carts and emergency carts as needed.

1. Specific Central Logistics staff will be assigned to inventory carts. Each cart will be assigned a specific day of each month to be inventoried ensuring a 30-day inventory rotation.

2. A pharmacist/or designee is responsible for opening and inspecting emergency drug supplies no less frequently than every 30 days.

B. Main Hospital Procedure:

1. Following a code, nursing staff will contact Central Logistics and request a cart exchange. The used drug tray will be locked with a color coded lock to indicate that it is incomplete.

2. Central Logistics staff will transport a ready cart from Central Logistics to Pharmacy. Pharmacy staff will place the drug tray in the designated cart drawer and secure the medication-containing drawer(s) with an approved, numbered lock, with documentation of lock number on crash cart log. The date and name of the 1st medication to expire shall be placed on the medication-containing drawer(s) of the crash cart.

3. Central Logistics staff will transport completed cart to requesting unit within 30 minutes of the initial nursing staff contact.

4. Upon arrival on the unit, staff will remove defibrillator, defibrillator pads, and notebook, from the top of the used cart and place onto the incoming cart. The compression board attached to the used cart will remain with the cart. Respiratory equipment utilized during the code will be sealed in a bag and left on the used crash cart. This equipment will be taken off the unit with the used cart.

5. Central Logistics will transport used cart to Pharmacy for removal of the drug tray.

6. Central Logistics will transport used cart to Sterile Processing and deliver Respiratory equipment to Sterile Processing staff for reprocessing. This equipment will be signed in on the Sterile Processing Log.

7. Central Logistics will return used cart to their department, where it will be cleaned with an approved germicidal agent.

8. Central Logistics staff will inventory and restock cart drawers per the Crash Cart Inventory form. Any product labeled to expire within 45 days of inventory will be replaced. Cart drawers will be secured with an approved lock, and cart will be stored in Central Logistics. Pharmacy is responsible for securing medication-containing drawer(s) with an approved lock. The date and the name of the first medication to expire shall be placed on the medication-containing drawer(s) of the crash cart.

9. All completed crash cart inventories will be documented on the Crash Cart Log located in Central Logistics.

Instances of crash cart drawer locks being broken during non-code situations should be communicated to Central Logistics and the Director of the area. Nursing staff will advise Central Logistics which drawer(s) are unlocked. Central Logistics staff will deliver the appropriate sealed drawer tray(s), exchange and lock the drawer(s). Unlocked drug drawers (drawer #3 of the adult crash cart) should be reported to Pharmacy and the Director.

C. Satellite Unit Procedure

1. Following a code, nursing staff will contact Central Logistics to request a full tray exchange on the emergency or crash cart. If a separate supply of emergency medications are stocked on the unit and have been used during the code, nursing will notify Pharmacy to re-stock the medications.

2. Central Logistics will transport the full tray to the unit by the end of the next business day.

VII. Exceptions/Special Considerations

A. If Code Blue occurs in (Main campus) Cafeteria, Main Lobby, Admitting, Physical Therapy, basement near E107, Blue Room or Lab, first floor hallways near PBX or in the Main Elevator, District staff member witnessing event shall dial “44” and the Emergency Department will respond with their crash cart. First staff member that identifies a code situation will begin resuscitation efforts.

VIII. Resuscitation Forms/Sheets

A. Complete entire form including both sides (Press firmly to assure legible copies).

B. Nurse Manager or Nursing Supervisor is responsible for assuring completion of form.

C. Copies are distributed post-code as follows:

1. White copy - patient chart

2. Yellow copy – Pharmacy

3. Pink copy – Quality and Patient Safety Department

Related Documents:

None

References:

None

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

Policy Number: PC.99	Date Created: 07/01/1997
Document Owner: Kathie Allred (Clinical Education Prg Coord)	Date Approved: Not Approved Yet
Approvers: Medical Executive Committee, Patient Care Policy Approval Committee, Patient Care Policy Committee, Pharmacy and Therapeutics	

Death: Pronouncement of Death by RN

Policy: A~~n~~ RN ~~with one or more years of experience~~ may pronounce death of a patient who meets the criteria to do so within the confines of Kaweah Delta Health Care District acute level of care.

Circumstances under which an RN may pronounce death:

1. Inpatient acute facility when documentation includes:
   a. Documentation by the physician in the Physician Progress Note that death is expected.
   b. Physician order for no cardiopulmonary resuscitation.
2. The patient ~~must not be~~is not a potential organ donor (excludes tissue).
3. The patient ~~must not be~~is not sustained by external mechanical life support equipment.
4. The patient ~~must not be~~is not a coroner's case in the inpatient setting. (Refer to Patient Care Policy Coroner's Cases, PC.64)

Procedure:

I. When a patient expires, the RN ~~will~~ assesses the patient for signs and symptoms of cessation of cardiopulmonary function as follows:

   A. Cessation of apical pulse, respirations and blood pressure

   B. Cessation of neurological or pupillary response

II. When death has been determined the RN ~~will~~completes the following notifications:

   A. ~~Notify t~~The ~~p~~physician ~~of the patient's death~~.

   B. ~~Notify the p~~Patient's next of kin. ~~The physician may prefer to do this him/herself.~~

C. ~~Notify the~~ House Supervisor.

D. ~~Notify the~~ Tissue Donor hotline. ~~(1-800-553-6667)~~

III. Notification to patient's next of kin is completed by RN/designee

~~III.~~IV. Nursing documentation ~~entered in the Physician Progress Note~~ will include:

A. Date and time of pronouncement.

B. Absence of apical pulse and respiration.

C. Patient is deceased.

D. Physician notification.

Related Documents:

Refer to Patient Care Policy, PC.75 Death: Preparation and Disposition of Body

Refer to Patient Care Policy Coroner's Cases, PC. 64 Coroner's Cases

References:

1. Board of Registered Nursing, *RN Scope of Practice Frequently Asked Questions.* Retrieved October 29, 2010 from Department of Consumer Affairs, Board of Registered Nursing website: http:www.rn.ca.gov/pdfs/regulations/npr-b-44.pdf
2. Regulation & Law, County of Tulare, Reporting Coroner's Cases, Government Code 27491.

Policy Number: PC.01	Date Created: 04/09/1997
Document Owner: Kathie Allred (Clinical Education Prg Coord)	Date Approved: Not Approved Yet
Approvers: Medical Executive Committee, Patient Care Policy Approval Committee, Patient Care Policy Committee, Pharmacy and Therapeutics	

IV Therapy: Adult Parenteral Nutrition

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

Policy: Registered Nurses will safely and accurately administer and monitor Peripheral/Central Nutrition.

Definitions:

"Total Parenteral Nutrition" (TPN). If the final concentration of dextrose is greater than or equal to ~~exceeds~~ 10% ~~and amino acid concentration exceeds 3%~~ the parenteral nutrition (PN) shall be administered via central venous access device (CVAD). Use of a central line is recommended if the total osmolarity of the solution exceeds 900 mOsm/L.

"Peripheral Parenteral Nutrition" (PPN) - Dextrose concentration of less than 10% ~~or less and Amino Acids no greater than 3%~~ shall be administered via short peripheral catheter or midline catheter.

Procedure:

For TPN/PPN

I. Reference Patient Care Policy, IV Therapy, PC.15.

II. See Order Set for Adult Parenteral Nutrition.

III. TPN/PPN will be infused via intravenous pump.

IV. **Medications are not added to or co-infused with the PN solution/emulsions before or during infusion without consultation with a pharmacist regarding compatibility and stability. No additional medication, may be given IV push or as a secondary through the venous access in which TPN/PPN is infusing except for the following:**

A. Infusion of lipid injectable emulsions

B. Intermittent infusions of supplemental **Magnesium Sulfate** or **Potassium Chloride** (KCL) may be administered using a separate channel/soldier with the tubing connected at the lowest port in the primary Total/Peripheral Parenteral Nutrition (TPN/PPN) infusion line.

1. The avoid exceeding the hourly rate limit of electrolyte infusion, the rate of the KCL intermittent infusion should be reduced to 8 mEq/hour in adult settings outside of the ICU or ~~3W~~ ICCU. Refer to the table below to guide adjustments to the pump duration setting.

2.

Supplemental KCL Intermittent infusion – Duration Adjustment	
KCL (mEq)	Duration (hh:mm)
10	01:15
20	02:30
30	03:45
40	05:00

V. Filters & Administration Set

A. Amino Acids

1. O.2 micron filter shall be used on Amino Acid/Dextrose solutions.

2. Filter and tubing shall be changed every 24 hours.

~~2.~~3. Do not exceed hang time of 24 hours.

B. Lipid Injectable Emulsions

1. 1.2 micron filter shall be used on lipid injectable emulsion and connected to the Amino Acid/Dextrose solution below 0.2 micron filter into the port closest to the patient.

2. Tubing and filter shall be changed every 12 hours.

~~2.~~3. Do not exceed hang time of 12 hours.

~~3.~~4. ~~May not hang greater than 12 hours per bag~~

~~4.~~5. ~~Administration set and filter should be discarded after each bag unless additional bags are administered consecutively.~~

C. Three-in-one PN solutions (lipid injectable emulsions combined with amino acids and dextrose in a single container to form a total nutrient admixture)

1. Shall be filtered with a 1.2-micron filter.

2. Tubing and filter shall be changed every 24 hours.

~~2.~~3. Do not exceed hang time of 24 hours.

~~VI. Hang time/infusion for these is 24 hours.~~

VI. Administration

A. Solution label shall be carefully compared with physician order for accuracy prior to administration.

B. Mixed solutions not infused must be discarded every 24 hours.

C. Parenteral nutrition shall be at room temperature prior to infusion.

VII. Glucose Monitoring ~~-(~~Point of Care Testing (POC)

A. ~~For patients currently receiving insulin p~~Perform POC glucose monitoring as directed ~~on~~ by the orders and PRN change in level of consciousness. ~~(or at a minimum of every 6 hours~~

~~A.~~B. Check blood glucose no less than every 6 hours while on TPN~~)~~.

~~B. For patients receiving TPN but not currently receiving insulin, perform POC glucose monitoring every 6 hours and prn acute change in mentation.~~

1. Call physician for insulin orders if 2 consecutive results are greater than 180mg/dL.

2. If POC glucose result is less than ~~69~~ 70 mg/dL ~~or less~~, refer to Patient Care Policy, Standardized Procedure: Hypoglycemia, Adult: Administration of Dextrose or Glucagon PC-SP.113.

VIII. Discontinuation of Parenteral Nutrition

A. Planned Discontinuation of Parenteral Nutrition ~~-~~(i.e. non-emergent situation)

1. Decrease parenteral infusion rate by 50% for two hours and then discontinue infusion.

a) Unless an alternative time is specified by the physician, BEGIN the process for discontinuing parenteral nutrition infusion between the hours of 0700 - 1600 regardless of the volume of solution remaining.

b) Upon discontinuation of parenteral nutrition, ~~monitor~~ check POC ~~bedside~~ glucose every 30 minutes x 2, then every 2 hours x 2 ~~checks~~. Notify physician if blood glucose level is less than 80 mg/dL.

B. Sudden Discontinuation of Parenteral Nutrition:

1. If a patient is receiving central TPN and administration of TPN is suddenly interrupted, infuse Dextrose 10% at same TPN rate and call physician for further orders.

2. PPN does not require tapering for sudden discontinuation or for medication administration.

C. Discontinuation of TPN for Medication Administration

1. If the infusion of TPN must be stopped suddenly, for medication administration, an infusion of Dextrose 10% at the same infusion rate must be initiated.

2. Check medication compatibility with Dextrose 10%.

~~X. Parenteral nutrition shall be infused at room temperature or brought to room temperature prior to infusion.~~

~~XI. Superimposed solutions not infused must be discarded every 24 hours.~~

~~XII.~~X. ~~Solution label shall be carefully compared with physician order for accuracy prior to administration~~.

Related Documents:

Patient Care Policy, IV Therapy, PC.15. IV Therapy - Adults
Patient Care Standardized Procedure: Hypoglycemia Identification & Treatment of, Adult: Collection of Point of Care Glucose & Administration of Dextrose or Glucagon

References:

~~Centers for Disease Control. (2011). *Guidelines for the Prevention of Intravascular Catheter-Related Infections.* Retrieved from http://www.cdc.gov/hicpac/guidelines/bsi-guidelines.2011.pdf~~

Charney, P. & Malone, A. (2007). ADA Pocket Guide to Parenteral Nutrition. Chicago, IL: Academy of Nutrition and Dietetics.

Gottschlich, M. M. (2012). The A.S.P.E.N. Nutrition Support Core Curriculum: A Case-Based Approach-The Adult Patient.

Infusion Nurses Society. (2016). Infusion Therapy Standards of Practice. Norwood, MA: Wolters Kluwer.

Krzywda, E. A. & Meyer, D. (2010). In Alexander, M., Corrigan, A., Gorski, L., Hankins, J., & Perucca, R. (Eds.) *Infusion Nurses Society, Infusion Nursing, an evidence-based approach* (pp.333-337). St. Louis: Elsevier.

~~Supplemental Infusion Nursing Standards of Practice 2016 S133 & S134,INS~~

~~The A.S.P.E.N. Nutrition Support Core Curriculum: A Case-Based Approach- Adult Patient. 2012~~

~~ADA Pocket Guide to Parenteral Nutrition. 2007~~

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Policy Number: PC.255	Date Created: No Date Set
Document Owner: Kathie Allred (Clinical Education Prg Coord)	Date Approved: Not Approved Yet
Approvers: Infection Prevention Committee, Medical Executive Committee, Patient Care Policy Approval Committee, Patient Care Policy Committee	

C. difficile Testing Criteria

Policy:

This policy is intended to help establish the appropriate situations for checking stool for the presence of toxigenic *C. difficile*.

Procedure:

Testing inclusion criteria:

Patient should meet all of the following:

- 3 or more loose and watery stools in a 24-~~-~~hour period. ~~–~~(If a solid or semi-solid stool occurs within the same 24-hour period, the specimen should not be sent). ~~does not count towards this amount~~
- Stool should take the form of the cup
- Documented presence of at least one of the following:
  - Abdominal cramps, tenderness, or pain
  - Temperature >38ºC (100.4ºF), oral preferred
  - Leukocytosis not otherwise explained
  - Radiologic evidence of colitis
  - Visual evidence of colitis (e.g. colonoscopy)

Testing exclusion criteria:

If the patient meets any of these criteria, lab will cancel the order and not test the stool sample. The lab will communicate with patient care staff of the cancellation:

- Patient stool is formed or semi-formed
  - Refer to Bristol Stool Chart for consistency description (see Appendix 1)
  - Stool consistency of Type 1 through 5 will be rejected for testing
- Stool specimen is submitted in a fluid transport medium (e.g. Cary-Blair), or is sent as a smear such that consistency is not discernible
- Less than 1mL of stool is sent to the lab for testing
- Patient had 1 or more doses of a laxative, stool softener, enema, or bowel prep within the 24 hours preceding collected sample
- Patient had a negative *C. difficile* stool test within the preceding 7 days
- Patient had a positive *C. difficile* stool test within the preceding 21 days

Testing exceptions:

If the patient's provider believes there is a strong clinical indication to test for *C. difficile* in a patient who does not meet the above testing criteria, he/she may contact the lab and request a consultation with the Medical Director. Once a patient is diagnosed with a C. *difficile* infection do not perform a test of cure.

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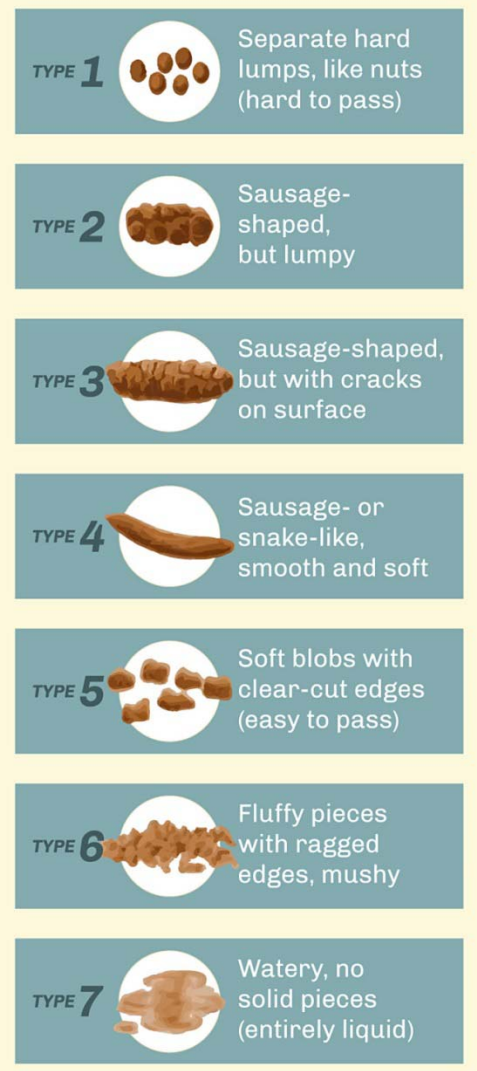
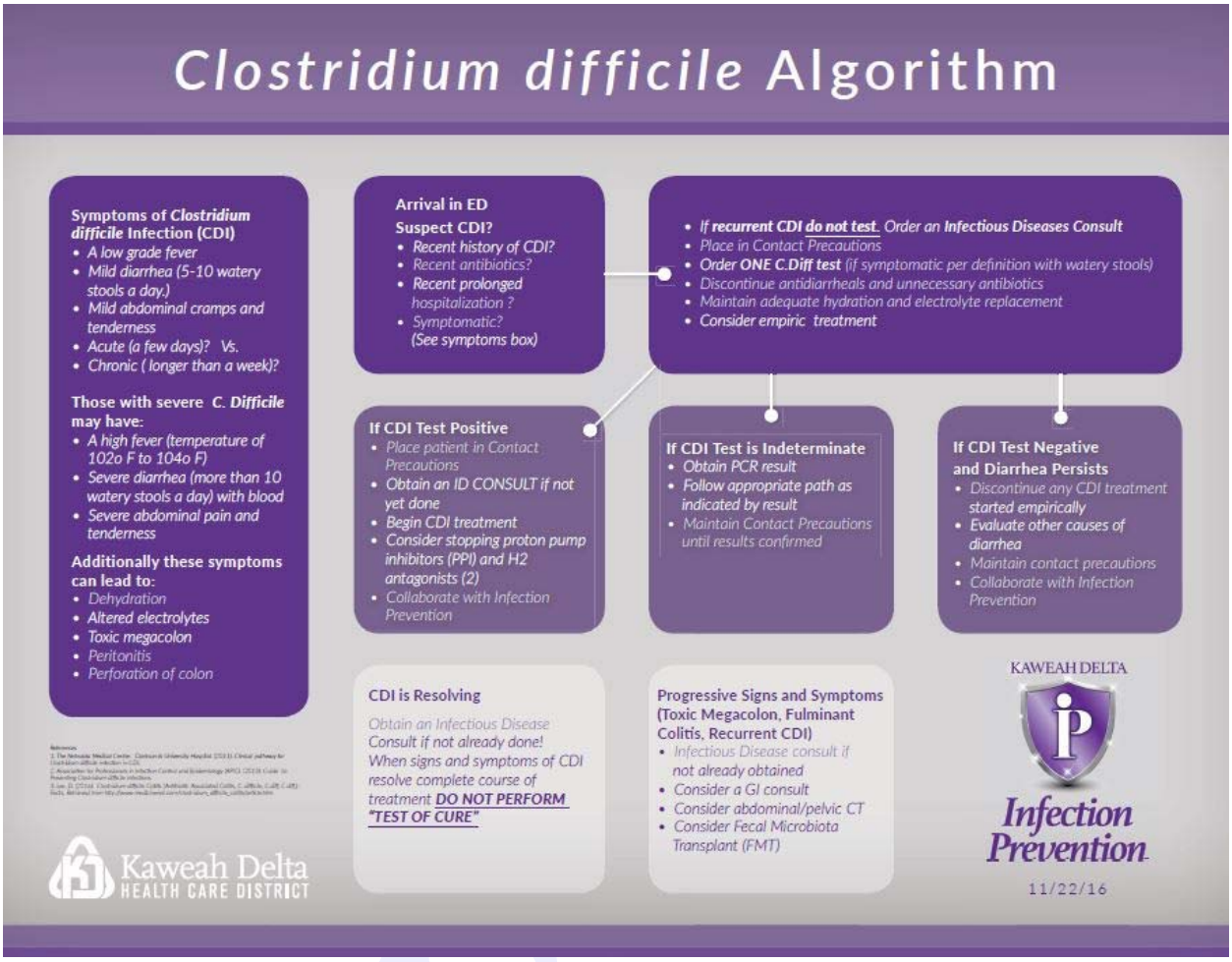
Related Documents:

Appendix 1: Bristol stool chart



Appendix 2: *Clostridium difficile* testing algorithm



References:

[1] Alasmari F, Seiler SM, Hink T, Burnham CA, Dubberke ER. Prevalence and risk factors for asymptomatic Clostridium difficile carriage. *Clin Infect Dis*. 2014;59(2):216-22.

Appendix D

Policy Submission Summary

Manual Name: Imaging Services Manual			Date: 3-12-2021
Support Staff Name: Jeannette Senn			
Routed to:			Approved By: (Name/Committee – Date)
☒ Department Director			Rose Brady
☐ Medical Director *(if applicable)*			Jeannette Senn
☐ Medical Staff Department *(if applicable)*			Suzanne Tomasiello
☐ Patient Care Policy *(if applicable)*			Dr. Glade Roper
☐ Pharmacy & Therapeutics *(if applicable)*			
☐ Interdisciplinary Practice Council *(if applicable)*			
☐ Credentials Committee *(if applicable)*			
☐ Executive Team *(if applicable)*			
☐ Medical Executive Committee *(if applicable)*			
☐ Board of Directors			
Policy/Procedure Title	**#**	**Status** (New, Revised, Reviewed, Deleted)	**Name and Phone # of person who wrote the new policy or revised an existing policy**
Imaging Services			
Contrast/Medication-CT/MRI IV Contrast Guidelines.	Con/Med.07	New	Renee Lauck 2345, Jeannette Senn 4087
MRI – Administration of Medications	IS 50.4	Archive	Tim Pedersen 3245
Contrast/Medication – BUN/Creatinine Evaluation Guidelines.	IS 11.14	Archive	Jeannette Senn 4087
MRI Guidelines for Patients receiving Gadolinium Based Contrast Agents.	IS 50.20	Archive	Tim Pedersen 3245
Contrast/Medication – CT IV Contrast Guidelines	IS 18.5	Archive	Jeannette Senn 4087

Policy Number: Con/Med.07	Date Created: No Date Set
Document Owner: Melissa Soares (Administrative Assistant)	Date Approved: Not Approved Yet
Approvers: Dept of Radiology, Medical Executive Committee, Pharmacy and Therapeutics, Glade Roper (Non-Employee Medical Staff), Jeannette Senn (Imaging Services Manager), Melissa Soares (Administrative Assistant), Renee Lauck (Dir Imaging & Radiation Svcs), Rose Brady (OP Imaging & Rad Onc Manager), Suzanne Tomasiello (Imaging Services Manager)	
Contrast/Medication - CT/MRI IV Contrast Guidelines	

Policy: Lab orders may be required for patients according to policy. Only Physicians or qualified Technologists/RN's may administer contrast in CT and MRI. RN or Physician may administer additional medications, for example, sedation or contrast reaction medications. Technologists may not administer any medication other than contrast used for imaging procedures.

Procedure:

I. **LAB Requirements for CT at Kaweah Delta Imaging Center (KDIC) and Kaweah Delta Medical Center (KDMC).** ~~(Labs are not required prior to injecting GBCA for MRI)~~

- **A.** Patients who present for imaging procedures where iodinated IV contrast ~~or Gadolinium~~ will be utilized, may need a renal panel, including, ~~BUN/~~eGFR within 90 days of the imaging procedure when meeting the criteria below. (eGFR is a calculation based ~~measurement based~~ on serum creatinine).

- **B. KDIC and KDMC patients** - Obtain eGFR in patients with a history of:
  1. Renal Disease or Renal Surgery
  2. Renal Malignancy
  3. Chemotherapy within 3 months or other potentially nephrotoxic drugs
  ~~4. Multiple Myeloma~~
  4. Single Kidney
  5. Prior or pending organ transplant

- **C. Review labs with radiologists if ordered**.
  1. If history of renal disease review eGFR within 90 days.
     - **a.** If eGFR greater than 30 mL/min/1.73 m^2, give contrast.
     - **b.** If eGFR is less than 30mL/min/1.73 m^2, discussion between ordering physician and Radiologist must occur to evaluate necessity of contrast.

- **D. KDMC Emergency Department Exceptions**
  1. If emergency (trauma or stroke), ~~give~~ may proceed with IV contrast administration before eGFR results are known. ~~– No labs required~~.
  2. For all other emergency patients with no history of renal disease, give contrast – No labs are required to assess renal function prior to IV contrast administration.
  3. If history of renal disease, review eGFR within 90 days.
     - **a.** If eGFR greater than 30 mL/min/1.73 m^2, give contrast.
     - **b.** If eGFR is less than 30 mL/min/1.73 m^2, discussion between ordering physician and Radiologist must occur to evaluate necessity of contrast.
     - **c.** If ordering physicians approves to move forward with study based on conversation with radiologist regarding risk versus benefit to patient, Technologist will document and list physicians involved in Radiology Information

System (RIS) EMR. Ordering physician will document decision to move forward with contrast in EMR.

II. **Patients~~Diabetics~~ taking Metformin (or a combination drug that contains Metformin)** ACR guidelines published in 2020.

A. ~~It is not necessary to discontinue metformin prior to administration of contra~~**~~st~~** ~~medication~~Category I – In patients with no evidence of AKI and with eGFR > 30 mL/min/1.73 m^2, there is no need to discontinue metformin either prior to or following the intravenous administration of iodinated contrast media, nor is there an obligatory need to reassess the patient's renal function following the test or procedure.

B. Category II – In patients taking metformin who are known to have acute kidney injury or severe chronic kidney disease (stage IV or state V; i.e., eGFR less than 30 mL/min/1.73 m^2) , metformin should be temporarily discontinued at the time of or prior to the procedure, and withheld for 48 hours subsequent to the procedure and reinstituted only after renal function has been re-evaluated and found to be normal.

~~**B.**~~**C.**

A. ~~**Category I** – In patients with no evidence of AKI and with eGFR greater than 30mL, there is no need to discontinue metformin either prior to or following the IV administration of iodinated contrast media.~~

B. ~~**Category II** – In patients taking metformin, who are known to have acute kidney injury or severe chronic kidney disease (stage IV or V, ie eGFR less than 30), or are undergoing arterial catheter studies that might result in emboli (atheromatous or other) to the renal arteries, metformin should be temporarily discontinued at the time of or prior to the procedure, and withheld for 48 hours subsequent to the procedure and reinstituted only after renal function has been re-evaluated and found to be normal.~~

C. ~~If creatinine is normal (< 2.0), I.V. contrast may be given; Metformin should be stopped for 2 days after CT and creatinine checked prior to restarting Metformin. Contact referring clinician to obtain lab values. Referring physician can follow up if clinically necessary~~

D. ~~If creatinine > 2.0, do not administer I.V. contrast. Contact clinician and reschedule patient. Metformin needs to be stopped two days prior and post administration of I.V. contrast in these cases and lab values need to be checked prior to restarting Metformin. Referring physician can follow up if clinically necessary~~

III. **Nephroprotection KDMC** ~~*Rheta to advise*~~

A. When practical, use of isotonic intravenous fluids (Lactated Ringers or 0.9% Sodium chloride) prior to contrast medium administration are a consideration to mitigate the risk of Contrast-induced nephropathy (CIN).

B. There is insufficient evidence to support the efficacy of N-actetylcysteine or Sodium bicarbonate prior to IV contrast medium administration to prevent CIN. Neither mannitol or furosemide is recommended for CIN risk reduction.

~~**B.**~~**C.** ~~N-Acetylcysteine~~

~~**C.**~~**D.** ~~Oral - 600mg twice a day, day before and the day of the exam~~

~~**D.**~~**E.** ~~IV – 1200 mg bolus given prior to study followed by 1200 mg twice a day IV for 48hrs after the exam (Ref: Marenzi G, et al. N-Acetylcysteine and Contrast- Induced Nephropathy in Primary Angioplasty. NEJM 2006; 354:2773-82.) Hydration - Excellent PO or IV hydration (normal saline preferably) of patients both prior to and after the exam.~~

~~**E.**~~**F.** ~~Bicarbonate - 3 amps of Bicarb (150 mEq) in one liter of 5% dextrose solution at 3mL/kg/hr for 1 hr prior to study, then at 1mL/kg/hr for 6 hours following study~~

IV. **Iodinated Contrast Allergies**

A. Patients with severe contrast allergies such as anaphylaxis, cardiac or respiratory arrest **will NOT** receive I.V. contrast; Discuss other possible imaging studies (US, MR, non-contrast CT, etc.) with clinicians.

B. All other patients with a history of moderate contrast allergies, moderate or severe reactions to foods or medications, or asthmatics on medication should be pre-medicated prior to procedure as referenced in radiology premedication protocol (see below).

1. Any patient with a history of contrast allergy of any kind must be reviewed with ordering physician and radiologist. Discussion between technologist noting radiologist and physician involved must be documented in RIS. In lieu of SBAR signature, ordering physician must document in EMR as to discussion and decision.
2. If patient has a history of a severe contrast allergy as described in the contrast categories of reactions policy ~~(IS 18.4)~~ (Con/Med.04) and in the absence of extraordinary circumstances (suspected aortic dissection, for example), ordering physicians may consider a non- contrast study. The patient can start a premedication protocol and receive a contrast exam the next day after review with radiologist.
3. If extraordinary circumstances necessitate an immediate contrast study on a patient with a severe contrast allergy and the ordering physician believes the risks outweigh the benefits to the patient, the following must take place and will exclude the need for a signature on the SBAR by physician;
   a. The ordering physician must discuss with the radiologist prior to moving forward and document discussion in EMR.
   b. If approved to move forward, Technologist will document the physicians involved in decision in RIS and can include name on SBAR form. No physician signature is necessary to move forward.

V. Iodinated Contrast Allergy Premedication:

A. Outpatient: Oral: 50 mg p.o. of prednisone 13 hour, 7 hour and 1 hour prior to procedure and 50 mg p.o. Benadryl IV, IM, or p.o 1 hour prior to procedure. Patient must have driver available.

B. Inpatient:

1. Methylprednisone (Medrol) – 32 mg p.o. 12 hour and 2 hour prior to procedure. An antihistamine as (option 1) can be added to this regimen injection.
2. If patient is unable to take p.o medication, 200 mg of hydrocortisone IV may be substituted for oral prednisone in the Greenberg protocol.
   a. Emergency premedication: Methylprednisolone sodium succinate (Solu-Medrol) 40 mg or hydrocortisone sodium succinate (Solu-Cortef) 200 mg IV every 4 hours (q4h) until contrast study required plus Benadryl 50 mg 1 hour prior to contrast injection.
   b. Dexamethasone sodium sulfate (Decadron) 7.5 mg or betamethasone 6~~.0~~ mg IV (q4h) until contrast study, must be done in patients with known allergy to Methylpred~~i~~nisolone, aspirin, non-steroidal anti-inflammatory drugs, especially if asthmatic. Also Benadryl 50 mg IV, 1 hour prior to contrast injection.
   c. Omit steroids entirely and give Benadryl 50 mg IV
   d. NOTE: IV steroids have not been shown to be affective when administered less than 4 to 6 hours prior to contrast injection.
   e. ANY adverse reaction – including hives, needs to be documented in dictation of the study as well as the EMR.

VI. Breast Feeding

A. ACR no longer recommends patients must pump & dump after the administrations of Iodinated Contrast or GBCA. The technologists will discuss with patient that the amount of contrast excreted in breast milk and absorbed by the baby is low, (less than 0.01% of the administered dose) and that it is felt to be safe to continue with breast-feeding. If the patient remains concerned, they can choose to discard breast milk for the next 24 hours.

VII. Central Venous Catheters/Inpatient

B. Dialysis catheters may be used for routine contrast injections only - 1.0-1.5mLs/second. Before using a dialysis catheter;

1. **NOTE:** Use as a **last resort** for power injection CTA when the study requires IV contrast and no other access can be obtained. The referring physician must obtain the approval from the on-call nephrologists. Also, the referring physician should verify the specific instructions for withdrawing the heparin from the line.
2. As these catheters contain **heparin, DO NOT flush** without withdrawing the heparin, since you will then bolus the patient with a large amount of heparin.
3. Nephrology must arrange for proper re-packing of the catheter with heparin following the study.
4. Other central venous catheters cannot be used for power injections unless they are "power rated." Determination of whether a catheter is "power rated" can be performed by:

   a. Visual inspection
   b. Radiographic inspection
   c. Verification with the medical record of the type of catheter placed.
   d. Verification with documentation provided by the patient.
5. NO power injections through the EJ (external jugular vein) when accessed with an angiocath.
6. If contrast is to be injected via a non "power rated" catheter, it must be via hand injection with a syringe that is 10cc or larger through the largest lumen of the catheter.

C. Dialysis is not required before or after injecting iodinated contrast.

VIII. Intraosseous Injection

IO lines may be used for CT power injection of iodinated contrast following these guidelines;

A. Flush IO line with 20mL IO saline. If IO line does not flush easily, DO Not Use.

B. If patient is unconscious, no analgesia is required. If patient is conscious and responsive to pain, IO 2% epinephrine free lidocaine should be administered by **RN or physician**, just prior to contrast as per the protocol below:

1. Adult:
   a. Prime EZ-Connect extension set with lidocaine.
   b. Slowly infuse lidocaine 40mg IO over 2 minutes.
   c. Allow lidocaine to dwell in IO space for 1 minute.
   d. Flush with 5-10mLs of normal saline.
   e. Slowly administer an additional 20mg of lidocaine IO over 1 minute.
3. Pediatric:
   a. Usual does is 0.5mg/kg, not to exceed 40mg of lidocaine.
   b. Prime EZ-Connect extension set with lidocaine.
   c. Slowly infuse lidocaine over 2 minutes.
   d. Allow lidocaine to dwell in IO space for 1 minute.
   e. Flush with 2-5mLs of normal saline.
   f. Slowly administer subsequent lidocaine (half the initial dose) IO over 1 minute.
4. Hook power injector tubing directly to IO line hub.
5. Contrast injection:
   a. Humeral IO-1.4mls/sec @ 300psi
   b. Tibial IO - 0.3mLs/sec @300psi
   c. Delay- scan immediately after contrast has been infused.
6. DC power injector tubing from IO line and flush with 20MLs normal saline.

XIII. Extravasation of contrast material in CT and/or MRI

A. ACR Guidelines for **evaluating extravasations** in patients during contrast injection include;

1. Physician and or RN should examine patient in whom extravasation has occurred. For inpatients, this can take place once patient is back in their room or the emergency department.
2. Review with patient, when possible, symptoms of pain, and paresthesia, assess extremity tenderness, swelling, erythema, active and passive range of motion of the fingers, and perfusion.
3. Physical exam should include;
   a. Evaluation of distal pulses, capillary refill, sensation, and motor skills.
   b. Examine the site itself for edema, mass effect, and tenderness.

B. Treatment for extravasation of contrast on inpatients (KDMC)

1. While there is no known effective treatment for contrast medium extravasation, physicians may recommend the following;
   a. Elevate extremity and apply warm compresses (20 minutes on, 20 minutes off). Per ACR Contrast Media Guidelines, elevation of the affected extremity above the level of the heart may decrease capillary hydrostatic pressure and promote reabsorption of extravasated fluid. Heat can also be used to improve bloodflow to the distal areas.
   b. Physicians may also recommend cold compresses, which has been reported as helpful in reducing pain at the site.
   c. Consider surgical consult prior to discharge whenever there is concern for severe extravasation injury including any of the following;
      1. Increased swelling or pain at 2-4 hours.
      2. Decreased capillary refill
      3. Change in sensation
      4. Skin ulceration or blistering
      5. Patient is at high risk of infection or tissue necrosis
         - Diabetics
         - Malignancy
         - Immunosuppression
         - Limb ischemia
         - Chronic steroid use
         - Connective tissue disease (scleroderma raynaud's)
         - Elderly
         - Venous insufficiency in the limb
         - Prior extensive surgery or radiation to limb (axillary lymph node dissection)

C. Treatment for extravasation of contrast on outpatients (KDIC)

1. Have RN and or Radiologist assess patient
2. Instruct and give patient discharge instructions in regards to monitoring site for;
   a. Site worsening
   b. Signs of infection
   c. Skin ulceration
   d. Instruct patient to call physician with any concerning signs or worsening of symptoms.
3. Contact patient the following day to check for signs of worsening.
   - If worsening, review with radiologist for next steps.

XIV. Administration of Gadolinium Based Contrast Agent (GBCA)

A. Labs are no longer required prior to injecting GBCA according to ACR guidelines.

B. Interval between injections

1. Typically 24 hours between contrast injections are advised, but can be performed sooner with radiologist review and approval.
2. In the event contrast is requested for an immediate post-operative exam which may result in the patient going back to surgery, contrast may be administered. Example: pre-op brain

studies requiring stealth protocol, post-op exams where patient may be returning to the OR post MRI.

C. Patients with Sickle Cell Disease

- Risk to patients with Sickle Cell Disease from IV-administered GBCA at approved dosages is very low or nonexistent and there is no reason to withhold these agents from these patients when their use is otherwise indicated.

D. Breast feeding patients

- 2020 ACR contrast manual states, that because of the very small percentage of GBCA is excreted into the breast milk and absorbed by the infant's gut, they believe that the available data suggest is it safe for the mother and the infant to continue to breast feed after receiving such and agent.

XV. Allergies to Gadolinium Based Contrast Agents

A. Use of Gadolinium is **contraindicated** for any patient with prior reaction to Gadolinium based contrast agent.

B. Consider non-contrast MRI or alternative studies in CT or US.

~~Old Policy IS 50.20~~
~~Extravasation~~
~~All patients who have had a contrast extravasation should be examined by a physician, either the radiologist, or, if the radiologist is off-site, the emergency department (outpatients) or clinical team (inpatients). Examine the site itself for edema, mass effect, and tenderness.~~
~~Elevate the extremity and apply warm or cold compresses (20 min on, 20 min off) Consider surgical consultation if:~~
~~Physical examination findings are worrisome: increased swelling or pain at 2-4 Hours, decreased capillary refill, change in sensation, skin ulceration or blistering. Any patient that meets the above criteria: Document the amount of extravasation and treatment taken in the dictation and a progress note.~~
~~Outpatients with Contrast Extravasation:~~
~~Instruct the patient to monitor the site for changes and what to do if the site worsens.~~
~~Contact the patient the following day by phone to check for signs of Compartment syndrome, infection, or skin ulceration.~~
~~Warming of Gadolinium-Based Contrast Media~~
~~Gadolinium-based contrast media are administered at room temperature (15 to 30o C [59 to 86o F]) and according to package inserts, should not be externally warmed for routine clinical applications.~~

~~For additional Information refer to the product insert. NEPHROGENIC SYSTEMIC FIBROSIS~~
~~Definition:~~
~~Nephrogenic Systemic Fibrosis (NSF) is a fibrosing disease, primarily involving the skin and subcutaneous tissues but also known to involve other organs, such as the lungs, esophagus, heart, and skeletal muscles. Initial symptoms typically include skin thickening and/or pruritis.~~
~~Symptoms and signs may develop and progress rapidly, with some affected patients developing contractures and joint immobility. In some patients, the disease may be fatal.~~

~~Patients at Risk:~~
~~Based on the above, the ACR Committee on Drugs and Contrast Media believes that patients receiving any GBCA should be considered at risk of developing NSF if any of the following conditions applies:~~
- ~~on dialysis (of any form)~~
- ~~severe or end-stage CKD (CKD 4 or 5, eGFR < 30 mL / min/1.73 m2) without dialysis~~
- ~~eGFR 30 to 40 mL / min/1.73 m2 without dialysis*~~
- ~~AKI (Acute Kidney Injury)~~

- patients who have received high doses of GBCA, either as a single administration or cumulatively in multiple administrations over months to years
- concomitant severe liver and renal dysfunction

* patients with eGFR 30 to 40 mL / min/1.73 m2 should also be considered at risk because eGFR levels may fluctuate (e.g., from the 30 to 40 mL / min/1.73 m2 range one day to below < 30 mL / min/1.73 m2 on another day).

Identifying Patients at Risk for NSF Prior to Any GBCA Injection
It is important to identify patients at risk of developing NSF, as defined above, prior to any GBCA injection. The method used to identify such patients may differ for outpatients and inpatients.

Identifying At-Risk Outpatients
Outpatients should be screened for conditions and other factors that may be associated with renal function impairment. Simply asking patients if they have a problem with their kidneys is not considered an effective screening tool, as this has been shown to fail to detect many patients with chronic kidney disease, regardless of severity.

The following risk factors warrants pre-administration eGFR calculation in individuals scheduled to receive any GBCA injection:

- Age > 60
- History of renal disease, including
  - Dialysis
  - Kidney Transplant
  - Single Kidney
  - Kidney surgery
  - History of known cancer involving the kidney(s)
- History of hypertension requiring medical therapy
- History of diabetes mellitus

When eGFR is recommended in Outpatients with Risk Factor(s) for Compromised Renal Function
Based on expert opinion and a need to maintain patient safety while minimizing the costs and burdens associated with additional laboratory testing, the ACR Committee on Drugs and Contrast Media recommends a new eGFR be obtained with the time

intervals listed in the Chart below (Appendix A) in outpatients who are identified by screening as at increased risk.
If no risk factors for reduced renal function were identified at screening, new laboratory testing for eGFR does not need to be done.

Identifying At-Risk Inpatients
For all inpatients, eGFR level should be obtained within two days prior to any GBCA administration. In addition, the ordering health professional should assess inpatients for the possibility of AKI, as eGFR calculation alone has limited sensitivity for the detection of AKI.

Emergency Department Patients
Patients from the Emergency Department that are at risk for NSF are to have an eGFR performed in the ED before receiving GBCA injection.

General Recommendations for Imaging Patients at Risk for NSF

Once a patient at risk for NSF is identified, alternative diagnostic examinations that do not employ a GBCA should be considered. In non-emergent or non-urgent cases if the potential benefits of a GBCA enhanced MRI are felt to outweigh the risk of NSF in an individual patient and there is no suitable alternative, the referring physician and patient should be informed of the risks of GBCA administration, and both should agree with the decision to proceed. In emergent or urgent cases it may not always be possible to inform the patient or referring physician prior to GBCA administration.

If the decision is made to administer a GBCA to a patient at increased risk for developing NSF, the name of the supervising radiologist, the reason for the examination and the rationale for use of intravenous GBCA are to be documented. Exceptions to the above recommendation may be made at the discretion of the supervising radiologist, such as in the rare instance of an acute, life-threatening condition, and after consultation with the referring health care professional.
However, the rationale for the exception must be documented.

Specific Recommendations for Specific Groups of Patients

Patients with end-stage renal disease on chronic dialysis
Consider administering iodinated contrast media and performing a CT rather than a MRI.

Patients with CKD 4 or 5 (eGFR<30mL) not on chronic dialysis
It is recommended that any GBCA be avoided in this patient group. However if GBCA enhanced MRI is deemed essential by the supervising radiologist, the name of the supervising radiologist, the reason for the examination and the rationale for use of intravenous GBCA are to be documented on the SBAR.

Patients with CKD 3 (eGFR 30 to 59)
GBCA may be administered to patients with an eGFR in the range of 30 to 40 by the use of a half-dose (0.05mmol/kg) of contrast. In comparison, no special precautions are required in patients with an eGFR of 40 to 59.

Patients with CKD 1 or 2 (eGFR 60 to 119)
GBCA can be administered safely to these patients.

Patients with acute kidney injury (AKI)
Patients with AKI who have been exposed to GBCA are at risk for developing NSF. Due to the temporal lag between eGFR (which is calculated using serum creatinine values) and actual glomerular filtration rates, it is not possible to determine whether a given patient has AKI based on a single eGFR determination. Accordingly, caution should be exercised in use of GBCA in patients with known or suspected AKI regardless of measured serum creatinine or calculated eGFR values. GBCA should only be administered to these patients if absolutely necessary.

Appendix A.

When a new eGFR should be obtained in outpatients with risk factor(s) for compromised renal function

Prior eGFR level (mL / min/1.73 m2) When was the last eGFR before MRI? When should new eGFR be obtained prior to MRI?
None Available Not Applicable Within 6 weeks
> 60 > 6 months Within 6 weeks
> 60 < 6 months (stable state*) New eGFR not needed
> 60 < 6 months (possibly unstable state**) Within 2 weeks
30-59 > 2 weeks Within 2 weeks

~~< 30 > 1 week Within 1 week~~
~~On dialysis Not applicable New eGFR not needed~~
~~* The patient does not have a known condition that might result in acute deterioration of renal function~~
~~** The patient has a known condition that might result in acute deterioration of renal function. Such conditions include severe dehydration, febrile illness, sepsis, heart failure, recent hospitalization, advanced liver disease, abdominal surgery~~

Related Documents:
https://www.acr.org/-/media/ACR/files/clinical-resources/contrast_media.pdf

Insert hyperlink here or delete if no existing related documents exist.

References:

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

ISBARQ

Optimizing "MED Central Venous Access Device Care" Power Plan

03/08/2021

Introduction:

Kimberly Roller, MSN, RN. Clinical Informaticist. Extension: 5341

Situation:

Power plan not being used. Need to optimize power plan and make separate plan for central line care so nurses can enter per policy.

Background:

Central line care orders not being placed. Central lines not being flushed. Current power plan has insertion and care orders. Nurses do not have their own power plan to order central line care per policy. CLABSI issue.

Requested by: Amy Baker

Assessment:

Category of change requested Category 1: Enhancement

Suggested changes to order sets:

1. Optimization of the MED Central Venous Access Device Care Power Plan. Make the following changes:
    a. Add order "Ok to use" – leave unchecked
    b. Update flushes to what Lippincott says (since that will be what policy states): see screen shot of flush orders. NS flush 10 ml q 12 hours. Flush central venous access device with 10 - 20 ml flush when not in use. & NS flush 20 ml
        i. PRN: Indication 1 : 10 to 20 mL flush after medication infusion when central venous access devices used intermittently
        ii. PRN Indication 2: 20 mL after blood sampling/transfusion from central venous access device.
    c. Change name of PowerPlan "MED Central Venous Access Device Care" to "MED Central Line Insertion and Care Order"
    d. Add a new Power Plan "Nursing Central Line Care Orders" for nurse to order per policy if other Power Plan is not ordered by MD and for patients returning from IR, or who have a central line present on admission.
        i. This new power plan will contain orders for flushes, line care (flush orders per above recommendation and line care orders that exist in the current power plan)

Recommended communication/education for affected disciplines (i.e. RNs Prescribers, Pharmacists, etc.: TBD

Recommendation:

- Approve changes/content ☒
- Approve design ☐
- Screenshots attached ☐
- Send back to Sponsor/SME with comments for further review ☐

Unique Plan Description: MED Central Line Insertion and Care
Plan Selection Display: MED Central Line Insertion and Care
PlanType: Medical
Version: 3
Begin Effective Date: 3/9/2021 3/9/2021 3:34 PM
End Effective Date: Current
Available at all facilities

MED Central Line Insertion and Care
Patient Care

- ☑ Central Line Insertion Setup
- ☑ Central Venous Access Device Line Care
  T;N, every week, PRN, Change semipermeable and chlorhexidine-impregnated sponge dressings and needleless connectors every 7 days and prn.
- ☑ Central Venous Access Device Line Care
  T;N, every other day, Change gauze dressing every 48 hours. If gauze dressing, change to semipermeable dressing when drainage stops.
- ☐ Central Line okay to use

Medications

- ☐ chlorhexidine topical
  1 app, Topical, Pad, every evening
  Comments: For prevention of CLABSI.Skin cleanser should not be used in the eyes, ears, mouth, or genitals.Avoid direct contact to brain tissue or meninges.
- ☑ Xylocaine 1% injectable
  20 mL, N/A, Injection, On Call
  Comments: To bedside - have available for practitionerPractitioner to administer as needed for central venous access placement.

Flushes

- ☑ sodium chloride 0.9% flush
  10 mL, IV Push, every 12 hours.
  Comments: Indication: Flush central venous access device with 10 - 20 ml flush when not in use.
- ☑ sodium chloride 0.9% flush
  20 mL, IV Push, Injection, As Directed, PRN other (see comment)
  Comments: PRN Indication 1 : 10mL flush after medication infusion when central venous access devices used intermittantlyPRN Indication 2: 20 mL after blood sampling/transfusion from central venous access device.

Laboratory

Consider obtaining blood culture prior to placing central line if signs of infection present (i.e. sepsis).(NOTE)*

- ☐ Blood Culture
  T;N, Blood, Stat collect, ST - Stat
  Comments: Please obtain from different site as other blood draw.
- ☐ Blood Culture
  T;N, Blood, Stat collect, ST - Stat
  Comments: Please obtain from different site as other blood draw.

Diagnostic Tests

- ☑ XR Chest 1 View Portable
  Stat, Reason: Line placement, RN to call when line is placed

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: Nursing Central Line Care Orders
Plan Selection Display: Nursing Central Line Care Orders
PlanType: Interdisciplinary
Version: 1
Begin Effective Date: 3/9/2021 3/9/2021 3:45 PM
End Effective Date: Current
Available at all facilities

Nursing Central Line Care Orders
Patient Care

- ☑ Central Venous Access Device Line Care
  T;N, every week, PRN, Change semipermeable and chlorhexidine-impregnated sponge dressings and needleless connectors every 7 days and prn.
- ☑ Central Venous Access Device Line Care
  T;N, every other day, Change gauze dressing every 48 hours. If gauze dressing, change to semipermeable dressing when drainage stops.

Medications
Flushes

- ☑ sodium chloride 0.9% flush
  10 mL, IV Push, every 12 hours.
  Comments: Indication: Flush central venous access device with 10 - 20 ml flush when not in use.
- ☑ sodium chloride 0.9% flush
  20 mL, IV Push, Injection, As Directed, PRN other (see comment)
  Comments: PRN Indication 1 : 10 mL flush after medication infusion when central venous access devices used intermittently PRN Indication 2: 20 mL after blood sampling/transfusion from central venous access device.

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GOAL - This component is a goal
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INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: Standardized Procedure: Treatment of Hypoglycemia
Plan Selection Display: Standardized Procedure: Treatment of Hypoglycemia
PlanType: Medical
Version: 3
Begin Effective Date: 6/13/2019 6/13/2019 9:51 AM
End Effective Date: Current
Available at all facilities

Standardized Procedure: Treatment of Hypoglycemia
Medications

Link to PC-SP.113 Hypoglycemia Identification & Treatment of, Adult: Collection of Point of Care Glucose & Administration of Dextroseor Glucagon(NOTE)*

POC Glucose LESS THAN 70

Able to eat AND Mild Symptoms (NOTE)*

Choose one of the following to equal 12-15 g carbohydrates:Give 4 oz of fruit juice, 6 oz regular soda or 8 oz milk.*For renal patients choose one of the following:4 oz apple juic or 6 oz of clear regular soda(NOTE)*

IV Access AvailableMild Symptoms AND NPO or unable to eat (NOTE)*

☐ Dextrose 10% Water Bolus*

100 to 150 mL, IV Bolus, Soln-IV, every 15 min, PRN other (see comment)

Comments: PRN Indication: Blood Glucose LESS than 70 with mild symptoms AND is NPO or unable to eat. Treat and notify practitioner per standardize procedure SP. 113Dosing Instructions:1) Initial dose = Dextrose 10% 100 ml (10g) IV bolus via infusion at 999 mL/hr x 1 2) If blood glucose remains less than 70 mg/dL (at 15 minute repeat blood glucose), start rapid infusion of Dextrose 10% 250 mL bag and administer 150 mL bolus (containing 15 g dextrose) via infusion pump at rate of 999 mL/hour. If blood glucose remains less than 70 mg/dL at 15 minute POC blood glucose repeat 150 mL bolus.

POC Glucose LESS THAN 70 with severe symptoms or patient is unresponseve and has alterted level of consciousness(NOTE)*

☐ dextrose 50% Syringe

25 mL, IV Push, Syringe-inj, every 15 min, PRN other (see comment)

Comments: PRN Indication: POC blood glucose less than 70 mg/dL with severe symptoms or patient unresponsive or has altered level of consciousness (ALOC). Treat and notify practitioner per standardize procedure SP.113May repeat 25 mL IV push every 15 minutes PRN blood glucose LESS THAN 70 mg/dL If ALOC persist after second dose of Dextrose 50% Water administrationed call RRT AND practitioner.

No IV Access(NOTE)*

☐ glucagon

1 mg, IM, Injection, As Directed, PRN other (see comment)

Comments: Blood Glucose LESS than 70 and if no IV access. May repeat once in 20 minutes if necessaryTreat and notify practitionerAdminister and monitor per Standardize procedure SP. 113Place patient on their side after administration to prevent aspiration (nausea & vomiting may be expected)

Non Categorized

☐ Initial Approval Date

☐ Annual Review Date

10/30/2019

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ISBARQ

CC General Admission PowerPlan

3/4/2021

Introduction:

Leah Daugherty

Situation:

The Culture of Culturing Committee would like to have the Blood Culture Communication order removed from the CC General Admission PowerPlan.

To improve our use of blood cultures the physicians on this committee have recommended to not have this order as standard and rather as a free standing adhoc order to place according to physician discretion.

Background:

Requested by: Dr. Malli

Assessment:

Category of change requested Category 1: Enhancement

Suggested changes to order sets:

Remove the Blood Culture Communication order from the PowerPlan, but keep the order available for individual ordering.

Also, Remove the Insert Indwelling Urinary Catheter Order and replace it with the Insert Indwelling Urinary Catheter Subphase.

Recommended communication/education for affected disciplines (i.e. RNs Prescribers, Pharmacists, etc.: Med Staff communication (KDHub Update)

Recommendation:

- Approve changes/content ☒
- Approve design ☐
- Screenshots attached ☐
- Send back to Sponsor/SME with comments for further review ☐

Unique Plan Description: CC General ICU Admission
Plan Selection Display: CC General ICU Admission
PlanType: Medical
Version: 11
Begin Effective Date: 3/4/2021 3/4/2021 2:11 PM
End Effective Date: Current
Available at all facilities

CC General ICU Admission
Admit/Transfer/Discharge/Status

- ☐ Admit to Inpatient
  - *Level of Care: ICU* (DEF)*
  - *Level of Care: CVICU*

Patient Care

- ☑ Vital Signs
  - *T;N, every 1 hr* (DEF)*
  - *every 2 hr*
  - *every 4 hr*
- ☑ Intake and Output
  - *T;N, every 1 hr* (DEF)*
  - *every 2 hr*
  - *every 4 hr*
  - *every 6 hr*
  - *every 8 hr*
- ☑ Weight in Kilograms
  - *Daily*
- ☐ Neurological Checks
  - *every 1 hr* (DEF)*
  - *every 2 hr*
  - *every 4 hr*
  - *every 6 hr*
  - *every 12 hr*
- ☐ No Blood Pressure (BP) or Veno-Arterial Punctures
  - *Left Upper extremity restriction* (DEF)*
  - *Right Upper extremity restriction*
  - *Bilateral Upper extremity restriction*
  - *Left Lower extremity restriction*
  - *Right Lower extremity restriction*
  - *Bilateral Lower extremity restriction*

Lines/Tubes/Drains

- ☐ Peripheral IV
  - *unless already in place*
- ☐ Peripheral IV
  - *second, unless already in place*
- ☐ Arterial Line
- ☐ Arterial Line Care
- ☐ Central Line Care
- ☐ Insert Indwelling Urinary Catheter(SUB)*
- ☐ Chest Tube Care
  - *Wall suction to -20cm water*
- ☐ Nasogastric (NG) Tube Insertion
- ☐ Nasogastric (NG) Tube Care
  - *Tube to: Low Intermittent Suction* (DEF)*
  - *Tube to: Low Constant Suction*
  - *Tube to: Clamped, Check residuals every 4 hr*
- ☐ Orogastric (OG) Tube Insertion
- ☐ Orogastric (OG) Tube Care
  - *Tube to: Low Intermittent Suction* (DEF)*

Tube to: Low Constant Suction
Tube to: Clamped, Check residuals every 4 hr

Activity

☑ Head of Bed
- *Head of Bed Level: 30 degrees or GREATER* (DEF)*
- *Head of Bed Level: 45 degrees or GREATER*
- *Head of Bed Level: flat*
- *Head of Bed Level: trendelenburg*
- *Head of Bed Level: reverse trendelenburg*

☐ Up with Assistance

☐ Up to Chair
- *BID* (DEF)*
- *TID*
- *As tolerated*

☐ Bedrest with Bathroom Privileges

☐ Bedrest (strict)
- *Rationale: Hemodynamic Instability* (DEF)*
- *Rationale: Femoral Vascular Catheter*
- *Rationale: Intra-Aortic Balloon Pump*
- *Rationale: Intracranial Pressure Monitoring*
- *Rationale: Open Abdomen*
- *Rationale: Unstable C-Spine*

☐ Ambulate
- *BID* (DEF)*
- *TID*
- *QID*

Diet/Nutrition

☐ NPO
- *Except for Medications* (DEF)*
- *No Exceptions*
- *Except for Ice Chips*
- *Except for Sips of Water*

☐ Regular Diet

☐ Cardiac Diet
- *Low Fat/Low Cholesterol Diet* (DEF)*
- *Renal*
- *Low Fat/Low Cholesterol Diet, Diabetic*
- *Renal | Low Fat/Low Cholesterol Diet, Diabetic*

☐ Diabetic Diet
- *Diabetic*

☐ Renal Diet
- *Renal*

Continuous Infusions

Bolus

☐ Sodium Chloride 0.9% - Normal Saline - Bolus
- *30 mL/kg, IV Bolus, Soln-IV, Once* (DEF)*
- *500 mL, IV Bolus, Soln-IV, Once*
- *1,000 mL, IV Bolus, Soln-IV, Once*

☐ Lactated Ringers Bolus
- *30 mL/kg, IV Bolus, Soln-IV, Once* (DEF)*
- *500 mL, IV Bolus, Soln-IV, Once*
- *1,000 mL, IV Bolus, Soln-IV, Once*

☐ Plasma-Lyte A PH-7.4 BOLUS
- *30 mL/kg, IV Bolus, Soln-IV, Once* (DEF)*
- *500 mL, IV Bolus, Soln-IV, Once*
- *1,000 mL, IV Bolus, Soln-IV, Once*

IV Continuous Drips

☐ Lactated Ringers Drip

1,000 mL, IV, 100 mL/hr

☐ Sodium Chloride 0.9%
1,000 mL, IV, 100 mL/hr

☐ Dextrose 5% Water/Sodium Chloride 0.45%/KCl 20 mEq
1,000 mL, IV, 100 mL/hr

☐ Dextrose 10% Water
1,000 mL, IV, 100 mL/hr

☐ Common IV Fluids(SUB)*

Cardiovascular Drips

norEPINEPHrine (Levophed) starting rate 0.01 mcg/kg/min(NOTE)*

☐ norEPINEPHrine (mcg/kg/min) 4 mg/Dextrose 5% Water 250 mL (Levophed) (IVS)*
Dextrose 5% Water*
250 mL, IV, Titration instructions: 0.02 mcg/kg/min as often as every 1 minute, Max Dose: 3 mcg/kg/min, Goal: Mean arterial pressure GREATER than 65 mmHg
Comments: When the infusion has been weaned to off with the patient stable and at goal for at least 6 hours, the RN may discontinue this order
norEPINEPHrine additive*
4 mg, EB, 0.01 mcg/kg/min

Vasopressin rate 0.03 units/min(NOTE)*

☐ vasopressin (Pitressin) 100 units/Sodium Chloride 0.9% 100 mL (IVS)*
Sodium Chloride 0.9%*
100 mL, IV, Goal: n/a
vasopressin additive*
100 units

☐ CC Vasoactive Drips(SUB)*

Medications

VTE Prophylaxis

To address VTE prophylaxis, order chemical and/or mechanical VTE prophylaxis via the subphase(s) below. Or, to document a risk score and/or contraindication to prophylaxis, select the VTE Advisor order below(NOTE)*

☐ VTE Critical Care Patients(SUB)*

☐ VTE Advisor

Sedation

☐ CC Analgesia and Sedation Management(SUB)*

Glycemic Control

☐ GM IV Insulin Infusion(SUB)*

☐ GM Subcut insulin Eating (basal/bolus + correction)(SUB)*

☐ GM Subcut insulin NPO/Continuous Enteral Feeding (basal + correction)(SUB)*

Gastrointestinal Agents

☐ Pepcid
20 mg, IV Push, Injection, every 12 hours. (DEF)*
20 mg, Oral, Tab, every 12 hours.
20 mg, NG Tube, Tab, every 12 hours.

☐ Protonix
40 mg, Oral, Tab-DR, Daily
Comments: Do not crush or chew.

Respiratory Medications

Albuterol/Ipratropium MDI removed due to a national shortage. If needed search for orders in powerchart and review restrictions. (NOTE)*

☐ Proventil 2.5 mg/3 mL (0.083%) inhalation solution
2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT (DEF)*
2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT

☐ Proventil 2.5 mg/3 mL (0.083%) inhalation solution
2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 2 hours. RT, PRN shortness of breath or wheezing (DEF)*
Comments: Give with ipratropium (Atrovent) if ordered and for same indication
2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT, PRN shortness of breath or wheezing
Comments: Give with ipratropium (Atrovent) if ordered and for same indication
2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT, PRN shortness of breath or wheezing

Comments: Give with ipratropium (Atrovent) if ordered and for same indication

☐ Proventil HFA 90 mcg/inh inhalation aerosol
6 puffs, Inhale, Aerosol, every 4 hours. RT (DEF)*
Comments: may keep at bedside
2 puffs, Inhale, Aerosol, every 4 hours. RT
Comments: may keep at bedside

☐ Atrovent 0.02% 500 mcg/2.5 mL solution for nebulization
0.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT (DEF)*
0.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT

☐ Atrovent 0.02% 500 mcg/2.5 mL solution for nebulization
0.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT, PRN shortness of breath or wheezing (DEF)*
Comments: Give with Beta-Agonist (albuterol or levalbuterol) if ordered and for same indication
0.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 2 hours. RT, PRN shortness of breath or wheezing
Comments: Give with Beta-Agonist (albuterol or levalbuterol) if ordered and for same indication
0.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT, PRN shortness of breath or wheezing
Comments: Give with Beta-Agonist (albuterol or levalbuterol) if ordered and for same indication

☐ Brovana 15 mcg/2 mL inhalation solution
15 mcg, NEB, Device: Aerosol, Soln-Inhalation, BID RT

☐ Pulmicort Respules 0.5 mg/2 mL inhalation suspension
0.5 mg, NEB, Susp, BID RT

Diuretics

☐ Lasix
40 mg, IV Push, Injection, BID

Antibiotics

☐ ID Empiric Severe Sepsis (Unknown Source) Antibiotics(SUB)*
☐ ID Empiric Pneumonia HCAP/HAP/VAP Antibiotics(SUB)*
☐ ID Empiric Pneumonia CAP Antibiotics(SUB)*
☐ ID Empiric Skin and Soft Tissue Infection (SSTI/Cellulitis) Antibiotics(SUB)*
☐ ID Empiric Urinary Tract Infection (UTI) Antibiotics(SUB)*
☐ ID Clostridium Difficile (C.Diff) Antibiotics (PO Vancomycin and Metronidazole (Flagyl))(SUB)*
☐ ID Empiric Febrile Neutropenia Antibiotics(SUB)*
☐ ID Empiric Intra-Abdominal Infection Antibiotics(SUB)*
☐ ID Empiric Meningitis Antibiotics(SUB)*

Smoking Cessation Medications

☐ Smoking and Tobacco Cessation(SUB)*

Miscellaneous

☑ chlorhexidine 2% topical pad
1 app, Topical, Pad, every evening
Comments: Skin Cleanser should not be used in the eyes, ears, mouth, or genitalsAvoid direct contact to brain tissue or meninges

Laboratory

☐ CBC with Differential
T;N, Blood, Stat

☐ PTT
T;N, Blood, Stat

☐ PT/INR
T;N, Blood, Stat

☐ Basic Metabolic Panel
T;N, Blood, Stat

☐ Complete Metabolic Panel
T;N, Blood, Stat

☐ Magnesium Level
T;N, Blood, Stat

☐ Phosphorus Level
T;N, Blood, Stat

- ☐ Ammonia Level
  T;N, Blood, Stat
- ☐ Lipase Level
  T;N, Blood, Stat
- ☐ Troponin-I (cardiac marker)
  T;N, Blood, Stat
- ☐ Creatine Kinase
  T;N, Blood, Stat
- ☐ B-Type Natriuretic Peptide (BNP)
  T;N, Blood, Stat
- ☐ Hemoglobin A1c (Glycosylated)
  T;N, Blood, Stat
- ☐ Lactic Acid, Plasma (Venous)
  T;N, Blood, Stat
- ☐ Procalcitonin
  T;N, Blood, Stat
- ☐ Liver Panel
  T;N, Blood, Stat
- ☐ Urinalysis with Microscopic
  T;N, Stat Collect
- ☐ Sputum Culture with Gram Stain
  T;N, Stat collect, ST - Stat
- ☐ Drugs of Abuse Screen, Urine toxicology
  T;N, Urine, Stat Collect, Nurse collect
- ☐ Blood Culture X 2 Lab to Draw(SUB)*
- ☐ Arterial Blood Gas (ABG) POINT OF CARE
- ☐ Venous Blood Gas (VBG) POINT OF CARE
- ☐ Type and Screen Only
- ☐ CC Add On Labs(SUB)*
- ☑ Creatinine
  T;N, Blood, Stat
- ☑ Bilirubin Total
  T;N, Blood, Stat
- ☑ Platelet Count
  T;N, Blood, Stat

Morning Labs

- ☐ CBC with Differential
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ PTT
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ PT/INR
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ Basic Metabolic Panel
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ Complete Metabolic Panel
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ Troponin-I (cardiac marker)
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ Lactic Acid, Plasma (Venous)
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☐ Liver Panel
  T+1;0330, Blood, AM Draw (Inpatient Only)
- ☑ Creatinine
  T+1;0330, Blood, AM Draw (Inpatient Only), Daily, for 3 days
- ☑ Bilirubin Total

T+1;0330, Blood, AM Draw (Inpatient Only), Daily, for 3 days

☑ Platelet Count
T+1;0330, Blood, AM Draw (Inpatient Only), Daily, for 3 days

Diagnostic Tests

☐ XR Chest 1 View Portable
ASAP, Reason: Shortness of breath (DEF)*
Stat, Reason: Shortness of breath
Routine, Reason: Shortness of breath

☐ XR Chest 1 View Portable
In AM, Reason: Shortness of breath

☐ XR Abdomen KUB 1 View
ASAP, Reason: Abdominal pain (DEF)*
Stat, Reason: Abdominal pain
Routine, Reason: Abdominal pain
ASAP, Reason: Feeding tube placement
Routine, Reason: Feeding tube placement

☐ CT Brain/Head w/o Contrast
ASAP, Reason: Altered level of consciousness (DEF)*
Stat, Reason: Altered level of consciousness
Routine, Reason: Altered level of consciousness

☐ CT Abdomen and Pelvis w/o Contrast
ASAP, Reason: Abdominal pain (DEF)*
ASAP, Reason: Ascites
ASAP, Reason: Bowel obstruction
ASAP, Reason: Sepsis
ASAP, Reason: Pancreatitis, known

☐ CT Abdomen and Pelvis w/ Contrast
ASAP, Reason: Abdominal Pain (DEF)*
Stat, Reason: Abdominal pain
Routine, Reason: Abdominal pain

☐ CT Chest W/ Contrast
ASAP

☐ CT Chest WO Contrast
ASAP

☐ CTA Chest
ASAP

Card/Vasc/Neuro

☐ Electrocardiogram 12 lead

Respiratory

☐ Oxygen Therapy
SpO2 goal 92% or GREATER, Use least amount of O2 to maintain oxygen level within parameters. (DEF)*
SpO2 goal 90 - 94 %
SpO2 goal 90% or GREATER
SpO2 goal 94% or GREATER
SpO2 goal 89 - 94 %

☐ Patient may use CPAP/BiPAP machine from home

☐ CC Ventilator Management Adult(SUB)*

Consults/Referrals

☐ OT Evaluation and Treatment Acute Per Protocol

☐ PT Evaluation and Treatment Acute Per Protocol

☐ Speech Language Pathology Bedside Swallow Evaluation and Treatment Per Protocol

☐ Consult to Wound Care RN with follow up as needed

☐ Consult to Physician

Communication Orders

☑ Notify Treating Practitioner Vital Signs
Systolic BP GREATER than 200 mmHg, Systolic BP LESS than 90 mmHg, Mean AP LESS than 65

mmHg, HR GREATER than 130 beats/min, HR LESS than 60 beats/min, RR GREATER than 35 breaths/min, RR LESS than 10 breaths/min, SpO2 LESS than 90 %, Urine Output LESS than

Non Categorized

☐ Initial Approval Date
10/17/2017

☐ Annual Review Date
10/20/2020

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: ED Sepsis 1 (Suspected or Present)
Plan Selection Display: ED Sepsis 1 (Suspected or Present)
PlanType: Medical
Version: 6
Begin Effective Date: 2/16/2021 2/16/2021 8:25 AM
End Effective Date: Current
Available at all facilities

ED Sepsis 1 (Suspected or Present)
Patient Care

- ☑ Weight in Kilograms
  T;N
- ☑ Cardiac Monitoring ED
  T;N
- ☑ Pulse Oximetry Continuous
  T;N
- ☑ Peripheral IV
  T;N, Large bore IV if not already placed
- ☐ Peripheral IV
  T;N, Large bore IV if not already placed
- ☑ Communication Order
  T;N, Do not return patient to WR, Notify zone 2 practitioner, Start Antibiotic order if unable to get blood culture in 30 minutes

Continuous Infusions
Bolus

For patients with a BMI > 30 use IBW to calculate target volume goal.(NOTE)*

- ☐ Lactated Ringers Bolus
  30 mL/kg, IV Bolus, Soln-IV, Once
  Comments: Administer within 30 minutes of orderingInfuse IV bolus over 1 hour
- ☐ Sodium Chloride 0.9% - Normal Saline - Bolus
  30 mL/kg, IV Bolus, Soln-IV, Once
  Comments: Administer within 30 minutes of orderingInfuse IV bolus over 1 hour

IV Continuous Drips

If concern for fluid overload (ESRD, CHF) [Pre-select kg range based on documented weight]. If BMI > 30, uncheck defaulted kg range and select order that matches IBW(NOTE)*

- ☐ Lactated Ringers Drip
  1,000 mL, IV, 126 mL/hr, Order Duration: 24 hr [90 - 100 kg] (DEF)*
  1,000 mL, IV, 126 mL/hr, Order Duration: 22 hr [80 - 89.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 19 hr [70 - 79.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 17 hr [60 - 69.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 14 hr [50 - 59.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 12 hr [40 - 49.9 kg]
- ☐ Sodium Chloride 0.9% - Normal Saline - drip
  1,000 mL, IV, 126 mL/hr, Order Duration: 24 hr [90 - 100 kg] (DEF)*
  1,000 mL, IV, 126 mL/hr, Order Duration: 22 hr [80 - 89.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 19 hr [70 - 79.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 17 hr [60 - 69.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 14 hr [50 - 59.9 kg]
  1,000 mL, IV, 126 mL/hr, Order Duration: 12 hr [40 - 49.9 kg]

Medications
Recommended Regimen

Recommended Regimen #1: Severe community acquired infections or meningitis.(NOTE)*

- ☐ Rocephin
  2 g, IV Piggyback, Soln-IV, Once, Indication: Sepsis
  Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Recommended Regimen #2: Severe infections with concern for multi-drug resistant organisms (Vancomycin and piperacillin/tazobactam order).(NOTE)*

- ☐ vancomycin
  20 mg/kg, IV Piggyback, Soln-IV, Once, Indication: Sepsis

Comments: Maximum of 2 grams. Pharmacist may adjust dose as necessary. Start antibiotic order if unable to get blood culture in 30 minutes

☐ Zosyn
4.5 g, IV Piggyback, Soln-IV, Once, Indication: Sepsis, Administer over: 30 minutes
Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Antibiotic BETA Lactam Alternative

☐ Merrem
1 g, IV Push, Injection, Once, Indication: Sepsis
Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Laboratory

De-select if already done(NOTE)*

☑ Blood Culture
T;N, Blood, Stat collect, ST - Stat, Nurse collect

☑ Blood Culture
T;N, Blood, Stat collect, ST - Stat, Nurse collect

☑ CBC with Diff
T;N, Blood, Stat, Nurse collect

☑ VBG (Lactic Acid Only) Gem
T;N, Blood, Stat, Nurse collect

☑ CMP
T;N, Blood, Stat, Nurse collect

☑ VBG (Lactic Acid Only) Gem
T;N+240, Blood, Timed Study, Nurse collect
Comments: per logic built into this order, if a Lactic Acid results LESS than 2.0, then all future Lactic Acid orders will be canceled.

☐ UA with Microscopic, Culture if Ind
T;N, Stat Collect

☐ ED COVID-19/Influenza Lab Orders(SUB)*

☐ Procalcitonin
T;N, Blood, Stat, Once, Nurse collect

☐ POC Strep A
T;N, Throat, Stat collect, Nurse collect

☐ BNP
T;N, Blood, Stat, Once, Nurse collect

☐ DDimer, Quantitative
T;N, Blood, Stat, Once, Nurse collect

Diagnostic Tests

☑ XR Chest 1 View Portable
T;N, Stat

☐ POCUS Abdomen
T;N

☐ POCUS Cardiac
T;N

☐ POCUS Chest
T;N

Card/Vasc/Neuro

☐ EKG (ED)
T;N, Stat

Respiratory

☑ Oxygen Therapy
T;N, Stat, Flow Rate (L/min): 2, SpO2 goal 94% or GREATER, Nasal Cannula, Contact practitioner if the pt. has an increase in O2 requirements or inability to maintain SpO2 as specified

☑ Respiratory Therapy to Evaluate
T;N, Stat, Oxygen Therapy

Non Categorized

☑ Sepsis Quality Measures

☐ Initial Approval Date
3/20/18 (DEF)*
revision changes approved 9/18/2018

☐ Annual Review Date
10/20/2020

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GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: ED Sepsis 1A (Atypical Presentation/Catch-Up Orders)
Plan Selection Display: ED Sepsis 1A (Atypical Presentation/Catch-Up Orders)
PlanType: Medical
Version: 3
Begin Effective Date: 2/16/2021 2/16/2021 8:28 AM
End Effective Date: Current
Available at all facilities

ED Sepsis 1A (Atypical Presentation/Catch-Up Orders)
Patient Care

- ☐ Weight in Kilograms
  T;N
- ☐ Cardiac Monitoring ED
  T;N
- ☐ Pulse Oximetry Continuous
  T;N
- ☐ Peripheral IV
  T;N, Large bore IV if not already placed
- ☐ Peripheral IV
  T;N, Large bore IV if not already placed
- ☐ Communication Order
  T;N, Do not return patient to WR, Notify zone 2 practitioner, Start Antibiotic order if unable to get blood culture in 30 minutes

Continuous Infusions
Bolus

If BMI > 30, uncheck defaulted kg range and select order that matches IBW(NOTE)*

- ☐ Lactated Ringers Bolus
  30 mL/kg, IV Bolus, Soln-IV, Once
  Comments: Administer within 30 minutes of orderingInfuse IV bolus over 1 hour
- ☐ Sodium Chloride 0.9% - Normal Saline - Bolus
  30 mL/kg, IV Bolus, Soln-IV, Once
  Comments: Administer within 30 minutes of orderingInfuse IV bolus over 1 hour

IV Continuous Drips

If concern for fluid overload (ESRD, CHF) [Pre-select kg range based on documented weight]. If BMI > 30, uncheck defaulted kg range and select order that matches IBW(NOTE)*

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  Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Recommended Regimen #2: Severe infections with concern for multi-drug resistant organisms (Vancomycin and piperacillin/tazobactam order).(NOTE)*

- ☐ vancomycin
  20 mg/kg, IV Piggyback, Soln-IV, Once, Indication: Sepsis

Comments: Maximum of 2 grams. Pharmacist may adjust dose as necessary. Start antibiotic order if unable to get blood culture in 30 minutes

☐ Zosyn
4.5 g, IV Piggyback, Soln-IV, Once, Indication: Sepsis, Administer over: 30 minutes
Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Antibiotic BETA Lactam Alternative

☐ Merrem
1 g, IV Push, Injection, Once, Indication: Sepsis
Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Laboratory

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T;N, Blood, Stat collect, ST - Stat, Nurse collect

☐ Blood Culture
T;N, Blood, Stat collect, ST - Stat, Nurse collect

☐ CBC with Diff
T;N, Blood, Stat, Nurse collect

☐ VBG (Lactic Acid Only) Gem
T;N, Blood, Stat, Nurse collect

☐ CMP
T;N, Blood, Stat, Nurse collect

☐ VBG (Lactic Acid Only) Gem
T;N+240, Blood, Timed Study, Nurse collect

☐ UA with Microscopic, Culture if Ind
T;N, Stat Collect

☐ ED COVID-19/Influenza Lab Orders(SUB)*

☐ Procalcitonin
T;N, Blood, Stat, Once, Nurse collect

☐ POC Strep A
T;N, Throat, Stat collect, Nurse collect

☐ BNP
T;N, Blood, Stat, Once, Nurse collect

☐ DDimer, Quantitative
T;N, Blood, Stat, Once, Nurse collect

Diagnostic Tests

☐ XR Chest 1 View Portable
T;N, Stat

☐ POCUS Abdomen
T;N

☐ POCUS Cardiac
T;N

☐ POCUS Chest
T;N

Card/Vasc/Neuro

☐ EKG (ED)
T;N, Stat, Once

Respiratory

☐ Oxygen Therapy
T;N, Stat, Flow Rate (L/min): 2, SpO2 goal 94% or GREATER, Nasal Cannula, Contact practitioner if the pt. has an increase in O2 requirements or inability to maintain SpO2 as specified

☐ Respiratory Therapy to Evaluate
T;N, Stat, Oxygen Therapy

Non Categorized

☑ Sepsis Quality Measures

☐ Initial Approval Date

☐ Annual Review Date
10/20/2020

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
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IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

ISBARQ

Spontaneous Breathing Trial Protocol Workflow Optimization

8/10/2020

Introduction:

Sandy Volchko

Situation:

Quality is working with Dr. Malli to improve this process. Our practice of performing SBTs to get patients off of vents and out of the ICU is not optimal. The ordering of the SBT protocol needs to be made explicit, and the RT and RN need to be tasked to perform the SBT according to our currently approved protocol (attached)

Background:

Requested by: Dr. Malli

Assessment:

Category of change requested Category 1: Enhancement

Suggested changes to order sets:

CC Ventilator Management Adult

- Adding Pre-checked Sedation Vacation/SBT Protocol order
  - tasking of order to RT and RN at 4am daily
  - building iView documentation of results of SBT for RT and RNs
  - making results of 4am SBT per protocol viewable in physicians workflow.

Recommended communication/education for affected disciplines (i.e. RNs Prescribers, Pharmacists, etc.: ICU RNs will huddle on new process, MDs will just order Mechanical Ventilation as normal to set off new process.

Recommendation:

- Approve changes/content ☒
- Approve design ☐
- Screenshots attached ☐
- Send back to Sponsor/SME with comments for further review ☐

Unique Plan Description: CC Ventilator Management Adult
Plan Selection Display: CC Ventilator Management Adult
PlanType: Medical
Version: 3
Begin Effective Date: 4/1/2020 4/1/2020 9:01 AM
End Effective Date: Current
Available at all facilities

CC Ventilator Management Adult
Patient Care
Mechanical Ventilation

- ☐ Ventilator - HFOV
- ☐ Ventilator - MMV
  Protocols Spontaneous Breathing Protocol
- ☐ Ventilator - Pressure Control A/C
  Protocols Spontaneous Breathing Protocol
- ☐ Ventilator - Pressure Control SIMV
  Protocols Spontaneous Breathing Protocol
- ☐ Ventilator - Volume Control A/C
  Protocols Spontaneous Breathing Protocol
- ☐ Ventilator - Volume Control SIMV
  Protocols Spontaneous Breathing Protocol
- ☐ Ventilator - Volume Targeted/PRVC: A/C
  Protocols Spontaneous Breathing Protocol
- ☐ Ventilator - Volume Targeted/PRVC: SIMV
  Protocols Spontaneous Breathing Protocol
- ☐ Pressure Support Ventilation
  Protocols Spontaneous Breathing Protocol
- ☐ Bi-level/APRV

Medications

- ☑ Peridex 0.12% mucous membrane liquid
  15 mL, Mucous Membrane, Liquid, BID
  Comments: Brush teeth, tongue, gums, and tooth surface for 30 seconds.

Nebulized Solutions(NOTE)*

- ☐ Proventil 2.5 mg/3 mL (0.083%) inhalation solution
  2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT (DEF)*
  2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT
- ☐ Proventil 2.5 mg/3 mL (0.083%) inhalation solution
  2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 2 hours. RT, PRN shortness of breath or wheezing (DEF)*
  Comments: Give with ipratropium (Atrovent) if ordered and for same indication
  2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT, PRN shortness of breath or wheezing
  Comments: Give with ipratropium (Atrovent) if ordered and for same indication
  2.5 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT, PRN shortness of breath or wheezing
  Comments: Give with ipratropium (Atrovent) if ordered and for same indication
- ☐ Xopenex 1.25 mg/3 mL inhalation solution
  1.25 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT (DEF)*
  1.25 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT
- ☐ Xopenex 1.25 mg/3 mL inhalation solution
  1.25 mg, NEB, Device: Aerosol, Soln-Inhalation, every 2 hours., PRN shortness of breath or wheezing (DEF)*
  Comments: Give with ipratropium (Atrovent) if ordered and for same indication
  1.25 mg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours., PRN shortness of breath or wheezing
  Comments: Give with ipratropium (Atrovent) if ordered and for same indication
  1.25 mg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours., PRN shortness of breath or wheezing
  Comments: Give with ipratropium (Atrovent) if ordered and for same indication
- ☐ Atrovent 0.02% 500 mcg/2.5 mL solution for nebulization
  500 mcg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT (DEF)*

500 mcg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT

☐ Atrovent 0.02% 500 mcg/2.5 mL solution for nebulization

500 mcg, NEB, Device: Aerosol, Soln-Inhalation, every 2 hours. RT, PRN shortness of breath or wheezing (DEF)*

Comments: Give with Beta-Agonist (albuterol or levalbuterol) if ordered and for same indication

500 mcg, NEB, Device: Aerosol, Soln-Inhalation, every 4 hours. RT, PRN shortness of breath or wheezing

Comments: Give with Beta-Agonist (albuterol or levalbuterol) if ordered and for same indication

500 mcg, NEB, Device: Aerosol, Soln-Inhalation, every 6 hours. RT, PRN shortness of breath or wheezing

Comments: Give with Beta-Agonist (albuterol or levalbuterol) if ordered and for same indication

Meter Dosed Inhalers(NOTE)*

Albuterol/Ipratropium MDI orders removed due to a national shortage. If needed search for orders in powerchart and review restrictions.(NOTE)*

☐ Proventil HFA 90 mcg/inh inhalation aerosol

6 puffs, Inhale, Aerosol, every 6 hours. RT

Comments: In-Linemay keep at bedside

☐ Atrovent HFA 17 mcg/inh inhalation aerosol

6 puffs, Inhale, Aerosol, every 6 hours. RT

Comments: In-Line

Long Acting Agents(NOTE)*

☐ Brovana 15 mcg/2 mL inhalation solution

15 mcg, NEB, Device: Aerosol, Soln-Inhalation, BID RT

Corticosteroid Solutions(NOTE)*

☐ Pulmicort Respules 0.5 mg/2 mL inhalation suspension

0.5 mg, NEB, Device: Aerosol, Susp, BID RT

Special

☑ Sedation Vacation & Spontaneous Breathing Trial Protocol

Non Categorized

☐ Initial Approval Date

☐ Annual Review Date

10/30/2019

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Sedation Vacation and Spontaneous Breathing Trial Protocol
Medical ICU

SETTING: ICU

Inclusion criteria: (Multidisciplinary team to determine if patient meets criteria for SBT)

1. Underlying condition that led to the need for an artificial airway is reversed or improved.
2. Hemodynamic stability is achieved.
3. Airway problems have resolved; there is minimal risk for aspiration.
4. Mechanical ventilatory support is no longer needed.
5. Target RASS scale of 0 or -1 for weaning (Sedation Vacation performed by RN. See Section "Daily Sedation/Analgesia Interruption (Sedation Vacation)" below for details.
    a. Level 0- alert and calm
    b. Level -1 drowsy
6. Adequate gas exchange on current ventilator setting
    a. PaO2 greater than 60, FiO2 less than .50, PEEP less than or equal to +8. pH 7.30 –7.50, PaCO2 30-50, AND SaO2 ≥92%.
7. Adequate muscle strength
    a. Maximum negative inspiratory force (NIF) greater than or equal to –20
    b. Patient able to follow commands.

SBT Process

1. RN to perform Sedation Vacation (Target RASS 0 or -1)
2. RT initiates SBT
    a. Successfully passes 10 minute trial of PS 5-8/Peep 5, if patient meets definition of stability (as defined below).
        i. **Definition of Stability:**
            1. **Respiratory rate/tidal volume in liters (F/Vt) less than 100**
            2. **Respiratory rate (RR) less than 30**
            3. **Appears comfortable**
3. If patient successfully passes SBT (i.e., meets "Definition of Stability") for 10-30 minutes, patient is a candidate for extubation (RNs in med ICU do not automatically extubate patients.)
4. Contact intensivist if unable to obtain parameters indicated for extubation.
5. Discontinue weaning if:
    a. Patient appears distressed
    b. Heart rate or blood pressure increases/decreases 20% of baseline
    c. F/Vt greater than or equal to 100
    d. Pulse oximetry oxygen saturation (SpO2) is less than 92% on 40% FiO2.

Daily Sedation/Analgesia Interruption (Sedation Vacation):

(Assess pain levels and treat as ordered throughout trial)

Stop continuous infusions every 24 hours at 0400. (See interruption instructions for Propofol and Precedex below).

Assess pain level. If patient exhibiting signs or symptoms of pain, attempt standard comfort measures (reposition, reassurance, distraction, presence, touch). If needed, medicate with prescribed pain medication (i.e. Fentanyl) prn as ordered

Initial/Date & Time Faxed to POMS: _____ Floor/Room: _____
MD Name: _____

Assess neurological status. Notify Physician immediately if new neurological deficits are noted.

Interruption of Propofol as ordered:
STOP continuous infusion.
Assess Neurological status.
Hold infusion until patient is awake and following commands with RASS score of 0 – 1.
If patient becomes agitated (RASS ≥ 2), respiratory rate increases greater than 40 breaths/minute, or becomes unstable, resume continuous IV infusion at HALF the previous rate and titrate to goal RASS in accordance with the orders. Identify causes of agitation or instability and correct accordingly.
If unable to identify a cause and/or correct it, consult with Physician regarding treatment or alternative methods of sedation.
If patient remains awake and follows commands with a RASS of 0-1, notify Respiratory Therapy for assessment of Spontaneous Breathing Trial.

Interruption of Precedex as ordered:
Do not stop infusion but decrease if necessary until patient is awake and following commands with a RASS score of 0-1. Do not wean off unless hemodynamic instability occurs.
If patient becomes agitated (RASS ≥ 2), respiratory rate increases greater than 40 breaths per minute, or becomes unstable, titrate IV infusion to RASS goals in accordance with the orders. Identify causes of agitation or instability and correct accordingly.
If unable to identify a cause and/or correct it, consult with Physician regarding treatment or alternative methods of sedation.
If patient remains awake and follows commands with a RASS of 0-1, continue infusion at same rate and notify Respiratory Therapy for assessment of Spontaneous Breathing Trial. Continue the infusion at the same rate unless hemodynamic instability occurs.

If patient is sedated with an agent other than Propofol or Precedex (e.g., Midazolam, Lorazepam, Ketamine, etc.,) then contact practitioner for weaning instructions.

Last Revised:
Last Reviewed No Revisions:
Initial Approval Date:
Annual Approval:

Initial/Date & Time Faxed to POMS: _____ Floor/Room: _____
MD Name: _____

CC Analgesia and Sedation Management

Admit/Transfer/Discharge/Status

NOTE: SETTING: Critical Care Units (ICU, CVICU), Ventilated patients in the ED and ICCU

Patient Care

☑ Sedation Vacation

T;~~0515~~0400, Daily

**Perform Daily at ~~0515~~0400*
**Propofol-STOP infusion*
**Precedex decrease to half of current rate*
**Hold infusion until pt is awake with RASS 0-1*
**Assess Neuro status, treat pain*
**RASS GREATER than 2 or RR GREATER than 40 resume infusion*
**RASS 0-1, start Spontaneous Breathing Trial*
**Click reference text link for further instructions related to the interruption of Propofol and Precedex in the context of Spontaneous Breathing Trials.~~Click Reference Text link for instructions~~*

Continuous Infusions

Injectable opioids were removed due to a national shortage. Changes made under direction of Medical Executive Team and P&T Committee

NOTE: Propofol (DIPRIVAN) continuous infusion are for use in mechanically ventilated patients only
NOTE: Propofol (DIPRIVAN) starting rate: 5 mcg/kg/min

☐ propofol (Diprivan) 1,000 mg/100 mL Premix
Premix*
100 mL, IV, Titration instructions: Adjust by 5-10 mcg/kg/min every 5 min, Max Dose: 50 mcg/kg/min, Goal: RASS -2 to 0
Comments: Click reference text link on Sedation Vacation orderable for further instructions related to the interruption of Propofol in the context of Spontaneous Breathing Trials.

When the infusion has been weaned to off with the patient stable and at goal for at least 6 hours, the RN may discontinue this order

NOTE: Dexmedetomidine (PRECEDEX) starting rate: 0.2 mcg/kg/hr

☐ dexmedeTOMidine (Precedex) 200 mcg/Sodium Chloride 0.9% 50 mL Premix*
Premix Sodium Chloride 0.9%*
50 mL, IV, Titration instructions: Adjust by 0.1 mcg/kg/hr every 15 minutes, Max Dose: 1.2 mcg/kg/hr, Goal: RASS -2 to 0
Comments: Click reference text link on Sedation Vacation orderable for further instructions related to the interruption of Precedex in the context of Spontaneous Breathing Trials.
When the infusion has been weaned to off with the patient stable and at goal for at least 6 hours, the RN may discontinue this order

NOTE: Midazolam (VERSED) starting rate: 2 mg/hr

☐ midazolam (Versed) 25 mg/Sodium Chloride 0.9% 50 mL
Sodium Chloride 0.9%*
50 mL, IV, Bolus Instructions: See Reference Text, Titration instructions: See Reference Text, Max Dose: 10 mg/hr, Goal: RASS -2 to 0
Comments: When the infusion has been weaned to off with the patient stable and at goal for at least 6 hours, the RN may discontinue this order

Floor/Room:
MDName:
Initial/Date & Time Faxed to POMS:

Formatted: Indent: Left: 1.33", First line: 0"

PATIENT LABEL or
Patient Name:
Acct#
DOB:

NOTE: Lorazepam (ATIVAN) starting rate: 1 mg/hr

☐ LORazepam (Ativan) 50 mg/Dextrose 5% Water 50 mL Premix
Premix Dextrose 5% Water*
50 mL, IV, Titration instructions: Adjust by 1 mg/hr every 1 hour, Max Dose: 5 mg/hr, Goal: RASS -2 to 0
Comments: When the infusion has been weaned to off with the patient stable and at goal for at least 6 hours, the RN may discontinue this order

Medications
PRN
Injectable opioids were removed due to a national shortage. Changes made under direction of Medical Executive Team and P&T Committee.

Date/Time: _____ Physician Signature: _____Physician # _____

PATIENT LABEL or
Patient Name:
Acct#
DOB:

PATIENT LABEL or
Patient Name:
Acct#
DOB:

ISBARQ

Epoprostenol Sodium (Veletri®) Administration via Nebulizer for ARDS

2/11/2021

Introduction:

L. Kit Chai, PharmD, BCPS; Dpt of Pharmacy; ext 5088

Situation:

Add protocol for inhaled epoprostenol (via nebulizer) for ARDS indication. Our existing protocol is for Pulmonary hypertension

Background:

Requested by: L. Kit Chai on behalf of Dr Jeff Javed (intensivist) before he left KDMC

Assessment:

Category of change requested Category 1: Enhancement

Suggested changes to order sets: See protocol attached

Recommended communication/education for affected disciplines (i.e. RNs Prescribers, Pharmacists, etc.: Education will be provided to Pharmacists, Respiratory therapists and Clinical Nurse Educators via the usual routes for disseminating such information. This protocol has already been used in the Critical Care settings by some intensivists and critical care pharmacists

Recommendation:

- Approve changes/content ☐
- Approve design ☐
- Screenshots attached ☐
- Send back to Sponsor/SME with comments for further review ☐

Epoprostenol Sodium (Veletri®) Administration via Nebulizer for ARDS

I. CIRCUMSTANCES FOR IMPLEMENTATION OF PROTOCOL

1. SETTING: Critical Care Units

2. PATIENT CONDITION/MEDICAL CONDITIONS:

a. Acute onset of respiratory failure (<1 week)
b. PaO_2/FiO_2 <300 mmHg on PEEP ≥5 cm H_2O
c. Worsening hypoxemia and clinical deterioration despite the use of ventilator strategies recommended by the ARDS network

II. TREATMENT PLAN – NURSING RESPONSIBLITIES

A. Medication and ABG Procedure

1. Verify physician order for nebulized epoprostenol dosing.
2. Use communication form to obtain desired dilution from pharmacy.
3. Obtain Arterial Blood Gas 10 minutes prior to starting nebulized epoprostenol

B. Equipment Procedure

1. Use a dedicated Alaris pump and soldier for administering epoprostenol via the nebulizer, and to the extent possible, **isolate** the Alaris pump connected to the nebulizer by placing it next to the ventilator, and on the opposite side of the patient's bed from the Alaris pumps infusing IV medications. Label for inhalation only. Do not connect any other soldiers to pump.
2. Label tubing both at the proximal and distal ends, and label the bag "for inhalation only".
3. Tape all needle free valve ports on tubing and extensions.
4. Respiratory Therapist to set-up MiniHEART nebulizer, oxygen tubing, and Neb-T connector.

C. Administration Procedure for Epoprostenol via Nebulizer

1. Cover prepared Epoprostenol sodium bag with amber ultraviolet bag. When stored or in use, reconstituted Epoprostenol sodium must not be exposed to direct sunlight.
2. Prime tubing and insert into IV pump.
3. Attach tubing to NEBULIZER PORT.
4. Infuse 15 mL prepared epoprostenol sodium into nebulizer as initial volume for nebulization.
5. Start epoprostenol sodium nebulizer treatment by setting the Alaris pump rate at 8 ml per hour, and the VTBI at the volume of epoprostenol sodium remaining in the bag. Respiratory Therapist will titrate the nebulizer flow rate between 2-3 lpm 02 to maintain 15 ml of epoprostenol sodium in nebulizer.
    a. First bag will have approximately 20 ml of epoprostenol remaining after priming tubing and nebulizer port.

D. Monitoring Procedure

1. Hemodynamic parameters should be documented prior to commencement of Epoprostenol sodium nebulizer treatment, every 15 minutes X 4, then hourly if stable. Hemodynamic parameters to be documented (if available): HR, BP, SpO_2, PAP (systolic, diastolic, and mean), CVP, CO, CI, SV, PVR, SVR, SvO_2 and $Pa02/FI0_2$ ratio.
2. Respiratory parameters should be documented by Respiratory Therapist and include peak airway pressure, plateau pressure and $Pa0_2/FI0_2$ ratio.
3. If hypotension occurs, notify Intensivist.

PATIENT LABEL or
Patient Name:
Acct#:
DOB:

E. Response to Therapy

1. Positive Response:
    a. Patient shows ≥20% increase in PaO_2
    b. Patient shows increase in PaO_2/FiO_2
    c. Patient response should be apparent within 10 minutes of initiating treatment
2. Weaning:
    a. When order is received to wean the patient off inhaled epoprostenol, stop delivery of epoprostenol from the infusion pump. Remove current dose bag and tubing but do not discard in the event the patient fails the weaning attempt and the previous dose needs to be resumed. Cover the end of the tubing with a sterile cap and keep the epoprostenol in the amber bag; discard in accordance with the labeling on the epoprostenol bag.

    b. Using the same infusion pump that the nebulized epoprostenol solution was being delivered from, set the infusion pump rate to 8 ml/hr to deliver Sodium Chloride 0.9% nebulized. With 15 ml in the nebulizer reservoir, over a 1 hour period the dose will be reduced by approximately 55% and at 2 hours the dose will be reduced by approximately 80%. Weaning time should be up to 2 hours when weaning from higher doses to prevent abrupt withdrawal rebound hypoxemia or pulmonary hypertension.

3. Record hemodynamic parameters every 15 minutes x 4 then hourly if stable.

F. Weaning Failure Parameters defined as:

- **Increase in PAP or PVR by 15% (If available)**
- **Decline in cardiac index by 10% (If available)**
- **Decline in PaO2/FIO2 ratio by 10%**
- **Notify physician if patient meets weaning failure parameter In addition, assessment of patient's toleration of weaning may include flushing, headache, jaw pain, or nausea and vomiting**

PATIENT LABEL or

Kaweah Delta Health Care District
400 West Mineral King – Visalia, CA 93291-6263 – 559.624.2000

COMMUNICATION FORM
CRITICAL CARE UNIT PROTOCOL INITIATION
Epoprostenol Sodium (Veletri®) Administration via Nebulizer for Acute Respiratory Distress Syndrome (ARDS)

1. Epoprostenol Sodium (Veletri®) Administration via Nebulizer for ARDS Protocol initiated.

Inclusion Criteria is met:
- Acute onset of respiratory failure (<1 week)
- PaO_2/FiO_2 <300 mmHg on PEEP ≥5 cm H_2O

2. **Ordering Physician is**: _____

3. **Ideal Body Weight (IBW) Calculation:**
   Females: 45.5 + 2.3 (height in inches – 60)=_____kg
   Males: 50 + 2.3 (height in inches – 60)=_____kg

4. **Medication**:

☐**IBW ≥54kg**
Concentration: 20,000 ng/ml
Dissolve contents of **TWO 0.5 mg vials** with 5 ml of Sodium Chloride 0.9% per vial. Withdraw entire vial contents and add sufficient Sodium Chloride 0.9% to make a total of 50 ml in empty IVPB bag for pump.

☐**IBW <54kg**
Concentration: 10,000 ng/ml
Dissolve contents of **ONE 0.5 mg vial** with 5 ml of Sodium Chloride 0.9%. Withdraw entire vial contents and add sufficient Sodium Chloride 0.9% to make a total of 50 ml in empty IVPB bag for pump.

_____ Per Protocol/RN_____
Date & Time RN Signature

Current Version
Initial Approval:
Annual Approval:

PATIENT LABEL or
Patient Name:
Acct #:
DOB: