September 22, 2023

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Wednesday September 27, 2023: 4:00PM Open Meeting; 4:01PM Closed meeting pursuant to Health and Safety Code 1461 and 32155; 4:15PM Open Meeting.

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 Health Medical Center, Mineral King Wing near the Mineral King entrance.

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

KAWEAH DELTA HEALTH CARE DISTRICT
Mike Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

City of Visalia – City Council Chambers {707 W. Acequia, Visalia}

Wednesday September 27, 2023

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 jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   1. **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 – *Daniel Hightower, MD, Chief of Staff*
   2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Daniel Hightower, MD, Chief of Staff*
   3. **Approval of the closed meeting minutes** – August 23, 2023.

   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 September 27, 2023 closed meeting agenda.
5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

CALL TO ORDER

1. **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.

   Daniel Hightower, MD, Chief of Staff

Mike Olmos – Zone 1 Secretary/Treasurer | *Lynn Havard Mirviss – Zone 2I Vice President* | *Garth Gipson – Zone 3 Board Member* | *David Francis – Zone 4 President* | *Ambar Rodriguez – Zone 5 Board Member*

2. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Daniel Hightower, MD, Chief of Staff

3. **APPROVAL OF THE CLOSED MEETING MINUTES** – August 23, 2023.

   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 closed meeting minutes – August 23, 2023.

   ADJOURN

OPEN MEETING AGENDA {4:15PM}

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 jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the August 23rd 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 August 23rd open board of directors meeting minutes.

6. **RECOGNITIONS** – *Director Olmos*
   - **6.1.** Presentation of Resolution 2204 to Ana Lopez, World Class Employee of the Month – August 2023.
7. **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.

   Daniel Hightower, MD, Chief of Staff

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

   Daniel Hightower, MD, Chief of Staff

Lynn Havard Mirviss – Zone II V *Mike Olmos – Zone I Secretary/Treasurer* *Garth Gipson – Zone III Board Member* *David Francis – Zone IV President* *Ambar Rodriguez – Zone V Board Member*

Kaweah Health
3/380

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 September 27th Consent Calendar.

9.1. REPORTS
- A. Strategic Plan
- B. Physician Recruitment
- C. Environment of Care
- D. Throughput

9.2. POLICIES – ADMINISTRATIVE
- A. Requirement for Contracting with Outside Service Providers – AP69 {Revised}
- B. Patient Privacy Administrative and Compliance Requirements – AP108 {Revised}

9.3. POLICIES – EMERGENCY MANAGEMENT POLICIES
- A. Code Purple Child Abduction - DM 2206 {Revised}
- B. Code Shelter in Place - DM 2209 {Revised}
- C. Surge Tent Use - DM 2226 {Revised}
- D. Total Evacuation Plan - DM 2810 {Revised}

9.4. POLICIES – ENVIRONMENT OF CARE
- A. Safety Officer Job Description - EOC 1007 {Revised}
- B. Disruption of Services Electric - EOC 1034 {Revised}
- C. Disruption of Services Natural Gas - EOC 1036 {Revised}
- D. Disruption of Services Sewage - EOC 1037 {Revised}
- E. Failure of Air Conditioner - EOC 1039 {Revised}
- F. Disruption of Service Telephone - EOC 1044 {Revised}
- G. Ergonomics - EOC 1071 {Revised}
- H. RCRA Disposal of Hazardous Waste - EOC 4010 {Revised}
- I. Interim Life Safety Measures - EOC 5020 {Revised}
- J. Infection Control Risk Assessment - EOC 5021 {Revised}
- K. Medical Equipment Management Policy - EOC 6001 {Revised}
- L. Medical Equipment Hazardous Device and Recall Notification - EOC 6004 {Revised}
- M. Utilities Management Plan - EOC 7001 {Revised}
- N. Utilities Management Emergency Power - EOC 7402 {Revised}
- O. Emergency Generator Testing and Fuel Levels – EOC 7403 {Revised}
- P. Heat and Illness Prevention Program - EOC 8000 {Revised}

9.5. Recommendations from the September 2023 Medical Executive Committee:
- A. Revised Privilege Form – Nurse Practitioner / Physician Assistant.
- B. Bylaws and Rules and Regulations Revisions
  1. Bylaws 3.B.2

Lynn Havard Mirviss – Zone II V *Mike Olmos – Zone I Secretary/Treasurer* *Garth Gipson – Zone III Board Member* *David Francis – Zone IV President* *Ambar Rodriguez – Zone V Board Member*

Kaweah Health
4/380

2. Bylaws 5.B.1
3. Rules and Regulations 3.2.g
4. Rules and Regulations 3.2.r
5. Rules and Regulations 3.4.a.2
6. Rules and Regulations 3.4.c

10. **QUALITY – DIVERSION PREVENTION** – A review of key initiatives to maintain safety by recognizing, preventing, and reporting potential medication drug diversion.

Evelyn McEntire, Director of Risk Management and Shannon Cauthen, Director of Critical Care Services

11. **STRATEGIC PLAN - PATIENT AND COMMUNITY EXPERIENCE** – Detailed review of Strategic Plan Initiative.

Keri Noeske, Chief Nursing Officer and Deborah Volosin, Director of Community Engagement

10. **FINANCIALS** – Review of the most current fiscal year financial results.

Malinda Tupper – Chief Financial Officer Chief Financial Officer

12. REPORTS

12.1. Chief Executive Officer Report - Report relative to current events and issues.
Gary Herbst, Chief Executive Officer

12.2. Board President - Report relative to current events and issues.
David Francis, Board President

13. ADJOURN

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

Lynn Havard Mirviss – Zone II V | *Mike Olmos – Zone I Secretary/Treasurer* | *Garth Gipson – Zone III Board Member* | *David Francis – Zone IV President* | *Ambar Rodriguez – Zone V Board Member*

Kaweah Health
5/380

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

KDHCD - BOARD OF DIRECTORS MEETING

WEDNESDAY SEPTEMBER 27, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-17

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY AUGUST 23, 2023, AT 4:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Havard Mirviss, Gipson, Rodriguez & Olmos; G. Herbst, CEO; D. Hightower, MD, Vice Chief of Staff, K. Noeske, CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information and Cybersecurity Office; R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer D. Cox, Chief Human Resources Officer, R. Berglund, Legal Counsel; E. McEntire, Director of Risk Management; R. Salinas, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:03PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – None

APPROVAL OF THE CLOSED AGENDA – 4:03PM

- **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) – *Richard Salinas, Legal Counsel and Evelyn McEntire, Director of Risk Management*
  A. Shipman v KDHCD Case # VCU287291
- **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 3 Case - *Rachele Berglund, Legal Counsel and Evelyn McEntire, Director of Risk Management*
- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 4 Cases **–** *Ben Cripps, Chief Compliance & Risk Officer and Rachele Berglund, Legal Counsel.*
- **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 – *Daniel Hightower, MD, Vice Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Daniel Hightower, MD, Vice Chief of Staff*
- **Approval of the closed meeting minutes** – July 26, 2023.

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 – No public present.

MMSC (Olmos/Havard Mirviss) to approve the August 23, 2023 closed agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Gipson, Rodriguez, and Francis

ADJOURN - Meeting was adjourned at 4:04PM

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

ATTEST:

Mike Olmos, 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 WEDNESDAY AUGUST 22, 2023, AT 5:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Havard Mirviss, Gipson, Rodriguez & Olmos; G. Herbst, CEO; D. Hightower, MD, Vice Chief of Staff, K. Noeske, CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information and Cybersecurity Office; R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer D. Cox, Chief Human Resources Officer, R. Berglund, Legal Counsel; E. McEntire, Director of Risk Management; R. Salinas, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:46 PM by Director Francis.

Director Francis asked for approval of the agenda.

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

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: Approval the closed minutes from July 26, 2023.

OPEN MINUTES – Request approval of the open meeting minutes July 26, 2023.

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 open minutes from July 26, 2023. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Gipson, Rodriguez, and Francis

RECOGNITIONS

Presentation of Resolution 2202 to Francisco Lizaola – Environmental Services Aide retiring with 14 years of service.

Presentation of AHA Silver Award- in recognition of the Kaweah Health Rapid Response Team acknowledging 12 consecutive months for consistent compliance with Quality Measures embedded within the registry tool.

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.

CHIEF OF STAFF REPORT – Report relative to current Medical Staff events and issues – *Daniel Hightower, MD, Vice Chief of Staff*

- Dr. Hightower noted that there was a new committee formed on blood utilization.
- Dr. Hightower also made note that the MEC passed to change TB testing to every 4 years instead of every year.

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.

MMSC (Gipson/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 – Olmos, Havard Mirviss, Gipson, Rodriguez, and Francis

CONSENT CALENDAR – Director Francis entertained a motion to approve the August 23, 2023, consent calendar.

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/Havard Mirviss) to approve the August 23, 2023, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Gipson, Rodriguez, and Francis

QUALITY REPORT – **KAWEAH HEALTH CERTIFIED STROKE PROGRAM** – A review of Kaweah Health's stroke program of key quality metrics and action plans associated with the care of stroke population. (Copy attached to the original of these minutes and considered a part thereof) – *Sean Oldroyd, DO, Stroke Program Medical Director*

STRATEGIC PLAN – ORGANIZATIONAL EFFECTIVENESSA ND EFFICIENCY – Detailed review of Strategic Plan Initiative (copy attached to the original of these minutes and considered a part thereof) – *Jag Batth, Chief Operating Officer & Rebekah Foster, Director of Care Management/Specialty Care*

PATIENT THROUGHPUT PERFORMANCE - Review of patient throughput performance improvement progress report (copy attached to the original of these minutes and considered a part thereof) - *Jag Batth, Chief Operating Officer*

FINANCIALS – Review of the most current fiscal year financial results. (Copy attached to the original of these minutes and considered a part thereof) – *Malinda Tupper – Chief Financial Officer*

REPORTS

Chief Executive Officer Report - Report relative to current events and issues – *Gary Herbst, CEO*

- Mr. Herbst noted that the hospital is staying busy. There is an uptick in the Kraken & Eris covid virus putting people in the hospital. We do not ask patients about their covid status anymore. Pfizer and Moderna have a new booster. There are no rumblings on any mandate for vaccinations or masking for healthcare workers.
- Mr. Herbst is trying to recruit Dr. Gray as Interim CMO until a permanent replacement is in place. Mr. Herbst spoke to Dr. Gray for an hour this day of August 23, 2023, and it might look promising he will accept. Mr. Herbst spoke to the same recruiter who recruited Dr. Willie Brien and had a great conversation and is optimistic that they will recruit great candidates.
- The Governance Restructure Committee has met and finally put a bow on the final structure. Next phase is implementation.

Board President **-** Report relative to current events and issues - *David Francis, Board President*

- None.

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 – No public present.

MMSC (Havard Mirviss/Rodriguez) to approve the August 23, 2023, closed agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Gipson, Rodriguez, and Francis

ADJOURN - Meeting was adjourned at 6:29PM

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

ATTEST:

Mike Olmos, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

RESOLUTION 2204

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing Ana Lopez, with the World Class Service Excellence Award for the Month of August 2023, for consistent outstanding performance, and,

WHEREAS, the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT on behalf of themselves, the hospital staff, and the community they represent, hereby extend their congratulations to Ana for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 27th day of September 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof

FY 2024 Strategic Plan

Monthly Performance Report

September 27, 2023

Kaweah Health Strategic Plan: Fiscal Year 2024

Our Mission

Health is our passion.
Excellence is our focus.
Compassion is our promise.

Our Vision

To be your world-class healthcare choice, for life.

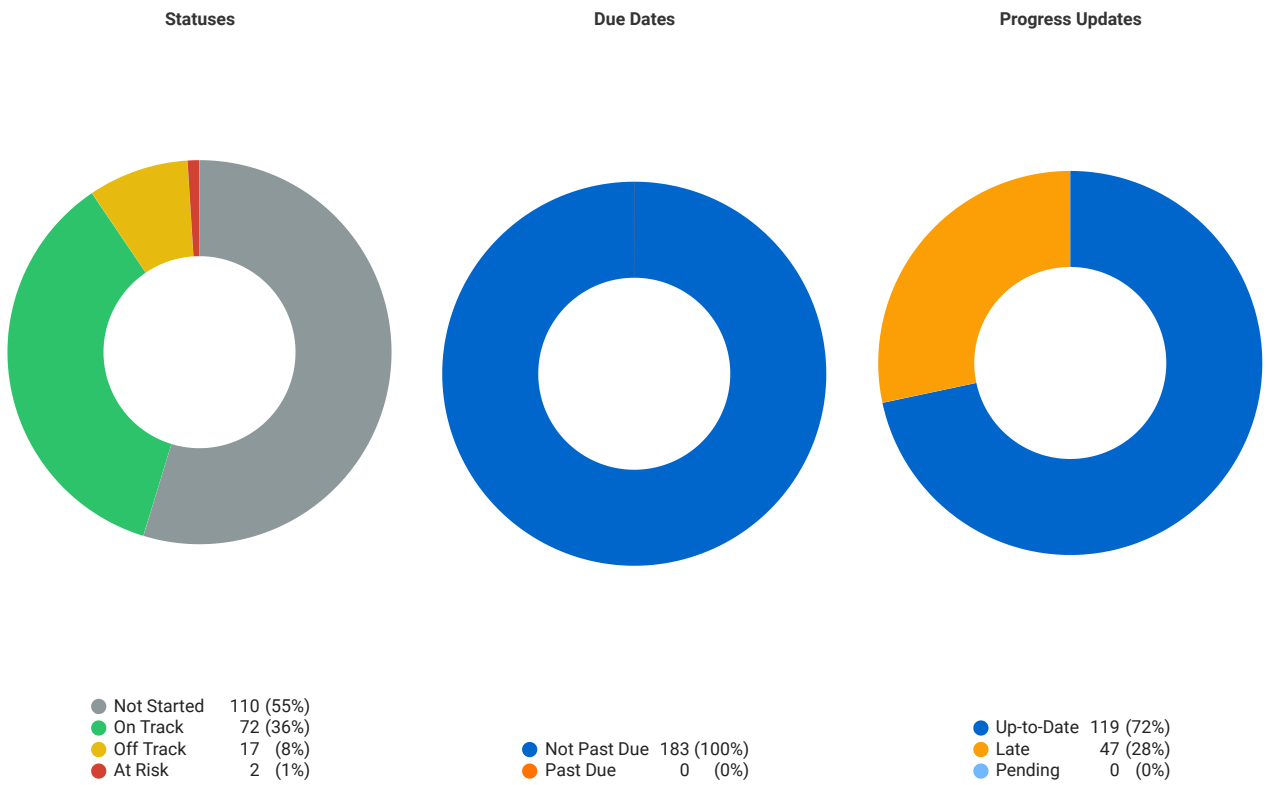
Our Pillars

Achieve outstanding community health.
Deliver excellent service.
Provide an ideal work environment.
Empower through education.
Maintain financial strength.

Our Six Initiatives

Empower Through Education
Ideal Work Environment
Strategic Growth and Innovation
Organizational Efficiency and Effectiveness
Outstanding Health Outcomes
Patient Experience and Community Engagement

Kaweah Health Strategic Plan FY2024 Overview



Empower Through Education

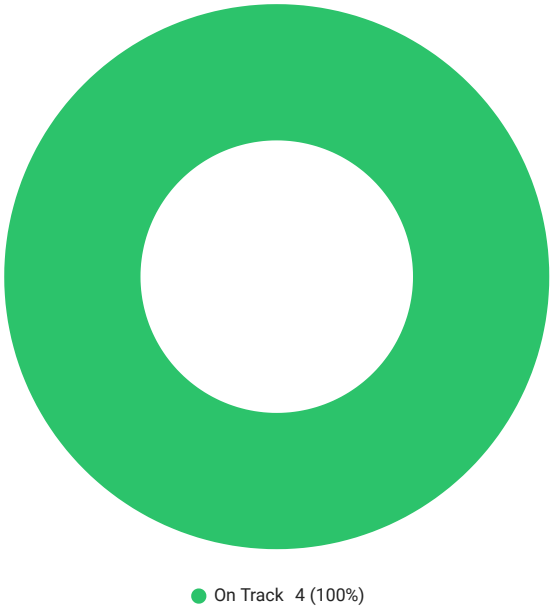
Champions: Dr. Lori Winston and Hannah Mitchell

*Objective: Implement inititatives to **develop the healthcare team** and **attract and retain** the very best talent in support of our mission.*

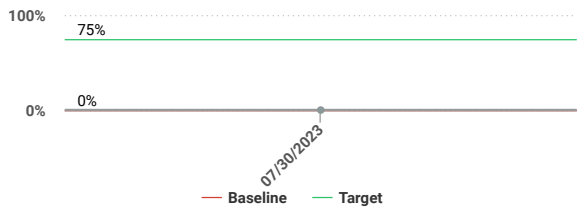
FY2024 Strategic Plan - Empower Through Education Strategies

#	Name	Description	Status	Assigned To	Last Comment
1.1	Expand Online Learning Opportunities and Participation	Increase and optimize existing and new educational opportunities and platforms to support on line and computer based learning.	On Track	Hannah Mitchell	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.
1.2	Increase the Use of and Exposure to Simulation in Education	Develop and implement strategies to expand exposure to the SIM Lab and simulation concepts in training and education.	On Track	Kimberly Sokol	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.
1.3	Expand Educational Opportunities for External Learners	Include external learners in existing and new training and educational opportunities.	On Track	Kimberly Sokol	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.
1.4	Improve Leadership Development and Education	Develop new and enhance existing educational and training opportunities for existing and emerging Kaweah Health and Medical Staff leaders.	On Track	Hannah Mitchell	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.

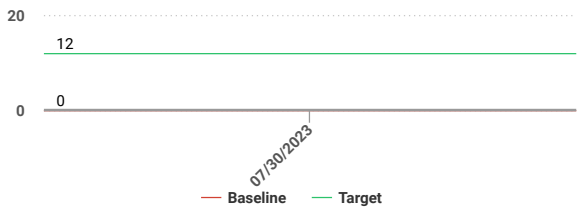
Objectives and Outcomes



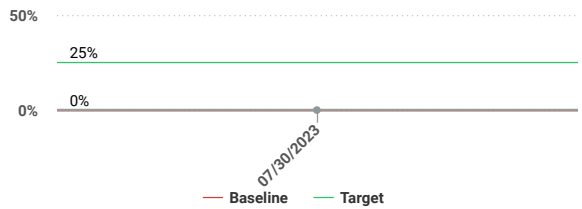
Automate the Week One Onboarding and Orientation Competencies for Patient Care Staff



Conduct Monthly in situ Simulations (Twelve in the Fiscal Year)



Host an Advanced Trauma Life Support Course with 25% Paying Participants



Ideal Work Environment

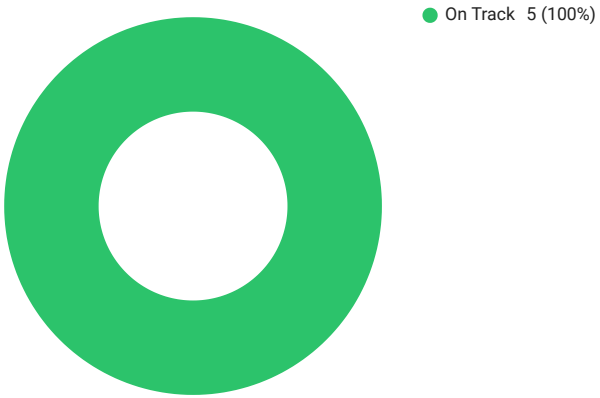
Champions: Dianne Cox and Raleen Larez

Objective: *Foster and support* ***healthy and desirable working environments*** *for our Kaweah Health Teams*

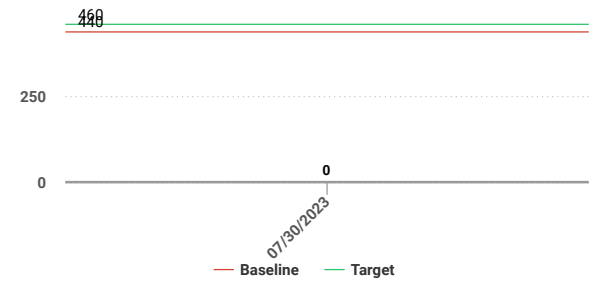
FY2024 Strategic Plan - Ideal Work Environment Strategies

#	Name	Description	Status	Assigned To	Last Comment
2.2	Ideal Practice Environment	Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.	On Track	Lori Winston	
2.5	Growth in Nursing School Partnerships	Increase the pool of local RN candidates with the local schools to increase RN cohort seats.	On Track	Dianne Cox	
2.1	Employee Retention and Resiliency	Kaweah Health is facing the same challenges as many employers in the labor market and must make retention a top priority.	On Track	Dianne Cox	No performance data for July. Will update in September.
2.3	Kaweah Care Culture	Recreate Kaweah Care culture into the various aspects of the organization.	On Track	Dianne Cox	
2.4	Expand Volunteer Programs	Volunteer engagement has declined with the pandemic. Kaweah Health relies on a strong volunteer program to continue to spark career path engagement and to provide world class service.	On Track	Dianne Cox	No performance data for July. Will update in September.

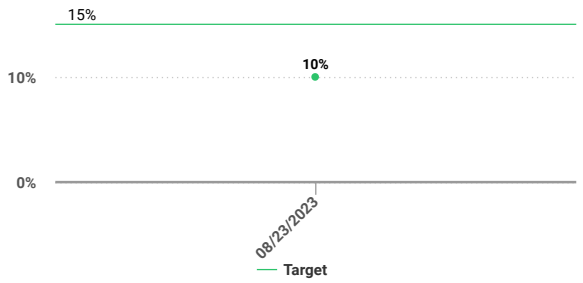
Objectives and Outcomes



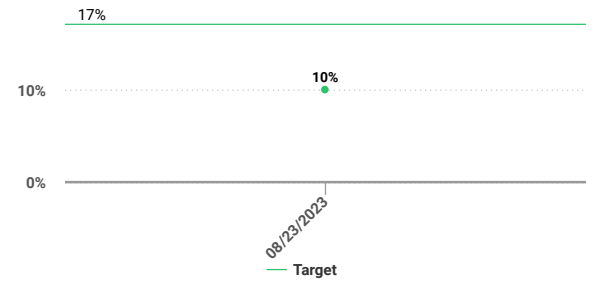
Increase to 460 Volunteers (by 6/30/24)



Decrease Overall KH Turnover Rate (< 15%)



Decrease Nursing Turnover Rate (< 17%)



Strategic Growth and Innovation

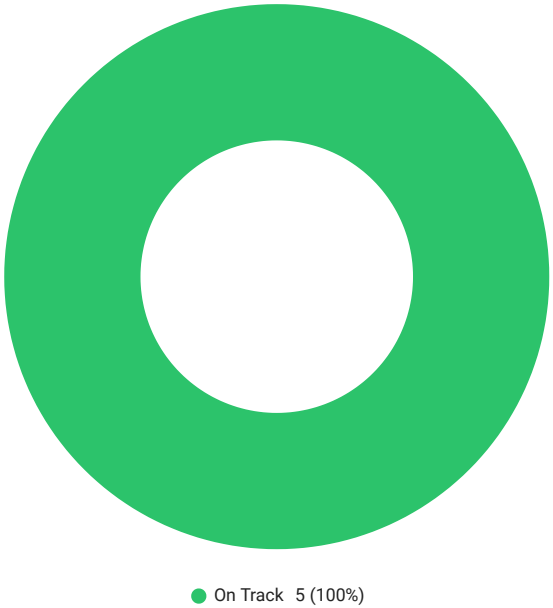
Champions: Ryan Gates and JC Palermo

Objective: Grow intelligently *by expanding existing services, adding new services, and serving new communities. Find new ways to do things to* ***improve efficiency and effectiveness****.*

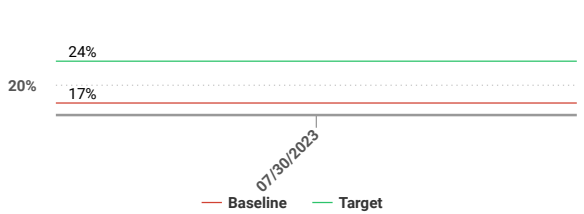
FY2024 Strategic Plan - Strategic Growth and Innovation Strategies

#	Name	Description	Status	Assigned To	Last Comment
3.1	Recruit and Retain Providers	Develop a recruitment strategy around top physician needs to recruit and retain physicians and providers to address unmet community needs and to support Kaweah Health's growth.	On Track	JC Palermo	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.
3.2	Grow Targeted Inpatient and Surgery Volumes	Grow our inpatient volumes, particularly the surgical cases, with an emphasis on key service lines such as Cardiac and Urology.	On Track	Kevin Bartel	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.
3.3	Grow Targeted Outpatient Volumes	Increase access to outpatient care in locations that are convenient to our community.	On Track	Ivan Jara	The 202 Willow Clinic and Industrial Park Clinics are scheduled to open as planned. Work continues on the other metrics which are reported on a quarterly basis.
3.4	Innovation	Implement and optimize new tools and applications to improve the patient experience, patient communication and patient outcomes.	On Track	Jacob Kennedy	We are moving in the right direction on key metrics related to this initiative.
3.5	Expand Health Plan & Community Partnerships	Improve and strengthen relationships with health plans, community partners, and participate in local/state/federal programs and funding opportunities to improve access, quality, and outcomes for the community	On Track	Sonia Duran-Aguilar	While work is underway, the metrics related to this initiative are reporting on a quarterly basis.

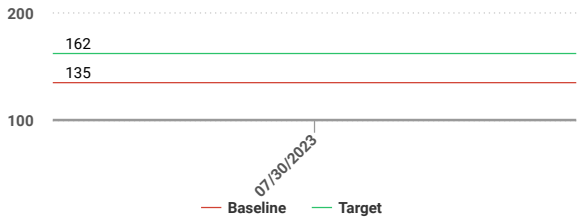
Objectives and Outcomes



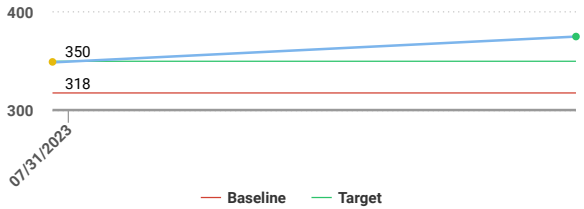
Increase the Percentage of Coronary Artery Bypass Graph Surgery Cases that are Elective



Increase Number of Urology Surgery Cases



Increase Monthly Endoscopy Case Volume



Organizational Efficiency and Effectiveness

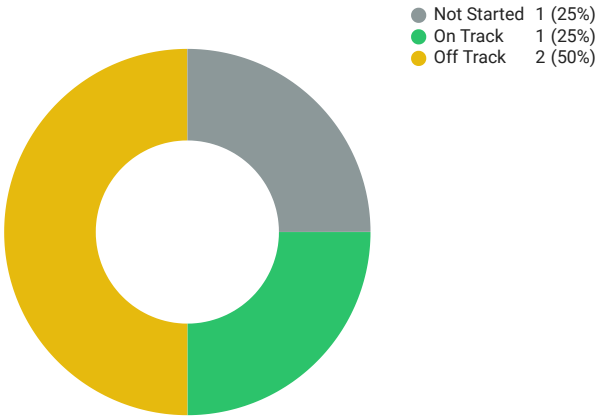
Champions: Jag Batth and Rebekah Foster

Objective: Increase the efficiency and effectiveness of the Organization *to reduce costs, lower length of stay and improve processes.*

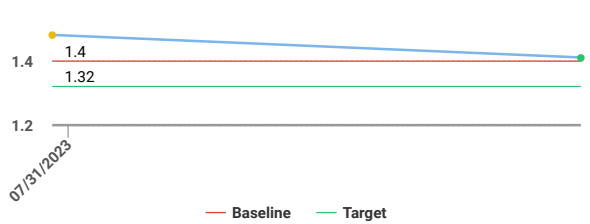
FY2024 Strategic Plan - Organization Efficiency and Effectiveness Strategies

#	Name	Description	Status	Assigned To	Last Comment
4.1	Patient Throughput and Length of Stay	Implement patient flow processes that are effective and efficient to improve patient throughput and lower the overall Length of Stay.	Off Track		Work continues in this important initiative and both Observation and Emergency Department length of stay are trending downward. There was a slight uptick in the length of stay measure for inpatients, but a number of long stay patients were discharged in the month.
4.2	Increase Main and Cardiac Operating Room Efficiency/Capacity	Improve Operating Room Efficiency, Capacity and Utilization to meet surgery volume needs.	Off Track	Lori Mulliniks	We continue to work on solutions to move these metrics toward the established goals.
4.3	Create a Process to Monitor Use of Tests and Treatments	Create and initiate a workgroup to identify areas of focus and establish benchmarks related to the use of tests and treatments.	On Track	Jag Batth	Initial workgroup meetings have commenced and the team is working to develop baselines and metrics for review.
4.4	Optimize Revenue Cycle Efforts	Focus efforts on key revenue cycle metrics to increase collections and reduce denials.	Not Started	Frances Carrera	We are working to finalize the data reporting for this metric and appropriate sources of data.

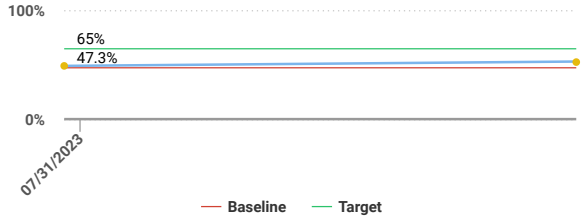
Objectives and Outcomes



Decrease Inpatient Observed to Expected Length ...



Improve Elective Case Main Operating Room Utili...



Increase Front End Collections

This plan item was deleted.

Outstanding Health Outcomes

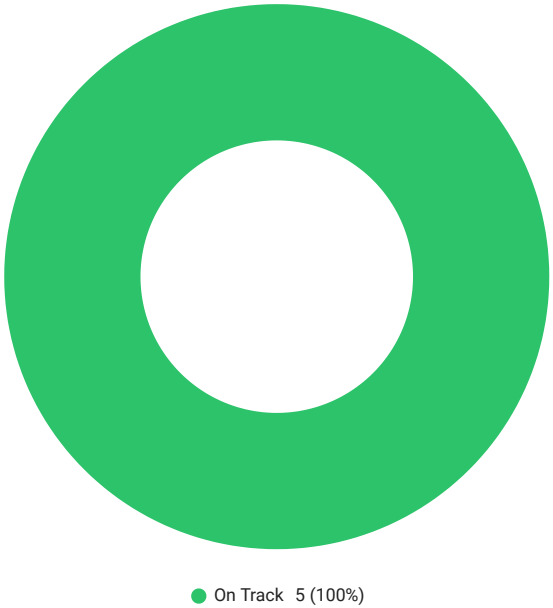
Champions: Dr. LaMar Mack and Sonia Duran-Aguilar

***Objective**: To consistently **deliver high quality care** across the health care continuum.*

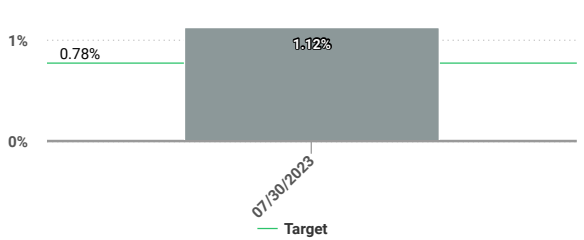
FY2024 Strategic Plan - Outstanding Health Outcomes Strategies

#	Name	Description	Status	Assigned To	Last Comment
5.1	Standardized Infection Ratio (SIR)	Reduce the Hospital Acquired Infections (HAIs) to the national 70th percentile in FYTD24 as reported by the Centers for Medicare and Medicaid Services	On Track	Sandy Volchko	
5.2	Sepsis Bundle Compliance (SEP-1)	Increase SEP-1 bundle compliance to overall 85% compliance rate for FY24 through innovative improvement strategies based on root causes.	On Track	Sandy Volchko	SEPSIS O/E Metric data is for June. July data is pending.
5.3	Mortality and Readmissions	Reduce observed/expected mortality through the application of standardized best practices.	On Track	Sandy Volchko	
5.4	Quality Improvement Program (QIP) Reporting	Achieve performance on the Quality Incentive Pool measures to demonstrate high quality care delivery in the primary care space.	At Risk	Sonia Duran-Aguilar	Update: Kaweah Health Re-attested to DHCS for QIP PY 6 (CY 2023) and will be reporting a total of 10 QIP Quality Measures. YTD, per Cozeva Proxy Performance, Kaweah Health is meeting 3 measures. Proxy Performance is at 30%, with 3.5 months in the reporting year to go. A lot of QI occurring around several key measures at the RHCs. Meeting performance on 10 measures should be achievable.
5.6	Inpatient Diabetes Management	Optimize inpatient glycemic management using evidence-based practices to improve patient's glycemic control and reduce hypoglycemic events.	On Track	Sonia Duran-Aguilar	SHM performance data reports twice a year. Current performance data is from 5/2023. Next report will be in Fall 2023.

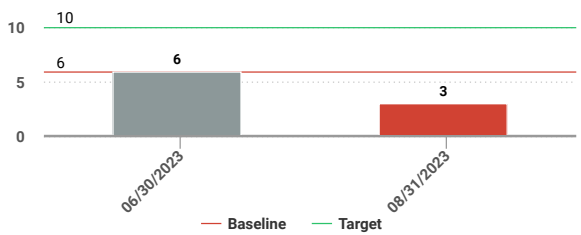
Objectives and Outcomes



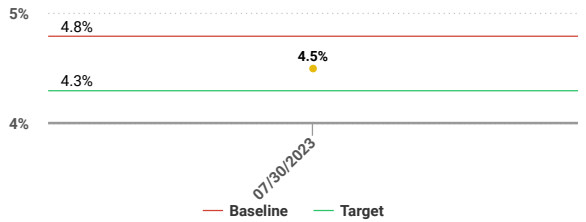
SEPSIS Mortality O/E



Meet 10 QIP Performance Measures



Hypoglycemia in Critical Care Patients (< 4.3%)



Patient and Community Experience

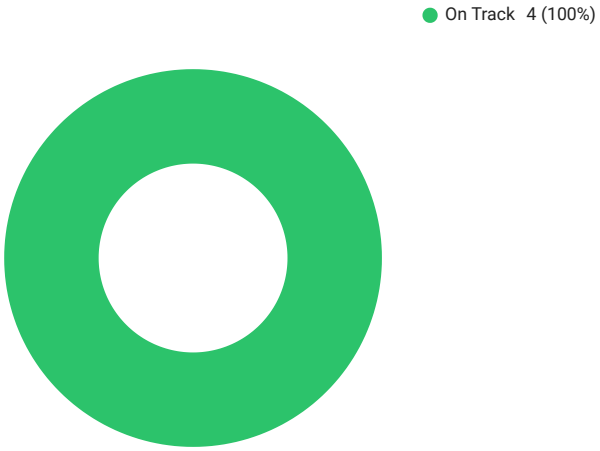
Champions: Keri Noeske and Deborah Volosin

Objective: Develop and implement strategies *that provide our health care team the tools they need to* ***deliver a world-class health care experience.***

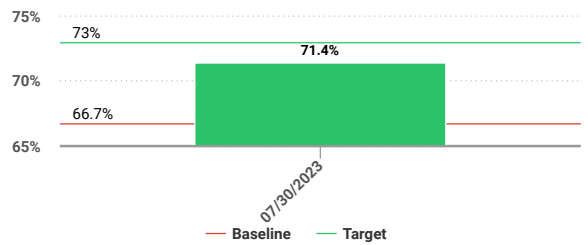
FY2024 Strategic Plan - Patient and Community Experience Strategies

#	Name	Description	Status	Assigned To	Last Comment
6.1	Highlight World-Class Service/Outcomes (Hospitality Focus)	Develop strategies that provide our health care team the tools they need to deliver a world-class health care experience.	On Track	Keri Noeske	HCAHPS Data: For FY24 will be 30 days behind d/t HCAHPS surveying timelines. Data for July 2023 will be updated in September 2023. ED Score: Value below baseline. ED Operations team to assess feedback and recommend an action plan to Patient Experience Committee to address decrease.
6.2	Increase Compassionate Communication	To reach the 50th percentile in physician and nursing communication and responsiveness of staff on the HCAHPS survey.	On Track	Keri Noeske	
6.3	Enhancement of Systems and Environment	To create a secure, warm and welcoming environment for patients and the community.	On Track	Keri Noeske	Two of seven lost belongings were located and returned to owners in July 2023. Investigations still pending on two items. Monitor departments for lost belongings trends and mandate action plans reported into patient care committee as needed.
6.4	Community Engagement	To provide an environment where community members and patients are able to assist staff in co-designing safe, high quality, and world-class care and services.	On Track	Deborah Volosin	

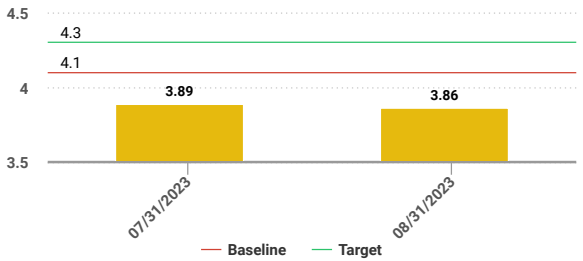
Objectives and Outcomes



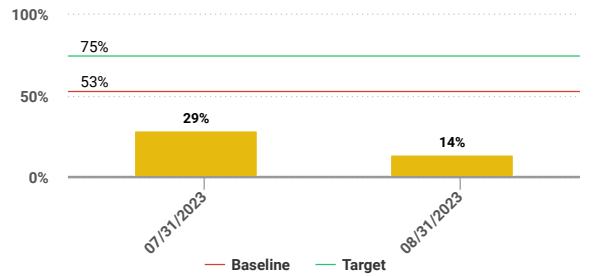
Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey



Achieve 4.3 Patient Feedback Score Goal on ED Survey



Reunite 75% of Lost Belongings with Owners



Physician Recruitment and Relations

Medical Staff Recruitment Report - September 2023

Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456

Date prepared: 9/18/2023

Central Valley Critical Care Medicine	
Intensivist	1
Step-Down Hospitalist	2

Delta Doctors Inc.	
Family Medicine	2
OB/GYN	1
Adult Psychiatry	1

Key Medical Associates	
Dermatology	1
Endocrinology	1
Family Medicine/Internal Medicine	4
Gastroenterology	1
Pediatrics	1
Pulmonology	1
Rheumatology	1
APP - Primary Care	3

Sequoia Oncology Medical Associates Inc.	
Hematology/Oncology	1

Orthopaedic Associates Medical Clinic, Inc.	
Orthopedic Surgery (General)	1
Orthopedic Surgery (Hand)	1
Orthopedic Surgery (Trauma)	1

Stanford Health Care	
Cardiothoracic Surgery	2

Sequoia Cardiology Medical Group	
EP Cardiology	1

Oak Creek Anesthesia	
Anesthesia - General/Medical Director	1
Anesthesia - Obstetrics	1
Anesthesia - Regional Pain	1

USC Urology	
Urology	3

Valley Hospitalist Medical Group	
GI Hospitalist	1

Other Recruitment/Group TBD	
Dermatology	2
Family Medicine	3
Gastroenterology	2
Hospice & Palliative Medicine	1
Neurology - Outpatient	1
Otolaryngology	2
Pediatrics	1
Pulmonology - Outpatient	1
Interventional Cardiology	1
General Cardiologist	1

Valley ENT	
Audiology	1
Otolaryngology	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	1
Pediatric Cardiology	1
Pediatric Hospialist	1

Offer Extended

#	Specialty	Group	Offer Sent
1	Family Medicine	Direct/1099	9/14/2023
2	Internal Medicine	Delta Doctors	7/5/2023
3	Hospice & Palliative Medici	Independent	6/23/2023
4	Hospitalist	Valley Hospitalist	6/1/2023
5	Cardiothoracic Surgery	Stanford	3/23/2023
6	Medical Oncology	Sequoia Oncology Medical Associates	9/1/2023
7	Endrocrinology	Delta Doctors	9/20/2023

Offer Accepted

#	Specialty	Group	Expected Start Date
1	CRNA	Oak Creek Anesthesia	Oct 2023
2	Family Medicine	Kaweah Health Faculty Group	Nov 2023
3	Pediatric Hospitalist	Valley Children's	Fall 2023
4	Anesthesia - General	Oak Creek Anesthesia	Spring 2024
5	CRNA	Oak Creek Anesthesia	Spring 2024
6	CRNA	Oak Creek Anesthesia	Spring 2024
7	CRNA	Oak Creek Anesthesia	Spring 2024
8	Neurology	Kaweah Health Neurology Group	Summer 2023
9	Orthopedic Trauma	Orthopaedic Associates Medical Clinic	Summer 2024
10	Anesthesia - General	Oak Creek Anesthesia	Winter 2023
11	CRNA	Oak Creek Anesthesia	Winter 2023
12	CRNA	Oak Creek Anesthesia	Winter 2023
13	CRNA	Oak Creek Anesthesia	Winter 2023
14	CRNA	Oak Creek Anesthesia	

Physician Recruitment and Relations

Medical Staff Recruitment Report - September 2023

Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456

Date prepared: 9/18/2023

Central Valley Critical Care Medicine	
Intensivist	1
Step-Down Hospitalist	2

Delta Doctors Inc.	
Family Medicine	2
OB/GYN	1
Adult Psychiatry	1

Key Medical Associates	
Dermatology	1
Endocrinology	1
Family Medicine/Internal Medicine	4
Gastroenterology	1
Pediatrics	1
Pulmonology	1
Rheumatology	1
APP - Primary Care	3

Sequoia Oncology Medical Associates Inc.	
Hematology/Oncology	1

Orthopaedic Associates Medical Clinic, Inc.	
Orthopedic Surgery (General)	1
Orthopedic Surgery (Hand)	1
Orthopedic Surgery (Trauma)	1

Stanford Health Care	
Cardiothoracic Surgery	2

Sequoia Cardiology Medical Group	
EP Cardiology	1

Oak Creek Anesthesia	
Anesthesia - General/Medical Director	1
Anesthesia - Obstetrics	1
Anesthesia - Regional Pain	1

USC Urology	
Urology	3

Valley Hospitalist Medical Group	
GI Hospitalist	1

Other Recruitment/Group TBD	
Dermatology	2
Family Medicine	3
Gastroenterology	2
Hospice & Palliative Medicine	1
Neurology - Outpatient	1
Otolaryngology	2
Pediatrics	1
Pulmonology - Outpatient	1
Interventional Cardiology	1
General Cardiologist	1

Valley ENT	
Audiology	1
Otolaryngology	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	1
Pediatric Cardiology	1
Pediatric Hospialist	1

Candidate Activity

#	Specialty	Group	Date Added	Current Status
1	EP	TBD	9/11/2023	Currently under review
2	Family Medicine	TBD	9/8/2023	Currently under review
3	Neurology	KD Neurology	9/8/2023	Currently under review
4	ENT	TBD	9/8/2023	Site Visit: Pending
5	EP	TBD	9/8/2023	Currently under review
6	Cardiothoracic Surgery	Stanford	9/8/2023	Site Visit: 9/18/23
7	Neurology	Kaweah Delta Neurology	8/11/2023	Site Visit: 10/6/23
8	Pediatric Hospitalist	Valley Children's	8/1/2023	Site Visit: 10/2023
9	Intensivist	Central Valley Critical Care Medicine	7/17/2023	Currently under review

Candidate Activity

#	Specialty	Group	Date Added	Current Status
10	Hospitalist	Central Valley Critical Care	7/17/2023	Currently under review
11	Hospitalist	Central Valley Critical Care Medicine	7/17/2023	Currently under review
12	Family Medicine	TBD	7/11/2023	Currently under review
13	Interventional Cardiology	Sequoia Cardiology	7/10/2023	Currently under review
14	Gastroenterology	TBD	6/21/2023	Currently under review
15	Adult Psychiatry	Key Medical	6/21/2023	Site Visit: 9/19/23
16	Family Medicine	TBD	6/21/2023	Currently under review
17	Family Medicine	TBD	6/21/2023	Currently under review
18	Orthopedic Trauma	Orthopaedic Associates Medical Clinic, inc	8/18/2022	Currently under review

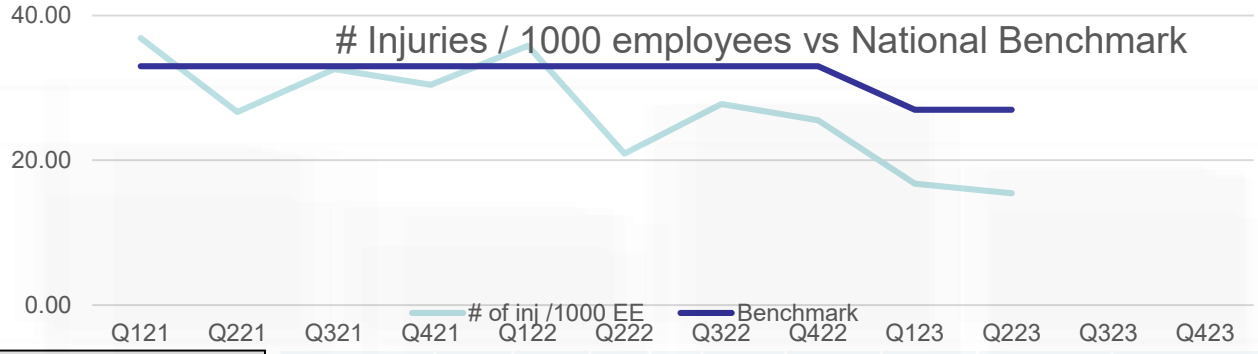
Environment of Care
2nd Quarter Report
April 1, 2023 through July 31, 2023
Presented by

Maribel Aguilar, Safety Officer
maaguila@kaweahhealth.org
559-624-2381

Kaweah Health
Performance Monitoring 2nd Qtr. 2023

EOC

Performance Standard: Employee Health: Reduce OSHA recordable work related injury cases in 2023 by 10% from 2022. Goal: Less than 364 cases for 2023. Cases currently lower than benchmark.



Evaluation:

- 75 OSHA recordable injuries in Qtr 2-2023 , plus 117 Covid 19 claims
- Covid 19 vaccination began 12/18/20, boosters began Oct 2021
- Provided ergo evaluations
- 2023 Sharps Exposure- Quarter 2 - 18 total
- Influenza vaccination rate 2022-2023 82%

Type of injury	Q1	Q2	Q3	Q4	Totals 2023	Totals 2022	Ann-ualized 2023	Per 1000 EE's Q2 2023	National Benchmark Per 1000 EE's
Total Incidents	94	163			257	608	514		
Covid 19+	276	117			393	2877	786		
OSHA recordable	85	75			160	361	320	15.44	27
Lost time cases	49	38			87	299	174		
Strain/sprain	35	18			53	125	106		
Sharps Exp	24	18			42	58	84		
# EE end of QTR	5063	4855							

- **Plan for Improvement:** Focus on Strains/Sprains and sharps exposures which are the most common type of injury.
- Assure that employees/managers are aware of proper training/instruction and noting any trends per employee and/or injuries.
- Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process changes and policy review. Investigation/ follow-up may include photos, video and interview of witnesses/ manager.
- Increase Sharps education in General Orientation by Infection Prevention and Manager orientation by EHS. Demo correct sharps activation in new hire physicals with all employees handling sharps.
- Utilize PTA in Employee Health for Ergo evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.
- Continue to work with Infection Prevention to track exposures/outbreaks amongst Health Care Workers in 2023. As of 6/30/23 only 8 positive employees on LOA for COVID (new cases).

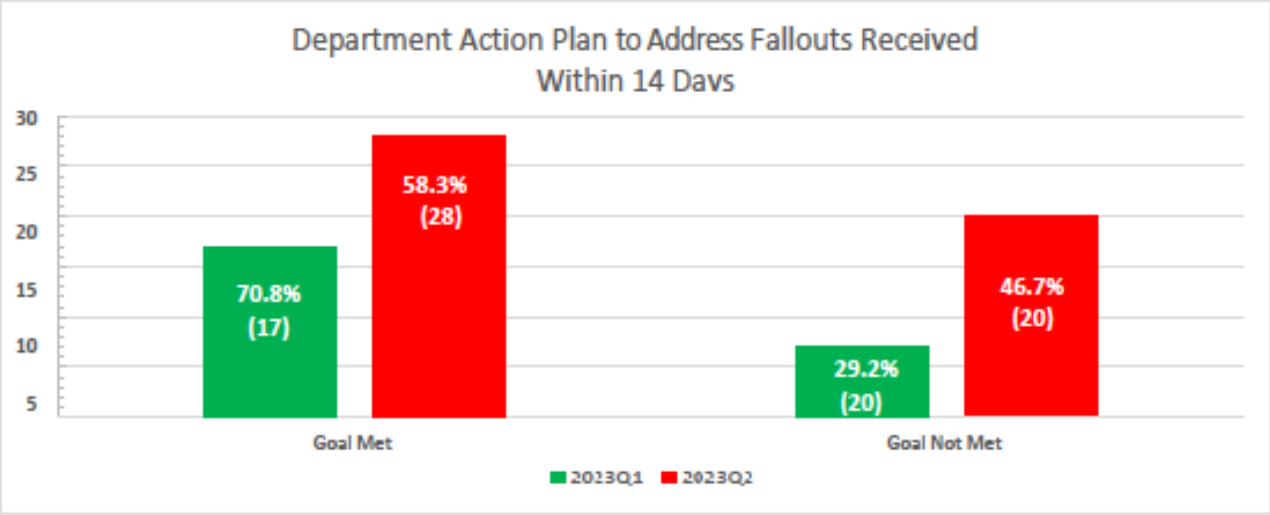
OSHA recordable injuries and Illnesses are as follows:

- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost work day, or modified work with restrictions (recordable)
- Medical treatment other than First Aid (recordable)

Total Incidents include First Aid and Report Only,

Infection Prevention Component:	**INFECTION PREVENTION COMPREHENSIVE ROUNDS**
Performance Standard:	**Comprehensive Rounds** - Action plans to correct elements out of compliance are returned by the department leader to Infection Prevention department within 14 days of report of findings to ensure safety issues are addressed in a reasonable timeframe in order to mitigate the risk of infection to patients and staff, to enhance patient safety and to optimize the environment of patient care. **Goal:** >90% compliance rate. **Minimum Performance Level:** 90% compliance rate.

Evaluation:
Action plans from department leaders within 14 days to address findings 2023 Q1&2: 62.5%
72 departments were surveyed for 2023 Q1&2.
45 departments met the goal. 27 departments did not meet the goal.



Improvements made to process:
Rounding schedule shared with affected departments in advance.
Manager or designee is asked to attend the rounds onsite.
The rounding tool has been consolidated into one comprehensive questionnaire so managers only receive one document outlining the fallouts.
Managers are provided 14 days to return the action plan versus 7 days as was previously expected.
Reminders are submitted to the manager initially and after the 14-day mark to submit the completed action plan.
Next Steps:
Contact Director for departments with fallouts
Attend Patient Care Management (PCM) to discuss fallouts and expectations.

SECURITY

SECOND QUARTER 2023

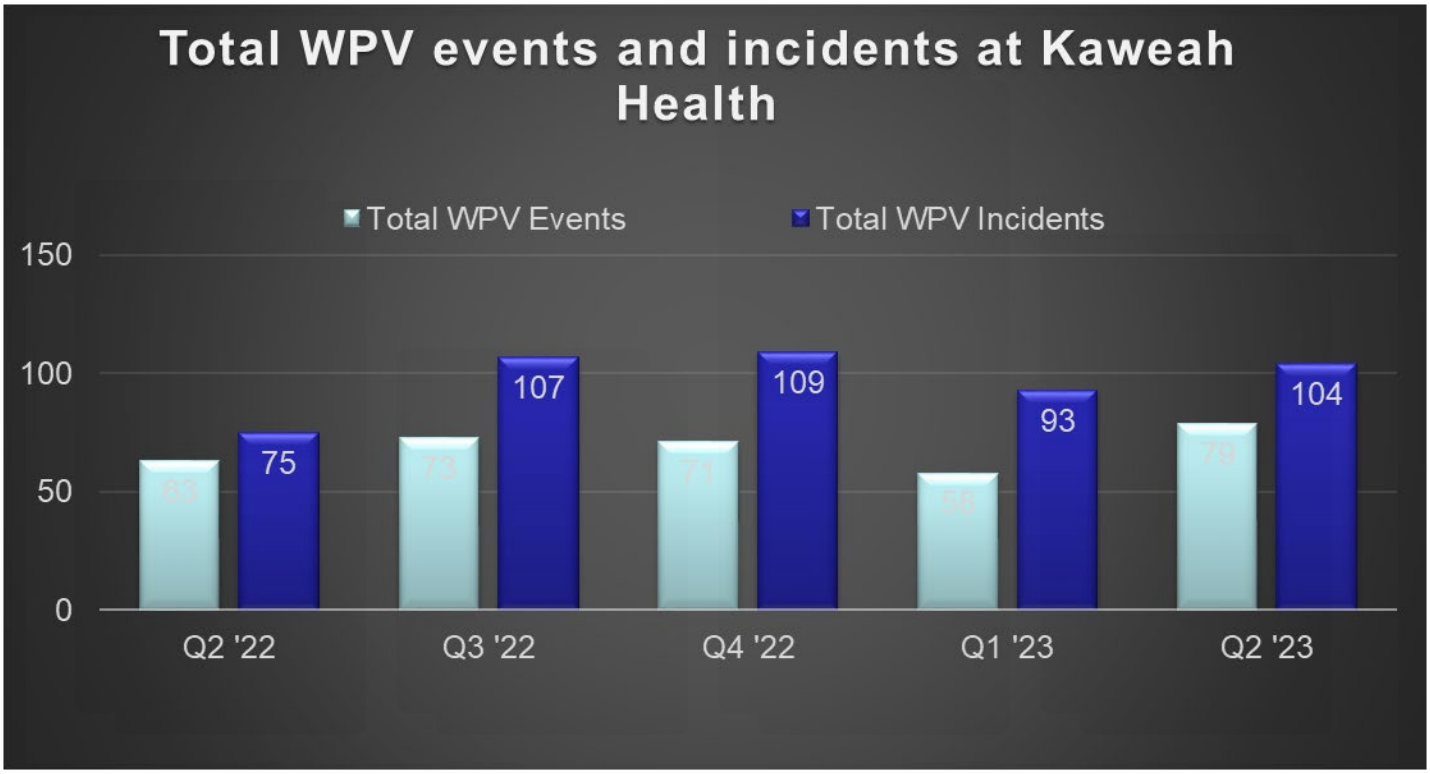
Performance Standard: Reduce Workplace Violence Events
Goal: 10% reduction in the 3 year average of the ED, MH, Medical Center, and off-campus facilities.
Status: 57 total WPV events in CY 2023.
Sponsor: Chris Luttrell, Safety Specialist

Detailed Plan for Improvement (2023):

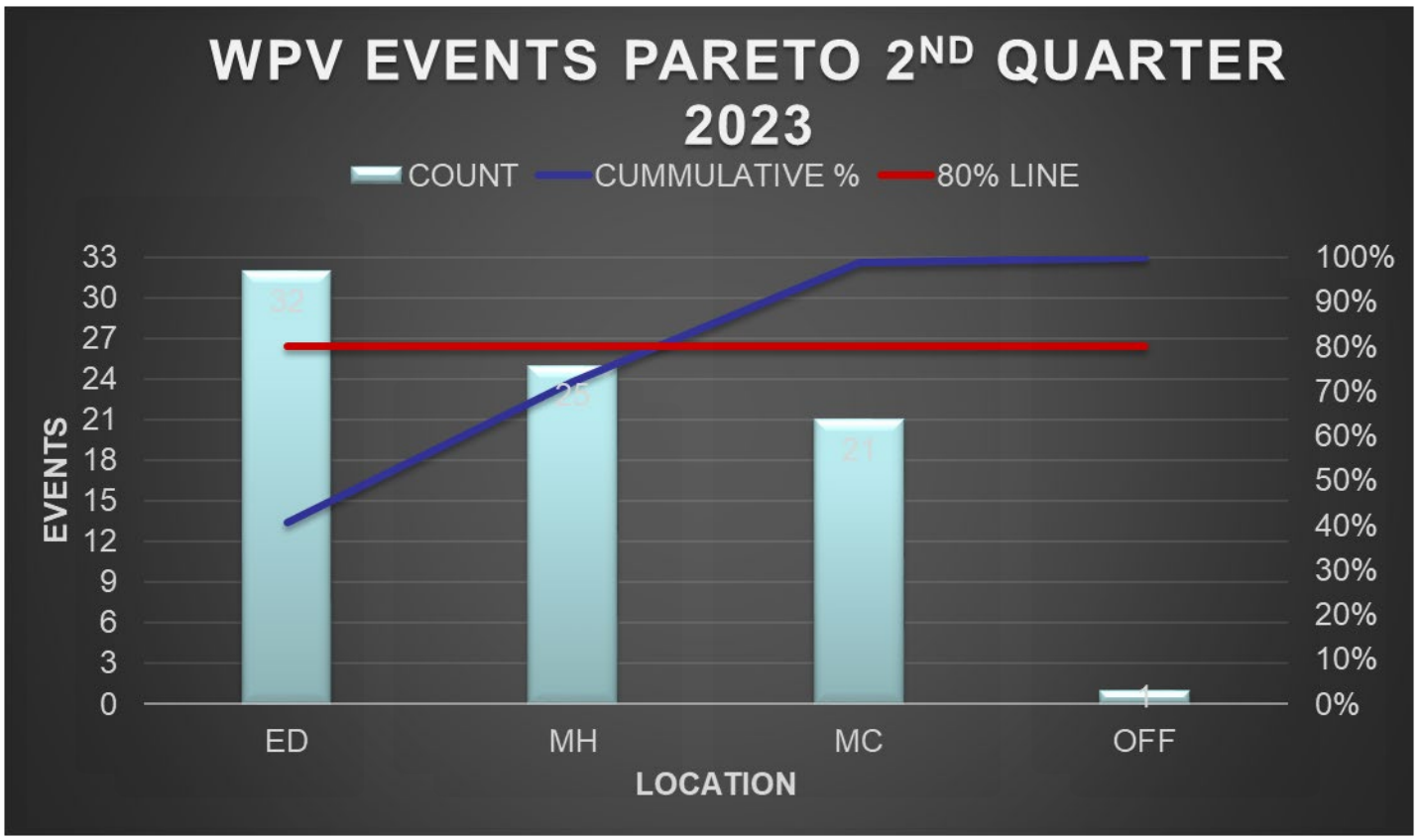
1. We must continue to encourage staff to enter incident reports for workplace violence on Midas.
2. All CNAs began CPI training in July of 2022. This should help our front line staff to be more aware and cautious when sitting for aggressive behavior patients.
3. The electronic flag is currently in place and working. We must continue to work to educate staff on how to use the toolkit to provide support in engaging with these high-risk patients.
4. We are continuing to project our focus of increasing the rigor of CPI training at mental health and at our behavioral health clinics off campus. Advanced CPI courses will continue with these high-risk groups.

Kaweah Health location	WPV events reported by security (2023)	WPV events entered into MIDAS reporting system (2023)	WPV events reviewed by WPV case review team (2023)
Emergency Department	54	5	3
Mental Health	43	97	N/A
Medical Center	36	28	23
Off-Campus facilities	3	3	0

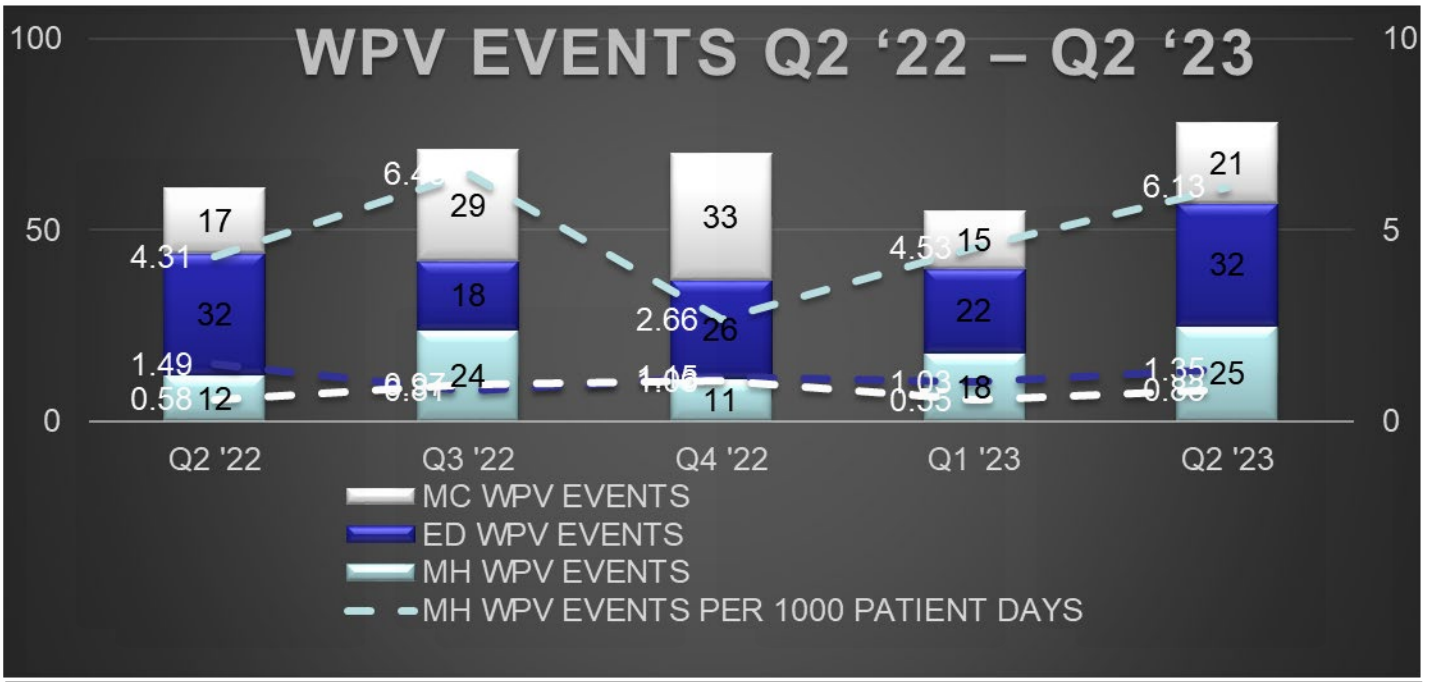
Evaluation: Workplace violence is inconsistently reported at Kaweah Health. It will be difficult to strengthen our response to WPV events if we continue to inconsistently report. Safety specialist Luttrell will continue to monitor WPV reporting in 2023 and report findings to QIC and WPVP committee.



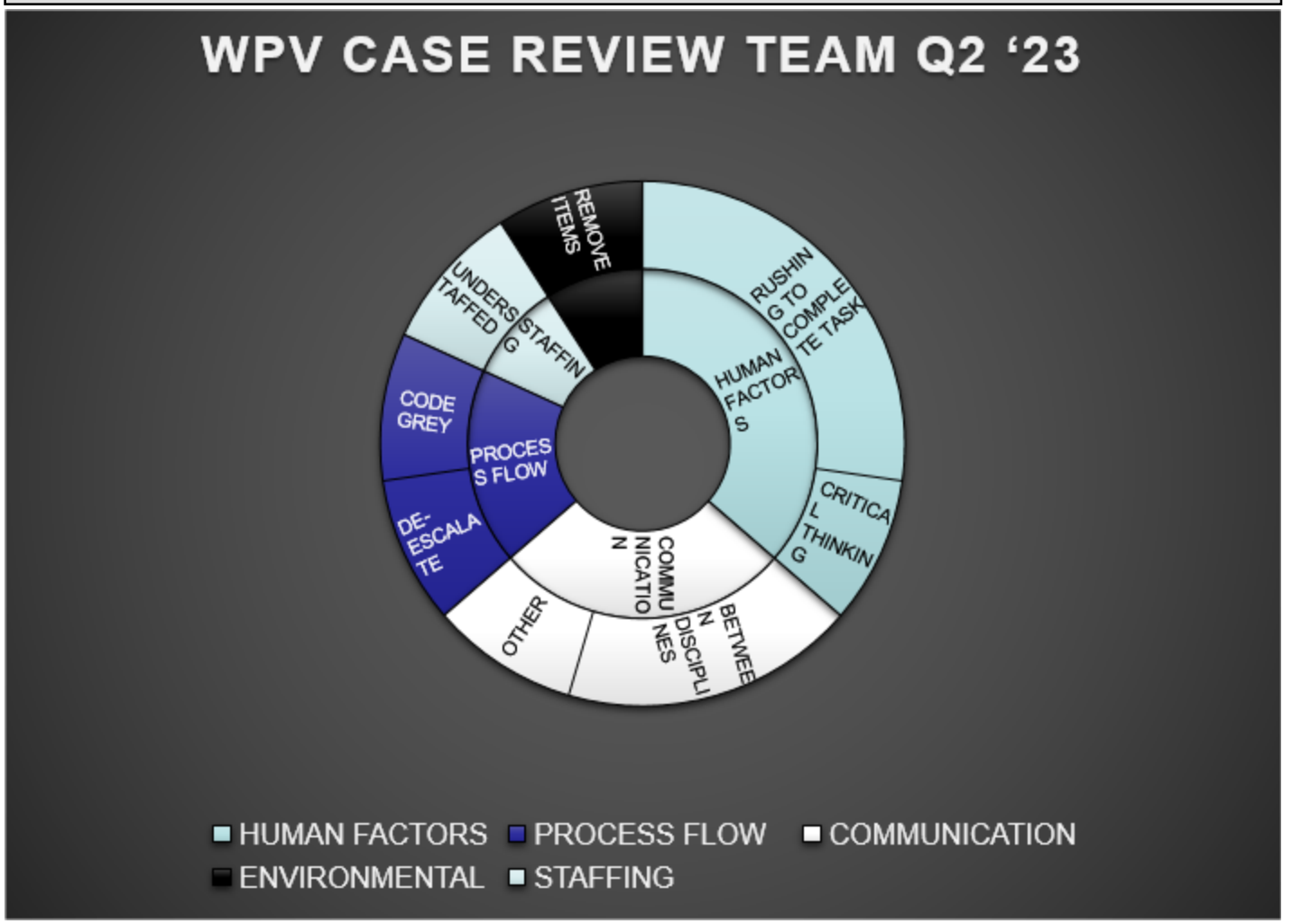
Evaluation:
There was a 25% increase in WPV events from Q2 of 2022 and Q2 of 2023. There was a 36% increase from the first to the second quarter of 2023.



Evaluation:
The Emergency Department (ED) had the most WPV events of the district in the 2nd quarter of 2023. Lowering WPV in the ED should be a priority, and would make a considerable change in our overall WPV numbers. We should focus our efforts toward the ED in the 3rd quarter of 2023.



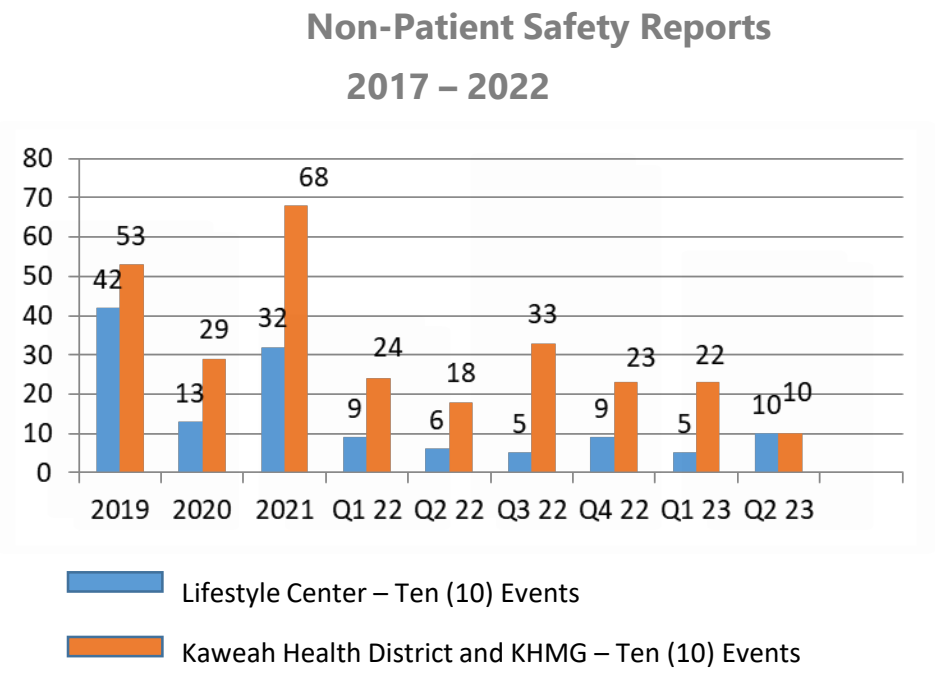
Evaluation: Mental Health WPV events were 6.13 per 1,000 patient days. This is an increase of 35% from last quarter. ED WPV events were 1.35 per 1,000 visits. This is an increase of 31% from last quarter. Medical Center WPV events were .83 per 1,000 patient days. This is an increase of 51% from last quarter.



Evaluation: Of the 26 WPV events reviewed by the WPV case review team, the most prominent root cause of WPV events were based on human factors, with rushing to complete a task being the most prevalent.

EOC Component: **SAFETY**
Performance Standard: **Risk Management –Reporting of non-patient safety related injuries within 7 days will to be compliant at 100%.**
Goal: **Report non-patient safety related events within 7 days**
Minimum Performance Level: Report non-patient safety related events within 7 days

Evaluation:
In 2nd Qtr. 2023, We identified one (3) safety risk concerns which have been addressed:
TLC = Member stumbled over own feet, hitting his head on the wall. Sustained minor cuts.
Member suffered a severe vertigo attack in the locker room
Member slipped and fell shortly after restroom floor was mopped by EVS staff.
Action Items:
1.Process will be implemented by EVS staff to use dry mop after initial mopping.
2.Evaluation will be completed related to installing an emergency pull cord in the restroom where fall occurred.
Minimum performance measure was met for 2nd Qtr. 2023 at 100% compliance.



EMERGENCY PREPAREDNESS

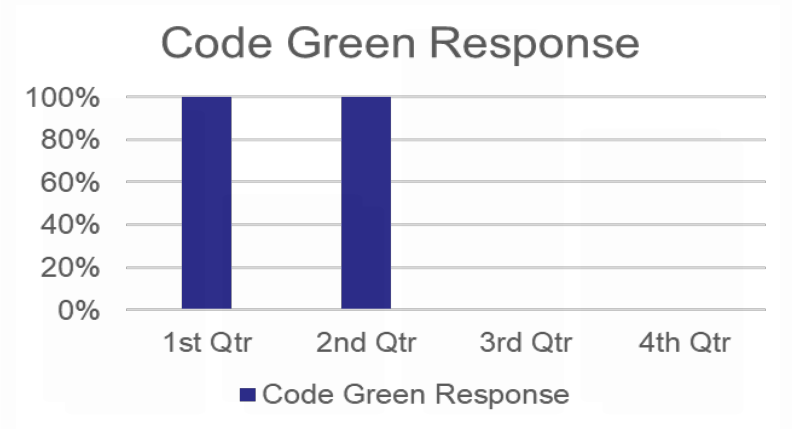
Second Quarter 2023

Performance Standard: Employees able to provide correct responses related to Code Green Response.
Goal: 100% Compliance (all employees surveyed answered correctly)
Status: Goal met for 2nd Quarter 2023

Evaluation:

Fifty-four departments were surveyed in the 2nd quarter. In all departments surveyed staff where able to verbalize Code Green response, which resulted in a 100% compliance rate.

95% minimum performance level was met for this quarter.

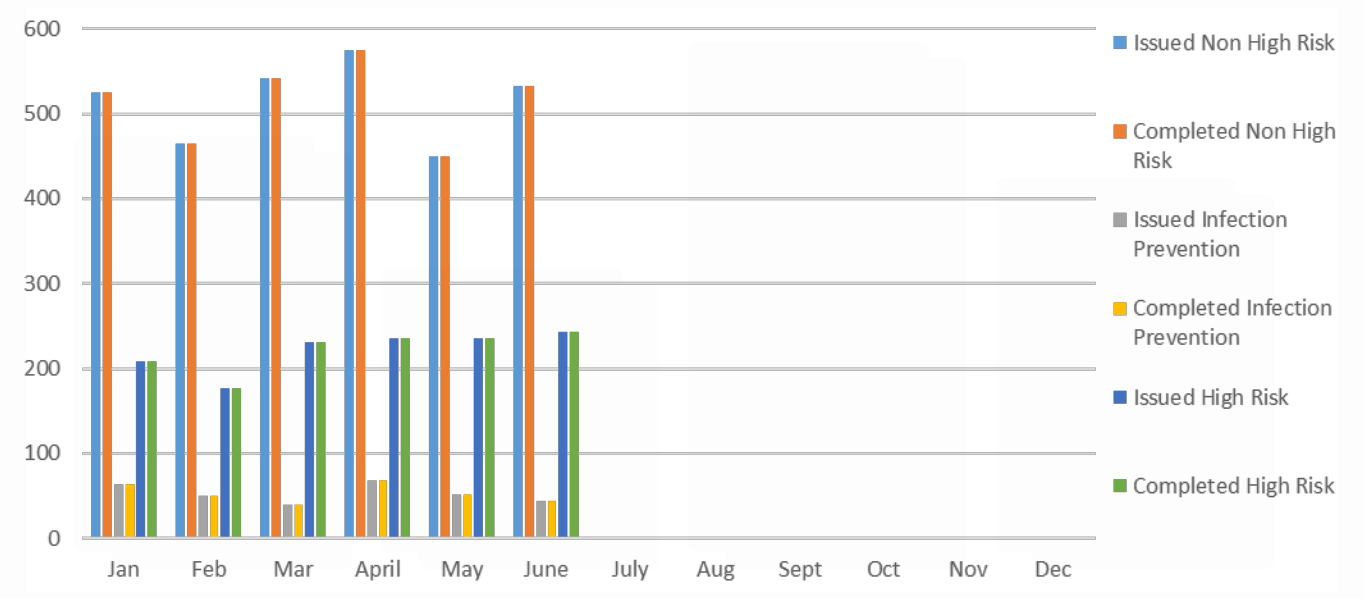


Detailed Plan for Improvement:
In each department visited there was knowledge of Code Green response.

UTILITIES MANAGEMENT

Second Quarter 2023

Performance Standard: High Risk, Low Risk, Infection Control Preventive Maintenance to be completed on time
Goal: 100% Compliance (no missed PM's)
Status: Goal met for 2nd Quarter 2023



Evaluation:
2436 of 2436 preventative maintenance work orders were completed on time.

Evaluation Summary:

For2023 2436 of 2436 preventative maintenance work orders completed on time.

PM Completion %

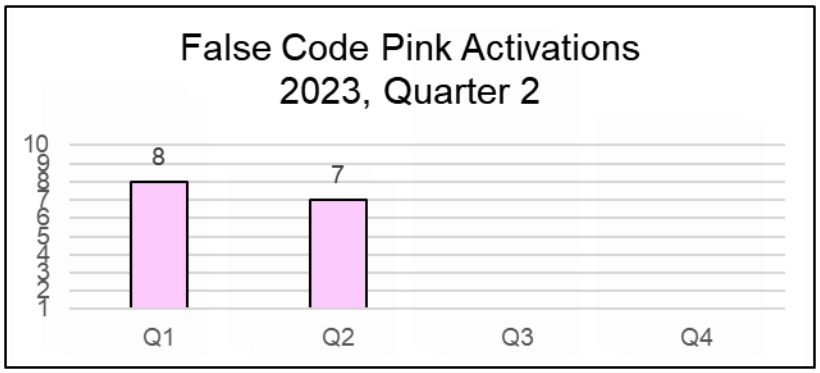
	Non-High Risk	Infection Prevention	High Risk	Q4 Summary
April	100.00%	100.00%	100.00%	100.00%
May	100.00%	100.00%	100.00%	100.00%
June	100.00%	100.00%	100.00%	100.00%
Q2 Summary:	100.00%	100.00%	100.00%	100.00%

EOC Component: SECURITY

Performance Standard:

False Code Pink Activations– Reduce ***false*** Code Pink activations. Frequent false Code Pink activations are creating alarm fatigue response from support departments and increasing our vulnerability to stop/identify an abductor in the event of a real Code Pink event.

Goal: 100 % compliance rate
Minimum Performance Level: <4 events per Quarter



Evaluation:
In year 2020 the Medical Center experienced 48 ***false*** Code Pink activations. In year 2021 we ended the year with 33 events, a 31% decrease. In year 2022 we ended the year with 22 events, a 33% decrease. For year 2023, the goal is to decrease Code Pink false alarms by 50% of the previous year - <11 events for the calendar year; 2.75 events per quarter.

Quarterly Goal **Not Met** – Eight (7) ***false*** Code Pink activations reported for the 2nd quarter

Plan for Improvement:
The majority of ***false*** Code Pink activations are due to staff forgetting to deactivate or to set the HUGS transmitter in transport when moving the child/newborn from the home unit to the transport unit. Unit leaders for Maternal-child Health units will work with their clinical-clerical staff to improvement system management, especially when short staffed.

Labor and Delivery leadership attended the September (2022) EOC meeting to speak to the increase in false code pink activations. Plan is to engage the new Maternal-Child Health director to review challenges and formulate a plan that supports staff and yields PI goal outcomes.

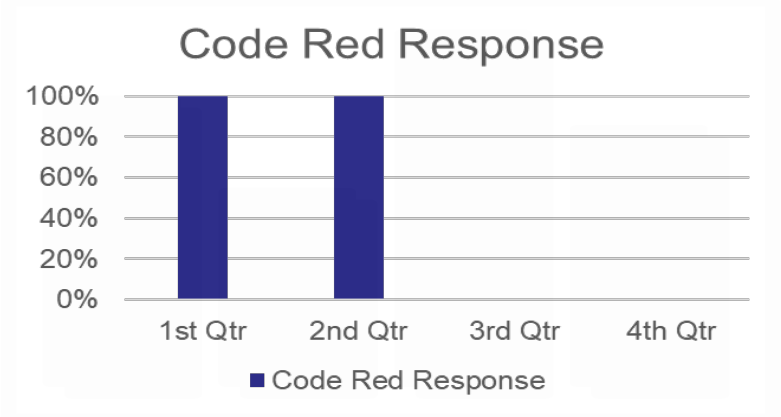
LIFE SAFETY

Second Quarter 2023

Performance Standard: Employees able to demonstrate the correct response to RACE, specifically Contain- Was the Fire contained, were the fire doors closed, were the patient room doors closed , If evacuation needed did they know the process of marking door with tape.
Goal: 100% Compliance
Status: Goal met for 2nd Qtr. 2023

Evaluation:
Fifty-four departments were surveyed in the 2nd quarter. All departments were compliant with RACE This resulted in 100% compliance rate.

Minimum Performance Level was met during this quarter.



Detailed Plan for Improvement:

All departments surveyed in the 2nd Quarter were knowledgeable of R.A.C.E (Rescue, Alarm, Contain and Extinguish) response.

EOC Component: Medical Equipment Preventive Maintenance Compliance

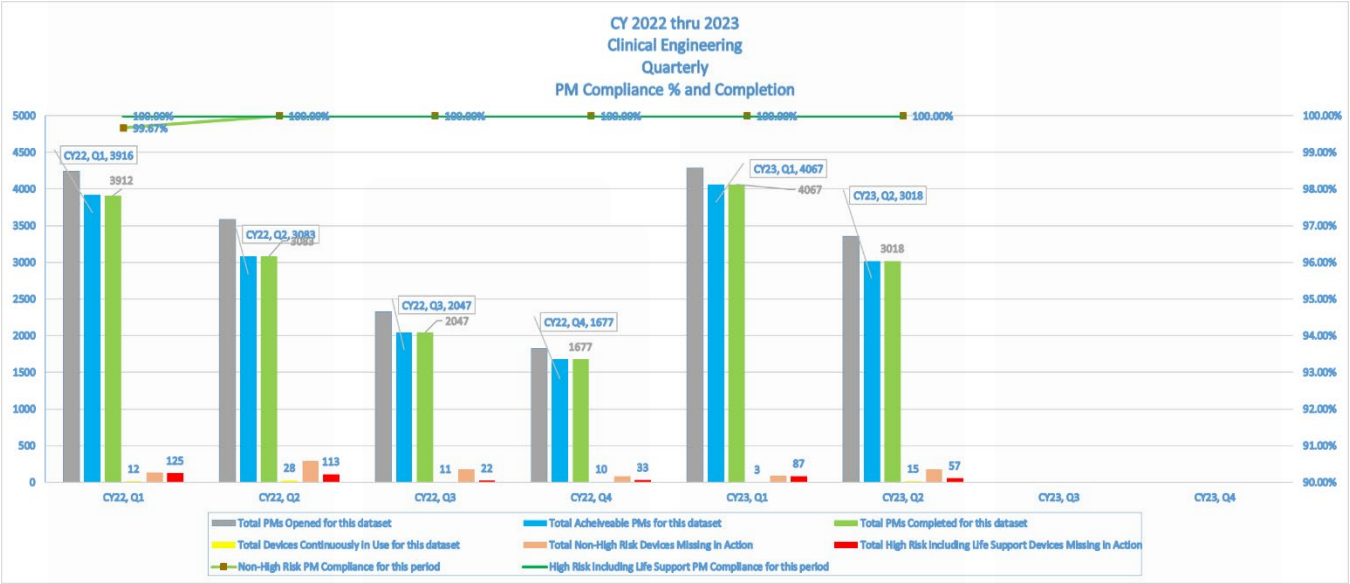
Performance Standard: **Medical Equipment–** Maintain a 100% compliance rate on non-high risk and high risk including

Life support devices
Goal: 100 % compliance rate
Minimum Performance Level: 100% completion rate.

Performance Standard: **<1% Total of High Risk Devices to be Missing for Preventive Maintenance**

Evaluation:
For the reporting quarter, CY 2023, Q2 (Apr-Jun). Medical Device count available to receive Preventive Maintenance is 3018 and 3018 of those devices received Preventive Maintenance as scheduled. **All Medical** Devices this Quarter received Planned Maintenance or were marked as In Use or Missing as defined by TJC.

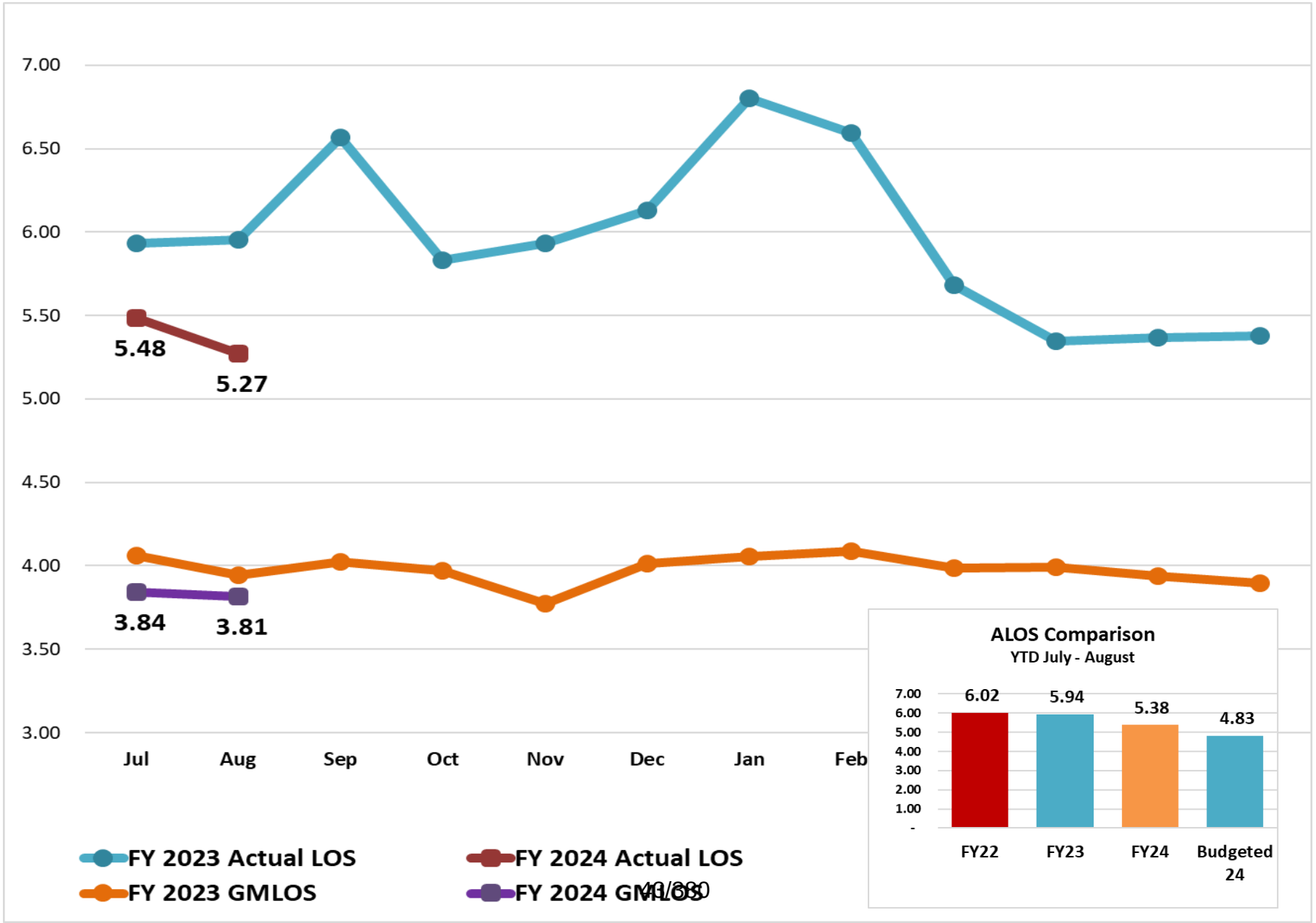
PM Compliance for Non-High Risk Devices is 100% and **meets the 100% Compliance Goal**.
PM Compliance for High Risk Including Life Support Devices is 100% and **meets the 100% Compliance Goal.**
PI Goal: Total High Risk Devices Missing count is 57 for the Quarter. This is 1.17% of the High Risk Equipment Inventory. The greater than 1% of HRiLS inventory does not meet goal of <1.0%.



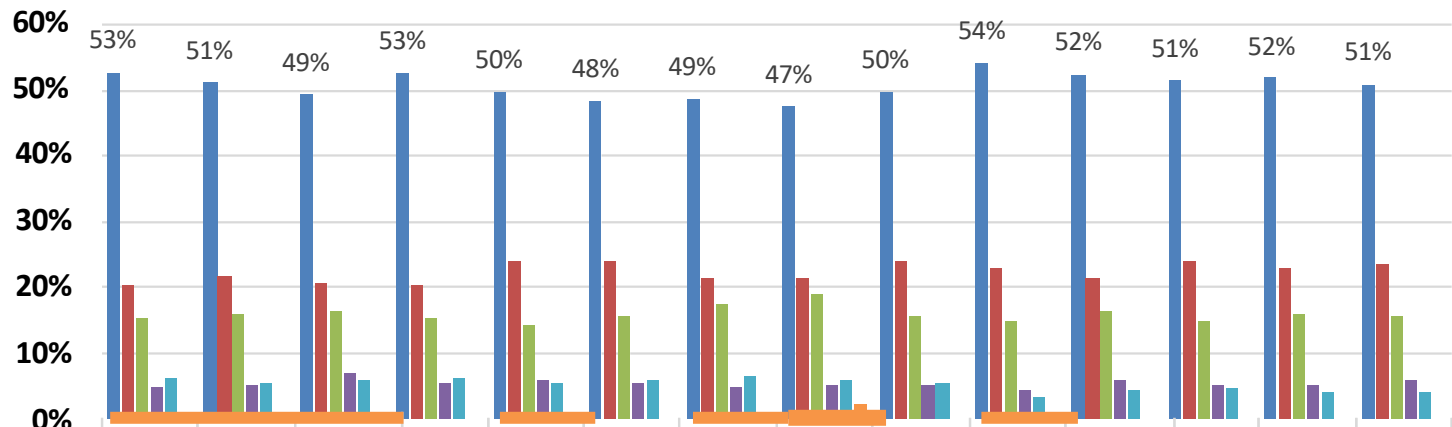
Plan for Improvement: Clinical Engineering is now notifying the department managers monthly about High Risk as well as Non-High Risk medical devices assigned to their areas that could not be located in the prior month. Clinical Engineering is also assigning a singular technician to work with these managers in an attempt to locate and collect overdue devices for proper processing. A request for a passive RFID tracking system was not funded this year. A majority of the leading hospital systems in the USA use this type of system providing accuracy and timely device inventory. Equipment that does not receive its scheduled preventive maintenance during the scheduled period due is a risk to patient care. While all medical devices have a dated PM due sticker on their forward facing side for the care provider to observe and take action upon, we do routinely find medical devices that continue to be used for months beyond the expired date. The RFID system would greatly reduce this timeframe. A Kaweah Health wide sweep is being made this month, August 2023, to track the devices currently listed as Missing and overdue for preventive maintenance. A report on the findings will be sent to the EOC in September on the success of this work.

Throughput Steering Committee

Average Length of Stay versus National Average (GMLOS)



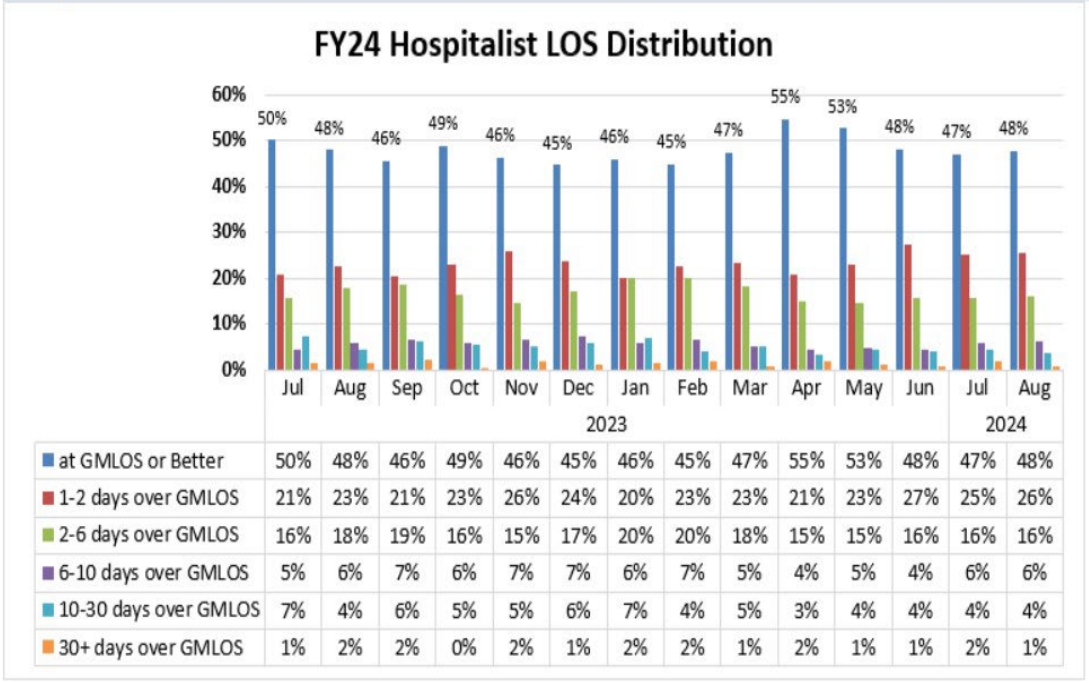
Overall



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
at GMLOS or Better	53%	51%	49%	53%	50%	48%	49%	47%	50%	54%	52%	51%	52%	51%
1-2 days over GMLOS	20%	22%	20%	20%	24%	24%	21%	21%	24%	23%	21%	24%	23%	23%
2-6 days over GMLOS	15%	16%	16%	15%	14%	16%	17%	19%	16%	15%	16%	15%	16%	16%
6-10 days over GMLOS	5%	5%	7%	5%	6%	5%	5%	5%	5%	4%	6%	5%	5%	6%
10-30 days over GMLOS	6%	5%	6%	6%	5%	6%	7%	6%	5%	3%	4%	5%	4%	4%
30+ days over GMLOS	1.2%	1.2%	1.7%	1.0%	1.2%	1.1%	1.6%	2.0%	0.5%	1.2%	0.5%	0.8%	0.9%	0.8%

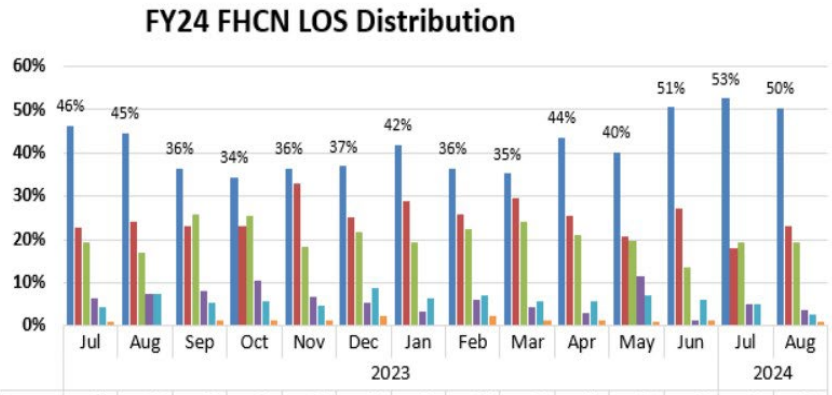
LOS Distribution

Hospitalist



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
at GMLOS or Better	50%	48%	46%	49%	46%	45%	46%	45%	47%	55%	53%	48%	47%	48%
1-2 days over GMLOS	21%	23%	21%	23%	26%	24%	20%	23%	23%	21%	23%	27%	25%	26%
2-6 days over GMLOS	16%	18%	19%	16%	15%	17%	20%	20%	18%	15%	15%	16%	16%	16%
6-10 days over GMLOS	5%	6%	7%	6%	7%	7%	6%	7%	5%	4%	5%	4%	6%	6%
10-30 days over GMLOS	7%	4%	6%	5%	5%	6%	7%	4%	5%	3%	4%	4%	4%	4%
30+ days over GMLOS	1%	2%	2%	0%	2%	1%	2%	2%	1%	2%	1%	1%	2%	1%

FHCN



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
at GMLOS or Better	46%	45%	36%	34%	36%	37%	42%	36%	35%	44%	40%	51%	53%	50%
1-2 days over GMLOS	23%	24%	23%	23%	33%	25%	29%	26%	30%	25%	21%	27%	18%	23%
2-6 days over GMLOS	19%	17%	26%	25%	18%	22%	19%	22%	24%	21%	20%	14%	19%	19%
6-10 days over GMLOS	6%	7%	8%	10%	7%	5%	3%	6%	4%	3%	11%	1%	5%	4%
10-30 days over GMLOS	4%	7%	5%	6%	5%	9%	6%	7%	6%	6%	7%	6%	5%	3%
30+ days over GMLOS	1%	0%	1%	1%	1%	2%	0%	2%	1%	1%	1%	1%	0%	1%

Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Metric	Patient Type	Definition	Goal	Baseline**	Discharge Date 4/1/2023 to 8/31/2023				
					Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Observation Average Length of Stay (Obs ALOS) *(Lower is better)**	**Overall**	Average length of stay (hours) for observation patients	**36**	**46.77**	**41.60**	**62.34**	**39.89**	**41.31**	**41.57**
					Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Inpatient Average Length of Stay (IP ALOS) *(Lower is better)**	**Overall**	Average length of stay (days) for inpatient discharges	**N/A**	**5.43**	**5.45**	**5.28**	**5.47**	**5.53**	**5.33**
					Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Inpatient Observed-to-Expected Length of Stay *(Lower is better)***	**Overall**	Observed LOS / geometric mean length of stay for inpatient discharges	**1.32**	**1.41**	**1.40**	**1.39**	**1.41**	**1.48**	**1.41**
					Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Discharges*	Inpatient	Count of inpateint discharges	**N/A**	**1,271**	**1,189**	**1,263**	**1,279**	**1,262**	**1,283**
	Observation	Count of observation discharges	**N/A**	**442**	**392**	**467**	**450**	**452**	**470**
	Overall	Count of inpatient and observation discharges	**N/A**	**1,713**	**1,581**	**1,730**	**1,729**	**1,714**	**1,753**

***All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data**

***O/E LOS to be updated to include cases with missing DRG when available**

**Baseline calculation: Previous 6-month rolling median or average based on the metric's calculation

Performance Scorecard

Leading Performance Metrics – Emergency Department

Metric	Patient Type	Definition	Goal	Baseline**	Check In Date and Time: 4/1/2023 12:00:00 AM to 8/31/2023 11:59:59 PM				
					Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
ED Boarding Time *(Lower is better)**	Inpatient	Median time (minutes) for admission order written to check out for admitted patients		144	124	138	125	141	158
	Observation	Median time (minutes) for admission order written to check out for observation patients		139	124	138	119	144	161
	Overall	Median time (minutes) for admission order written to check out for inpatient and observation patients		144	124	138	124	141	158
ED Admit Hold Volume *(Lower is better)**	**Overall >4 Hours**	Count of patients (volume) with ED boarding time ≥ 4 hours	**N/A**	267	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
					136	234	160	236	301
ED Length of Stay (ED LOS) *(Lower is better)**	Discharged	Median ED length of stay (minutes) for discharged patients		283	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
					265	281	287	294	297
	Inpatient	Median ED length of stay (minutes) for admitted patients		527	492	491	499	506	555
	Observation	Median ED length of stay (minutes) for observation patients		517	488	479	477	527	552
	Overall	Median ED length of stay (minutes) for admitted and discharged patients	**N/A**	332	312	326	332	337	347
ED Visits*	Discharged	Count of ED visits for discharged patients	**N/A**	5,020	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
					4,941	5,075	4,880	5,142	5,444
	Inpatient	Count of ED Visits for admitted patients	**N/A**	1,131	1,054	1,126	1,122	1,139	1,163
	Observation	Count of ED Visits for observation patients	**N/A**	441	420	448	472	444	463
	Overall	Count of ED visits	**N/A**	6,592	6,415	6,649	6,474	6,725	7,070

***All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data.**

**Baseline calculation: Previous 6-month rolling median or average based on the metric's calculation

Encounter Types
- [x] Inpatient
- [x] Observation

Discharge Date
8/1/2022 to 8/31/2023

% of Discharges Before 12 PM *(Higher is better)*

		Goal	Baseline
Overall	% of Inpatient & Observation discharged before 12 PM	**35%**	**11.5%**

Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul
10.7%	10.9%	11.5%	9.9%	11.7%	11.3%	12.5%	9.5%	9.8%	8.7%	9.0%	

Discharges Before Noon by Nurse Unit

Unit Group	Loc Nurse Unit	Month of Discharge Date: Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Med/Surg	KHMC 1E Emergency Room ...	15.2%	8.8%	10.0%	12.5%	16.2%	15.1%	25.0%	23.3%		21.4%	8.3%	21.4%	18.2%
	KHMC 2N Medical Surgical	11.9%	12.3%	16.4%	14.9%	11.4%	13.2%	10.7%	7.2%	12.0%	10.4%	10.6%	14.1%	6.0%
	KHMC 2S Medical Surgical	9.6%	5.4%	5.6%	3.3%	4.8%	4.5%	7.2%	5.2%	5.4%	5.3%	5.7%	3.3%	3.7%
	KHMC 3N Medical Surgical	13.2%	12.8%	12.8%	9.3%	13.6%	10.8%	15.2%	10.7%	9.6%	10.2%	9.3%	15.2%	16.2%
	KHMC 3S Medical Surgical	9.4%	12.9%	10.2%	8.6%	7.6%	12.0%	10.6%	7.8%	10.2%	14.2%	10.3%	10.3%	12.6%
	KHMC 4N Medical Surgical	5.4%	8.8%	8.1%	5.8%	5.2%	7.3%	5.7%	8.9%	3.9%	4.6%	4.4%	6.8%	4.9%
	KHMC 4S Medical Surgical	7.8%	12.1%	9.1%	9.0%	13.7%	12.8%	16.4%	9.0%	6.0%	6.1%	5.6%	8.4%	7.9%
	KHMC 14 Medical Surgical	4.9%	6.4%	8.8%	4.5%	8.7%	7.9%	9.0%	8.3%	8.1%	2.4%	3.0%	4.3%	5.7%
	KHMC BP Broderick Pavilion	15.7%	13.5%	13.5%	21.2%	18.8%	18.7%	12.4%	16.2%	14.0%	7.4%	14.2%	11.0%	10.7%
	KHMC PE Pediatrics								10.5%					
ICU	KHMC 3W ICCU	15.2%	9.1%	31.4%	17.2%	20.0%	18.2%	45.5%	21.2%	35.3%	28.6%	24.0%	13.3%	19.0%
	KHMC 15 ICCU	12.2%	12.5%	14.8%	9.1%	15.2%	11.8%	8.8%	8.6%	21.7%	18.0%	15.0%	17.9%	3.3%

Discharges Before Noon by Nurse Unit Calendar Year

Unit Group	Loc Nurse Unit	Discharge Date: 2022	2023
Med/Surg	KHMC 1E Emergency Room Overflow	13.4%	18.2%
	KHMC 2N Medical Surgical	13.3%	10.4%
	KHMC 2S Medical Surgical	5.4%	5.0%
	KHMC 3N Medical Surgical	12.5%	12.1%
	KHMC 3S Medical Surgical	9.7%	11.1%
	KHMC 4N Medical Surgical	6.6%	5.8%
	KHMC 4S Medical Surgical	10.5%	8.9%
	KHMC 14 Medical Surgical	6.6%	5.9%
	KHMC BP Broderick Pavilion	16.4%	13.3%
	KHMC PE Pediatrics		9.1%
ICU	KHMC 3W ICCU	18.5%	25.6%
	KHMC 15 ICCU	12.8%	12.8%

Discharges Before Noon by Month

Month of Discharge D..	Discharge Date: 2022	2023
January		11.0%
February		12.0%
March		9.7%
April		9.4%
May		8.7%
June		8.7%
July		9.9%
August	10.6%	8.7%
September	10.8%	
October	11.5%	
November	9.6%	
December	11.1%	

Discharges Before Noon by Calendar Year

Year of Discharge Date	Discharge Date: 2022	2023
2022	10.7%	
2023		9.7%

Encounter Types
- [x] Inpatient
- [x] Observation

Discharge Date
8/1/2022 to 8/31/2023

Observed-to-Expected Length of Stay

		Month of Discharge Date												
Unit Group	Loc Nurse Unit	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Med/Surg	KHMC 1E Emergency Room ..	0.36	0.33	0.32	0.34	0.40	0.39	0.35	0.36	0.34	0.28	0.13	0.37	0.27
	KHMC 2N Medical Surgical	1.58	1.79	1.43	1.85	1.61	1.82	1.46	1.44	1.25	1.27	1.48	1.64	1.42
	KHMC 2S Medical Surgical	1.38	1.77	1.31	1.17	1.20	1.45	1.05	1.32	0.84	0.82	0.95	0.80	0.81
	KHMC 3N Medical Surgical	1.74	1.77	1.67	2.55	2.02	1.46	1.92	1.48	1.30	1.53	1.61	1.29	1.40
	KHMC 3S Medical Surgical	1.72	1.80	1.72	1.87	1.97	1.71	1.81	1.72	1.75	1.57	1.65	1.49	1.64
	KHMC 4N Medical Surgical	1.86	1.92	1.91	1.69	1.71	2.11	1.89	1.45	1.68	1.49	1.16	1.73	1.39
	KHMC 4S Medical Surgical	1.76	2.14	1.65	1.52	1.83	2.06	2.09	1.57	1.78	1.66	1.56	1.60	1.92
	KHMC 14 Medical Surgical	1.61	1.46	1.50	1.39	1.44	1.51	1.63	1.45	1.31	1.32	1.47	1.72	1.36
	KHMC BP Broderick Pavilion	0.89	0.86	0.90	0.86	0.91	1.12	0.81	0.70	0.67	0.78	0.86	0.76	0.82
	KHMC PE Pediatrics	1.48				0.87			0.94					
ICU	KHMC 3W ICCU	1.34	1.46	1.81	1.31	1.28	1.96	2.03	1.43	1.01	1.41	1.46	1.19	1.25
	KHMC 15 ICCU	0.89	1.81	1.27	1.43	1.30	1.34	1.37	1.08	1.29	1.16	1.17	1.37	0.86
	KHMC CV Intensive Care	0.91	1.14	0.64	1.20	0.97	1.35	1.33	1.10	1.28	0.88	1.17	1.05	1.03
	KHMC IC Intensive Care	1.53	1.05	0.72	1.29	1.31	1.08	1.06	0.84	0.77	1.03	1.05	1.05	0.74
Grand Total		1.53	1.69	1.51	1.64	1.60	1.65	1.67	1.40	1.40	1.39	1.41	1.48	1.41

Observed-to-Expected Length of Stay by Calendary Year

		Disch Dt Tm	
Unit Group	Loc Nurse Unit	2022	2023
Med/Surg	KHMC 1E Emergency Room Overflow	0.36	0.32
	KHMC 2N Medical Surgical	1.64	1.47
	KHMC 2S Medical Surgical	1.40	1.02
	KHMC 3N Medical Surgical	1.92	1.49
	KHMC 3S Medical Surgical	1.82	1.66
	KHMC 4N Medical Surgical	1.81	1.59
	KHMC 4S Medical Surgical	1.79	1.77
	KHMC 14 Medical Surgical	1.48	1.47
	KHMC BP Broderick Pavilion	0.88	0.81
	KHMC PE Pediatrics	1.20	0.94
ICU	KHMC 3W ICCU	1.46	1.52
	KHMC 15 ICCU	1.34	1.22
	KHMC CV Intensive Care	0.97	1.18
	KHMC IC Intensive Care	1.15	0.97

Patient Throughput Updates – September 2023

Update	Next Steps
Patient Progression: Discharge lounge – start date 10//23. Workflows and processes developed. Discharge nurse in orientation, will start on floors with discharge support on 10/1/23. DC lounge staff hired, starting in October. Established routine meetings and collaborations with community SNFs to improve discharge availability. Success measures for discharge lounge – discharge by noon and shorter ED boarding times.	Patient Progression: Develop preferred provider network for skilled nursing facilities.
ED to Inpatient Admission Process: HealtheAnalytics data availability – Cerner developed access to the data, dashboard complete, validating data and creating access for leaders. ED and Throughput leaders will analyse and monitor data for gaps in the process from admit order to physical placement in inpatient bed.	ED to Inpatient Admission Process: Use data from patient movement to identify process breakdowns and opportunities to improve patient movement. Identify and action plan opportunities when data available- due October/November 2023 based on data analysis and committee decisions for project plans.
Transfer Center Operations: Repatriation of patients underway. Developed routine script and delivered education to eliminate variability in transfer decision making. Negotiating transport rates with ambulance company for returns from Bay area health center partners.	Transfer Center Operations: Data access – reconfiguration of the transfer center software underway, available in September. Use data to assess opportunities in transfers and develop action plans – due October 2023. Work with ambulance companies to contract the costs - ongoing
Long Stay Committee: Committee is stable, making good progress and keeping volume of patients over 30 days down consistently. Throughput steering committee will monitor patient volumes and movement. Current 19 patients over 30 days (all time high was 70 patients).	Long Stay Committee: Recommend closure of Long Stay committee development project. – Committee will stay in place but is stable and developed. Initiate new project based on barrier analysis from long stay committee data. October – review recommendations from Long Stay Committee on new project to remove major/complex barriers from long stay patient discharges.
Patient Placement: Finalized placement matrix, will place by service and diagnosis. Will not place by provider group d/t variations in provider and beds. Review of patient volumes by diagnosis to be performed annually – set up to be monitored by throughput steering committee.	Patient Placement: Recommended closure of this project. Placement of patients by diagnosis hardwired, will monitor and will review annually for appropriateness and make changes as needed. No further routine updates.
Observation Program: Order set changes complete, going through approval process. Observation patients primarily placed in 2S. PCP scheduling for follow-up finalized, occurring before discharge. Dashboard for observation patients in HealtheAnalytics developed and being demo'd.	Observation Program: Focus on scheduling outpatient procedures for patients who can discharge. Working through the process around scheduling, authorizations and moving appropriate care to outpatient. (EEG, Stress tests, Nuclear studies)

Policy Number: AP69	Date Created: 06/07/2007
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Requirement for Contracting with Outside Service Providers

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

POLICY: Kaweah Delta Health Care District (herein after referred to as Kaweah Health~~"District" or "KDH"~~) enters into contracts with various providers for services. A contract may be department, division and/or entity-specific or it may incorporate the entire ~~District~~ Kaweah Health organization.

Each ~~Senior Vice President, Vice President~~ Executive Team Member and/or his/her designee/departmental owner through formal designation shall be responsible for monitoring, negotiating and executing contracts pertaining to their Division. All contracts shall be reviewed and executed according to the standard procedures outlined in this policy.

REFERENCES:

AP96	Public Bidding of Construction Contracts
AP156	Standard Purchasing Practices
AP166	Competitive Bidding of Contracts
AP167	Quote and Proposal Guidelines
CP03	Physician Relationships

Definitions:

"Contract" means a contract, agreement, engagement letter, letter of understanding, statement of work, memorandum of understanding or other legal document which binds a third party to perform services on behalf of ~~the District~~ Kaweah Health.

~~"Contracted services directly affecting patient care" are defined as contracted agreements for providing care, treatment and/or services to patients. These would include any services that are needed to provide care to patients at the District.~~

"~~Clinical c~~Contracted services affecting patient care" ~~are~~ are defined as those contracted services for providing care, treatment and/or services to patients. These services ~~that~~ provide both direct (e.g., temporary

staffing) and indirect (e.g., ~~dietary~~ interpreter services) patient care services; however, ~~. This would include services such as equipment maintenance and service contracts, but it~~ would not include contracted arrangements such as landscaping or other exclusively administrative services. The same level of care must be provided whether ~~the District~~ Kaweah Health provides these services directly or through contract services. ~~District~~ Kaweah Health leadership must oversee the contracted service to make sure they are provided safely and efficiently in compliance with Centers for Medicare and Medicaid Services and The Joint Commission contracting requirements. The "Quality Term" provision, as outlined in section F1 of this policy, is required for these types of agreements (See F1 – Quality Term)

"Goods" are defined as a purchase of ~~a single piece of~~ equipment or disposable items that are used in the business of ~~the District~~ Kaweah Health. Included in this definition is the purchase of software license agreements that are independent of any software support agreement.

"Services" are defined as the furnishing of time and effort by a contractor that binds a third party to perform services on behalf of ~~the District~~ Kaweah Health.

"Protected Health Information (PHI)" is defined as any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; (ii) the provision of health care to an individual; (iii) the past, present, or future payment for the provision of health care to an individual; or (iv) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103,164.501. Protected Health Information includes Electronic Protected Health Information as defined above.

"Business Associate Agreement/Addendum" is defined as a legal document between a healthcare provider and a third party that will create, receive, maintain, or transmit Protected Health Information of our patients and/or employees.

PROCEDURE:

When an Executive Team Member ~~Senior Vice President, Vice President~~ or his/her designee is contemplating a new contract, the following steps shall be taken:

I. Items to consider (see Flowchart in Exhibit A): Consider the economic implications of a contract arrangement or other alternatives that may be available. Economic consideration must be documented on the Contract ~~c~~Checklist Exhibit B.

A. Lease versus buy decision

B. In-house versus out-source decision

C. Administrative Policy AP96 "Public Bidding of Construction Contracts"

D. Administrative Policy AP156 "Standard Procurement Practices"

E. Administrative Policy AP166 "Competitive Bidding of Contracts"

F. Administrative Policy AP167 "Quote and Proposal Guidelines"

G. Compliance Policy CP03 "Physician Relationships"

II. Determine when a contract is required **(see Flowchart in Exhibit A)**:

A. Purchase of Goods: All purchases of goods must adhere to ~~District~~ Kaweah Health Administrative Policy AP156 and a service contract is not required.

B. Purchase of Services: Services includes but are not limited to general service agreements, independent contractor agreements and professional services. Any purchase of services must adhere to ~~District~~ Kaweah Health Administrative Policy AP167.

~~1.~~ 1. Services directly affecting patient care: A contract is required regardless of the cost.

2. Services that do not directly affect patient care:

a) If the cost of the service being retained exceeds $10,000 annually and has a contract service life greater than thirty (30) days, a contract is required.

b) If the cost of the service being retained is **LESS THAN $10,000 BUT**:

(1) engages services from or to a physician (a contract is **REQUIRED** contact the Compliance Department. (Follow CP03)

(2) engages Information Technology (IT) services ~~(~~will not require a contract but requires written pre-approval by the Chief Information Office (CIO)

(3) engages the services of an employee, contact HR. ~~(~~

III. Determine if an Associate "Agreement" or "Addendum" (BAA) is required

A. A Business Associate Agreement is required if ~~the third party **DOES NOT** meet the criteria for a contract mentioned in Section I of this policy~~ third party contracted services result in the creation, receipt, or transmission of PHI.

1. Examples of when a BAA is required include, but are not limited to, claims processing or administration, data analysis, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, legal, actuarial, accounting, consulting, data aggregation, management services, administrative services, accreditation services or financial services.

2. Note: The Business Associate rule does not apply to disclosures by Kaweah Health to a health care provider for the purpose of treating a patient. Furthermore, incidental contact and/or viewing (service or maintenance agreements) of PHI do not require the use of a BAA; as long as the incidental contact by the third party does not result in the creation, receipt, or transmission of PHI. In situations where a third party may have incidental contact with PHI, a Confidentiality Statement may be used in place of a BAA.

3. For any modification requests to the Kaweah Health BAA template, contact the Compliance Department.

B. A Business Associate Addendum is required when using the third party's contract [**NOT** the ~~KDHCD~~ Kaweah Health contract template] unless the stand-alone Business Associate Agreement is utilized.

~~Examples of when a BAA is required include, but are not limited to, claims processing or administration, data analysis, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, legal, actuarial, accounting, consulting, data aggregation, management services, administrative services, accreditation services or financial services.~~

~~Note: The Business Associate rule does not apply to disclosures by Kaweah Delta to a health care provider for the purpose of treating a patient. Furthermore, incidental contact and/or viewing (service or maintenance agreements) of PHI do not require the use of a BAA; as long as the incidental contact by the third party does not result in the creation, receipt, or transmission of PHI. In situations where a third party may have incidental contact with PHI, a Confidentiality Statement may be used in place of a BAA.~~

~~For any modification requests to the KDHCD BAA template, contact the Compliance Department.~~

IV. Determine if a ~~KDHCD~~ Kaweah Health Contract Template should be used

When negotiating contractual obligations with a third party, every effort should be made to utilize ~~the District~~ Kaweah Health's standard contract templates described below. In the event the contracted party refuses to use ~~the District~~ Kaweah Health's standard contract template, please refer to ~~s~~Section V.

below. If terms are significantly different, the contract changes must be reviewed and approved by the responsible Executive Team Member. ~~the VP or SVP.~~ Contract templates, samples of standard language for general provisions and the contract checklist are located on Finance Online under Brain/ Mgmt Team/ Contracts/Contract forms.

A. **The Independent Contractor template** – Contact the HR department. HR Department will regularly engage with Materials Management for contract maintenance, archiving, Annual Contracted Services Evaluation Checklist, etc.

B. **The General Service template** - used when negotiating services to be provided to or from a third party – Contact the Materials Management department.

C. **The Professional Service (Physician Contracts) Agreement template** - used when negotiating clinical services to be provided to or from a third party – Contact the Compliance department.

D. **The Transfer Agreement template** - used when negotiating services to be provided by or for another health care entity for reciprocal inter-facility transfers – Contact Care Management / Materials Management. Care Management will regularly engage with Materials Management for contract maintenance, archiving, Annual Contracted Services Evaluation Checklist, etc.

V. Determine what Language requirements must be included in the contract, if a District contract template is not use

A. Each contract must use ~~the District~~ Kaweah Health's legal name of "**Kaweah Delta Health Care District (herein after referred to as "~~DISTRICT~~Kaweah Health"),** a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 *et seq*.," and the other party's full legal name.

B. Responsibilities and services as well as compensation shall be specifically delineated with timing and processes clearly outlined.

C. Insurance clause shall include:

1. Other party's responsibilities to carry, at own costs, general liability insurance coverage in amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate, workers compensation insurance, professional liability insurance, and unemployment insurance to protect against loss relating to their employees during the term of this agreement. Such policies must be obtained from a professional insurance carrier and provide for at least thirty (30) days prior written notice to District of cancellation or modification. If

general liability coverage doesn't meet the one million/three million stated above, an exception must be discussed with the Director of Risk Management and approval by responsible Executive Team Member. If other party is self-insured, self-insured policy must state that the trust assets available must exceed the one million/three millions limits of liability.

2. That the third party will provide District with certificates of insurance before Effective Date of contract, when applicable.

3. That the District is self-insured for both General and Professional Liability purposes. The self-insured program has been in place since 1977, is reviewed annually by a licensed actuary and is audited annually by its financial auditors. The trust assets available exceed the one million/three million limits of liability.

4. That the District shall be named as an additional insured on worker's compensation and employer's liability policies.

D. Term and termination clauses shall include:

1. A set termination date rather than automatic renewal ("evergreen" clause);

2. The ability to terminate without cause with 30-90 day notice;

3. The ability to terminate for breach if breach is not cured within a specified number of days.

4. **Exceptions** to the termination date includes agreements such as Transfer Agreements, Business Associate Agreements, Hospice Facility Provider Agreements, and Ownership Agreements, such as Partnerships and Joint Ventures, and contracts satisfied by completion of a project obligation. Other exceptions to the termination date must be reviewed and approved by the responsible Executive Team Member VP or SVP.

E. Indemnification clauses shall:

1. Only govern the services under contract;

2. Not increase the District's liability beyond the value of the contract;

3. Not limit the other party's liability to the dollar value of the contract, where possible; and

4. Make each party responsible for the errors and omissions of their own employees.

F. Other Specific language or provisions that must be included [if not using Kaweah Health contract templates] are described below in concept form. Specific language ~~Examples~~ of each provision are located on Finance Online Contracting Module/Kaweah Health ~~DHCD~~ Required Language Template:

1. **Quality –** This standard applies to contracted agreements for providing care, treatment and/or services to patients. Contractor shall provide its services to Kaweah ~~Delta~~ Health ~~Care District (KDHCD)~~ in accordance with high professional standards of care in the area and consistent with the quality standards of ~~KDHCD~~ Kaweah Health as determined by the applicable oversight committee, applicable standards of TJC, and Kaweah Health~~DHCD~~'s quality assurance/performance improvement programs and in compliance with all laws and regulations.

2. **Waiver –** Any waiver granted by a party must be in writing to be effective and shall apply solely to the specific instance expressly stated.

3. **Assignment** - Agreement cannot be transferred or encumbered by without the prior written consent of both parties.

4. **Third Party Beneficiary Rights** – No other party can benefit from the contract.

5. **Compliance with laws** – Each party will comply with all state, local and federal laws, ordinances, codes and regulations. In the event of any changes reasonable efforts to revise this Agreement to conform and comply with such changes will be made.

6. **Applicable Law; Venue** – All disputes will be heard in the Superior Court of the County of Tulare, Visalia Division, State of California. **Exceptions to this requirement must be reviewed and approved by the responsible ~~VP~~ Executive Team Member.**

7. **Severability** – If the courts find a section of the contract legally invalid or unenforceable, the remainder of the Agreement shall not be affected.

8. **Amendment** - The Agreement may be modified or amended only by mutual written agreement signed by all the parties.

9. **Attorney fees** – If there is a dispute, the prevailing party shall be entitled to recover its reasonable attorneys' fees and other costs incurred.

10. **OIG Contracting Exclusion** - ~~CONTRACTOR~~ Contractor represents that neither it nor any of its officers, directors,

employees, subcontractors or agents is on the General Services Administration's list of parties excluded from federal procurement programs and is not debarred by the U.S. Food and Drug Administration.

11. **The Joint Commission accreditation clause** - Must be included if the other party is accredited.

12. **Access to Books and Records clause** - Must be included in every contract where the value of services equals or exceeds $10,000 in a twelve (12) month period or when the contracted services directly affect patient care.

13. **District Professional and Administrative on Responsibilities clause** – Must be included if the contract is a Consultant, Medical Director or Professional Services Contract.

VI. Determine if contract checklist needs to be completed (**Exhibit B**): The contract checklist must be completed by department designee(s) for all contracts that are not prepared by Legal counsel and presented at time of contract signature to responsible Executive Team Member or his/her designee. Required documentation in contract packet also needs to include a current Certificate of Insurance and W-9.

VII. Determine who has to review the contract before it is signed: Except for contracts prepared by Legal counsel, before a contract can be signed it must be reviewed by the following. **Approval must be acknowledged in the ~~c~~Contract ~~c~~Checklist.**

A. **Special Review** – Prior to a contract being signed contracts must be reviewed and approved by appropriate personnel as described below;

1 ~~Vice President/~~Chief Information Officer or designee for agreements or purchases relating to IT systems, software, telecommunications or any other IT contract.

2. Chief Financial Officer or designee for agreements relating to equipment leases or rental agreements in excess of $25,000.

3. ~~VP of~~ Chief Human Resources Officer or designee for any of the following situations: all staffing and recruiting agreements, independent contractor agreements when the contractor performs work that is performed or could be performed by an employee, or any independent contractor agreement when the income reporting identifier is the contractor's Social Security number

4. Director of Risk Management for agreements that do not have ~~the District~~ Kaweah Health's approved standard insurance and indemnification language or by nature of the contract the

responsible ~~VP~~ Executive believes could expose ~~the District~~ Kaweah Health to a high or unusual liability risk.

5. Responsible ~~VP or SVP~~ Executive for any third party contract that has terms and language that is significantly different from the ~~KDHCD~~ Kaweah Health contract template.

6. Compliance Department for any Business Associate Agreement or Business Associate Addendum where ~~the District~~ Kaweah Health's standard template is not used or the ~~District~~ standard template language is modified.

B. **Final Review – Contract draft and completed ~~c~~Contract ~~c~~Checklist** with all pertinent vendor selection documentation must be submitted for review to either the:

1. Director of Procurement and Logistics or Materials Manager/Contract Agent for preventative maintenance agreements or other non- physician related service contracts.

2. Compliance Department for physician related contracts.

VIII. Ensure appropriate signor(s) for a service contract and/or BAA Only after VII. above has been completed, the contract can be signed. All contracts MUST be signed by either 1) the Chief Executive Officer, or 2) an ~~Senior Vice President or Vice President~~ Executive of ~~the District~~ Kaweah Health, or their approved designee. A list of authorized ~~District~~ Kaweah Health signors can be found on Finance Online under Brain/ Mgmt Team/ Contracts/Contract forms.

IX. Ensure executed contracts ~~get~~ are submitted appropriately. Once Steps I. through VIII. have been completed, submit a copy of the fully executed contract along with the completed Contract ~~c~~Checklist and any other appropriate documentation [i.e. Certificate of Insurance, W-9] to the Materials Manager/Contract Agent in the Materials Management Department (Non-physician contracts) or Compliance Department (Physician contracts) for retention. All contracts must be retained for a minimum of six (6) years. Failure to complete any of the above steps will result in delay or non-payment to the vendor.

X. Annual Contracted Services Evaluation Checklist (Exhibit C). Each contract/agreement will need to be evaluated on an annual basis by a departmental owner/designee to ensure performance and quality standards are met on behalf of Kaweah Health. The Annual Contracted Services Evaluation Checklist evaluates both contracted services and the contract for such services, and is used to determine whether a particular contractor or third party is providing an expected and appropriate level of service. Answers to all questions should ideally by Y for Yes (unless they are not applicable). Any N for No responses need additional Comments to include if departmental owner/designee is comfortable continuing said contracted

services until remedy or resolution is met. Annual Contracted Services Evaluation Checklists will be monitored and archived by the Materials Management team.

approval

AP46 Commercial Card Expense (CCER) Program
AP135 Capital Budget Purchases
AP156 Standard Purchasing Practices
AP166 Competitive Bidding of Contracts
AP167 Quote and Proposal Guidelines

Let

"Contract" means a contract, agreement, engagement letter, letter of understanding, statement of work, memorandum of understanding or other legal document which binds a third party to perform services on behalf of the District.

"Contracted services directly affecting patient care" means contracted agreements for providing care, treatment and/or services to patients. These would include any services that are needed to provide care to patients at the District. A clinical contracted services is defined as those contracted services that provide both direct (e.g., temporary staffing) and indirect (e.g., dietary services) patient care services. This would include services such as equipment maintenance and service contracts, but it would not include contracted arrangements such as landscaping or other exclusively administrative services. The same level of care must be provided whether the District provides these services directly or through contract services. District leadership must oversee the contracted service to make sure they are provided safely and efficiently in compliance with Centers for Medicare and Medicaid Services and The Joint Commission contracting requirements. The "Quality Term" provision, as outlined in section F1 of this policy, is required for these types of agreements (See F1 – Quality Term)

PROCEDURE:

When a Senior Vice President, Vice President or his/her designee is contemplating a new contract, the following steps shall be taken:

I. What should I consider? (see Flowchart in Exhibit A): Consider the economic implications of a contract arrangement or other alternatives that may be available. Economic consideration must be documented on the Contract checklist Exhibit B.

A. Lease versus buy decision

B. In-house versus out-source decision

C. Administrative Policy AP96 "Public Bidding of Construction Contracts"

D. Administrative Policy AP166 "Competitive Bidding of Contracts"

E. Administrative Policy AP167 "Quote and Proposal Guidelines"

F. Compliance Policy CP12 "Physician Relationships"

II. When Is A Contract Required? **(see Flowchart in Exhibit A)**:

III. Purchase of Goods: Goods are defined as a purchase of a single piece of equipment or disposable items that are used in the business of the District. Included in this definition is the purchase of software license agreements that are **independent** of any software support agreement. All purchases of goods must adhere to District Administrative Policy AP156. (**A contract is NOT REQUIRED**)

A.

B. Purchase of Services:

1. Services are defined as the furnishing of time and effort by a contractor which binds a third party to perform services on behalf of the District. Example of services includes but is not limited to general service agreements, independent contractor agreements, professional services, and **administrative support**.

a) If the services directly affect patient care, **A CONTRACT IS REQUIRED REGARDLESS OF THE COST OF THE SERVICE**.

b) If the services do not directly affect patient care and the cost of the service being retained **EXCEEDS $10,000 ANNUALLY AND has a contract service LIFE GREATER THAN 30 days, A CONTRACT IS REQUIRED.**

2. If the cost of the service being retained is **LESS THAN $10,000 BUT**:

a) engages services from or to a physician (A CONTRACT IS **REQUIRED** – (Follow CP.12.)

b) engages Information Technology (IT) services (**WILL NOT REQUIRE A CONTRACT BUT REQUIRES APPROVAL by the Chief Information Office (CIO)** - see additional contract review requirements under Section VII.A.1)

c) engages the services of an employee (HR MUST DETERMINE IF A CONTRACT IS REQUIRED - see additional contract review requirements under Section VII.A.4.)

IV. When Is A Business Associate "Agreement" or "Addendum" (BAA) Required? Any third parties that will create receive, maintain, or transmit Protected Health Information (PHI) of our patients and/or employees must have either a Business Associate Agreement or Addendum on file with the Finance Manager.

approved

A Business Associate Agreement is required if the third party **DOES NOT** meet the criteria for a contract mentioned in Section I of this policy **BUT WILL** use, receive, transmit, or disclose Protected Health Information (PHI) of our patients and/or employees. The agreement template is located on Finance Online Contracting Module.

A Business Associate Addendum is required when using the third party's contract **NOT** the KDH contract template **AND** the third party will create, receive, maintain, or transmit, Protected Health Information (PHI) of our patients and/or employees. The addendum template is located on Finance Online Contracting Module. The KDH contract templates already have the Addendum included as an exhibit to the contracts.

1. Examples of where a BAA is required include, but are not limited to, claims processing or administration, data analysis, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, legal, actuarial, accounting, consulting, data aggregation, management services, administrative services, accreditation services or financial services.

2. Note: The Business Associate rule does not apply to disclosures by Kaweah Delta to a health care provider for the purpose of treating a patient. Furthermore, incidental contact and/or viewing (service or maintenance agreements) of PHI do not require the use of a BAA; as long as the incidental contact by the third party does not result in the creation, receipt, or transmission of PHI. In situations where a third party may have incidental contact with PHI, a Confidentiality Statement may be used in place of a BAA.

Determine if a Which KDH Contract Template Do I Use? When negotiating contractual obligations with a third party, every effort should be made to utilize the District's standard contract templates described below. In the event the contracted party refuses to use the District's standard contract in favor of their own or modifications are made to the District's standard contract template, the general requirement for terms discussed in Section VI of this policy must be met. If terms are significantly different, the contract must be reviewed and approved by the VP or SVP as identified in Section V.G. below. Contract templates, samples of standard language for general provisions and the contract checklist are located on KD CENTRAL under Applications/Forms/Contract Templates.

a. **The Independent Contractor template** - used when negotiating services to be provided to or from an *individual*.

b. **The General Service template** - used when negotiating services to be provided to or from a *company*.

c. **The Professional Service Agreement template** - used when negotiating *clinical services* to be provided to or from a company

d. **The Transfer Agreement template** - used when negotiating services to be provided by or for another health care entity for reciprocal interfacility *transfer services*.

6. If I Do **Not Use** A District's Contract Template, What Language Requirements Must Be Included In The Contract?

A. Each contract **MUST** use the District's legal name of "**Kaweah Delta Health Care District ("DISTRICT"), a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 *et seq*.,"** and the other party's full legal name.

B. Responsibilities and services as well as compensation shall be specifically delineated with timing and processes clearly outlined.

C. Insurance clause shall include:

1. Other party's responsibilities to carry, at own costs, general liability insurance, workers compensation insurance, professional liability insurance, and unemployment insurance to protect against loss relating to their employees during the term of this agreement. Such policies must be obtained from a professional insurance carrier and provide for at least thirty (30) days prior written notice to District of cancellation or modification. If other party is self-insured, self-insured policy must state that the trust assets available must exceed the one million/three millions limits of liability.

2. If requested by District, other party will provide District with certificates of insurance;

3. That the District is self-insured for both General and Professional Liability purposes. The self-insured program has been in place since 1977, is reviewed annually by a licensed actuary and is audited annually by its financial auditors. The trust assets available exceed the one million/three million limits of liability.

4. District shall be named as an additional insured on worker's compensation and employer's liability policies; and

D. Term and termination clauses shall include

1. A set termination date rather than automatic renewal ("evergreen" clause);

2. The ability to terminate without cause with 30-90 day notice; and

approval

3. The ability to terminate for breach if breach is not cured within a specified number of days.

4. **Exception to the termination date includes** agreements such as Transfer Agreements, Business Associate Agreements, Hospice Facility Provider Agreements, and Ownership Agreements, such as Partnerships and Joint Ventures, and contracts satisfied by completion of a project obligation. **Other exceptions to the termination date must be reviewed and approved by the Director of Logistics Planning, Compliance Officer or higher authority.**

E. Indemnification clauses shall:

1. Only govern the services under contract;

2. Not increase the District's liability beyond the value of the contract;

3. Not limit the other party's liability to the dollar value of the contract;

4. Make each party responsible for the errors and omissions of their own employees

F. Other Specific language or provisions that must be included is described below. Examples of each provision is located on Finance Online Contracting Module/KDH Required Language Template:

1. **Quality – This standard applies to contracted agreements for providing care, treatment and/or services to patients.** Contractor shall provide its services to Kaweah Delta Health Care District (KDHCD) in accordance with high professional standards of care in the area and consistent with the quality standards of KDHCD as determined by the applicable oversight committee, applicable standards of TJC, and KDHCD's quality assurance/performance improvement programs and in compliance with all laws and regulations.
2. **Waiver –** Any waiver granted by a party must be in writing to be effective and shall apply solely to the specific instance expressly stated.
3. **Assignment** - Agreement cannot be transferred or encumbered by without the prior written consent of both parties.

4. **Third Party Beneficiary Rights** – No other party can benefit from the contract.

5. **Compliance with laws** – Each party will comply with all state, local and federal laws, ordinances, codes and regulations. In the event of any changes reasonable efforts to revise this

Agreement to conform and comply with such changes will be made.

6. **Applicable Law; Venue** – All disputes will be heard in the Superior Court of the County of Tulare, Visalia Division, State of California. **Exceptions to this requirement must be reviewed and approved by the responsible VP.**

7. **Severability** – If the courts find a section of the contract legally invalid or unenforceable, the remainder of the Agreement shall not be affected.

8. **Amendment** - The Agreement may be modified or amended only by mutual written agreement signed by all the parties.

9. **Attorney fees** – If there is a dispute, the prevailing party shall be entitled to recover its reasonable attorneys' fees and other costs incurred.

10. **OIG Contracting Exclusion** - CONTRACTOR represents that neither it nor any of its officers, directors, employees, subcontractors or agents is on the General Services Administration's list of parties excluded from federal procurement programs and is not debarred by the U.S. Food and Drug Administration.

11. **The Joint Commission accreditation clause** - Must be included if the other party is accredited.

12. **Access to Books and Records clause** - Must be included in every contract where the value of services equals or exceeds $10,000 in a twelve (12) month period or when the contracted services directly affect patient care.

13. **District Professional and Administrative on Responsibilities clause** – Must be included if the contract is a Consultant, Medical Director or Professional Services Contract.

VI Do I Need To Complete The Contract Checklist? (**Exhibit B**): The contract checklist must be completed for all contracts that are not prepared by Legal counsel.

VII Who Has To Review The Contract Before It Is Signed?: Except for contracts prepared by Legal counsel, before a contract can be signed it must be reviewed by the following. **Approval must be acknowledged in the contract checklist.**

A. **Special Review** – **Prior to a contract being signed by District personnel** or a representative of the District, contracts must be reviewed and approved by appropriate personnel as described below;

1. Vice President/Chief Information Officer for agreements or purchases relating to IT systems, software, telecommunications or any other IT contract.

2. Chief Financial Officer or designee for agreements relating to equipment leases or rental agreements in excess of $25,000.

3. CFO or Finance Committee – for any third party contracts that is unbudgeted in excess of $10,000.

4. VP of Human Resource or designee for any of the following situations: all staffing and recruiting agreements, independent contractor agreements when the contractor performs work that is performed or could be performed by an employee, or any independent contractor agreement when the income reporting identifier is the contractor's Social Security number

5. Director of Risk Management for agreements that do not have the District's approved standard insurance and indemnification language or by nature of the contract the responsible VP believes could expose the District to a high or unusual liability risk.

6. Responsible VP or SVP for any third party contract that has terms and language that is significantly different from the KDH contract template. The VP or SVP should seek the advice of legal counsel when deemed appropriate.

7. Compliance Department for any Business Associate Agreement or Business Associate Addendum where the District standard template is not used or the District standard template language is modified.

B. **Final Review** – **Contract draft and completed contract checklist** with all pertinent vendor selection documentation must be submitted for review to either the:

1. Director of Financial and Logistical Planning for preventative maintenance agreements or other related service contracts.

2. Finance Manager or designee, for all other contracts.

VIII Who Can Sign a Contract? Only after VII above has been completed, the contract can be signed. All contracts MUST be signed by the Chief Executive Officer, Senior Vice President or Vice President of the District or their approved designee. A list of authorized District signors can be found on Finance Online Contract Module.

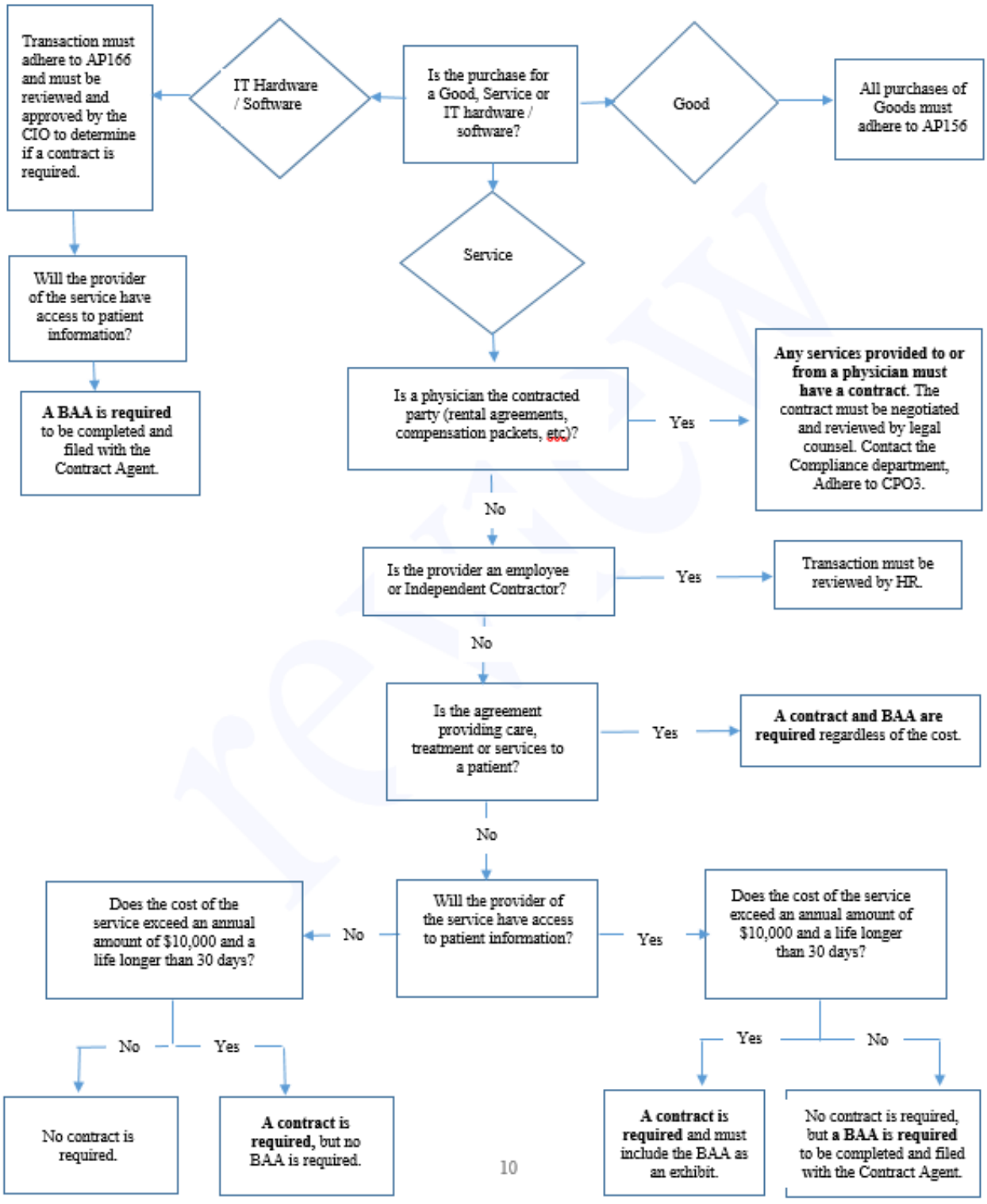
IX Where do I submit an executed contract? Once Steps I through VIII have been completed, submit the signed contract along with the completed

checklist and a completed Form W-9 to the Finance Manager for scanning and retention. All original contracts may be retained by either the Finance Manager or the responsible department for a minimum of six (6) years. **Failure to complete any of the above steps will result in delay or non-payment to the vendor**.

X When Do I Complete the Contract Evaluation Tool?: A Contract Evaluation is completed for all agreements that relate to contracted services directly affecting patient care. The evaluation must be completed annually to ensure appropriate performance and quality standards are met on behalf of the District. Information related to the evaluations will be reported to the Board of Directors, through the Consent Calendar process, at least annually. See Exhibit C for the Contract Evaluation Form.

approval

EXHIBIT A
Contract Decision Tree



10

EXHIBIT B
KAWEAH ~~DELTA~~ HEALTH ~~CARE DISTRICT~~
CONTRACT CHECKLIST

Checklist is not required to be completed for contracts prepared by Legal counsel*

❑New ❑Renewal/Re-negotiation – replaces contract #_____ ❑ Addendum

Contracted Party: _____
Purpose: _____
Total Contract Cost: _____
Negotiated by (District Rep): _____
Responsible ~~VP~~ Executive Team Member:
_____
Responsible Director: _____
Effective Date: _____
Term Date: _____ (if n/a indicate project, LLC, Assignment, etc)
_____

Contract Type: (select one)
❑AP 166:
- ❑ Materials & Supplies over $25,000 lease or sold, no Medical Equipment,
- ❑ Electronic Data Processing or Telecommunications Goods/Services (ISS);

❑AP 167: Other Professional Services (i.e. staffing, consulting, training, service contracts, services requiring license, certificate or registration under law)

AP 166: (select one)
❑Competitive bidding with lowest "qualified" bidder
❑ISS Only Exemption 1: Vendor selected is the only vendor that can provide goods/services that meet District's needs
❑ISS Only Exemption 2: Immediate need in emergency and for protection of public health, welfare, or safety.

AP 167: (select one)
❑GPO Contract
❑Quotes (Greater than $10,000 but less than $100,000 annually)
❑RFP required (Greater than $100,000 annual spend)
❑ Sole Source

❑GPO Contract # (If applicable): _____

❑Two or more quotes are: _____

1. Vendor selected: _____

approval

2. Why: _____

_____

☐ Sole Source arrangement approved by RFP Committee – approval attached.

☐ RFP selection approved by RFP Committee – approval attached.

Contract type:

☐ General Service - _____ (Describe: Consulting, General Maintenance, etc)

☐ Professional Service (Clinical) ☐ Independent Contractor

☐ Staffing ☐ Transfer Agreement

☐ Property/Space Lease ☐ Capital Lease/Purchase/Operating Lease

☐ Disposable Supply Purchase ☐ Construction Service Agreement

☐ Information Systems (ISS Use Only) ☐ Other _____

_____

Contract Document: ☐ Standard ☐ Changes ☐ Other Party document

☐ As is ☐ Addendum

Special Requirements: _____

Language included: *(*must be present in every contract)*

☐ **Quality ***

☐ **Waiver*** ☐ **Amendment***

☐ **Assignment*** ☐ **Termination Date**

☐ **Compliance with Laws*** ☐ **Applicable Law; Venue***

☐ **Third Party Beneficiary Rights*** ☐ **OIG Contracting Exclusion***

☐ **Severability*** ☐ **JCAHO Clause** (If Other Party Is Accredited)

☐ **Indemnification Clause*** ☐ **Access to Records Clause** (If >$10,000 in 12 months)

☐ **Self-insured Clause*** ☐ **Attorney fees***

☐ **District Professional & Administrative Responsibilities Clause** (If Contract is Consultant, Medical Director or Professional Service)

☐ **Business Associate Agreement/Addendum** (If Other Party has access to identifiable health or demographic information, other than health care purposes)

SPECIAL REVIEWS

☐ **Independent Contractor performing same duties of an employee or contractor using Social Security number as income reporting identifier :**

Approved by ~~VP of~~ Chief HR Officer~~HR~~: _____

Date: _____

_____

☐ **System/Software/Telecommunications/IS Technology:**

Approved by CIO: _____ Date: _____

_____

☐ **Insurance Coverage provisions significantly changed:**

Approved by Risk Manager: _____ Date: _____

_____

❑ **Equipment Lease greater than $25,000:**
Approved by CFO:_____
Date:_____

❑ **Capital Lease/Equipment:**
Approved by CFO:_____
Date:_____

FINAL REVIEW AND CONTRACT SUBMISSION

❑ **Director of Procurement and Logistics:**
Approved by:_____ Date:_____

OR

❑ **Materials Manager/Contract Agent:**
Approved by:_____ Date:_____

approval

Kaweah Health
MORE THAN MEDICINE. LIFE.

EXHIBIT C

Annual Contracted Services Evaluation Checklist

This checklist includes questions to ask to evaluate both contracted services and the contract for those services. Use it to determine whether a particular contractor is providing an expected and appropriate level of service. Answers

Organization: **Kaweah Health** Dept/Unit + Cost Center:

Date of Review: Reviewer:

Vendor (Name of Other Party):

Workday Strategic Sourcing Contract #:

Contracted Services:

Effective Date: Expiration Date:

Expectation, Communications, and Observations	Y	N	N/A	Comments
Did the Vendor (Other Party) meet expectations regarding Customer Service?	☐	☐	☐	
Did the Vendor (Other Party) meet expectations regarding quality of service?	☐	☐	☐	
Did the staff provided by the Vendor (Other Party) meet expectations regarding competency levels?	☐	☐	☐	
Did the Vendor (Other Party) meet expectations regarding all applicable accreditation, state and federal requirements?	☐	☐	☐	
Did the Vendor (Other Party) meet expectations regarding all contractual obligations?	☐	☐	☐	
Did the Vendor (Other Party) meet expectations regarding all applicable performance metrics?	☐	☐	☐	

approval

EXHIBIT A

AP.69

Contract Decision Tree

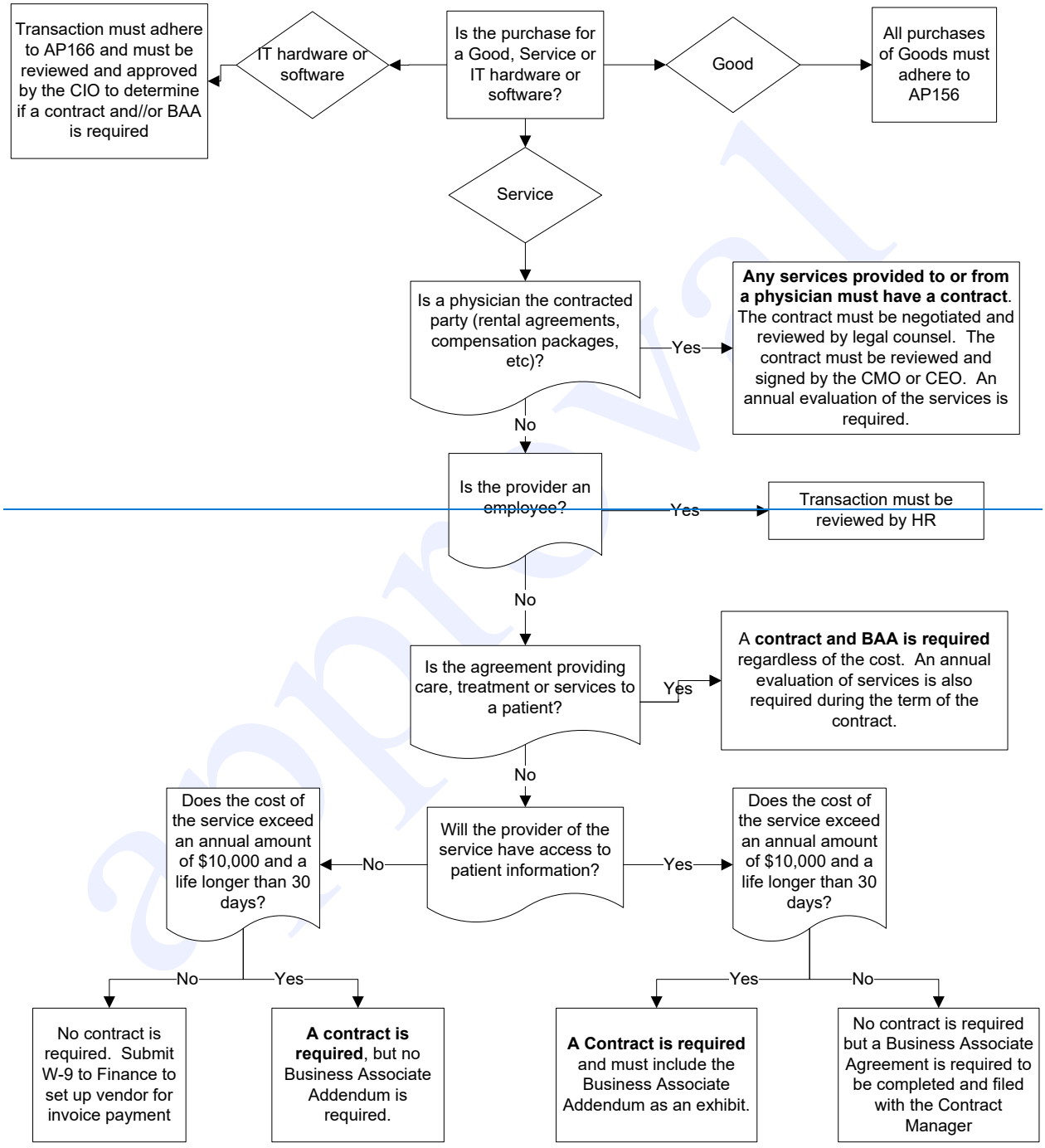


EXHIBIT BKAWEAH DELTA HEALTH CARE DISTRICT CONTRACT CHECKLIST

****Not required to be completed for contracts prepared by Legal counsel****

New ☐ Renewal/Re-negotiation – replaces contract #_____ ☐ Addendum

Contracted

Party:_____

Purpose:_____

Negotiated by (District Rep): _____

Responsible VP: _____

Responsible Director: _____

Effective Date: _____

Term Date: _____ (if n/a indicate project, LLC, Assignment, etc)

Budgeted: _____

Capital ☐ Operational _____

Economic Consideration:

☐ Quotes ☐ Sole Source ☐ RFP required

☐ Two or more quotes were considered – complete questions below:

Quotes received _____

Vendor selected: _____

Why: _____

☐ Sole Source arrangement approved by RFP Committee – approval attached.

☐ RFP selection approved by RFP Committee – approval attached.

Contract type:

☐ General Service – _____ (Describe: Consulting, General Maintenance, etc)

☐ Professional Service (Clinical) ☐ Independent Contractor

☐ Staffing ☐ Transfer Agreement

☐ Property/Space Lease ☐ Capital Lease/Purchase/Operating Lease

☐ Disposable Supply Purchase ☐ Construction Service Agreement

☐ Information Systems (ISS Use Only) ☐ Other _____

Contract Document: ☐ Standard ☐ Changes ☐ Other Party document

approval

☐ As is ☐ Addendum

Special Requirements

Language included: *(*must be present in every contract)*
VP signoff for any missing language:

Quality *

Waiver* ☐ **Amendment***

Assignment* ☐ **Termination Date**

Compliance with Laws* ☐ **Applicable Law; Venue***

Third Party Beneficiary Rights * ☐ **OIG Contracting Exclusion***

Severability* ☐ **Joint Commission Clause** (If Other Party is Accredited

Indemnification Clause* ☐ **Access to Records Clause** (If >$10,000 in 12 months)

Self-insured Clause* ☐ **Attorney fees***

District Professional & Administrative Responsibilities Clause (If Contract is Consultant, Medical Director or Professional Service)

Business Associate Addendum (If Other Party has access to identifiable health or demographic information, other than health care purposes)

SPECIAL REVIEWS

Independent Contractor performing same duties of an employee or contractor using Social Security number as income reporting identifier :

Approved by VP of HR:
Date:

System/Software/Telecommunications/IS Technology:

Approved by CIO:
Date:

Insurance Coverage provisions significantly changed:

Approved by Risk Manager: Date:

Unbudgeted greater than $10,000:

Approved by CEO or Finance Committee: Date:

Equipment Lease greater than $25,000:
Approved by CFO:
Date:

Capital Lease/Equipment (See Logistical Planning Requirements)
Approved by Director of Logistical Planning:
Date:

Business Associates Agreement language modifications/non-use of KDHCD standard BAA template

Approved by Compliance Officer or Designee _____ Date: _____

FINAL REVIEW

Director of Financial and Logistical Planning:

Approved by: _____ Date: _____

OR

Finance Manager:

Approved by: _____ Date: _____

☐ **Contract entered into the Contract database**

Verified: _____ Date: _____

****STOP HERE IF EQUIPMENT IS NOT BEING PURCHASED****

approval

iS EXHIBIT C
Kaweah Delta Health Care District Contract Evaluation Tool

Evaluation Period: _____

_____

Contractor: _____ Written Contract ? ❑ YES ❑ NO

Contractor Liaison Name: _____

Title: _____ Telephone Number: _____

Service Provided: _____

Director/ Manager Responsible for Contractor Performance:

_____

Vice – President Responsible for Contractor Performance:

_____

Evaluation

Degree to which the contractor is flexible and responsive to requests for service.

1 2 3 4 5

Poor Excellent

Comment

_____

Degree to which the contractor meets its contractual obligations.

1 2 3 4 5

Poor Excellent

Comment

_____

_____

Degree to which the contractor meets its performance expectations.

1 2 3 4 5

Poor Excellent

Comment _____

As appropriate to the contracted service: Degree to which the contractor meets Joint Commission and CMS standards and regulations related to provision of care, treatment and services, human resources and medical staff requirements

1 2 3 4 5

Poor Excellent

Comment

Overall, does the contractor provide the level of service consistent with meeting patient need and complying with external requirements, including the Medicare Conditions of Participation?

❑ Yes ❑ No (**If no,** document the actions taken to compensate for the gap in performance on back of sheet or in attached memorandum)

approval

~~EVALUATOR SIGNATURE/ DATE~~

approval

"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."

approval

Policy Number: AP108	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Patient Privacy Administrative and Compliance Requirements

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

PURPOSE: To outline Kaweah Delta Health Care District's (~~"~~herein after referred to as Kaweah ~~Delta~~Health") compliance with administrative requirements of Federal and State Privacy regulations.

POLICY: Kaweah ~~Delta~~Health employees and its agents shall comply with all Federal and State regulations governing the protection and use of patient information.

DEFINITIONS:

I. "Hybrid Entity" means a single legal entity that is a covered entity whose business included both covered and non-covered functions.

II. "Protected Health Information" (PHI) means health and demographic information created by Kaweah ~~Delta~~Health and relating to the physical or mental health or the provision of care to an individual that identifies the individual. It includes oral, written or electronically maintained information.

III. "Privacy notice" means a written document provided to each Kaweah ~~Delta~~Health patient before services are provided. The Notice outlines Kaweah ~~Delta~~Health's legal duties governing the protection and use of PHI.

IV. "Workforce" includes all Kaweah ~~Delta~~Health employees, independent contractors, Medical Students and Residents, and students working with Kaweah ~~Delta~~Health patients in the course of their learning processes, temporary help and all volunteers ~~of the Kaweah Delta Health Guild~~.

PROCESS: Kaweah ~~Delta~~Health has established the following structures and processes to protect patient privacy and administrate appropriate use of patient information:

I. Entity designations:

A. Kaweah ~~Delta~~Health has two functions that are not healthcare components of our business. The Lifestyle Center and Quail Park are both designated as non-covered functions.

II. Personnel designations:

A. The Kaweah ~~Delta~~Health Chief Compliance and Risk Officer (CCRO) (or designee) is designated as the institutions Privacy Officer, and is responsible to oversee the development and implementation of privacy policies and procedures as required by law. The CCRO shall monitor compliance with the law and with Kaweah ~~Delta~~Health privacy policies and procedures following Compliance Policy CP.05~~.~~

B. Designated contacts:

1. The CCRO is the designated contact person for receiving complaints about patient privacy. Privacy Complaints received through the Complaint and Grievance Management process outlined in AP.08 Patient Complaint & Grievance Management will be forwarded to the Compliance Department for investigation and resolution.

2. The Compliance Department is the designated contact for patients or family members who have questions about the Kaweah ~~Delta~~Health Privacy Notice.

III. Training:

A. Each member of Kaweah ~~Delta~~Health's workforce shall have a signed confidentiality statement on file in Human Resources. Medical Staff members shall have a signed confidentiality statement on file in the Medical Staff Office.

B. Each new employee and Medical Staff member of Kaweah ~~Delta~~Health shall receive education about patient privacy, including Kaweah ~~Delta~~Health policies and procedures at New Hire Orientation.

C. Each volunteer or student/intern will receive privacy training provided by the supervising manager/director of the area where the student will be working. Additionally, if they will be using fax transmission in the course of their assignments, they will review the fax transmission policy.

D. When changes are made to privacy policies and procedures, ~~all staff~~Kaweah Health workforce ~~-~~affected by the change shall be notified of the change.

E. Training records shall be retained for a period of six (6) years.

IV. Safeguards:

A. Every member of the Kaweah ~~Delta~~Health workforce shall prevent inappropriate use or disclosure of patient PHI.

B. Each Department shall follow the safeguards established by Information Systems policies including Information Security Administration, Physical Access Control Procedure, Network Security, Data Integrity Controls and Logical Access Control. Department Directors shall implement additional department-specific policies as may be necessary to protect patient privacy in their own department.

V. Complaints:

A. Patients or their personal representatives have the right to submit a complaint or grievance to Kaweah ~~Delta~~Health regarding patient privacy policies or practices.

B. Complaints shall be handled as any other patient complaint or grievance as outlined in AP.08 Patient Complaint & Grievance Management ~~Patient Complaint & Grievance Management~~. ~~Patient Experience~~Risk Management shall notify the Compliance Department immediately upon receipt of a complaint related to privacy.

VI. Monitoring:

A. Kaweah ~~Delta~~Health ~~shall~~ has established proactive audit processes to monitor access to protected health information. Audit process may include, but are not limited, to:

1. Proactive audits of high-valued, widely publicized or VIP patients~~.~~;

2. Random audits of access by patient or user;~~.~~

3. Complaint driven audits;

4. Focused audits by stated criteria (e.g. co-worker, same last name, same address, unit-based, etc.).

B. The Compliance Department will complete periodic random ~~audits by conducting~~ observations in key business and clinical areas to evaluate physical safeguards of PHI. The results will be documented and maintained in the Compliance Department and reported to the Compliance and Audit Committee as appropriate. Feedback of deficiencies will be communicated to Management for corrective actions.

VII. Sanctions:

A. All members of the Kaweah ~~Delta~~ Health workforce shall comply with all privacy policies and procedures.

B. Appropriate sanctions, in accordance with Human Resources policies HR.216 Progressive Discipline and HR.217 Involuntary Termination shall be ~~applied against~~applied to members of Kaweah ~~Delta~~Health workforce who fail to comply with all requirements of privacy policies and procedures.

C. Documentation of sanctions ~~applied against~~of employees or independent contractors shall be kept on file in Human Resources. Documentation of sanctions applied against ~~Guild~~ volunteers shall be maintained by the ~~Guild Director~~Volunteer Coordinator.

D. Documentation of sanctions applied to non-Kaweah ~~Delta~~Health employees shall be kept on file in the Compliance Department.

VIII. Mitigation:

approval

A. Any actual or suspected use or disclosure of PHI in violation of Kaweah ~~Delta~~Health policies and procedures shall be reported immediately to the Compliance Department.

B. The Compliance Department shall investigate the incident in accordance with CP.05 Compliance and Privacy Issues Investigation and Resolution.

C. The Compliance Department, if required by Federal and State law, will notify the patient and Federal and State agencies.

IX. Refraining from intimidating or retaliatory acts:

A. Kaweah Health~~ta~~ and/or members of its workforce shall not intimidate, threaten, coerce, discriminate or take other retaliatory action against any individual for exercising any right to privacy as required by law. Examples include, but are not limited to:

1. Exercising any right to privacy as permitted by law;

2. Filing a complaint with the Secretary of the Department of Health and Human Services ("the Secretary");

3. Testifying, assisting or participating in an investigation, compliance review, proceeding or hearing;

4. Opposing any act or practice made unlawful by privacy regulations as long as the manner of opposition is reasonable and does not involve a disclosure of protected health information.

X. Waiver of rights:

A. Kaweah ~~Delta~~Health, nor any member of its workforce, shall require any individual to waive their rights to privacy as a condition for the provision of treatment.

B. Any actual or suspected incident of any member of Kaweah ~~Delta~~Health workforce asking any individual to waive their rights to privacy shall be reported immediately to the Compliance Department.

XI. Policies and Procedures:

A. Kaweah ~~Delta~~Health ~~shall implement, maintain and modify (as necessary)~~ has established policies and procedures which are designed to comply with Federal and State privacy laws.

B. When the law ~~that~~ necessitates a change to policies and procedures, the CCRO shall ensure that changes are made promptly, documented and immediately implemented.

C. Any changes in Kaweah ~~Delta~~Health privacy practices shall be reflected in the policies and procedures and/or Privacy Notice.

1. Changes made to Kaweah ~~Delta~~Health privacy policies and procedures shall be documented according to Section XII below.

approval

2. Kaweah ~~Delta~~Health Privacy Notice shall reserve the right to change privacy practices. Kaweah ~~Delta~~Health shall revise its Privacy Notice to reflect the change in privacy practices prior to implementing any changes to policies and procedures.

D. Kaweah ~~Delta~~Health may change policies and procedures if the changes do not materially affect the content of its Privacy Notice. Such changes shall comply with all Federal and State privacy laws and shall be documented according to AP.38 Policy Manuals Policy Manuals.

XII. Documentation:

A. Kaweah ~~Delta~~ Health shall maintain documentation in written or electronic form of:

1. All privacy policies and procedures;

2. All communication required by privacy rules and regulations;

3. All actions and activities taken or designations made to comply with privacy rules and regulations.

B. Policies and procedures shall be retained for a period of six (6) years from the date of its creation or the date when it was last in effect. Old policies shall be archived in Risk Management per AP.38 Kaweah ~~Delta~~ Health Policy Manuals Policy Manuals .

XIII. Compliance:

A. Kaweah ~~Delta~~ Health shall keep records and submit compliance reports as required by the Secretary.

B. Kaweah ~~Delta~~ Health shall cooperate with the Secretary, if the Secretary undertakes an investigation of a complaint or a compliance review of policies, procedures or practices.

Kaweah ~~Delta~~ Health shall permit the Secretary, during normal business hours, to access its facilities, books, records, accounts and other information pertinent to ascertaining compliance with applicable requirements and standards.

"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."

approval

Policy Number: DM 2206	Date Created: 03/14/2008
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Code Purple - Child Abduction

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

Policy

This policy is designed to provide a coordinated and effective response by a trained team of professionals to child abduction.

II. Procedure

A. Background

In the event of a removal of a child from Kaweah Health by unauthorized persons, Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) will activate its Code Purple procedure (See Administrative Policy #AP.140). Assigned staff must respond immediately to their assigned exits of the hospital. Other hospital staff should remain in their areas, stay alert and report any suspicious persons to the PBX Operator at Ext. 44.

B. Response

See attached checklist and flowchart.

CODE PURPLE – CHILD ABDUCTION

Purpose: To protect children from removal by unauthorized persons and to define healthcare facility response to child abduction

Children are discharged from the hospital in a wheelchair and accompanied by parent or guardian.

STAFF RESPONSE CHECKLIST

☐ Medical Center staff must respond immediately to the exits of the medical center as follows:

Name of Exit or Area	Department To Respond
First Floor Doors:	
1. Mineral King Main Lobby	Patient Access after 2100 hr Emergency Department
2. Ambrosia Exit	Food & Nutrition Services
3. Nurse Supervisor /Bed Coordinator Office	Bed Coordinator
4. Endoscopy Hallway	Respiratory
5. Surgery Center Exit	Surgery Waiting Patient Access after 1700 Pharmacy
6. Acequia West Staircase Exit	EVS
7. Acequia West Employee Entrance/Exit by Visitor Elevators	Patient Access after 2100 hr CVICU
8. Acequia Wing Lobby	Patient Access after 2100 hr 4-Tower
9. Acequia East Employee Entrance/Exit	EVS
10. ED Zone 2	ED
Acequia Zone A - Outside by Ambulance Bay with clear view of East Stairwell exit, EMS Door, Ambulance Door, and Emergency Department Stairwell exit.	Emergency Department
Acequia Zone B – East Stairwell Exit	Emergency Department
Acequia Zone C – Northeast Employee Entrance/ Exit	Patient Access after 1700 hr CV
Acequia Zone D – Acequia Main Stairwell & Exit Door – northeast side	Patient Access after 1700 hr 4Tower
Acequia Zone E – Acequia Main Entrance	Patient Access after 1700 hr Emergency Department.
Acequia Zone F – Northwest exit & stairwell	Environmental Services
Acequia Zone G - Acequia Southwest Exit with clear view of west stairwell, , recessed exit,	Environmental Services
Mineral King Zone H – Surgery Center Pre-Op West Exit door with view of courtyard walkway, back surgery door.	Laundry Department
Mineral King Zone I – Surgery Center Main Entrance	Surgery Patient Access after 1700 hr Pharmacy
Mineral King Zone J – Loading Dock	Shipping and Receiving after 1500 hr Maintenance
Mineral King Zone K – Food & Nutrition Services Exit Door	Food & Nutrition Services
Mineral King Zone L – Ambrosia Exit	Ambrosia Staff after 2000 hr Security

Name of Exit or Area	Department To Respond
Mineral King Zone M – Mineral King Main Entrance	Patient Access after 2100 hr Security
Mineral King Zone N – Emergency Department Main Entrance	Security
Second Floor Doors:	
ICU patio exit and back stairwell to their unit	ICU
2 North stairwell	2 North
2 North stairwell next to nurse manager's office	2 North
Third Floor Doors:	
3 West Patio exit and back stairwell to their unit	3 West
3 North back stairwell	3 North
3 North central stairwell	3 North
3 South back stairwell	3 South
3 South visitor and utility elevators & patio	3 South
Fourth Floor Doors:	
4 North back stairwell	4 North
4 North central stairwell, employee elevators	4 North
4 South back stairwell	4 South
4 South Visitor and utility elevators	4 South
*After 1700 an outside perimeter will be established by Maintenance/Security with Maintenance covering the outside south side exits. Security will cover outside the ambulance bay and the main entrance and the exit at the Ambrosia Café.	

- ☐ Other medical center staff, not specifically assigned to respond, should remain in their areas, stay alert, and report any suspicious persons to the PBX Operator at Ext. 44.
- ☐ Redirect all **exiting** visitors to Main Lobby exit without impeding entry to facility. (Script, "I'm sorry, you'll have to exit through the Main Lobby, thank you.")
- ☐ If a person runs, do not attempt to apprehend them. Without losing the person, ask for someone to call Security. Take special note of their appearance, what they are wearing (style, color, etc.), how they leave the medical center grounds, and note their car's make, color and license plate number.
- ☐ Immediately report above information to Security.
- ☐ Should the person abandon the child and escape, keep the child with you and report above information to Security.
- ☐ Do not leave exit until you hear "All Clear."

AFFECTED AREA CHECKLIST

- ☐ Dial Ext. 44 and instruct the operator to initiate "Code Purple" and give PBX Operator the description, age and gender of missing child. Identify the department, floor and room.
- ☐ Instruct available staff to start a room-to-room search of the floor areas.

Charge Nurse will:

- ☐ Initiate a search on 2 East, Pediatrics, Broderick. Notify medical center operator and Hospital Command Center (HCC) of results.

- ☐ The search includes areas not limited to: Patient rooms, Corridors, Nourishment Center, Waiting Room/Classrooms, Conference Rooms, Elevator/Stairways, Storage Rooms, Restrooms, Housekeeping/Utility closets, dietary/housekeeping carts, Offices.
- ☐ Contact the attending physician to relay information regarding the incident and request that they respond to the medical center
- ☐ Protect the area where the abduction occurred; close the door to the room. DO NOT TOUCH OR MOVE ANYTHING.
- ☐ Assign a staff member and social worker to the mother/parent/caregiver and who will accompany the family at all times for immediate crisis assistance, obtain an interpreter is required.
- ☐ Arrange for additional staffing on the unit if necessary.
- ☐ Gather all relevant information in preparation for the arrival of the police department.
- ☐ Complete an *Incident Report* at the conclusion of the event and submit to Risk Management.

PBX/HELP DESK CHECKLIST

☐ IF HUGS Alarm:

- Security
- Immediately overhead page “Code Purple and location

In the event of a HUGS Alarm Unit Staff or Security can authorize a “Code Purple, All Clear”

Confirmed Child Abduction-Call:

- Visalia Police Department (911)
- Call House Supervisor
- Risk Management

- ☐ Initiate a “No Information” status for this patient.
- ☐ In the event of a child abduction, only Security or Visalia Police Department will have the authority to announce a “Code Purple, All Clear”.

SECURITY CHECKLIST

- ☐ Immediately respond to the location of the possible abduction. Secure the scene by stopping the flow of traffic out of the unit.
- ☐ Attempt to get information on possible description of suspected abductor.
- ☐ Greet police with description and any known information.
- ☐ Escort police to location of incident.
- ☐ The police will assume leadership in an internal search of the medical center with assistance of Maintenance and/or Nursing Supervisor.
- ☐ Following the “All Clear,” notify other local hospitals of any attempted child abduction.

ADMITTING STAFF CHECKLIST

Admitting staff stationed at Main Lobby:

- ☐ Ask individuals with children to wait to exit. If individual does not wish to cooperate, immediately report their description to the HCC. Get description of vehicle and license plate number.
- ☐ **DO NOT PROVIDE ANY INFORMATION REGARDING A POSSIBLE ABDUCTION.**

INCIDENT COMMANDER CHECKLIST

- ☐ Maintain radio contact with Security and PBX at all times.

- ☐ Serve as liaison with the police department personnel.
- ☐ Provide decision-making authority and commit medical center resources as appropriate in support of the plan response activities and needs.
- ☐
- ☐ Request that police set up a traffic stop at the entrance/exit.
- ☐ As soon as possible, dispatch additional personnel to assist Security with control of the hospital's perimeter.

MARKETING

- ☐ Arrange for a communication center and supply the media with regular briefings. Information released to the media will only be done by the Nursing Supervisor, Administration Representative, or Marketing Director.

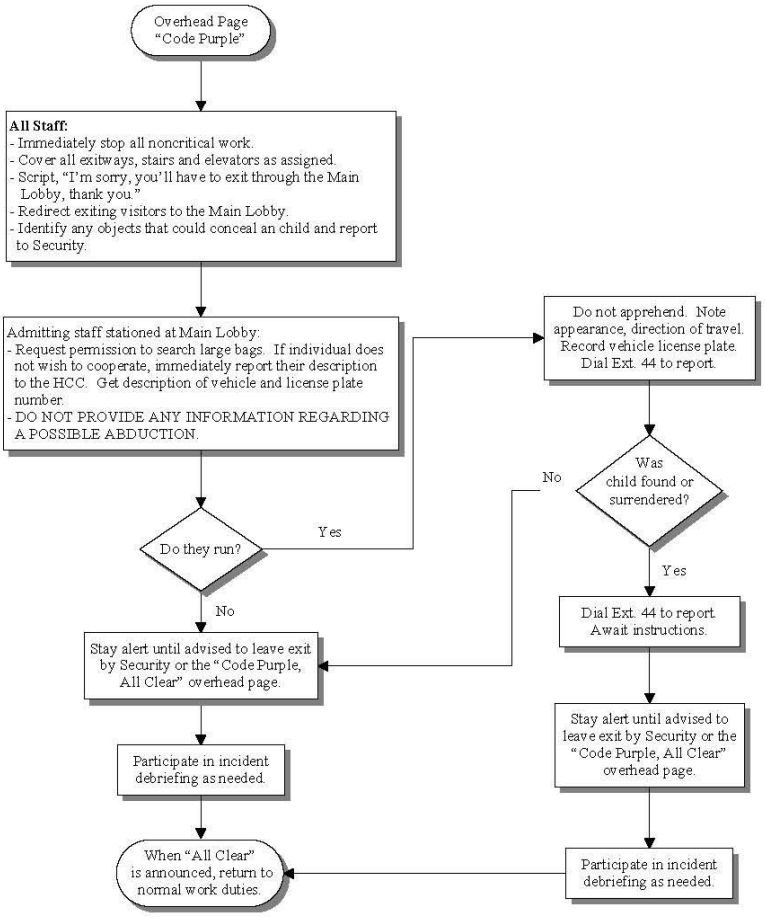
ALL CLEAR

Only the AOD (Incident Commander) can authorize the PBX to page "Code Purple, All Clear" when operations may return to normal.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall complete an Incident Report and submit to Risk Management.

Kaweah Health

Emergency Management Manual
Code Purple - Child Abduction



"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: DM 2209	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Code Shelter-In-Place

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

I. Policy

Upon notification of a potentially hazardous airborne chemical/radiation cloud, smoke or other pollutants in the atmosphere surrounding a facility in the Kaweah Delta Health Care District herein referred to as Kaweah Health (KH), will activate its Toxic Cloud (Code Shelter-in-Place) procedure to protect the health of patients, employees and visitors.

"Shelter-in-Place" is a nationally accepted emergency code indicating the need to stay inside of a shelter or facility during periods of potential exposure to airborne hazards. County Communications may divert ambulance traffic to other facilities during a Shelter-in-Place incident.

II. Procedure

A. Plan Activation

Authority for activation of the Shelter-in-Place rests with Administration/Administrator On Duty/Nursing Supervisor following an alert from Tulare County Communications, as received in the Emergency Department via the ER communications system.

The Emergency Department staff receiving the alert will notify Emergency Department Manager or, after hours, the Nursing Supervisor who will then notify Administration. Administration will direct PBX to overhead page "Code Shelter-in-Place."

If the incident has potential to overwhelm normal hospital operations, Code Triage will also be activated. The Incident Commander will assume responsibility for emergency operations.

B. Notification of Staff

1. Activation – When advised to do so by the Incident Commander, PBX announces "Code Shelter-in-Place" (2x) and contacts the ISS Help Desk to activate xMatters messaging system, CISCO phone display messaging..

2. Termination – When the incident is over, only the Incident Commander has the authority to terminate the Code Shelter-in-Place, and direct PBX to announce "Code Shelter-in-Place, All Clear" via overhead page, xMatters messaging system. Areas not served by overhead page will be notified by a pre-established telephone tree initiated by PBX.

C. Code Shelter-in-Place Response

Please see attached Shelter in Place checklist and flowchart for detailed response guidelines.

CODE SHELTER-IN-PLACE

Purpose: To protect the health of all occupants within the facility in the event of potentially hazardous atmospheric contamination from chemicals, smoke, radiation or other pollutants.

Background:

- ☐ "Shelter-in-Place" is a nationally accepted term indicating the need to stay inside of a shelter or facility during periods of potential exposure to an airborne chemical, smoke, radiation or other contaminants. It is a process of "sheltering" individuals from these hazards by using prearranged measures including, but not limited to, entrance and exit limitations, securing outside air sources, communicating the danger of its occupants, and at the same time trying to maintain a normal business function. Upon notification from County Communications, EMS and/or the fire department, the Incident Commander will have PBX page "Code Shelter-in-Place" (2x). All outside persons wishing to enter the facility will be directed to the Main entrance. Engineering and Security will help secure the building.
- ☐ County Communications may divert ambulance traffic during a Shelter-in-Place incident.

INCIDENT COMMANDER CHECKLIST

- ☐ Notify, even if off-site, the Administrator on Call, Emergency Management Coordinator, and Public Information Officer.
- ☐ Notify PBX and request that they call Security and the Engineer On Duty.
- ☐ Order a facility lock down.
- ☐ Notify PBX, when appropriate, to request overhead page of "Code Shelter-in-Place."
- ☐ Document all communications.

STAFF RESPONSE CHECKLIST

Upon hearing Code Shelter-in-Place:

- ☐ Stay inside and notify visitors to also remain inside the hospital.
- ☐ Ensure all external windows and doors are closed and locked until the "All Clear" is announced.
- ☐ Use plastic sheeting and blue tape to seal any doors and windows with obvious air leaks.
- ☐ Discontinue using any devices that require an exhaust hood, and/or the replenishment of air from outside the hospital (i.e., lab or pharmacy equipment, dietary gas ovens and cook tops).
- ☐ Provide assistance as requested.
- ☐ County Communications will divert ambulance traffic during a Shelter-in-Place incident.

PBX CHECKLIST

- ☐ Upon direction from the Incident Commander, announce "Code Shelter-in-Place" (2x).
- ☐ Contact ISS Help Desk to send out Berbee message to all phones "Code Shelter in Place"
- ☐ Contact ISS Help Desk to send out an xMatters message to all employees "Code Shelter in Place"
- ☐ Upon direction from the Incident Commander, announce "Code Shelter-in-Place, All Clear" (2x).

EMERGENCY MANAGEMENT COORDINATOR CHECKLIST

- ☐ Assist the Incident Commander in managing the incident.
- ☐ Request status on toxic cloud from County Communications.
- ☐ Direct and inform staff based on information received from agencies managing the incident (FD, HazMat).

ENGINEERING CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Engineering will:

- ☐ Shut Down HVAC
- ☐ Bring elevator down by manual operation to the first floor and secure them.
- ☐ Lock down the Central Plant (doors are supposed to be locked at all times).
- ☐ Lock Down Facility
- ☐ Proceed to perform the Facility Lock Down.

- ☐ Ensure all external windows and doors are closed (to minimize any outside air seeping into the hospital).
- ☐ Notify Security Officer via mobile radio that the lock down has been completed.
- ☐ Update the HCC when each of the preceding procedures has been completed.

If Main entrance is to be used, set up fans between the sets of double doors to blow air outside.

SECURITY CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Security will:

- ☐ Post signs on exterior doors directing people to authorized main entrance.
- ☐ Assist with crowd control.
- ☐ Post a monitor from the Labor Pool to redirect exiting people to remain in the Lobby until "All Clear" is announced.
- ☐ Immediately lock all entrances and the cafeteria patio door.
- ☐ Confirm that the ED and other entrances are locked. If not locked, proceed with "Facility Lock Down."
- ☐ Ensure the ED Ambulance door is in locked position.
- ☐ Notify Engineer on duty via radio that Facility Lock Down has been completed.
- ☐ Notify Director of Plant Operations and Security supervisor.
- ☐ Limit foot traffic into and out of the facility by alerting and discouraging anyone from leaving the facility during the Shelter-in-Place and funneling patients into a pre-assigned location/entrance thus keeping the outside air from entering the facility.
- ☐ Maintain radio contact with the HCC, ED, PBX and Engineering.
- ☐ Do not leave post unless instructed to do so by the Incident Commander, Director of Plant Operations or by the Security supervisor.

EMERGENCY DEPARTMENT STAFF CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Emergency Department Team Lead or designee will:

- ☐ Act as the communications liaison between the County and the ED Leadership or the Nursing Supervisor and the HCC.
- ☐ Notify the ED Director or the Nursing Supervisor of the alert, giving known details of the type and extent of the crisis.
- ☐ Notify visitors in the waiting room of the alert and explain that the doors will remain closed until after the "All Clear."
- ☐ Communicate regularly with the HCC.
- ☐ Notify the HCC of any updates from government agencies.
- ☐ Document all communications.

ALL CLEAR

When "Code Shelter-in-Place, All Clear" is announced, return to your normal work duties unless otherwise directed.

- ☐ When the danger has passed, Engineering will turn on supply fans first to pressurize building with filtered air and then turn on exhaust fans.
- ☐ Security will open doors, remove signs, and assist with crowd control.

"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: DM2226	Date Created: 09/01/2011
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Surge Tent Use

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

Policy

In the event of an influx of patients the Emergency Department may determine the need to activate the Surge Tents as an Alternate Care Site. The decision to activate the Surge Tent Plan will be made by the Incident Commander, Administrator on Call, CEO or Nursing Supervisor and they will activate the Emergency Operations Plan.

In the absence of any specific suspension of statute or regulation by Governor's Executive Order, tents will be approved for use only as waiting rooms, to conduct triage and Medical Screening Exams, to provide basic first-aid, and outpatient treatment that meets all applicable rules and regulations. To insure compliance with Surge Tent requirements approval from the Safety Officer or the Director of Facilities or designee must be obtained prior to patients being cared for in the tents.

Tent Use/Space Conversion Approval:
Approval to set up a tent is required by California Code of Regulations Title 22 (22 CCR), §70805, which states that, "Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department." Use of hospital property for tents constitutes a conversion of space. This means that hospitals must obtain CDPH's written approval for tent use. Approval of tents will not be provided unless the hospital has obtained written approval from the local fire authority for tent use.

To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval. (see Attachment CDPH Form for Approval) The form to use in submitting requests for L&C approvals, as referenced above, can also be accessed at https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph5000a.pdf
See Surge Tent Checklist.

"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."

SURGE TENT USE - ALTERNATE CARE SITE

Purpose:

In the event of an influx of patients, the Emergency Department may determine the need to activate the Surge Tents as an Alternate Care Site. The decision to activate the Surge Tent Plan will be made by the Incident Commander, Administrator on Call, CEO or Nursing Supervisor and they will activate the Emergency Operations Plan.

In the absence of any specific suspension of statute or regulation by Governor's Executive Order, tents will be approved for use only as waiting rooms, to conduct triage and Medical Screening Exams, to provide basic first-aid, and outpatient treatment that meets all applicable rules and regulations. To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval.

To insure compliance with Surge Tent requirements approval from the Safety Officer or the Director of Facilities must be obtained prior to patients being cared for in the tents.

INCIDENT COMMANDER DIRECTOR CHECKLIST

- ☐ Establish HCC.
- ☐ Assess situation and activate HICS to the extent necessary to manage the incident.
- ☐ Direct PBX Operator for all overhead emergency announcements.
- ☐ Brief managers and medical staff on anticipated impact and update them on the event's status.
- ☐ Provide leadership for HICS Command Team (see Incident Commander Job Action Sheet).
- ☐ Determine when the incident has been stabilized to the point where normal hospital operations may be resumed and deactivate HICS. Authorize PBX Operator to announce "All Clear."
- ☐ Conduct an incident debriefing as soon as possible following the deactivation of Code Triage.

HOUSE SUPERVISOR OR CNO CHECKLIST

☐ To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval. The form to use in submitting requests for L&C approvals, as referenced above, can also be accessed at.

https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph5000a.pdf

PBX CHECKLIST

- ☐ As directed, PBX Operator implements "Code Triage, Alert" to summon key HICS staff to the HCC.
- ☐ If directed by the Incident Commander, the PBX Operator announces: "Code Triage" (3x). PBX Operator will notify areas not receiving overhead page via pre-established telephone tree.

☐ Notify the Safety Officer and Director of Facilities.

ENGINEERING CHECKLIST

Upon being notified that the Surge Tents need to be set up:

- ☐ Notify the Director or Manager of Facilities
- ☐ Arrange for the Disaster Trailers that contain the tent equipment to be transported from the Warehouse to the Emergency Department parking lot.

Engineering shall insure the following:

- ☐ Fire apparatus access roads shall be provided to all sides of the tent in accordance with Section 503 of the Fire Code.
- ☐ Tents may not be located within 20 feet of lot lines, buildings, other tents, canopies or membrane structures, parked vehicles or internal combustion engines. For the purpose of determining required distances, support ropes and guy wires shall be considered as part of the tent.
- ☐ An unobstructed fire break passageway or fire road not less than 12 feet wide and free from guy ropes or other obstructions shall be maintained on all sides of all tents, canopies and membrane structures unless otherwise approved by the fire department.
- ☐ Tents and their appurtenances shall be adequately roped, braced and anchored to withstand the elements of weather and prevent against collapsing. Documentation of structural stability shall be furnished to the fire department on request.
- ☐ Exit openings from tents shall remain open unless covered by a flame-resistant curtain. Curtains shall be free sliding on a metal support. The support shall be a minimum of 80 inches above the floor level at the exit. The curtains shall be so arranged that, when open, no part of the curtain obstructs the exit. Unless approved otherwise by the fire department, curtains shall be of a color or colors that contrast with the color of the tent.
- ☐ Smooth-surfaced, unobstructed aisles having a minimum width of not less than 44 inches shall be provided from exits to all portions of the interior of the tent. The arrangement of aisles shall be subject to approval by the fire department and shall be maintained clear at all times during occupancy.
- ☐ Exits shall be clearly marked, Exit signs shall be installed at required exit doorways and where otherwise necessary to indicate clearly the direction of egress when the exit serves an occupant load of 50 or more. Exit signs shall be of an approved self-luminous type or shall be provided with an internal back-up battery capable of illuminating the sign for a minimum of 90 minutes after power has failed.
- ☐ The means of egress shall be illuminated with light having an intensity of not less than 1 foot-candle at floor level while the structure is occupied. Fixtures required for means of egress illumination shall be supplied from a separate emergency power circuit or from an internal battery.
- ☐ The areas within and adjacent to the test shall be maintained clear of all combustible materials or vegetation that could create a fire hazard within 30 feet of the structure. Combustible trash shall be removed at least once a day from the tent during the period the structure is occupied.
- ☐ Smoking shall not be permitted in tents. Approved “No Smoking” signs shall be conspicuously posted.
- ☐ Open flame or other devices emitting flame, fire or heat or any flammable or combustible liquids, gas, charcoal or other cooking device or any other unapproved devices shall not be permitted inside or located within 20 feet of the tent, canopy or membrane structures while open to the public unless approved by the fire code official.
- ☐ Portable fire extinguishers shall be provided as required by the fire department.
- ☐ Heating equipment, tanks, piping, noses, fittings, valves, tubing and other related components shall be installed as specified in the California Mechanical Code and shall be approved by the fire department. Gas, liquid and solid fuel-burning equipment designed to be vented shall be vented to the outside air as specified in the California Mechanical Code. Such vents shall be equipped with approved spark arresters when required. Where vents or flues are used, all portions of the tent, canopy or membrane structure shall be not less than 12 inches from the flue or vent. Heating equipment shall not be located within 10 feet of exits or combustible

materials. Electrical heating equipment shall comply with the California Electrical Code.

- ☐ LP-gas equipment such as tanks, piping, hose, fittings, valves, tubing and other related components shall be approved and in accordance with Chapter 38 of the Fire Code and the California Mechanical Code. LP-gas containers shall be located outside and safety release valves shall be pointed away from the tent. Portable LP-gas containers with a capacity of 500 gallons or less shall have a minimum separation between the container and structure not less than 10 feet. Portable LP-gas containers, piping, valves and fittings which are located outside and are being used to fuel equipment inside a tent shall be adequately protected to prevent tampering, damage by vehicles or other hazards and shall be located in an approved location. Portable LP-gas containers shall be securely fastened in place to prevent unauthorized movement.
- ☐ Generators and other internal combustion power sources shall be separated from tents, canopies or membrane structures by a minimum of 20 feet and shall be isolated from contact with the public by fencing, enclosure or other approved means.
- ☐ Tents shall not obstruct the acquired means of egress from the hospital or obstruct fire department access, or access to fire protection equipment including fire hydrants, sprinkler control valves and fire department hose connections unless expressly permitted by the fire department.

SAFETY OFFICER CHECKLIST

Upon being notified of the Surge Tent activation, Safety Officer (or designee) will:

- ☐ Immediately notify Visalia Fire Department that the tents have been erected.
- ☐ Approve tent set up prior to patients being treated in the tents

EMERGENCY DEPARTMENT CHECKLIST

Emergency Department Charge Nurse will arrange the following:

- ☐ Arrange for the following equipment and supplies for the Surge Tent:
  - Portable blood pressure machine with disposable cuffs
  - Thermometers
  - Pulse Oximeter
  - One computer
  - One phone
  - One hand held radio
  - Two desks
  - Twelve chairs
  - Partitions for privacy
  - Lighting
  - Extra Electrical Cords
  - Admitting Supplies – armbands, dashew plates, clipboards
  - Emesis Basins
  - Thermometer probes & covers (temporal and Oral)
  - Nelcore Pulse Ox (disposable)
  - Sanitizer Wipes
  - Portable upright hand sanitizer
  - PPE – masks, gloves (small, med, large, xl)
  - Linen cart
  - 2 Doffit-Kits
  - Hand washing station/hand sanitizer station
- ☐ Staff Roles
  - Triage Tent Nurse
  - ILI Runner
  - Tent RN

- Physician/PA
- Team Leader
- Admitting Clerk
- Main Triage Reception RN
- Triage Reception EDT
- WO RN
- WO EDT
- WO Admitting
- Dispo RN
- MICN
- Customer Service Rep
- Social Worker
- Respiratory Tech

☐ Patient Care

- Triage algorithm
- Screening tool for ILI
- Registration Process

Subcategories of Department Manuals not selected.

Policy Number: DM 2810	**Date Created: 09/11/2011**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Total Evacuation Plan	

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

TOTAL EVACUATION PLAN

I. Policy:

The Total Evacuation Plan is activated only as a last resort and upon the order of the Hospital Incident Commander or designee and/or the responding Incident Commander from Visalia Fire Department. In the event of a total facility evacuation, a Joint Incident Command (Kaweah Health/Visalia Fire Department) would be used. The Fire Chief would assume the role of primary Incident Commander in the event of a fire.

II. Scope:

This is an organization-wide plan that incorporates all services and sites of care provided by Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) (in patient offsite areas listed below). This plan applies to staff, , contract workers, and volunteers.

The following is a list of KH in-patient off site areas:

o Kaweah Health Mental Health, 1100 South Akers, Visalia, CA.
o Kaweah Health Rehab Hospital, 840 South Akers, Visalia, CA.
o Kaweah Health Skilled Nursing, 1633 South Court Street, Visalia, CA.

Each off site area is required to have a unit-specific Fire Safety plan that addresses the unique considerations of each area in the case of evacuation.

III. Procedure Response Plan

I. ACTIVATION/NOTIFICATION

A. Evacuation Criteria

1. The decision to evacuate is the responsibility of the Hospital Command Center (HCC) staff, led by the Incident Commander and in consultation with local authority having jurisdiction (e.g., Visalia Fire, Visalia Police, Central California EMS Agency).

2. The factors upon which a decision to evacuate include but are not limited to:
   a. Structural integrity of the building.

   b. Emergency (life threatening) conditions such as fire and chemical spills.

   c. Impending disaster, which is expected to compromise the hospital (i.e., imminent flood).

B. Activation It is anticipated that the event resulting in the need for total facility evacuation will have resulted in activation of Code Triage and use of the Hospital Incident Command System (HICS). The HCC will be established to coordinate and direct the emergency response.

C. Notification – Internal In the event of a major emergency triggering facility-wide evacuation response, PBX will announce “Code Triage” (2x). Upon instruction from Administrator on Call /Incident Commander, PBX will announce “Code Triage, Evacuate the Building.”

If main hospital patients will need to be transported offsite for continuation of care the Emergency Department Team Leader will be immediately notified of possible evacuation. If evacuating patients from offsite campuses, Hospital Command Center will ensure 911has been called for EMS Disaster response.

D. Notification – External

The Incident Commander will instruct the Liaison Officer to notify:
1. California Department of Public Health (DHS) at 408-277-1784
(Monday–Friday, 8 a.m.–5 p.m.) or OES (Office of Emergency Services) at 916-845-8911 (after hours/weekends).
2. Tulare County Department of Public Health
Public Health Officer – Dr. Thomas Overton
559-624-7499 ext 4 or 559-471-7092 after hours
3. Complete the Hospital Status Report Form (see Appendix) and send to the Tulare County Department of Emergency Operations Center (DEOC). If the DEOC is not activated, send the Hospital Status Report Form by fax to the Operational Area EOC.

E. Total Evacuation Procedure – All Staff Checklist

EVACUATION, TOTAL

Purpose: To safely remove all individuals from all floors of the hospital to designated outside areas.

Background: Total evacuation means removing all individuals from the dangerous structure to an area outside the structure which offers safety and is free from danger. **Evacuation is done only as a last resort and only upon the order of the Incident Commander (IC) or local authority having jurisdiction (fire department).**

Note: Elevators will be used for evacuation only when authorized and supervised by Fire Department or Maintenance Department staff.

ED TEAM LEADER OR MICN DESIGNEE CHECKLIST

- ☐ Notify TCCAD (Tulare County Consolidated Ambulance Dispatch) of possible hospital evacuation and request disaster response.
- ☐ Notify CCEMSA (Central California EMS Agency) Coordinator On-Call of possible hospital evacuation and request them to respond.
- ☐ Notify area hospitals of possible evacuation. Initial notifications will be to all CCEMSA EMS Base Hospital MICN Hotlines. Secondary notifications will be to all other area hospitals.
- ☐ Have EMS Medical Group Supervisor and CCEMSA Coordinator report to the ED Team Leader (or designee) for briefing with the Hospital Command Center.
- ☐ Work with Security and Visalia Police Department to establish ambulance staging area & patient staging areas.
- ☐ Hospital Evacuation Coordinator (or designee) will work EMS Medical Group Supervisor and EMS Transportation Officer to assign ambulance transport destinations for evacuated patients.
- ☐ Request Closed Status Ambulance Diversion from CCEMSA if main hospital is to be evacuated. Refer to KH Policy CP85.

STAFF RESPONSE CHECKLIST

Immediately upon receiving orders to evacuate:

- ☐ Evacuate to the evacuation assembly area in this order:
  (**Note:** If 48-hour advance planning time, reverse this order.)
  - ☐ **Ambulatory patients** closest to danger (if visibility is reduced, form chain by holding hands and lead to safety). Travel down nearest stairwell according to posted Evacuation Maps or direction from the IC.
  - ☐ **Wheelchair patients** by elevator, if cleared for use, or down nearest stairwell using evacuation equipment.
  - ☐ **Non-ambulatory patients** in their beds by elevator (if operational), or down nearest stairwell using evacuation equipment. (Nursing will determine whether patient care equipment and/or traction can be discontinued and assign sufficient number of staff to move patients.) If wheelchair is needed for further evacuation, remove patient from wheelchair and make comfortable. Take wheelchair to remove additional patients.
  - ☐ **Critical Care/Ventilator-Dependent Patients** are the last to be moved. Move entire bed if necessary.
- ☐ Evacuation Monitor will make a final room check to determine the area is completely empty, doors are closed and marked with a large "X" to signify that the room has been checked and is empty.
- ☐ Take patient's hard chart or paper record charts medications and associate staffing assignment sheet when relocating. Ensure patients being removed from Respiratory Precautions wear a mask. (See page 8, Checklist – Nursing Care Guidelines for Special Situations.)
- ☐ During total hospital evacuation, charge personnel will direct patients, visitors and staff to the department-specific evacuation route and convene in the appropriate evacuation assembly area, outside the building.
- ☐ Once evacuated to the evacuation assembly areas, charge personnel will:
  - ☐ Conduct a patient/staff headcount and assessment for injuries and report this information to the Hospital Command Center (HCC).
  - ☐ Keep medical records, medications, assistive devices and personal belongings with patient.
  - ☐ Continue to observe patients. Report any problems or injuries, or staff injuries to charge personnel.
  - ☐ Stand by for specific instructions and prepare to assist, as instructed by charge personnel.

  Note: Patients may need to be transferred to other facilities for continued care or may be evaluated by a physician for immediate discharge home.

  Note: See Evacuation Assembly Areas identified on site map

MAINTENANCE CHECKLIST

- ☐ Clear roadways.
- ☐ Man the elevators (or cordon off if not authorized for use).
- ☐ Secure building mechanical/electrical systems, begin shutdown procedures. (See Maintenance Department Manual.)
- ☐ Relocate evacuation equipment to priority areas.
- ☐ Rotate and change radio batteries.
- ☐ Help Clinical Engineering load any medical equipment onto trucks.
- ☐ Provide extension cords to evacuation assembly/staging areas for medical equipment.
- ☐ Provide lighting at evacuation assembly/staging areas.

SECURITY CHECKLIST

- ☐ Secure area to prevent persons from entering evacuated area (including staff, patients, visitors, and possible intruders/vandals). Direct vehicular traffic to and around three staging areas. Stage/prioritize vehicles.

ALL CLEAR

Do not return to the building until cleared by fire department and Incident Commander and instructed by the Floor Monitor. When "All Clear" is announced, return to your normal work duties, unless otherwise directed.

TOTAL EVACUATION PLAN

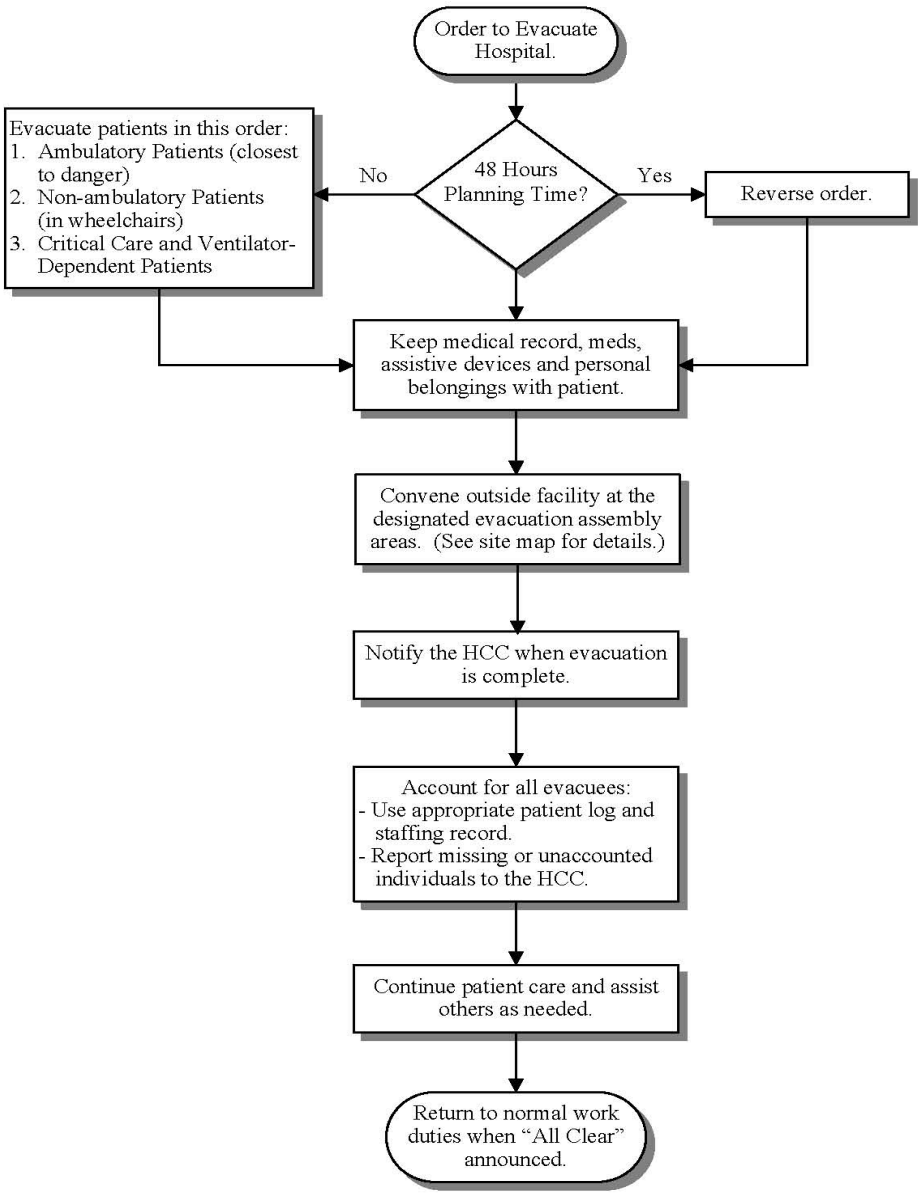
Equipment/ Carry Type	Staff Needed	Instructions
1. One-Person Assist (semi-ambulatory)	1	If patient can walk, accompany patient to area of refuge. If patient requires assistance to walk: 1. Stand next to patient and place his/her nearest arm around your waist. 2. Reach behind and around patient's waist and grasp his/her other arm. 3. "Hug from behind" and walk side by side in step – grasping your wrist. 4. When items 1, 2 and 3 have been accomplished, in order, walk the patient to the area of refuge. (If elevators are not functional, use evacuation equipment as needed to transport the patient down the stairs.)
2. Stryker Evacuation Chair	2	1. Unfold chair, place on floor. Set up following the instructions on back of seat. 2. Transport patient to chair. 3. Place restraints (for lap, chest and ankles) according to guidelines on chair. Fit should be firm but comfortable. 4. Transporters face forward in the direction of carry. The strongest person(s) should always be on the down side when ascending or descending stairs. 5. Evacuation chairs should be rolled, not carried, on all even surfaces.

Equipment/ Carry Type	Staff Needed	Instructions
3. Evacusled	1	1. Clear evacuation route, angle bed, lower bed and lock bed brakes when deploying Evacusled from bed deck. 2. Reassure patient, cocoon patient with bed linen and put IV/charts etc. in with patient. Note: Deployment can also be directly from floor position. 3. At head end of bed pull the orange cord straight up with a quick tug, over patient's head, ease white cords around mattress corners. Repeat at foot end. Velcro together. 4. Pull down to tighten cords at 4 self-locking cleats, secure patient and mattress. Tighten toggles. 5. With palms up grasp 2 carry handles below cleats. Shift your body weight to pull foot end of mattress to floor at a 45 degree angle, then guide head end gently to the floor. 6. Go to foot end of the mattress and pull out orange towing cord. Pull/roll feet first. Roll down hallway with foot end raised so sled is rolling on wheels. Make wide turns. 7. At stairwell, double check that cleats are secure. Walk down a few steps until underside wheels begin to roll downstairs. Always keep at least 2 steps between yourself and the foot end of sled. Wheels and gravity are doing the work as you guide the Evacusled down the stairs. 8. Speed of Evacusled is easily controlled with simple braking system on underside. Simply lower foot end of sled against stairs and /or press hand into sled at foot end. Pass off to next rescuer and return to get next patient.
4. Litter/Stretcher • Cervical Traction Board • Back Board		1. Place patient on stretcher. 2. Transporters should walk out of step (person in front should walk, start walking with left foot while person in back should walk right foot first). 3. Patient should be carried feet first if possible.
5. Blanket Drag		To be used as a last resort. 1. Unfold blanket. 2. Place patient face up diagonally on blanket. 3. Lift corner of blanket nearest to patient's head. 4. Drag patient, head first, to place of safety. 5. Mattress may be used in stairwells to assist with patients' evacuation.
6. Swing Method		1. Place patient in sitting position. 2. With a nurse on each side, both nurses pass one arm under the patient's arm and cross the patient's back. Each nurse should secure a firm grip on each other's shoulders. 3. The nurse's free arm is then passed under the patient's knees. One nurse keeps her palm up and the other nurse keeps her palm down, grasping each other's wrist. 4. Lift patient with arms and shoulders and remove to safety.

Kaweah Health

Total Evacuation Plan

All Staff Flowchart



Checklist – Nursing Care Guidelines for Special Situations

Mode of Hospitalized Patient Transportation	
Patient Type	**Mode of Transportation to Stairwell**
Ambulatory	Walking
Sitting patients or patients who get out of bed easily	Wheelchair
Bedridden patients	Bed or Gurney
Babies	In Arms, Cribs, or Aprons
Toddlers	In Arms or Cribs

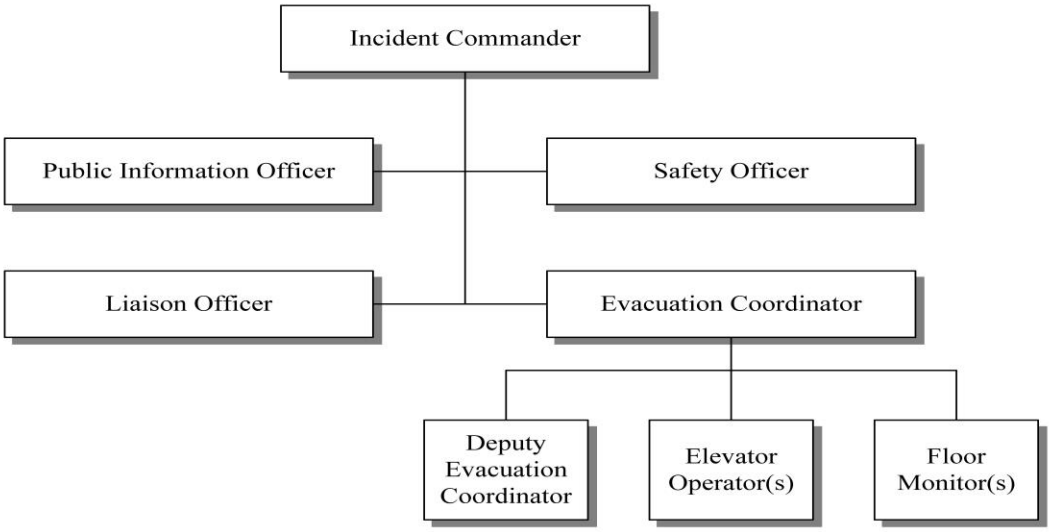
Protocol to Follow When the Hospitalized Patient is Attached to Special Equipment		
Equipment	**Procedure**	**Mode of Transportation***
Traction	Stabilize limbs – gently place weights on bed	In Bed
Stryker Bed	Transfer patient to gurney	Gurney
Central Venous Lines	All central lines must be maintained	Wheelchair or Gurney
Oxygen	Continue use with portable tank. If not available, then stop oxygen; shut off and remove flowmeter from wall, restart as soon as possible.	Walking, Wheelchair, Gurney or Bed
Precaution/Isolation Patients	Continue precautionary measures	Wheelchair or Gurney
Monitors/Telemetry	Disconnect and re-establish as soon as possible.	Wheelchair, Gurney or Bed
Ventilator Patients	Use Transport Ventilator. If not available then disconnect ventilators; connect manual resuscitator; manually ventilate patient	Gurney or Bed
Note: A nurse or respiratory therapist or physician must ventilate during transport, unless a transport ventilator is being utilized.		
Arterial Lines Central Venous Lines	Disconnect from monitor and maintain continuous flush pressure system/ all central lines must be maintained	Gurney or Bed
Intra-Aortic Balloon Pump	• If elevators approved for use: maintain IABP using internal battery If elevators are not usable: Disconnect IAB from pump. Maintain Artline as noted above. Hand inflate the balloon every 5 minutes with half its total volume. Clamp off drain during egress from unit and unclamp as soon as possible	Gurney or Bed

Hemodialysis Patients on Dialysis	• Emergently return blood to patient. • Flush lines • Clamp and disconnect	Gurney or Bed	
Vasoactive medications	• Continue via battery powered pump if possible	Gurney or Bed	
Swan-Ganz Catheter	• Continue monitoring & infusions with portable monitor and battery powered pumps if possible. • Consult with physician to see if patient is a candidate to have Swan-Ganz Catheter removed.	Gurney or Bed	
Special handling for patients who have received Radiopharmaceuticals (Muga Scan, Bone Scan, Brain Scan): Ambulatory Patients – flush toilet two times after voiding. Bedridden Patients (with Foley catheters) – wrap catheter in linen while in transport. Incontinent Patients – wrap patients in linen. **Note:** Follow decision of the HCC depending on results of assessment of situation.			Continue via battery powered pump if possible

Total Evacuation Plan

II. HICS – EVACUATION INCIDENT MANAGEMENT TEAM

A. Organization Chart



EVACUATION COORDINATOR

Mission:
Coordinate evacuation with Floor Monitors and keep Incident Commander updated on efforts. Work with Deputy Evacuation Coordinator to confirm arrival of evacuees at Evacuation Assembly Area.

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Incident Commander (IC).
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest, megaphone and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Incident Commander.
- ☐ 6. Activate Deputy Evacuation Coordinator (station at Evacuation Assembly Area).
- ☐ 7. Serve as a liaison with emergency responders (e.g., fire department, police department, etc.).
- ☐ 8. Meet responders upon their arrival and convey specific information about hazards in the building, access, locations of persons with special needs, etc.
- ☐ 9. Maintain communication with Floor Monitors regarding the status of the evacuation their floor.

Intermediate:

- ☐ 10. Keep Floor Monitors updated on incident status as necessary. Relay pertinent information from Floor Monitors to the HCC.
- ☐ 11. Document activities on the HICS Activity Log.
- ☐ 12. Obtain progress reports from Floor Monitors as appropriate.
- ☐ 13. Assist Public Information Officer in preparing information updates for hospital staff as needed.

Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

DEPUTY EVACUATION COORDINATOR

Mission:
Coordinate evacuation with Floor Monitors and keep Evacuation Coordinator updated on efforts. Work with Evacuation Coordinator to confirm arrival of evacuees at Evacuation Assembly Area.

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building –	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building – Roof)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest, megaphone and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Report to Evacuation Assembly Area.
- ☐ 7. Maintain communication with Floor Monitors regarding the status of the evacuation on their floor.

Intermediate:

- ☐ 8. Keep Evacuation Coordinator updated on status as necessary. Relay pertinent information from Evacuation Assembly Area to the HCC.
- ☐ 9. Document activities on the HICS Activity Log.
- ☐ 10. Obtain progress reports from Floor Monitors as appropriate.
- ☐ 11. Assist HICS Human Services Director (see JAS in Chapter 9) in preparing information updates for hospital staff as needed.

Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

ELEVATOR OPERATOR

Mission:

Operate designated elevator, if authorized, during an evacuation.
[Note: Elevators will be used for evacuation only when authorized and supervised by Fire Department or Engineering Department staff.]

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Use handheld radio for communication with Evacuation Coordinator.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Use elevator override key to efficiently transport non-ambulatory patients.
- ☐ 7. Evacuate patients in the order directed by the Evacuation Coordinator.

Note: Report to Engineering Department for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

FLOOR MONITOR

Mission:
Coordinate evacuation of floor to external Evacuation Assembly Area.

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Evacuation Coordinator) _____ (phone/pager)

Key contacts: _____ (Deputy Evacuation Coordinator) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Ensure that all floor occupants are aware of the emergency and the need to evacuate. (Use megaphone.)
- ☐ 7. Be aware of patients/staff with special needs who may need assistance during an evacuation (e.g., hearing- or sight-impaired, on crutches, in a wheelchair, etc.).
- ☐ 8. Rank order patients to be moved. Prioritize. Write order on *Patient Evacuation Log*. (Contains name plus list of items accompanying patient.)
- ☐ 9. Assign designee to get equipment to evacuate/transport patients.
- ☐ 10. Assign trained staff to do various types of transport.
- ☐ 11. Assign runner if communications down.
- ☐ 12. Send information/status sheet to the HCC on available evacuation equipment/supplies.
- ☐ 13. Call Ext. 44 whenever a situation could pose immediate danger to people, property, or processes in the building.
- ☐ 14. Direct staff, patients and visitors to appropriate Evacuation Assembly Area.
- ☐ 15. Verify arrival of evacuees at Evacuation Assembly Area and note on *Patient Evacuation Log*.

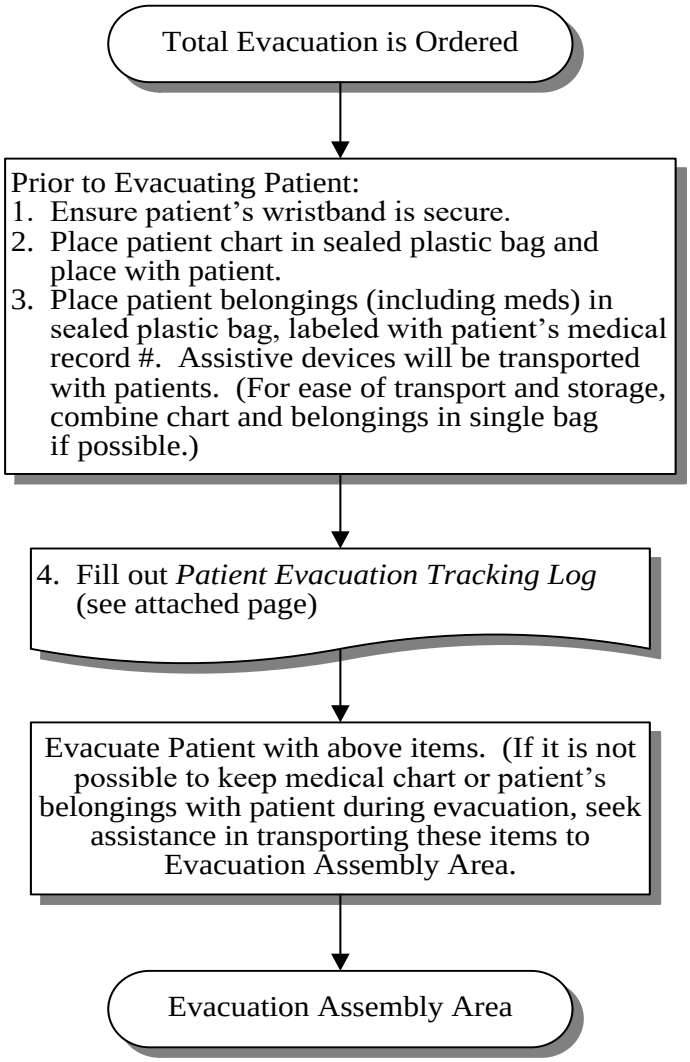
Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

III. PATIENT TRACKING METHOD

A. Patient Tracking Process

In the event of total facility evacuation, Kaweah Health may implement its disaster patient tracking process. This tracking system will ensure that all patients may be readily located at all times. The Patient Tracking Officer will receive all information about patient movement and be the resource for patient location. Patients will be documented as described in the following procedural steps:



IV. EVACUATION ASSEMBLY AREAS

Once occupants are out of the building, they must be directed to a safe area away from the building. The following site map highlights evacuation assembly areas for each floor. These areas are where head counts will be completed. Employees should gather in these areas so that additional information can be provided easily.

Employees must be accounted for after an evacuation so that we can determine if people are missing. Floor monitors confirm that all patients and staff are out of the building or identify who is missing. This information is provided to the Hospital Command Center and local authorities when they arrive.

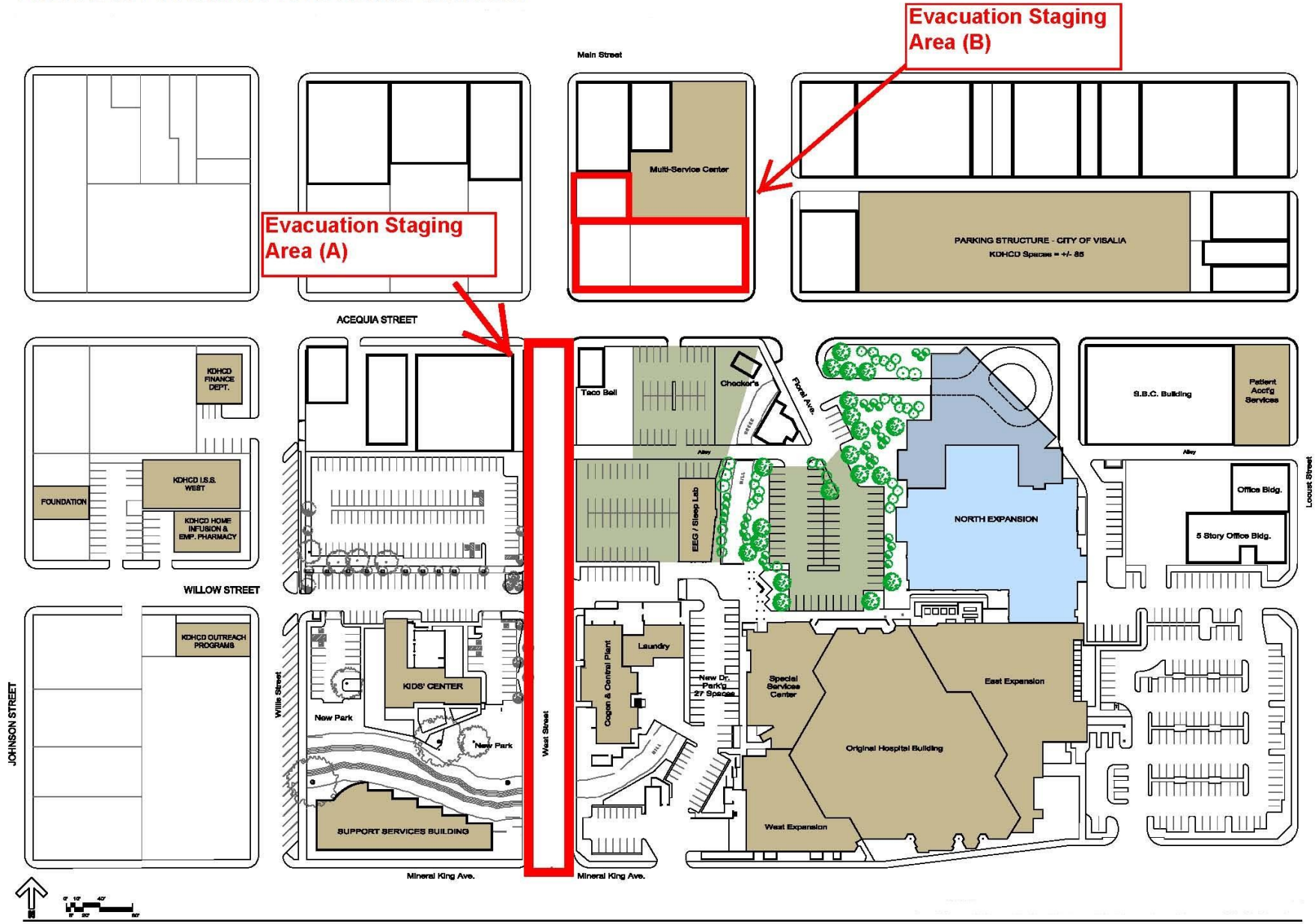
A. Designated Evacuation Assembly Areas:

• Go to nearest Evacuation Assembly Point (see attached Evacuation Assembly Site Map).

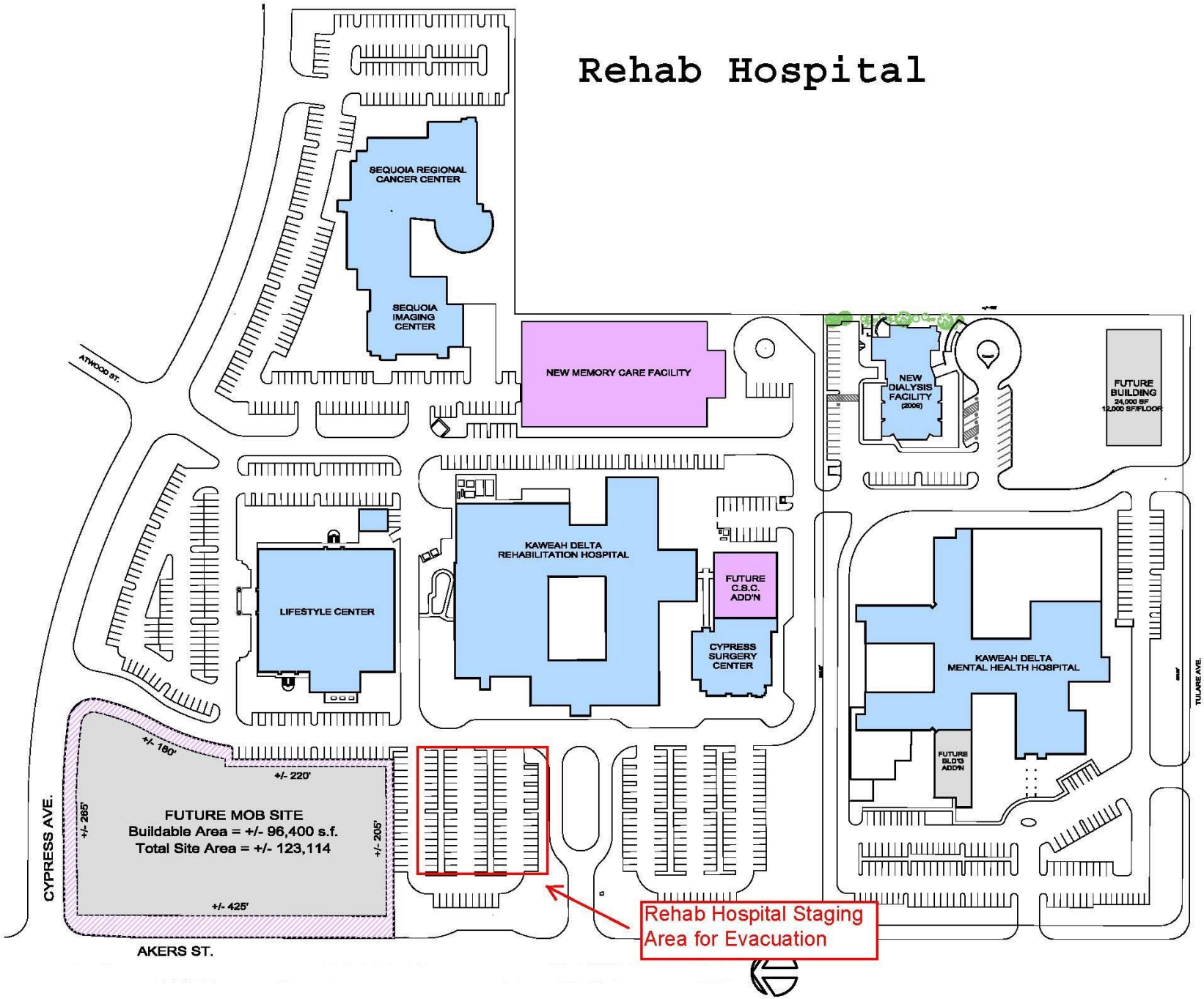
B. Location of Exterior Assembly Points
1. Kaweah Health Medical Center
• Primary: West Street between Acequia & Mineral King
• Secondary: Multiservice Center parking lot.
2. Kaweah Health Mental Health
• Primary: Main parking lot west of hospital
• Secondary: Rehab Hospital Main Lot
3. Kaweah Health Rehab Hospital
• Primary: Main parking lot west of hospital
• Secondary: Mental Health Hospital Main Lot
4. Kaweah Health – South Campus
• Primary: Main parking lot south of hospital
Secondary: North Paradise House area

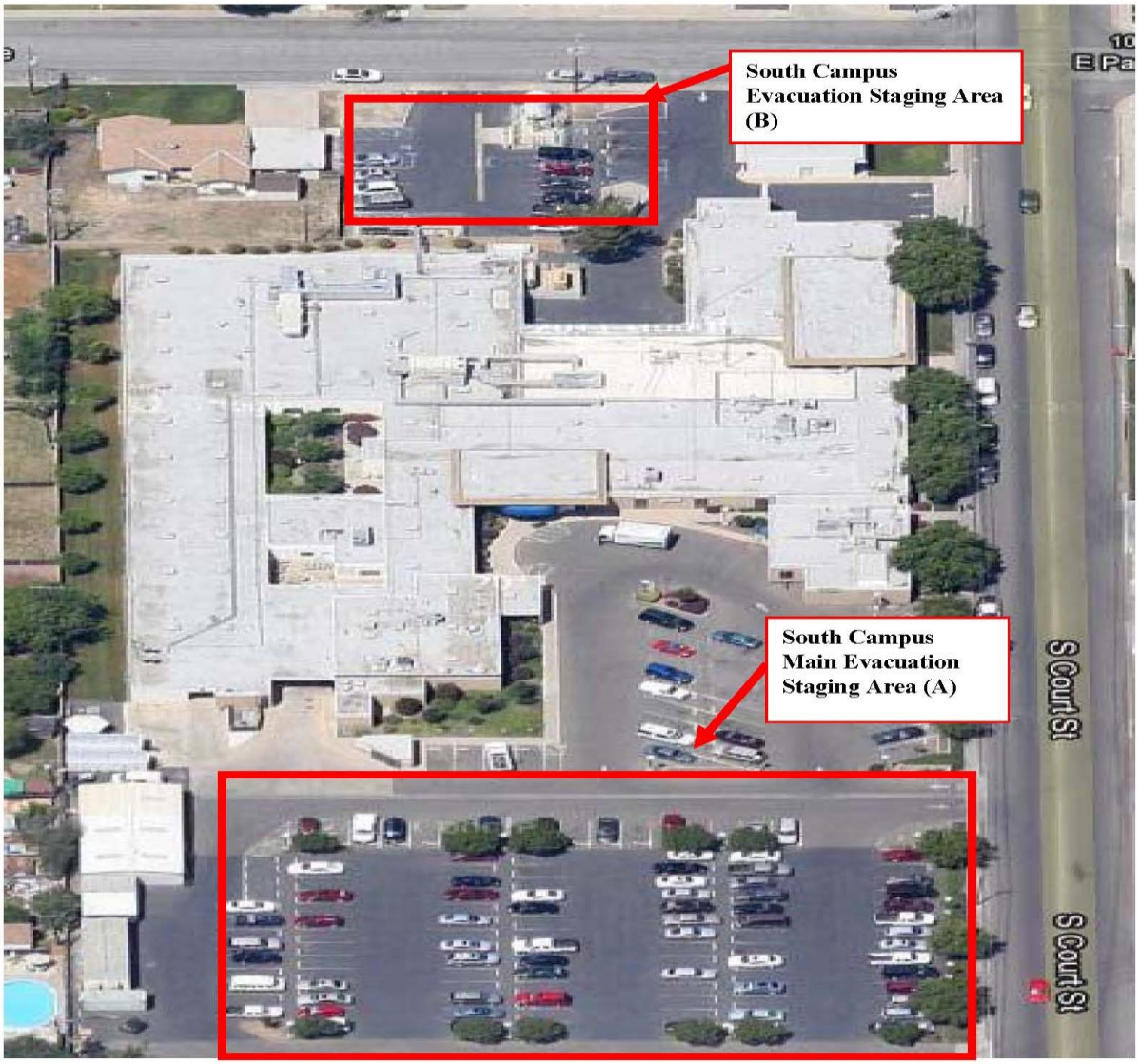
NOTE: If designating alternate evacuation assembly areas, these assembly areas should be far enough from the building to ensure the safety of personnel and should not block access for emergency responders. Plans should include an alternate assembly area in case the primary area is affected by the emergency. Include visitors, outside contractors and vendors, and employees from other sites. A system should be in place to monitor the arrival and departure of all people in the facility.

Kaweah Health Medical Center



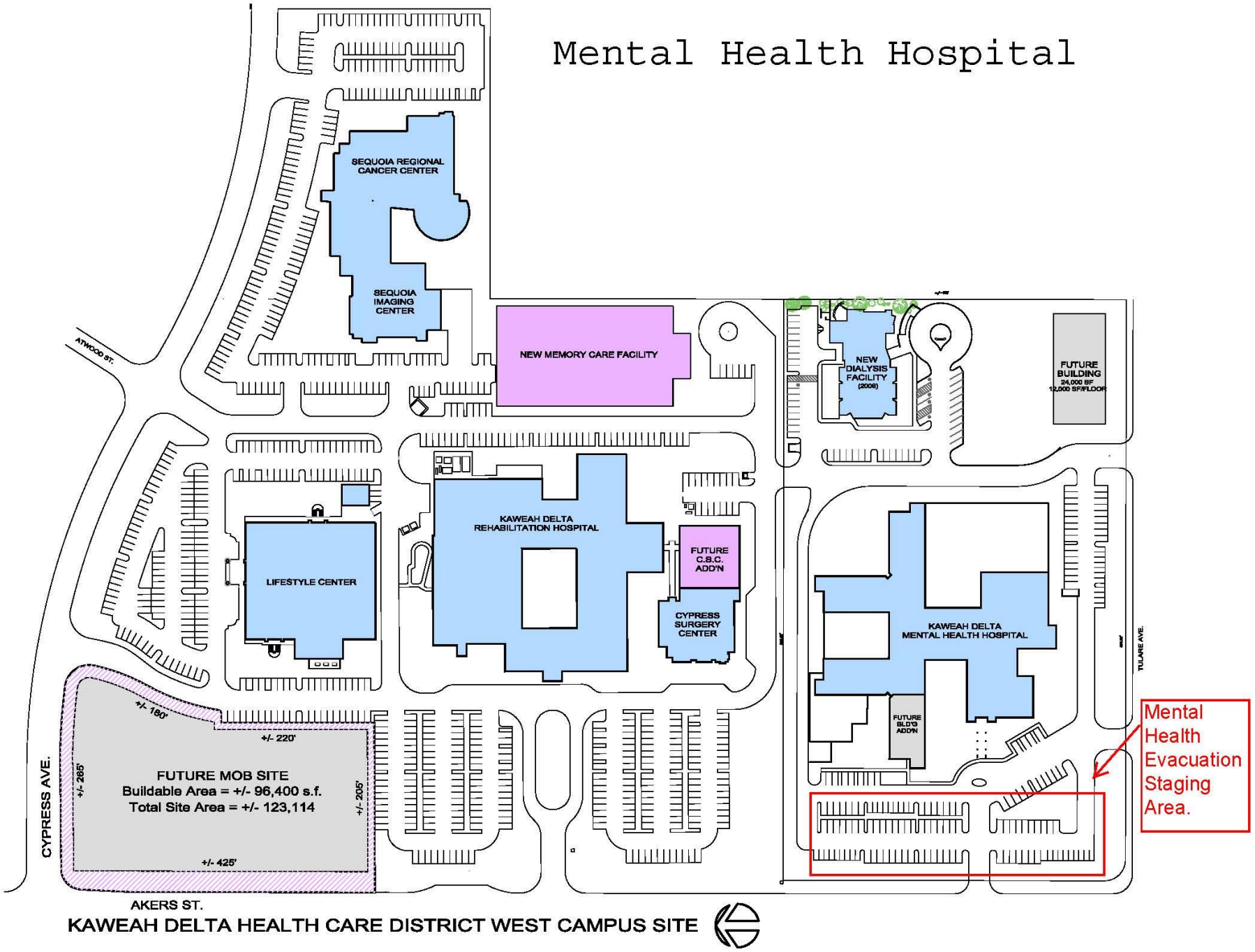
Rehab Hospital





South Campus Facility

Mental Health Hospital



KAWEAH DELTA HEALTH CARE DISTRICT WEST CAMPUS SITE

ALTERNATE TREATMENT LOCATIONS

A. Overview

Kaweah Health will transfer patients and arriving casualties to identified alternate care sites when the hospital environment cannot support adequate patient care. The Alternate Care Site(s) Plan is a tool that establishes a process for managing patients during emergencies including activation/notifications, modification or discontinuation of services, control of patient information and patient transportation. It is anticipated that the event resulting in the need for alternate care site(s) will have resulted in an activation of Code Triage and the use of the Hospital Incident Command System (HICS).

B. Activation/Notification

1. Tulare Department of Public Health- Department Emergency Operations Center (DEOC) – Incident Commander, or designee, will notify the DEOC of the need to evacuate patients and provide information as to the number of patients and types of specialty care required.
2. California Department of Public Health (CDPH) – Incident Commander, or designee will notify DHS of the need to utilize alternate care site(s) for patient care.

C. Emergency Transfer of Patients

1. Discharge or transfer procedures in an emergency situation:
   a. Discharge
      The Medical Staff Director, as requested by the Incident Commander, will initiate the Emergency Rapid Discharge Plan. (See Section I.)
   b. Transfers

      The Kaweah Health Incident Commander will request that Public Health activate the DEOC, via County Communications. The DEOC will survey hospitals in the county for their bed status to determine their ability to receive transferred patients. The DEOC will instruct Kaweah Delta Health Care District as to the number of patients to be transferred to each facility. Arrangements with receiving facilities will be coordinated through the Nursing Unit Leader and Medical Staff Director. Staff will ensure that medical records and personal belongings accompany each patient. The Nursing Unit Leader will maintain a record of patient transfers and destination.

   c. Transportation

      Arrangements will be made to transport patients from the hospital by the Transportation Unit Leader in collaboration with the Nursing Unit Leader and the Tulare County Emergency Medical Services (EMS

2. Alternate Care Site(s) – Acute Care Facilities
   Acute care hospitals in the CCMSA five county MOU plan. Counties may be able to accept Kaweah Health patients, depending upon the circumstances of the disaster. The Tulare County DEOC assists in locating hospitals with beds appropriate for placement of patients at alternate care sites.

If necessary, a request for National Disaster Medical System (NDMS) assistance would be made through the DEOC to the Governor. The NDMS is a federally coordinated system that augments the nation's emergency medical response capability to ensure resources are available to provide medical services following a disaster that overwhelms the local health care resources.

3. Interim Alternate Care Site(s)

In the event that evacuated patients and incoming casualties cannot be transferred to other acute care facilities, they will be routed to interim alternate care sites. These non-sterile, "hostile" environments may need to be maintained for hours or days, depending upon the circumstances of the disaster. Therefore, the HCC will:

a. Select buildings on the hospital campus to be used and/or utilize tents for staff and patients and set up in the hospital parking lot.

b. Coordinate available staff, equipment and supplies, water, power/lighting, shelter, Food & Water resources, security, recordkeeping, and other needs to support interim care sites.

"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: EOC 1007	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Safety Officer Job Description

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

SUMMARY:
Manage and oversee all hospital safety programs in order to maintain a safe environment for patients, visitors and personnel by performing the following duties.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
The essential duties and responsibilities of the Safety Officer include the following. Other duties may be assigned.

Develops and recommends new procedures and approaches to safety and loss prevention based on reports of incidents, accidents and other relevant information.

Disseminate information to department heads and others regarding toxic and hazardous waste and materials, safe medical devices and supplies, emergency preparedness and other safety information.

Assesses need for and initiates interim life safety measures.

Provide interpretation and enforcement of the Life Safety Code.

Assist department heads and administrators in enforcing safety regulations and codes.

Measures and evaluates effectiveness of environment of care program, using established goals.

Act as a reporting member of the Environment of Care Committee on findings, recommendations, actions and monitoring at least every other month. Support Environment of Care Committee meetings by collecting and formulating relevant information in such a way that decision-making is facilitated.

Conducts building and grounds hazard surveillance surveys on a periodic and regular basis to detect code violations, hazards and incorrect work practices and procedures.

Develops, reviews and participates in safety training for District staff. Present at new employee orientation. Presents in-services to various departments on request; maintains various resource media for training.

Maintains administrative control of records related to safety and health programs.

Prepares and disseminates memos and reports. Maintains required records.
Plan, coordinate, oversee and train as needed regarding asbestos control.
Directs the OSHA required hazard communication program through:
Responsible to Maintain a comprehensive file of Safety Data Sheets.
Provide assistance to Directors in conducting the annual chemical inventory.
Provide training in the use of and need for Safety Data Sheets.
Assist the Personnel Department in administering worker compensation program.

QUALIFICATION REQUIREMENTS:
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE:
Four year college or university program certificate; or two to four years related experience and/or training; or equivalent combination of education and experience.

LANGUAGE SKILLS:
Ability to read, analyze and interpret common scientific and technical journals, financial reports and legal documents. Possess skills to respond to common inquiries or complaints from patients, employee's regulatory agencies or members of the business community. Ability to write speeches and articles for publication that conform to prescribed style and format. Effectively communicate information to management, public groups and/or Governing Body.

MATHEMATICAL SKILLS:
Demonstrates ability to apply mathematical concepts such as probability, statistical inference and fundamentals of both Plane and Solid geometry and trigonometry. Applies standard mathematical concepts using fractions, percentages, ratios and proportions to represent practical situations.

REASONING ABILITY:
Ability to define problems, collect data to establish facts, draw valid conclusions, interpret an extensive variety of technical instructions in mathematical or diagram form to deal with both abstract and concrete variables.

PHYSICAL DEMANDS:
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to stand; walk; sit; use hands to finger, handle, or feel objects, tools, or controls; reach with hands and arms; climb or balance; stoop, kneel, crouch, or crawl; talk or hear; and taste or smell.

The employee must frequently lift and/or move up to 10 pounds and occasionally lift and/or move up to 50 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus.

WORK ENVIRONMENT:
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee occasionally works near moving mechanical parts; in high, precarious places; in outside weather conditions; and with explosives and is occasionally exposed to wet and/or humid conditions, fumes or airborne particles, toxic or caustic chemicals, extreme cold, extreme heat, risk of electrical shock, risk of radiation, and vibration.

The noise level in the work environment is usually moderate.

"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: EOC 1034	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Disruption of Services, Electrical

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

PURPOSE:

To notify the proper service of failure, and steps to be taken in the event of electrical failure.

PROCEDURE:

Check to make sure the electrical generating plant is functioning at the Medical Center and that off site inpatient locations' generators are functioning. Confirm that adequate emergency power is provided to the following essential services:

Alarm Systems
Obstetrical Delivery Rooms
Elevators (at least one)
Emergency care areas
Emergency communication system
Illumination of exit signs
Medical air compressors
Medical/surgical vacuum systems
Newborn nurseries
Operating rooms
Postoperative recovery rooms
Special care units.

Maintenance will notify affected departments and the Nursing Supervisor of the failure and the expected downtime.

The Nursing Supervisor shall decide if Code Triage or Code Triage Alert needs to be called, if patients and/or building occupants need to be relocated, and if cases need to be cancelled/rescheduled.

After Normal Utility Power is restored, check for proper operation of:

Ventilating Systems

Pumps
Motors

Air Compressors

Air Conditioning
Vacuum Pumps, etc. Boilers

Notify PBX to contact all departments and relay that service has been restored.

"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: EOC 1036	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Disruption of Service, Natural Gas

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

PURPOSE:
To notify the proper services of failure and steps to be taken in the event of a natural gas failure.

PROCEDURE:
In the event that a gas leak or rupture of a regulator that is servicing the hospital, the following steps will be taken:

Notify the Maintenance Department to initiate problem resolution

Maintenance will notify affected departments and the Nursing Supervisor of the failure and the expected downtime

Notify Central Services and Surgical Department/Services that their steam sterilizers will not work because the boiler will not function and instruct them to use electric sterilizers only.

Food Services will need to be notified to arrange alternative meal preparations due to the fact that stoves will be non-functional.

After the natural gas service is restored light all pilot lights and check equipment for proper operation.

Notify PBX to notify all departments that service has been restored

The Natural Gas Main Shut Off Valve is located in the following areas on the following campuses:

Mineral King Wing/Laundry/Co-Gen – On Willow Street, in the generator yard

Co-Gen Turbine – West side of the Co-Gen building located on West Street.

Acequia Wing – North East Employee entrance, alley way

South Campus – South side of building behind the Dietary Department

Rehabilitation Hospital – North side of the building, outside of the big therapy gym

Mental Health – South side of the building, outside of the boiler room

Facility Staff is authorized to shut off natural gas valves. In an emergency situation, at the direction of charge nurse, staff is authorized to shut off natural gas valves.

"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: EOC 1037	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Disruption of Service, Sewage

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

POLICY:

In the event that a stoppage occurs in any main sewer system of Kaweah Delta Health Care District, herein after referred to as Kaweah Health (KD), the following procedure will be implemented.

PROCEDURE:

Maintenance will notify affected departments and the Nursing Supervisor of the failure and the expected downtime.

Should sewage stoppage or disruption of service be unable to be repaired in a reasonable amount of time, maintenance will order portable toilets for patient, visitor and staff use.

The Nursing Supervisor shall decide if Code Triage or Code Triage Alert needs to be called, if patients and/or building occupants need to be relocated, and if cases need to be cancelled/rescheduled.

It may be necessary to shut off all water at the campus to keep sewage waste to a minimum. This decision will be made by Administration and the Director of Facility Operations or designee. See Policy #DM2216 for “Water Systems Failure/Disruption.”

"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: EOC 1039	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Failure of Air Conditioner

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

POLICY:

The Engineering Department, will take the necessary steps to correct any failures of essential equipment or major utilities

PROCEDURE:

Notify **a qualified vendor** when repair of the air conditioning system is beyond the scope of engineering staff. Consider utilizing fans or portable HVAC units to assist in cooling until repairs can be completed.

Notify the house supervisor and all departments that are affected. Tell them approximately how long repairs will take.

Follow unit specific procedures.

The Nursing Supervisor shall decide if Code Triage or Code Triage Alert needs to be called, if patients and/or building occupants need to be relocated.

Notify affected departments upon restoration of service.

"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: EOC 1044	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Disruption of Service, Telephone

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

PURPOSE: To assure that communication shall be maintained when telephone system interruptions occur throughout the district.

POLICY: The following action is to be taken in the event of a telephone system failure.

PROCEDURE: ISS with facilities assistance, if requested, will assess the failure and initiate repairs.

Communication

Telephone Downtime Procedures

In the event of a telephone system outage, using the Centrex lines call the ISS HelpDesk at 559-741-4741, and email the Helpdesk hd@kdhcd.org stating that the Cisco phones are down.

ISS and/or PBX will notify the House Supervisor of the telephone system outage via the house supervisor emergency pager at 559-501-0703.

The House Supervisor is to inform the Administrator on Call (AOC) and will determine if it becomes necessary to announce via PA system if able or via district urgent “the Telephone System is down, utilize downtime Centrex phones”.

A. DEPARTMENT RESPONSIBILITIES:

A. PBX:

In the event of a Code, any department may, on a downtime Centrex phone dial 559-731-5230 for the PBX Operator. The appropriate code team will be paged overhead if able, called over the radio, or paged by paging system.

For the Code Triage response by PBX refer to HICS procedures.

B. Telecommunications

1. Downtime Centrex phones shall become the primary mode of communication during the phone system downtime. District departments have been provided red phones. (Attachment A-Centrex phone list)

C. ISS

1. Cell phones shall become the secondary mode of communication during the phone system downtime for those departments possessing them.
2. Upon phone system downtime ISS will distribute cell phones and two way radios to departments (Attachment B- Cell phone list)

II. NURSING RESPONSIBILITIES

A. All Patients will be informed of telephone outage and reassured of stability and status of repairs as necessary or as directed by the house supervisor or AOC. If Nurse Call System is involved, refer to Policy EOC 1043.

"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."

Emergency Analog Lines-Attachment A

Location	Number
2N	635-4196
2S	635-4191
ICU	635-4198
3N	635-4192
3S	636-3640
3W	635-4094
4S	635-4193
4N	635-4197
BP	635-4195
PEDS	635-4194
3T	635-6154
MB	635-4172
4T	635-6155
PBX	624-7844
Pharmacy	741-4818
Lab	TBD
Radiology	TBD
ISS	TBD
L&D	TBD
NICU	TBD

Downtime Cell Phone List – Attachment
Emergency Phone List - Attachment

Kaweah Health afety Officer/Life Safety Mgr)	Date Created: 04/01/2010 Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Ergonomics

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

POLICY: Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) has adopted this ergonomics program to minimize repetitive motion injuries (RMI's) through (A) Worksite Evaluations, (B) adoption of control measures and (C) training of employees in a manner consistent with Title 8 CCR 5110.

DEFINITIONS:

1. "RMI's" are musculoskeletal injuries resulting from a job, process, or operation of identical work activity which have been the predominant cause of objectively identified and diagnosed musculoskeletal RMI's to more than one employee reported within a twelve-month period. The identification and diagnosis of a RMI must be performed by a licensed physician.
2. "Identical Work Activity" means the employees were performing the same repetitive motion tasks, such as, but not limited to, word processing.
3. "Potentially Exposed Employee" is an employee working a job, process or operation of identical work activities in which more than one RMI has been reported within a twelve-month period.
4. "Predominant cause" means that 50% or more of the injury was caused by a repetitive job, process or operation of identical work activity.

PROCEDURE:

A. Worksite Evaluations:

1. Where more than one RMI is reported as defined below, a representative number of the applicable job, process, or operation of identical work activity will be evaluated.
2. Employee Health Services will maintain a list of all jobs, processes and operations, which have been evaluated.
3. The evaluation identifies potential exposures and suggests the methods Kaweah Health can use to control or minimize these exposures.
4. Potentially exposed employees will be informed of the potential exposures and trained in Kaweah Health's control measures.

B. Control of Exposures Which Have Caused RMI's.

1. It is Kaweah Health's policy to timely correct exposures that have caused RMI's or if the exposure is not capable of being corrected, it is Kaweah Health's policy to minimize the exposure ***t***o the extent feasible**.**

2. It is Kaweah Health's policy to consider the following engineering and administrative controls in determining how to correct or minimize exposures:

Engineering Controls	*Administrative Control*
- workstation redesign	- job rotation
- adjustable fixtures	- work pacing
- tool redesign	- alternative work breaks

Kaweah Health may also consider other reasonable, cost effective engineering or administrative controls.

3. If engineering and administrative controls cannot reasonably correct or minimize exposures to the extent feasible, Kaweah Health will consider minimizing exposure through the use of personal protective equipment.

C. Training.

1. *Scope of Training.* Employees (including managers and supervisors are provided with training that includes an explanation of:
   a. The ergonomics program.
   b. Exposures, which have been associated with RMI's.
   c. The symptoms and consequences of injuries caused by repetitive motion.
   d. The importance of reporting symptoms and injuries to the employer.
   e. The methods used by the District to minimize RMI's.

2. *Timing and frequency of training.* Training is provided to potentially affected employees as follows:
   a. Initial training is provided as part of the establishment of the ergonomics program.
   b. Upon completion of a worksite evaluation which identifies exposures which may have caused RMI's.
   c. To all new potentially exposed employees.
   d. To all potentially exposed employees given new job assignments for which training has not previously been received.
   e. Annually for potentially exposed employees.
   In addition, general ergonomics awareness training is provided to all employees upon hire and annually.

D. *Employee Reporting Obligations.* All employees are required to report to manager/supervisor and Employee Health Service. All RMI's which have been objectively identified and diagnosed by a licensed physician which are suspected

of being 50% or more caused by a job, process or operation within Kaweah Health will then be handled as above in A, B, C.

All employees are encouraged to report all suspected RMI's or RMI symptoms or ergonomic concerns in a timely manner in Orientation and in Department meetings.

"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: EOC 4010	Date Created: 09/01/2014
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

RCRA Disposal of Hazardous Waste

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

RCRA Disposal of Hazardous Waste and Soft Trace Chemotherapy PPE Waste Resource Conservation and Recovery Act

I. General

1. Purpose

To ensure that Pharmaceutical Wastes, classified as hazardous waste under the federal Resource Conservation and Recovery Act (RCRA), including chemotherapy/biotherapy wastes, are stored, handled, packaged, transported and disposed of in accordance with all federal, state and local government regulations.

2. Responsibilities:

A. Staff: Personnel, providers and volunteers participate in training and adhere to all defined roles and responsibilities as outlined in this policy and procedure.

B. Safety Committee: Responsible for the review and approval of this policy and procedure.

C. Department Managers and Supervisors: Responsible for ensuring that all staff are knowledgeable and adhere to their roles and responsibilities as defined in this policy and procedure.

II. Policy

1. General

A. All items which come in contact with hazardous drugs during preparation or administration should be treated as hazardous waste and be discarded in a DESIGNATED container.

B. The items include needles, syringes, empty drug vials/ampoules, IV tubing, IV bags and bottles, IV connecting devices, alcohol wipes, Chemotherapy PPE (gowns, gloves, masks) and leak proof drapes and /or pads.

C. Barium contrast not used for its intended purpose must be discarded as RCRA waste. Barium removed from a patient is considered bio-hazardous waste and should not be placed in the RCRA container.

III. Definitions

1. Hazardous Drugs (HD): Drugs that are capable of causing toxicity to personnel and others who come in contact with them. Hazardous drugs pose

a potential health risk to personnel who prepare, handle, administer and dispose of these drugs.

2. Drugs may be classified as hazardous when they possess any one of the following characteristics.
    A. Genotoxicity
    B. Carcinogenicity
    C. Teratogenicity
    D. Reproductive toxicity
    E. Organ toxicity at low doses
    F. Structure and toxicity profiles of new drugs mimic existing drugs determined to be hazardous by the above criteria.
3. Potential exposure routes to hazardous drugs may occur through inhalation, skin contact, skin absorption, ingestion or injection.
4. National Institute for Occupational Safety and health (NIOSH) Alert, Centers for Disease Control and Prevention:
    A. NIOSH alert was revised in 2004. The purpose of the document is to increase awareness among health care workers and their employers about the health risks posed by working with hazardous drugs and to provide them with measure for protecting their health.
5. RCRA hazardous Waste:
    A. Resource Conservation and Recovery Act. California regulations are more stringent than federal regulations and impact pharmaceutical waste management.
    All pharmaceutical waste that meets the definition of federal hazardous waste (RCRA) must be managed as such and is under the jurisdiction of Cal/EPA Department of Toxic Substances Control (DTSC). A pharmaceutical waste that is federally non-hazardous but meets the expanded definition of a hazardous waste in California is considered a “California only hazardous waste” and must be managed under the Medical Waste Management Act.
6. Regulatory bodies that oversee pharmaceutical waste management are:
    A. Environmental Protection Agency (EPA)
    B. Department of Transportation (DOT)
    C. Drug Enforcement Agency)DEA)
    D. Occupational Safety and Health Administration (OSHA)
    E. California Department of Public Health (CDPH)
    F. California State Pharmacy Boards
    G. Local Publically Owned Treatment Works (POTW)
    H. Department of Toxic Substance Control (DTSC)
7. RCRA hazardous waste is divided into the following categories:
    A. Listed waste
    P – Listed chemicals (acutely hazardous)
    U – Listed chemicals (toxic)
    B. Characteristic waste:
    Ignitability
    Corrosivity
    Reactivity

Toxicity

C. D-Listed (Characteristics toxicity)

IV. Procedure

1. The following medications must be discarded in black RCRA containers:
   A. Hexachlorophene (Phisohex)
   B. Insulin (E.g. insulin pens and vials)
   C. Nicotine (e.g. patches, gum, lozenges)
   D. Nitroglycerin 50 mg/ml INJ ONLY
   E. Phenol (e.g. Choraseptic spray)
   F. Phentermine
   G. Physostigmine
   H. Warfarin
   I. Aerosol Propellants (pressurized containers)
   J. Alcohol-containing products .=24% (Dehydrated alcohol injection, Ethyl alcohol for compounding, Benzoin compound, Isopropyl alcohol, Avagard hand sanitizer, green soap, Guaic(Hemocult developer (75%), any other product containing .=24%.
   K. ALL Chemotherapy Drugs and biotherapy drugs and their immediate containers, vial, bag, bottle, medicine cup full, partially empty or empty and associated PPE and spill kit contents.
   L. Selenium-containing products
   M. Silver-containing products (Silver nitrate sticks, Silver Sulfadiazine)
   N. Trace elements/minerals (cadmium, chromium, selenium found in multi-vitamins and with minerals and multi-trace 4).
   O. Health metals (Barium Sulfate used in Radiology).
2. RCRA containers will be placed in all departments that utilize pharmaceuticals considered hazardous under the Resource Conservation and Recovery Act (RCRA). The size of the RCRA container will depend on the anticipated amount of waste.
3. Write the start date and the name of the department, using a Sharpie, on the lid of the RCRA container. This ensures that the RCRA container will be disposed of within the 120 day limit.
4. RCRA hazardous waste should be placed in the black RCRA containers located in the designated areas. The lid to the container should be kept closed except when placing an item into the container. The largest section of the lid should be in the locked position. Listen for the clicks that indicate it is locked.
5. Chemotherapy and biotherapy: Bags/bottles with attached IV tubing and connection, IV piggyback bags with attached tubing and connections should be placed in chemotherapy zip lock bags before disposal into the RCRA containers.
6. Chemotherapy and Biotherapy pill containers, medicine cups, pack again and all other items that come into contact with the hazardous drugs such as gauze, alcohol wipes, paper drapes and pads should be placed in chemotherapy zip lock bags and placed in the black RCRA containers.
7. Other RCRA waste can be placed directly into the RCRA container.

8. Spills will be handled according to the KDHCD Hazardous Material Policy and procedure. Chemotherapy spill items-items that have become contaminated by chemotherapy/biotherapy such as PPE, linens, patient gowns, mop heads, used for spill clean-up should be placed in the RCRA container after being placed in a yellow chemotherapy waste bag.
9. When RCRA container is ¾ full, lock it down and notify Housekeeping to schedule it to be transported to the designated hazardous waste holding area. Housekeeping staff will remove locked containers from the department and place in a storage area designated for hazardous waste.
10. A Hazardous Materials Management Company will pick up and properly dispose of RCRA waste as needed from the designated hazardous waste holding area.

"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."

Kaweah Delta Health Care District

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 5020	**Date Created: 05/04/2007**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Interim Life Safety Measure Plan	

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

I PURPOSE

The hospital shall ensure the appropriate management of all areas in which new construction, renovations, significant repairs or other activities conditions result in impairments of the life safety systems and any deficiencies identified through the PFI (Plan for Improvement) process by providing for the appropriate evaluation for, and implementation of Interim Life Safety Measures (ILSMs) to minimize or eliminate those risks. In those cases in which the organization implements ILSMs, failure to adhere to implemented measures will result in immediate cessation of work.

II SCOPE

This program applies to all Kaweah Health (KH) locations, including off-site facilities. (This standard does not apply to facilities classified as business occupancy by the Life Safety Code). The evaluation for ILSMs is required for all construction, repair, renovation or maintenance activities that can or do result in the impairment of any life safety system. Appropriate Measures will be implemented based on that evaluation.

IIIRESPONSIBILITY

The Safety Officer, in collaboration with the Director of Facilities, is responsible for managing the Interim Life Safety Measures program.

The Safety Officer, Director of Facilities and the Facilities Construction Manager coordinate the risk assessment for construction, renovation and other activities and serve as the interpreting authorities relative to the need and scope of Interim Life Safety Measures implementation. These individuals, in collaboration with appropriate regulatory authorities and others, as applicable, will determine what, if any, Interim Life Safety Measures are necessary to compensate for any life safety conditions found to be deficient as the result of any event or activity, including surveillance, maintenance, construction and renovation activities.

The Safety Officer, Director of Facilities and the Facilities Construction Manager share the primary responsibility for ensuring compliance, providing ongoing monitoring of performance, and enforcement of all implemented Interim Life Safety Measures.

The Safety Officer is responsible for communicating the findings to appropriate managers, staff, contractors, and senior leaders. In addition, the Safety Officer, in concert with the Director of Facilities and Facilities Construction Manager, is responsible for monitoring implementation of the ILSM and taking action when they are not being observed.

The schedule of monitoring and documentation is determined on a per project basis. The Safety Officer is responsible for maintaining all ILSM documentation from the onset through elimination of the deficiencies. In the event of ILSM program implementation, regular reports of ILSM program performance are submitted to the EOC Committee.

Security staff will be responsible for conducting rounds and other related activities (fire watches, etc.) as necessary, including off-shifts and weekends.

IV PROCEDURE

Assessment:

A hazard-specific risk assessment process is used to evaluate each situation or condition to determine if the degree of deficiency warrants ILSM and what specific measures are required to appropriately manage the effects of the deficiency. The ILSM Data Collection Tool is used to review deficient conditions or the potential thereof, and then to identify an appropriate slate of ILSMs for implementation

The evaluation includes consideration of:

- Construction design and work practices and whether unobstructed egress can be maintained. KH will provide alternate routes for public access if work affects normal access routes. All appropriate staff will receive education regarding alternative / altered egress routes if they are designated.

- Temporary partitions and whether their construction appropriately complies with requirements for protection and non-combustibility.
- Temporary partitions and whether their construction appropriately protects adjacent and other areas from the infiltration of dust and/or smoke.
- Modifications to fire alarm, detection, and suppression systems and whether those modifications result in impairment to their appropriate operation. Before any of these systems are taken out of service, KH will identify and implement strategies and activities to compensate for the deficiencies. Facilities staff will undergo education, as appropriate, to provide support and oversight of those strategies and activities.
- Provision of additional fire-fighting equipment, including type, numbers, and placement to provide appropriate coverage / mitigation of deficient conditions. Should provision equipment exceed complement / type of equipment found in the Hospital, education will be provided to appropriate staff.
- Identification and implementation of strategies for maintaining construction and renovation spaces in an appropriate fashion. This includes consideration of hazardous storage (flammable liquids & gases), housekeeping, debris removal, noise levels, and access control. KH staff, as well as construction staff must pay particular attention to identifying penetrations in rated partitions and ensuring timely remediation of identified deficiencies.
- Appropriate programs of fire drills, hazard surveillance activities, and staff education programs to ensure all areas and persons affected by conditions are adequately prepared and provided sufficient oversight. The frequency and scope of these activities will be assessed and revised as conditions dictate.

Compliance, monitoring, and enforcement:

The authorities noted above, to ensure consistent compliance with all implemented Interim Life Safety Measures, will conduct surveillance rounds of applicable locations when indicated by the assessment, for the duration of implementation. In the event a determination is made that the conditions of any (or all) implemented ILSM are not met, actions to immediately resolve the resulting condition will be initiated.

A completed and signed ILSM assessment is appropriate documentation of compliance by KH with its Interim Life Safety Measures Plan and Process. Record copies of completed assessments will be maintained in the Safety Department.

ILSM Data Collection Tool

Project Name:	
Project Description (Brief):	
Estimated Start Date:	Estimated Completion Date:
Contractor:	
Contractor Representative(s):	
Hospital Representative(s):	

Life Safety Project Data (place a mark in the applicable box):

Will the project include general construction, renovation, or significant repairs within or immediately adjacent (connected) to an occupied building?		Yes		No	
If yes, document assessment of ILSM #1, 5, & 7					
Does the project involve the major renovation of an occupied floor or department?		Yes		No	
If yes, document assessment of ILSM # 1, 2, 5, 6, & 7					
Will the project result in the total or partial obstruction of an approved exit or egress path?		Yes		No	
If yes, document assessment of ILSM # 1, 5, 6, 7					
Will the project result in obstructed access to the Hospital by emergency services – fire, police, or other emergency forces?		Yes		No	
If yes, document assessment of ILSM # 2, 4					
Will the project result in the rerouting of emergency vehicles to the Emergency Department?		Yes		No	
If yes, document assessment of ILSM # 2, 4					
Does the project involve the significant modification of smoke and/or fire barrier walls?		Yes		No	
If yes, document assessment of ILSM # 1, 5, 7					
Does the project involve an addition to an existing structure?		Yes		No	
If yes, document assessment of ILSM # 2, 4, 7					
Does the project involve the replacement or impairment of the fire alarm, detection, or suppression system.		Yes		No	
Which systems?	Alarm	Detection	Suppression		
If yes, document assessment of ILSM # 1, 3, 4, 6, 7					
Will the project require implementation of temporary fire alarm, detection, or suppression system?		Yes		No	
If yes, document assessment of ILSM # 1, 3, 4, 6, 7					
Will the project require the use of temporary construction partitions for any reason (security, infection control, etc.)?		Yes		No	
If yes, document assessment of ILSM # 5, 7					

Will the project result in any of the following:									
Excavation		Yes		No	Construction Area(s)		Yes		No
Construction Storage		Yes		No	Field Offices		Yes		No
If yes, document assessment of ILSM # 1, 5, 7									
Will the project require disruption of the sprinkler system for < 4 hours?							Yes		No
If yes, document assessment of ILSM # 1, 3, 4, 5, 6, 7									
Will the project require disruption of the sprinkler system for > 24 hours?							Yes		No
If yes, document assessment of ILSM # 1, 3, 5, 6, 7 ILSM; #4 is mandatory									
Will the project result in any other Life Safety Code deficiencies? (Describe below)							Yes		No
Other Life Safety Code Deficiencies:									
If yes, document assessment of ILSM #									

A “yes” response to any of these questions automatically triggers an assessment for the implementation of Interim Life Safety Measures.

NB – Deficient conditions noted while project is under way may trigger an additional review of the project, including a reassessment for ILSM implementation.

Place a check mark in each applicable ILSM activity as determined by an assessment of the risks identified in the Project Data Collection tool.

#1 INSPECTIONS / SURVEILLANCE

- ☐ Increased surveillance of buildings, grounds, and equipment: shift / daily / other:
- ☐ Means of exiting construction areas inspected daily
- ☐ Implementation of Fire Watch
- ☐ Not applicable

#2 ACCESSIBILITY

- ☐ Maintenance of escape/egress routes from construction areas
- ☐ Maintenance of access to emergency services for emergency equipment, fire alarm pull stations, Fire Department connections (internal & external)
- ☐ Not applicable

#3 EQUIPMENT – LIFE SAFETY

- ☐ Temporary fire alarm, detection, suppression system in place
- ☐ Monthly testing and inspection of temporary
- ☐ Provide additional firefighting equipment in project area
- ☐ Provide additional firefighting equipment in adjacent areas
- ☐ Not applicable

#4 COMMUNICATIONS

- ☐ Notification of municipal Fire Department (or applicable emergency forces group)
- ☐ Not applicable

#5 CONSTRUCTION MATERIALS / PRACTICES

- ☐ Partitions smoke tight and constructed of noncombustible or limited combustible materials
- ☐ Prohibition of smoking throughout building and in and near construction areas
- ☐ Implement appropriate storage practices
- ☐ Implement appropriate housekeeping practices
- ☐ Implement appropriate debris removal practices
- ☐ Not applicable

#6 FIRE DRILLS

- ☐ 2 fire drills per shift per quarter throughout Hospital (one additional drill beyond requirement of EC.5.30).
- ☐ 2 fire drills per shift per quarter in areas adjacent to project (one additional drill beyond requirement of EC.5.30)
- ☐ >2 fire drills per shift per quarter throughout Hospital. If yes, how many
- ☐ >2 fire drills per shift per quarter in areas adjacent to project. If yes, how many
- ☐ Not applicable

#7 TRAINING

- ☐ Additional training for staff in immediate area
- ☐ Additional training for staff throughout hospital
- ☐ Additional training for incident response team
- ☐ Training to promote awareness of fire-safety building deficiencies, construction hazards, ILSM
- ☐ Training on changes in physical environment (egress routes)
- ☐ Training on firefighting equipment
- ☐ Training on compensating for impaired structural or compartmentalization features of fire safety
- ☐ Not applicable

Interim Life Safety Measures Assessment Summary

Date: _____

Project: _____

_____

Building location: _____ Floor: _____Rooms: _____

Project safety coordinator: _____

Title: _____

General contractor: _____

Estimated construction start date: _____

Estimated construction completion date: _____

Implementation checklist:	
☐	Review the scope of the construction or renovation project for actions required by the ILSM assessment.
☐	Notify the general contractor of his or her responsibilities regarding ILSMs.
☐	Notify the maintenance/facilities department about potential shutdowns of fire alarms, sprinkler systems, smoke detector systems, etc. Prior to modifications that necessitate shutdowns, implement the necessary ILSMs to provide equivalent system protection. The safety and security department will coordinate the scheduling of fire drills as appropriate.
☐	Develop a plan and train appropriate hospital staff and construction personnel on ILSMs
☐	Regularly inspect and report on the construction site regarding ILSMs (see the ILSM checklist and fire watch documentation).
Note: If the above construction project does not warrant implementation of ILSMs, indicate the reasons below:	
Project Safety Coordinator:	

INTERIM LIFE SAFETY MONITORING

Date of Survey	
Inspector	
Area Surveyed	
Project Number	
Project Name	
Date Safety was Notified of the Project	

		YES	NO	N/A
A.	**EXITS**			
1.	Do exits provide free and unobstructed egress?			
2.	Did personnel receive training for alternative exits?			
3.	Are means of egress in construction area inspected daily?			
4.	Is there free and unobstructed access to Emergency Department/Services and for emergency forces?			
B.	**FIRE EQUIPMENT**			
1.	Are fire alarms, detection, and suppression systems in an operational function?			
2.	Are fire alarms, detection and suppression systems impaired?			
3.	Have temporary fire alarm, detection, and suppression systems been inspected and tested monthly.			
4.	Have training and additional fire equipment been provided for personnel?			
C.	**FIRE SYSTEMS**			
1.	Power properly secured at the end of each workday?			
2.	Has the no smoking policy been implemented in adjacent to the construction areas?			
3.	Are construction areas free of storage and housekeeping materials, food, food waste, and debris for daily operations to reduce flammable and combustible fire load of the building?			
4.	Has there been a minimum of two fire drills conducted per shift per quarter?			
5.	Has hazard surveillance in construction area been inspected daily?			
6.	Have safety education programs been conducted to ensure awareness of any Interim Life Safety Measures Life Safety Code deficiencies and construction hazards?			
D.	**GENERAL SAFETY**			
1.	Is power properly secured at the end of each workday?			
2.	Are hand and safety rails in place and in good condition?			
3.	Are extension cords grounded and in good condition?			
4.	Are power tools in good condition?			

5. Are hard hats used regularly?			
6. Are cutting and welding operations properly conducted?			
7. Are new employees instructed in Right-To-Know regulations?			
8. Do fire watch personnel receive appropriate training?			
9. Are all construction activities conducted in a safe manner?			
10. Does all scaffolding comply with OSHA requirements (1926.421)?			
11. Are employees trained in fall hazards in work areas near roof edge?			
E. INFECTION CONTROL			
1. No construction activity takes place within 25 feet of existing fresh air intakes?			
2. Materials used (i.e., fire retardants) comply with necessary safety regulations?			
3. Monitoring of impervious construction barriers to verify negative pressure?			
4. Demonstrated compliance with traffic patterns?			
5. Demonstrated compliance with appropriate use of cover garbs when outside construction area?			
6. Demonstrated use of appropriate equipment to prevent airborne particulate matter/debris; this includes HEPA filtration units, HEPA vacuum equipment, and continuous use of exhaust fans?			
7. Ducts remain sealed/capped?			
8. Doors are closed and gaskets/hardware are intact?			
9. Methods of debris transport are monitored and found to be consistent with process designed to minimize airborne particulate matter/debris?			
10. All windows and doors remain closed to prevent circulation of dust/debris?			
11. Carpet or adhesive strips are clean and available at doorways for shoe dust collection?			
12. Areas are found to be cleaned at the end of each day?			
13. No signs of water leakage?			
14. No signs of pests?			

Comments: (Corrective Action for "No" responses)

"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: EOC 5021	**Date Created: 12/01/2013**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Infection Control Risk Assessment

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

SUBJECT: Infection Control Risk Assessment (ICRA) for Construction, Maintenance and Repair Projects

PURPOSE:

To prevent transmission of infectious agents to vulnerable patient populations, health care workers and visitors during construction/renovation and repairs.

BACKGROUND:

A. Applicable state and local jurisdictions having authority over the work. The Facilities Guideline Institute (FGI) "Guidelines for Design and Construction of Health Care Facilities," and the APIC State of the Art Report: Role of Infection Control during Construction in Health Care Facilities (APIC, 2000) will be used as a resource when designing and planning for construction activities.

B. Preventing environmental dispersal of microorganisms during construction (i.e., Aspergillus, Legionella, Streptococcus, etc.) resulting in health care-associated infections (HAIs) has been described in scientific research and is the basis of this policy.

C. Guidelines strongly support Infection Prevention's consultation and input early in the conceptual stage, throughout and after completion of the construction project.

D. Infection Prevention provides epidemiological leadership throughout the project by the completion of an Infection Control Risk Assessment (ICRA).

E. The ICRA provides for strategic and proactive design to mitigate environmental sources of microbes and for prevention of infection through architectural design as well as specific needs of the population served at Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH).

POLICY:

A. Infection Prevention will be included in all discussions involving facility-wide projects and will work within the confines of the Facilities Construction Policy and the ICRA process.

B. A proactive (ICRA) for infection control hazard identification will be completed prior to any construction, renovation or repairs project conducted within KDHCD (see Attachment B).

C. An ICRA will be completed on all classes of risk (II-IV)
D. Note: Critical emergent repairs may be conducted on an emergency basis (adhering to risk/dust mitigating strategies) with IP consultation as soon as possible after the event.
E. Facilities construction crews (in-house or outside contractors) will follow the recommendations posted on the ICRA throughout the project.

ROLES:

A. Facilities

1. Facilities Planning Director is responsible for the planning, design and supervision of all "construction" projects.
2. Director of Facilities plans and supervises all maintenance and repair projects.
3. Notifies the Infection Preventionist before the start of every project and will work with IP team on all projects requiring infection prevention policy implementation.
4. Shall assure all staff follow the recommendations of the ICRA.
5. Shall receive education and training regarding Infection Control and Construction. Education will be documented in the employees file (See Attachments E and F).
6. Monitors air ducts, windows and air filters adjacent to the work site and changes as needed.
7. Coordinates interventions in remediation of environmental emergencies.

B. Infection Preventionist

1. Infection Preventionist provides leadership and consultation initially and through broad and long range involvement in the project.
2. Partners with Facilities, architects and contractors during design and pre-construction.
3. Serves as a resource during all phases of construction and in remediation of environmental emergencies or outbreaks associated with construction.
4. The IP Manager (or designee) has the authority to stop the project should it be deemed unsafe to continue due to potential patient/staff risk of contamination.

C. Outside Contractors

1. Construction Companies shall be responsible for instituting and implementing all required recommendations as per the ICRA.
2. Will be given an educational packet and are required to return the packet with evidence all potential workers have completed the training.
3. Documentation of education will be maintained by Facilities (See Attachments E and F).Contractor/worker badges will not be issued without the required documentation.

PROCESS/IMPLEMENTATION (See Attachment A)

A. A construction project is identified. Infection Prevention may be notified in one of two methods:
   1. Infection Prevention is notified via the Facilities Project Team for advanced planning.

a. Pre-bid Infection Control Risk Assessment (ICRA) is completed by the Infection Preventionist (IP), if appropriate (See ICRA Attachment B).
b. When the project is ready to start, the final ICRA is completed by the IP.

2. Infection Prevention is notified by Facilities of unplanned project.
a. An ICRA request form is submitted to IP no later than 48 hours prior to the project start date.
b. (ICRA) is completed by the IP (See ICRA Attachment B).

B. The project is ready to start.

C. Facilities assures construction crew is educated about Infection Prevention construction risk strategies (See attachments E-F)

D. Facilities assists/assures appropriate IP barriers are placed by construction crews.

E. After placement, IP or IP designee inspects barriers/precautions , as specified on ICRA. IP authorizes/signs the ICRA for posting in construction area prior to start.

F. Construction crew starts project using appropriate IP strategies as per ICRA until project is completed.

G. Facilities monitors staff to assure all appropriate strategies are being employed during project.

H. Infection Prevention spot checks for compliance and use of appropriate barriers/strategies (See Monitoring Form Attachment C).

I. When project is completed, a post-construction walk through is performed by Facilities, EVS and IP, as specified on ICRA, to assure project is ready to be released (See Checklist Attachment D).

GUIDELINES:

A. Infection Prevention may identify the following hazards/risks and mitigating strategies related to the project:

1. <u>Hazards with internal construction</u>
a. Dissemination of dust/debris which may carry microorganisms (especially Aspergillus).
b. Contamination of clean/sterile patient care surfaces, supplies, equipment.
c. Accumulation on ventilation system filter; results in decreased filtration and airflow.

2. <u>Hazards of utility interruption during construction/renovation</u>
a. Lack of potable water for drinking, food preparation.
b. Lack of water for hand washing, patient bathing, hand/skin scrubs of invasive procedures, patient procedures.
c. Affect on water quality with resumption of service.
d. Affects upstream and downstream when there is an interruption of ventilation.

3. <u>Corrective Action and Containment Measures</u>

a. Ventilation:
1) Airflow in the construction site will not be re-circulated (if possible). Use a HEPA filtration unit as specified on the ICRA.

and create negative flow until completion of the project. Air must flow from clean to dirty areas.

2) External construction: external windows will be sealed to minimize infiltration from excavation debris. Ventilation media filters adjacent to the construction site will be changed as indicated. The filters will be bagged and sealed before being transported out of the area.
3) Air supply and return vents are to be sealed, if indicated.

b. Barriers:
1) Barriers shall be constructed as mandated by the permitting agency having jurisdiction over the project and be in compliance with the infection prevention policy.
2) Project must be completely contained by impervious barriers.
3) Barriers will extend from the floor, beyond the false ceiling, to the underside of the floor above as appropriate and must be fire rated.
4) Closed doors with tape over the frames and doors are acceptable for projects contained within a single room.
5) Walk off mats (or other pre-determined suitable means i.e. wet blanket) are to be utilized at the entrance and exit of the construction site. Walk off mats are changed at least daily or as necessary and when no longer effective.

c. Environmental Considerations:
1) HEPA filtered vacuum and damp mopping will be utilized for dust control.
2) Thorough cleaning is to be conducted at the completion of the project and prior to occupancy.
3) Environmental cleaning frequency around the project site will be evaluated and increased accordingly.
4) Tools and equipment will be damp wiped before entry and exit from the work areas.

d. Construction Traffic / Transport Material:
1) Route for work site entrance and exit for personnel, delivery, and debris removal shall be predetermined and specified on the ICRA.
2) Traffic will be routed away from patient flow as much as possible.
3) Debris transport requires use of clean, tight fitting covered containers.

e. Miscellaneous considerations:
1) HEPA filtration may be necessary when penetration of ceiling and walls occur or when project is near patients susceptible to airborne contaminants.

2) Dust accumulation may indicate the need to change the HVAC (air handling equipment) filters and an increase in the frequency of changes may be indicated.
3) Vibration/disturbances due to drilling and other sources of vibration have potential to dislodge dust collected above suspended ceilings and loosen corrosion within water pipes, as well. Affected areas must be vacuumed and debris flushed from water systems before re-occupancy.
4) When possible, schedule interruptions for low activity time periods (nights, weekends).

4. Worksite Garb

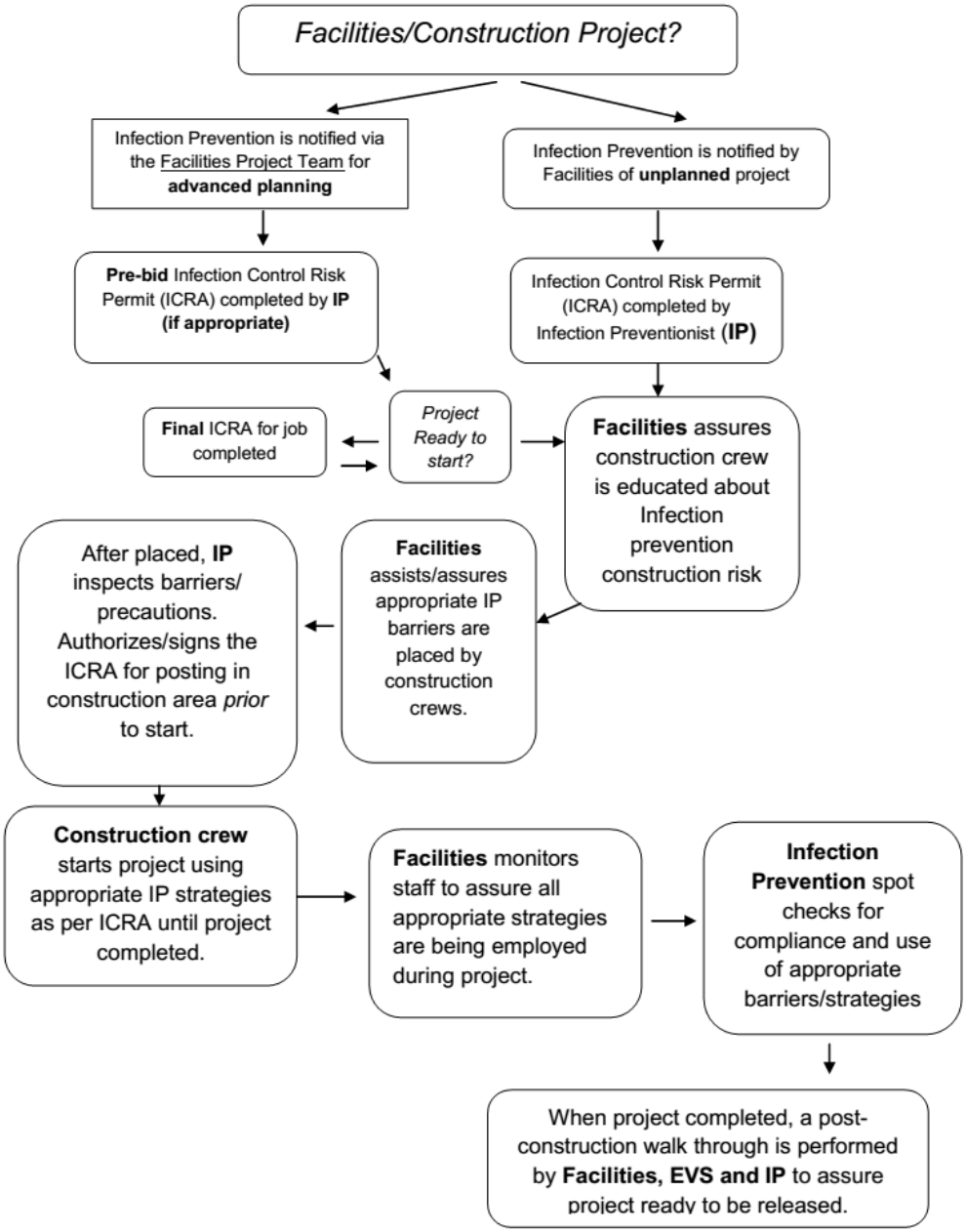
a. Worker personnel clothing will be free of loose soil and debris before leaving the construction area.
b. If protective apparel is not worn, a HEPA-filtered vacuum will be used to remove dust from clothing before leaving the barricade.
c. Personal protective equipment is worn as appropriate/indicated.
d. Workers entering certain procedure areas shall be provided with disposable jump suits, head and shoe covers.
e. Protective clothing will be removed before exiting the work area.

5. Impact on Special Areas

Immuno-suppressed populations require special planning. Patients will be located in areas as remote as possible from construction activities, including but not limited to CVICU, ICU, Oncology, Dialysis, ED and NICU

See Attachments A-F Attachment A

Kaweah Delta Local Healthcare District
Infection Prevention Role in Construction
Flow Diagram



Attachment B

KAWEAH DELTA HEALTHCARE DISTRICT INFECTION CONTROL RISK ASSESSMENT PERMIT (ICRA)

Location of Construction:	ICRA #:	Project Start Date:	Estimated Duration:
Project Coordinator:		Contractor Performing Work:	
Contact Number:		Contact Number:	
RISK ASSESSMENT (SEE PAGE 2)	Completed By:	Date:	

Construction Activity Type		Infection Prevention Risk Group		Recommendations	
	TYPE A: Inspection, non-invasive activities		GROUP 1: Low Risk		CLASS I
	TYPE B: Small scale, short duration which create minimal dust.		GROUP 2: Medium Risk		CLASS II
	TYPE C: Work generating moderate to high level of dust or requires Modifications to Fixed Building Components or Assemblies.		GROUP 3: Medium to High Risk		CLASS III
	TYPE D: Major Demolition or Construction Projects.		GROUP 4: Highest Risk		CLASS IV

RECOMMENDATIONS

	DURING PROJECT	UPON PROJECT COMPLETION
CLASS I	1. Execute work by methods to minimize raising dust from construction operations. 2. Immediately replace ceiling tile following inspection.	Notify Infection Prevention for final walkthrough after terminal cleaning of construction site is complete.
CLASS II	1. Provide active means to prevent dust from dispersing into atmosphere. 2. Water-mist work surfaces to control dust while cutting. 3. Use a dust containment unit working section to section of conduit and ceiling tile removal. 4. Place dust mats at entrance / exit of work area. 5. Remove or isolate HVAC system in work area. 6. Cover construction waste in containers before transport.	1. Wipe work surfaces with hospital disinfectant. 2. Vacuum work area with HEPA filter. 3. Wet mop with disinfectant. 4. Remove isolation of HVAC system.
CLASS III	1. Remove or isolate HVAC system in work area. 2. Install appropriate barriers (i.e. sheetrock, plywood, plastic) to seal area from non-work areas. 3. Maintain negative pressure within work site utilizing HEPA equipped air filtration units. 4. Cover construction waste in containers before transport. 5. Provide adhesive walk-off mats at entrance to work area. Replace as necessary. 6. Notify Infection Prevention Dept, or IP Designee for final inspection prior to start of construction.	1. Do not remove barriers until completed project is inspected and thoroughly cleaned by Environmental Services. 2. Remove barrier materials carefully to minimize spreading of dirt and debris. 3. Vacuum work area with HEPA filter. 4. Wet mop with disinfectant. 5. Remove isolation of HVAC system in work area. 6. Notify Infection Prevention Dept., or IP Designee for final walk through after terminal cleaning of construction site is complete.
CLASS IV	1. Remove or isolate HVAC system in work area. 2. Initially install plastic barriers followed semi-permanent barrier (i.e. sheetrock, or plywood) to seal area from non-work areas. 3. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 4. Seal holes, pipes, conduits, and punctures appropriately. 5. Cover construction waste in containers before transport. 6. Provide adhesive walk-off mats at entrance to work area within anteroom. Replace as necessary. 7. Personnel entering work area required to wear shoe covers. Covers must be changed each time worker exits area. 8. Personnel must wear cloth or paper coveralls that must be removed each time they leave the work area. 9. Notify Infection Prevention Dept., or IP Designee for final inspection prior to start of construction.	1. Do not remove barriers until completed project is inspected and thoroughly cleaned by Environmental Services. 2. Remove barrier materials carefully to minimize spreading of dirt and debris. 3. Vacuum work area with HEPA filter. 4. Wet mop with disinfectant. 5. Remove isolation of HVAC system in work area. 6. Notify Infection Prevention Dept., or IP Designee for final walk through after terminal cleaning of construction site is complete.

Date:	Initials:	Exceptions/Additions to this permit are noted by attached memoranda.
Permit Requested By:		Permit Authorized By:

Laminated ICRA will be posted at all entrances to the construction site.

CONSTRUCTION ACTIVITY TYPES:

TYPE A	Inspection & Non-Invasive Activities: • Removal of ceiling tiles for visual inspection. Painting without sanding. Activities that do not require cutting of walls or access to ceilings other than for visual inspection. Drilling holes in the wall that are ½ inch in diameter or less.
TYPE B	Small Scale, Short Duration Activities Which Create Minimal Dust: • Installation of telephone and computer cabling. Access to chase spaces and Cutting walls or ceiling where dust migration can be controlled.
TYPE C	Work Generating Moderate to High Level of Dust or Requires Modifications to Fixed Building Components or Assemblies: • Sanding of walls. Removal of floor coverings, ceiling tiles, or casework. Minor duct work or electrical work above ceilings. Major cabling activities. Activity beyond a single work-shift.
TYPE D	Major Demolition or Construction Projects: • Activities requiring multiple work shifts. New Construction. Heavy Demolition. Removal of a complete cabling system.

INFECTION PREVENTION RISK GROUPS:

roup 1 Low Risk	Group 2 Medium Risk	Group 3 Medium to High Risk	Group 4 High Risk
Office areas Public areas: corridors, waiting rooms, stairwells, lobbies, etc	• Noninvasive Cardiology • Nuclear Medicine • Physical Therapy • Radiology • Respiratory Therapy • Linen Storage • Admitting • Outpatient Ambulatory Clinics • Mental Health • Laundry Facilities	• Emergency Room • Labor & Delivery • Post Anesthesia Care Units • Pediatrics • Newborn Nurseries • Renal patients • Day Surgery • Cafeteria / Food Services • Endoscopy • Pharmacy • Medical / Surgical Units • Clinical Laboratories • Oncology • Bronchoscopy • SNF/Rehab	• Operating Rooms • Labor and Delivery Operating Rooms • Cardiac Cath Lab • Dialysis • Anesthesia • Intensive Care Units • Any Area Caring for Immuno-compromised Patients • Central Sterile Supply • Negative Pressure Rooms • Interventional Radiology Lab • ICCU/Telemetry • NICU • Sterile Pharmacy Rooms

CONSTRUCTION ACTIVITY – INFECTION PREVENTION MATRIX

An Infection Prevention Permit will be required when the Construction Activity and Risk Level indicate a Class II – Class IV.

CONSTRUCTION ACTIVITY RISK LEVEL ↓	TYPE A	TYPE B	TYPE C	TYPE D
GROUP 1	I	II	II	III / IV
GROUP 2	I	II	III	IV
GROUP 3	I	III	III / IV	IV
GROUP 4	III	III	III / IV	IV

Laminated ICRA will be posted at all entrances to the construction site.

Attachment C

Kaweah Delta Infection Prevention ICRA Rounds

ICRA CLASS	ICRA #	Area Surveyed	ICRA Recommendations Followed	General Observations (Address Fall Outs)
			Barrier Intact:______________________ Negative Press. With HEPA__________ Walk off Mats_____________________ Construction Waste Handled Correct__ HVAC Isolation in Place_____________ Other ____________________________	
			Barrier Intact:______________________ Negative Press. With HEPA________ Walk off Mats_____________________ Construction Waste Handled Correct__ HVAC Isolation in Place_____________ Other ____________________________	
			Barrier Intact:______________________ Negative Press. With HEPA_________ Walk off Mats_____________________ Construction Waste Handled Correct__ HVAC Isolation in Place__________ Other ____________________________	
			Barrier Intact:______________________ Negative Press. With HEPA__________ Walk off Mats_____________________ Construction Waste Handled Correct__ HVAC Isolation in Place_____________ Other ____________________________	
			Barrier Intact:______________________ Negative Press. With HEPA__________ Walk off Mats___________________ Construction Waste Handled Correct__	

			HVAC Isolation in Place_____ Other _____	

Attachment D

Kaweah Delta Health Care District

Infection Prevention
Post-Construction
Walk-through

Location:

Date/Time:

Scope of Work:

Inspection Team:

Item	Met Expectations Yes/No	Comments
All work completed		
Environment clean (bathroom, floors, windows, screens, window coverings, etc.). Terminal Clean.		
All patient equipment cleaned and without dust.		
Patient bed cleaned-clean linen		
All barriers removed		
Cleaning and replacement of filters and other equipment if affected by major or minor disruptions or conditions that could have contaminated the air or water supply.		
All sinks, lights, toilets, etc. in working order.		

Area Released: Yes_____ No_____

Inspection Team:

1)_____

2)_____

3)_____

Attachment E

Kaweah Delta Healthcare District

INFECTION PREVENTION
FOR THE CONSTRUCTION WORKER CHECK-OFF LIST

Items needed before the Class:

- ☐ 1 Sign-in sheet and 1 packet for contractor
- ☐ 1 Construction DVD
- ☐ DVD "Building on the Plan: Infection Prevention for Construction Personnel"
- ☐ DVD Player
- ☐ Handouts
- ☐ Lesson Plan
- ☐ Class Sign-in

After Class:

- ☐ Return DVD and class sign-ins.
- ☐ Completed sign-in logs stored in Facilities.

Kaweah Health

CONTRACTORS/ PROCEDURE

The purpose of this module is to assure all construction workers understand the differences related to working in a hospital environment. The module consists of a short (8 minute) DVD entitled: Building on the Plan: Infection Control for the Construction Worker, as well as a lesson plan to be used by the contractor.

The contractor is responsible to assure all staff see the DVD and are knowledgeable about Infection Prevention issues in the hospital environment.

The contractor will be given the packet of information, will arrange classroom space though the KH Facilities Department (and/or can make their own arrangements outside).

The contractor will provide the following program to their construction workers (use of DVD and classroom time) *prior* to the start date of construction.

The contractor will assure all employees who will be on the KH premises complete the attached classroom sign-in form after the education.

The **completed** sign-in form and the DVD will be returned to Facilities. The sign-in form will be stored in the Facilities Department.

The Construction Crew will not receive name badges without proof of receiving education.

Content	Activity
1. Introduction Explain reason behind the concerns involving construction workers in the healthcare environment.	Introduce the subject to construction workers
Understanding the importance of Infection Prevention during construction. *WHY* is Infection Prevention in a hospital so important? • Recent studies have shown that construction presents a significant danger to immuno-compromised (high-risk) patients in a hospital. • 1.4 million people worldwide receive infections while in the hospital called *Nosocomial or Healthcare associated infection (HAI).* • There are many causes, but construction work in healthcare buildings is emerging **(first recognized in 1975 and then again in the 1980s – 1990s-taking note as a significant source of infection)** as a known risk for our high-risk patients, sometimes resulting in negative patient outcomes. Possibly 40% - 90% of those could get disease, which might be fatal. • Such infections are associated with aspergillosis-fungal spores, Cocci-Valley Fever (soil), TB by release in air, MRSA, bird droppings, Legionella (water), mold. • Arising from dust-environmental transmission routes of air, surface and water. • The best approach is to contain the dust/mold. • No longer “business as usual” for construction workers in hospitals. • Especially infrastructure repair and renovations in “aging” hospitals. • Mostly preventable! • Emphasize protecting patient, visitors and staff for cross-infection.	Contractor conducts class for construction workers
2. Introduce the movie: **Building on the plan: Infection Prevention for Construction Personnel.**	DVD (8 minutes) Show in English and/or Spanish

Attachment F

Kaweah Health

Construction Worker Education Program
Attendance Record

Program Title: Infection Control for Construction Workers

Instructor(s): Contractor: _____

Name of Construction Project: _____

Department Sponsoring: Facilities/Safety/IP

Instruction Methods (Lecture, Discussion, etc.) DVD: Building on the Plan. Refer to the Lesson Plan for IC Construction Workers.

Please Print
Please fill in all boxes

Last Name	First Name	Company Name

"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: EOC 6001	Date Created: 07/01/2009
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Medical Equipment Management Policy

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

I. OBJECTIVES

EC 02.04.01 – The hospital manages medical equipment risks.

The objectives of the Medical Equipment Management Policy (MEMP) govern Kaweah Health to provide an environment that works to ensure medical equipment is safe, reliable, properly maintained and efficiently used in the delivery of patient care. Specific goals of the MEMP include but are not limited to the following:

- Inventory Management Program
- Preventive Maintenance Program
- Corrective Maintenance Program
- Performance Indicators Reports
- Annual Evaluation of the Medical Equipment Management Plan (ME Plan)
- Equipment Selection and Review Process
- Contract Review and Financial Oversight

The MEMP is inclusive of the below listed policies and others and is defined as the Medical Equipment Management Plan (ME Plan):

- EOC 6002 Medical Equipment Defective Repairs Policy
- EOC 6004 Medical Equipment / Hazardous Device Notification and Recall Policy
- EOC 6009 District Safe Medical Device / Device Tracking and Reporting
- EOC 6018 Retirement and Deletion of Medical Equipment
- AP.60 Technology Assessment Process (Administrative Policy Manual)
- AP41 Quality Improvement Plan

II. SCOPE

The scope of this ME Plan applies to the operation of Kaweah Delta Health Care District, DBA, Kaweah Health, any off-site locations included on its license, for all medical equipment used for the benefit of our patients, whether the device is owned, rented, leased or non-hospital owned.

Areas included are monitored bi-annually for compliance to the ME Plan through EOC Surveillance Rounding at Hospital and Off-Site Locations and is the responsibility of the Safety Officer to assess and document compliance with the ME Plan through the structure of the EOC Committee.

III. AUTHORITY

The authority for the Medical Equipment Management Plan (ME Plan) is EC 02.04.01. The authority for overseeing and monitoring the Medical Equipment Management Policy and ME Plan lies in the Environment of Care Committee (EOC), whose members will ensure activities relating to medical equipment management are identified, monitored, evaluated and ensure that regulatory activities are monitored and enforced as necessary.

IV. ORGANIZATION

The chart below represents the organization of the Management Equipment Management Plan (ME Plan) for Medical Equipment at Kaweah Health:

V. RESPONSIBILITIES

Leadership within Kaweah Health may have varying levels of responsibility and work together in the management of medical equipment as identified below:

Governing Board: The Board of Directors supports the MEMP and ME Plan by:

- Review and feedback if applicable of the quarterly and annual EOC report.
- Endorsing budget support as applicable to fund and empower implementation of the Medical Equipment Management Policy and the Medical Equipment Plan.

Medical Care Review Committee: Reviews annual EOC reports and provides feedback as applicable.

Quality Council: Reviews annual EOC report, provides direction in the establishment of performance monitoring standards relating to medical equipment risks.

Administrative Staff: Provide active representation at EOC meetings and set accountability expectations for compliance to the MEMP and its associated parts (ME Plan).

EOC Committee: Members review and approve the quarterly report and oversee any issues relating to the MEMP and its associated parts (ME Plan).

Directors and Department Managers: Support the MEMP and its associated parts (ME Plan) by:

- Reviewing and correcting deficiencies identified through EOC Surveillance Rounds.
- Communicating recommendations from the EOC to staff in a timely manner.
- Developing education plans for staff that ensure compliance with the MEMP and its associated parts (ME Plan).
- Supporting all required medical equipment education and training to include a disciplinary policy for employees who fail to meet the expectations.
- Serve as a resource for staff on matters of medical equipment usage.

Clinical Engineering Director: The Director of Clinical Engineering is responsible for the coordination, liaison, development and establishment of the overall organization and management of the MEMP and its associated parts (ME Plan).

- Submits completed reports to the EOC Quarterly or more frequently as requested. Reports are to include Compliance to TJC Standards,

Departmental Process Improvement Goals, Identify MEMP and ME Plan compliance issues, safety risks and device recall information that will effect operation and safety of medical devices.
- Submits the Annual evaluation on the effectiveness of the MEMP and its associated parts (ME Plan) to the EOC Committee.
- Works Independently and collaboratively developing departmental and organizational equipment management policies and procedures.
- Ensures departmental clinical equipment management policies and procedures are consistent with Kaweah Health Safety, Infection Prevention, Risk Management and Facilities Management; reviews as needed but at least every three years.
- Ensures all medical equipment incidents are reported to the appropriate authorities/committees/departments/individuals (HH-L-4-012 Occurrence Reporting).
- Monitors Hemodialysis Department to ensure completion of infection prevention activities/preventive and corrective maintenance activities are completed, recorded and reported.

Employees: Employees of Kaweah Health are required to adhere to the MEMP and its associated parts (ME Plan) by:
- Completing applicable medical equipment training as assigned.
- Not using medical devices without ensuring a non-expired Clinical Engineering inspection sticker exists on the device in order to promote a safe environment.
- Will report medical equipment failures to their supervisors and Clinical Engineering per policy EOC 6002.
- Will report any observed or suspected unsafe conditions to their supervisor as soon as possible upon identifying a medical equipment risk.
- Will report any medical device with an expired PM Inspection sticker to their supervisors and Clinical Engineering per policy EOC 6002.

Medical Staff: Will support the MEMP and its associated parts (ME Plan) by:
- Will abide by hospital policies and procedures relating to the use, care and reporting of failures, safety concerns and incidents as are related to medical equipment.

EC 02.04.01 – EP 01: The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment.

Selection and acquisition of medical equipment that is new to the organization: Selection and acquisition of medical equipment is a combined effort of the Value Analysis Committee (VAC), Clinical Engineering, Materials Management, the department personnel using the device(s), Finance, Medical Staff, Vendors and Administration of the Hospital as is required.
- These devices must meet or exceed NFPA 2012 standards as is required.
- Meet NRTL (UL, TUV …), FDA, NFPA and other regulatory standards as apply.
- Must meet or exceed Manufacturer, Kaweah Health Electrical Safety or other regulatory standards as apply.
- Must be evaluated through VAC prior to purchase.
- Clinical Engineering will provide VAC with technical evaluations as requested to support the evaluation decision.

EC 02.04.01 – EP 02: The hospital maintains a written inventory of all medical equipment

Equipment Inventory: All owned, leased, rented, borrowed, loaned and non-facility owned medical devices will be evaluated for inclusion in the Medical Equipment Plan including all equipment at all sites on the hospital license.

All equipment will be evaluated and assigned to a department for management. These departments include; Clinical Engineering, Facilities Engineering, Information Systems Services, Clinical Laboratory, Pharmacy.

Medical Devices assigned to the Clinical Engineering department will be included in the ME Plan will be assigned a Biomedical ID# and entered into a Medical Equipment Database Inventory (MEDI). The devices shall include but are not limited to; any and all Electrical, Electronic, Mechanical, Electro-mechanical, Hydraulic medical devices that are used to Treat, Diagnose, Monitor and provide Analysis for the care of medical patients by any of the parties listed in the section (V. Responsibilities) of this policy.

All equipment that are recorded in the Medical Equipment Database Inventory (MEDI) will be:

- Subject to action by the EOC, RISK MANAGEMENT, MATERIALS MANAGEMENT, FDA, Manufacturer and State Regulators including recalls and hazard notices issued and tracked by the Risk Management Department.
- Monitored and addressed if subject to a medical incident. If a device is suspected in the death, serious injury or illness of an individual it is required per policy EOC 6009 to be reported immediately but not more than 24 hours to Risk and Clinical Engineering after the patient is no longer in danger of further risk or harm. (EOC 6009 Safe Medical Device Act Tracking and Reporting).

EC 02.04.01 – EP 03: The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail. Note, high-risk equipment includes life-support equipment.

All selected equipment included in the MEDI shall be evaluated for risk and be assigned to either;

- EC 02.04.03 – EP 3 Non-High Risk (NHR)
- EC 02.04.03 – EP 2 High Risk including Life Support (HRiLS) classification of medical device.

All devices included in the MEDI will be assigned a risk number. The Risk number is assigned based on a formula applied to all devices. The formula will include will provide a weight based evaluation considering multiple factors that account for:

- Equipment Function
- Physical Risk
- Maintenance Requirements
- Equipment Service Experience
- Environment of Use

Medical Devices included in the MEDI with a Risk score equal to or greater than 13 are included in the High-Risk including Life-Support (HRiLS) Classification.

Medical Devices included in the MEDI with a Risk score equal to or below 12 are included in the Non-High-(NHR) Classification.

EC 02.04.01 – EP 04: The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturer's recommendations or with strategies of an alternative maintenance (AEM) program.

Note 1: The strategies of an AEM program must not reduce the safety of equipment and must be based on accepted standards of practice, such as the American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI) handbook ANSI/AAMI EQ56:2013, Recommended practice for a Medical Equipment Management Program.

Note 2: Medical Equipment with activities and associated frequencies in accordance with manufacturer's recommendations must have a 100% completion rate.

Note 3: Scheduled maintenance activities for both high-risk and non-high-risk medical equipment in an alternative equipment maintenance (AEM) program Inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.

The Clinical Engineering Department is responsible, unless otherwise specified, for Initial Inspection, Scheduled Preventive Maintenance, Corrective Maintenance, Retirement Inspection/Status, and Incident Management through the recording of records in a Computerized Maintenance Management System or other record keeping system. This is by way of direct action or management of outside manufacturer, or third party contracted services.

The hospital does employ an AEM program.

Scheduled maintenance intervals shall reference the manufacturer's service guidelines or alternative sources to attain the maintenance guidelines (OneSource, Documentation Service). The inspection intervals can and shall be modified as the service history, use type, manufacturer recommendations change and are reviewed in coordination with the AEM program.

Devices that are Non-Hospital Owned including Rental, Leased and Consignment devices can be assigned to other departments for asset management but will still be subject to inclusion in the MEDI and are subject to all parts of the MEMP.

EC 02.04.01 – EP 5: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which, inspecting, testing, and maintaining must be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements.
- Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies
    - NOTE: Maintenance history includes any of the following documented evidence:
        - Records provided by the hospital's contractors
        - Information made public by nationally recognized sources
        - Records of the hospital's experience over time

EC 02.04.01 – EP 6: A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use
- Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
- Availability of alternative or backup equipment in the event the equipment fails or malfunctions
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment
    - For more information on defining staff qualifications, refer to Standard HR.01.02.01

EC 02.04.01 – EP 7: The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program (AEM):

- Equipment Identified as included in the AEM will have been reviewed by the AEM Committee and be marked in the MEDI as AEM.

EC 02.01.04 – EP 9: The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.

- The hospital follows EOC 6002, Medical Equipment Defective Repairs Policy to remediate equipment failures. This includes Red Tagging the machine, notifying local management and Clinical Engineering. This includes ensuring the patients safety and quickest remediation measures possible.

EC 02.04.01 – EP 10: The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.

- The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.01 – EP 11: The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Device Act of 1990.

- The hospital follows Policy EOC 6009, Safe Medical Device Act/Device Tracking and Reporting Policy, in coordination with Department Management, Risk Management, Clinical Engineering and Leadership.

EC 02.04.03 – EP 1 Before initial use and after major repairs or upgrades of medical equipment on the Medical Equipment Database Inventory, the hospital performs safety, operational, and functional checks.

- Hospital Staff follow policy “EOC 6004 Initial Equipment” and “EOC 6002 Equipment Failure” to report new equipment to be used in the patient care vicinity.

EC 02.04.03 – EP 2 The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented.

Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member if it should fail, which includes life-support equipment

Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equ8ipment completed in accordance with manufacturer's recommendations must have a 100% completion rate.

Note 3: Scheduled maintenance activities for High-Risk medical equipment in an Alternative Equipment Maintenance (AEM) inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program. (See also: PC 02.01.11,EP 2)

EC 02.04.03 – EP 3 The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.

Note 1: Scheduled maintenance activities for non-high-risk medical equipment in an Alternative Equipment Maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.

EC 02.04.03 – EP 4 The hospital conducts performance testing and maintains all sterilizers. These activities are documented. (See Also IC.02.02.01, EP 2)

The Clinical Engineering department or contracted vendors maintain the sterilizers for manufacturer required preventive maintenance, cleaning and corrective maintenance activities. These activities are documented. Daily testing of the sterilizers is maintained by the Sterile Processing Department and activities are documented.

EC 02.04.03 – EP 5 The hospital performs equipment maintenance and chemical and biological testing of water used in Hemodialysis. These activities are documented.

The hospital's Hemodialysis technicians perform equipment maintenance and chemical and biological testing of water used in Hemodialysis. These activities are documented and presented to the EOC committee quarterly.

EC 02.04.03 – EP 8 Equipment listed for use in oxygen-enriched atmospheres is clearly and permanently labeled (withstands cleaning/disinfecting) as follows:

- Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier.
- Oxygen-metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL"
- Labels on flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus designate the gasses for which they are intended.
- Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7 (for full text, refer to NFPA 99-2012:11 5 3 1)
    - Note: Color coding is not utilized as the primary method of determining the cylinder or container contents.

EC 02.04.03 EP 10 – All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.

Maintenance of Hyperbaric Chambers is performed by the Manufacturer and a verification of services performed annually is recorded by the Clinical Engineering Department.

EC 02.04.03 EP 16 – Qualified hospital staff inspect, test, and calibrate Nuclear Medicine Equipment Annually. The results and completion dates are documented.

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 18 – The hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced.

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 20 – For diagnostic Computed tomography (CT) services: at least annually, a diagnostic medical physicist does the following:

- Measures the radiation dose (in the form of volume computed tomography dose Index (CTDIvol) produced by each diagnostic CT system for the following for CT protocols: adult brain, adult abdomen, pediatric brain and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted.
- Verifies that the radiation dose (In the form of CTDIvol) produced and measured for each protocol for each measure tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results and verifications of these measurements are documented.
    - Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses
    - Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
    - Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4)

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 21 – For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT Imaging equipment. The evaluation results along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging matrix:

- Image uniformity
- Scout prescription accuracy
- Alignment light accuracy
- Table travel accuracy
- Radiation beam width

- High-contrast resolution
- Low-contrast detectability
- Geometric or distance accuracy
- Artifact evaluation
    - Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
    - Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4)

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 22 – At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging matrix:

- Image uniformity for all radiofrequency (RF) coils used clinically
- Signal-to-noise ratio (SNR) for all coils used clinically
- Slice thickness accuracy
- Slice position accuracy
- Alignment light accuracy
- High-contrast resolution
- Low-contrast resolution (or contrast to noise ratio)
- Geometric or distance accuracy
- Magnetic field homogeneity
- Artifact evaluation
    - Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4)

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 23 – At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging matrix:

- Image uniformity / system uniformity

- High-contrast resolution / system spatial resolution
- Sensitivity
- Energy resolution
- Count-rate performance
- Artifact evaluation
    - Note 1: The following test is recommended but not required: Low contrast resolution or detectability for non-planar acquisitions
      Note 2: The medical physicist or nuclear medicine physicist is accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.01.02.01, EP 1; Hr.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD 03.06.01, EP 4.)

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 24 – At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics:

- Image uniformity / system uniformity
- High-contrast resolution / system spatial resolution
- Low-contrast resolution or detectability (not applicable for planar acquisitions)
- Artifact evaluation
    - Note 1: The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution and count rate performance.
      Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist, (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD 03.06.01, EP 4.)

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 25 – For computed tomography (CT) position emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: the annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.

- Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

Note 2: Medical physicist or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have they required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD 03.06.01, EP 4.)

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.03 EP 26 – The hospital performs equipment maintenance on anesthesia apparatus. The apparatus are tested at the final path to patient after any adjustment, modification, or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. (For full test, refer to NFPA 99-2012: 11.4.1.3; 11.5.1.3; 11.6.2.5; 11.6.2.6)

The Clinical Engineering Department or contracted vendor performs equipment maintenance on anesthesia apparatus. Testing to the manufacturers' standards are completed throughout the service. Each connection is tested for proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas used for servicing of oxygen equipment are clean and free of oil, grease or other flammables.

EC 02.04.03 EP 27 – The hospital meets NFPA 99-2012: Healthcare Facilities code requirements related to electrical equipment in the patient care vicinity. (For full text refer to NFPA 99-2012: Chapter 10)

Note: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment. (TIA) 12-5

EC 02.04.03 EP 34 – For hospitals that provide fluoroscopic services: At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following:

- Beam alignment and collimation
- Tube potential/Kilovolt peak (kV/kVp) accuracy
- Beam filtration (half-value layer)
- High-contrast resolution
- Low-contrast detectability
- Maximum exposure rate in fluoroscopic mode
- Displayed air-kerma rate and cumulative-air kerma accuracy (when applicable)
    - Note 1: Medical physicist conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist.
    - Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.

The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of

the equipment. The Radiology department maintains the records to support these activities.

"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: EOC 6004	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Offi Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedne	

Medical Equipment Hazardous Device and Recall Notification Policy

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

DEFINITION:

Medical Device:

Medical devices range from simple tongue depressors and bedpans to complex programmable pacemakers with micro-chip technology and laser surgical devices. In addition, medical devices include in vitro diagnostic products, such as general purpose lab equipment, reagents, and test kits, which may include monoclonal antibody technology.

Certain electronic radiation emitting products or products with medical application and claims meet the definition of medical device. Examples include diagnostic ultrasound products, x-ray machines and medical lasers. If a product is labeled, promoted or used in a manner that meets the following definition in section 201(h) of the Federal Food Drug & Cosmetic (FD&C) Act it will be regulated by the Food and Drug Administration (FDA) as a medical device and is subject to premarketing and postmarketing regulatory controls.

A device is:

1. "An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:

   A. recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them,

   B. intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or

   C. intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes."

This definition provides a clear distinction between a medical device and other FDA regulated products such as drugs.

If the primary intended use of the product is achieved through chemical action or by being metabolized by the body, the product is usually a drug.

Human drugs are regulated by FDA's Center for Drug Evaluation and Research (CDER).

Biological products which include blood and blood products, and blood banking equipment are regulated by FDA's Center for Biologics Evaluation and Research (CBER).

FDA's Center for Veterinary Medicine(CVM) regulates products used with animals.

If your product is not a medical device but regulated by another Center in the FDA, each component of the FDA has an office to assist with questions about the products they regulate.

In cases where it is not clear whether a product is a medical device there are procedures in place to use The Division of Industry and Consumer Education (DICE) Staff Directory to assist you in making a determination.

PURPOSE:

To promulgate notifications of Device Recalls and Hazardous Device Notifications from manufacturers and / or the Food and Drug Administration, a system shall be installed to provide a means of follow-up and compliance with these Recalls and Notifications. To this end, the following guidelines and procedures shall be strictly adhered to without exception.

STANDARD OF PRACTICE:

Hospitals normally receive notifications of Hazardous Devices or Device recalls through certified letters from the Device Manufacturer or the Food and Drug Administration. These notices contain the device or item identification, the problem, and any recommendations for resolution. These notices are normally directed to the Hospital Chief Executive Office, the Chair of the EOC Committee, Director of Materials Management, or other designated individuals. All such received Notifications, or Recalls shall be followed-up to their conclusion. Hard copies of all received and completed notifications will be maintained for a minimum of two (2) years. Alternative (electronic or electronic media) storage methods will also be utilized as backup methods of record storage.

PRESCRIBED ACTION:

RECALLS

1. Medical Devices that have been identified as having been recalled for whatever reason by the device manufacturer, or the Food and Drug Administration, acted upon per the recall guidelines including the immediate cessation of user and removal of the device, until such time

that the device(s) have been certified safe for use by the appropriate manufacturer or the Food and Drug Administration.

2. All Recall Notifications received by Kaweah Delta Health Care District shall be processed utilizing the processes outlined in the Flowchart attached to this policy.

3. Copies of ALL Recall notifications shall be maintained for a minimum of two (2) years and electronic media copies shall be maintained in a separate database for security and compliance purposes.

4. The individual assigned responsibility for the Recall Notification, (Or their designee), will:

   A. Complete all steps shown on the Recall notice to its final completion
   B. Document these steps as required on the form
   C. Forward the completed form to Risk Management for processing

5. The Risk Management Department shall be responsible for keeping an accurate log of all incoming Recalls and Hazardous Device Notifications, and for ensuring compliance with all Hazardous Device Notifications. A log shall be maintained which lists the following information:

   A. Date the Recall or Notification was received by the Risk Management Dept
   B. Where the Recall or Notification was originated, (Manufacturer or FDA)
   C. Device or Product affected
   D. Departments or units that are affected by the Recall or Notification
   E. Date the Recall or Notification was complied with
   F. Any Follow-up information

6. Recalled devices that have been implanted by Physicians shall be identified and patient notification shall be coordinated through the Medical Staff office. The implanting physician shall have the option and responsibility for notifying the patient of an applicable recall.

HAZARDOUS DEVICE NOTIFICATIONS

1. Copies of the Device Notification shall be provided to the appropriate individual(s) or designee, that have direct control of the suspect device(s). Risk Management, or designee, shall be responsible for the correct routing of these copies. Copies of all Notifications shall be routed to the following (Non-inclusive):

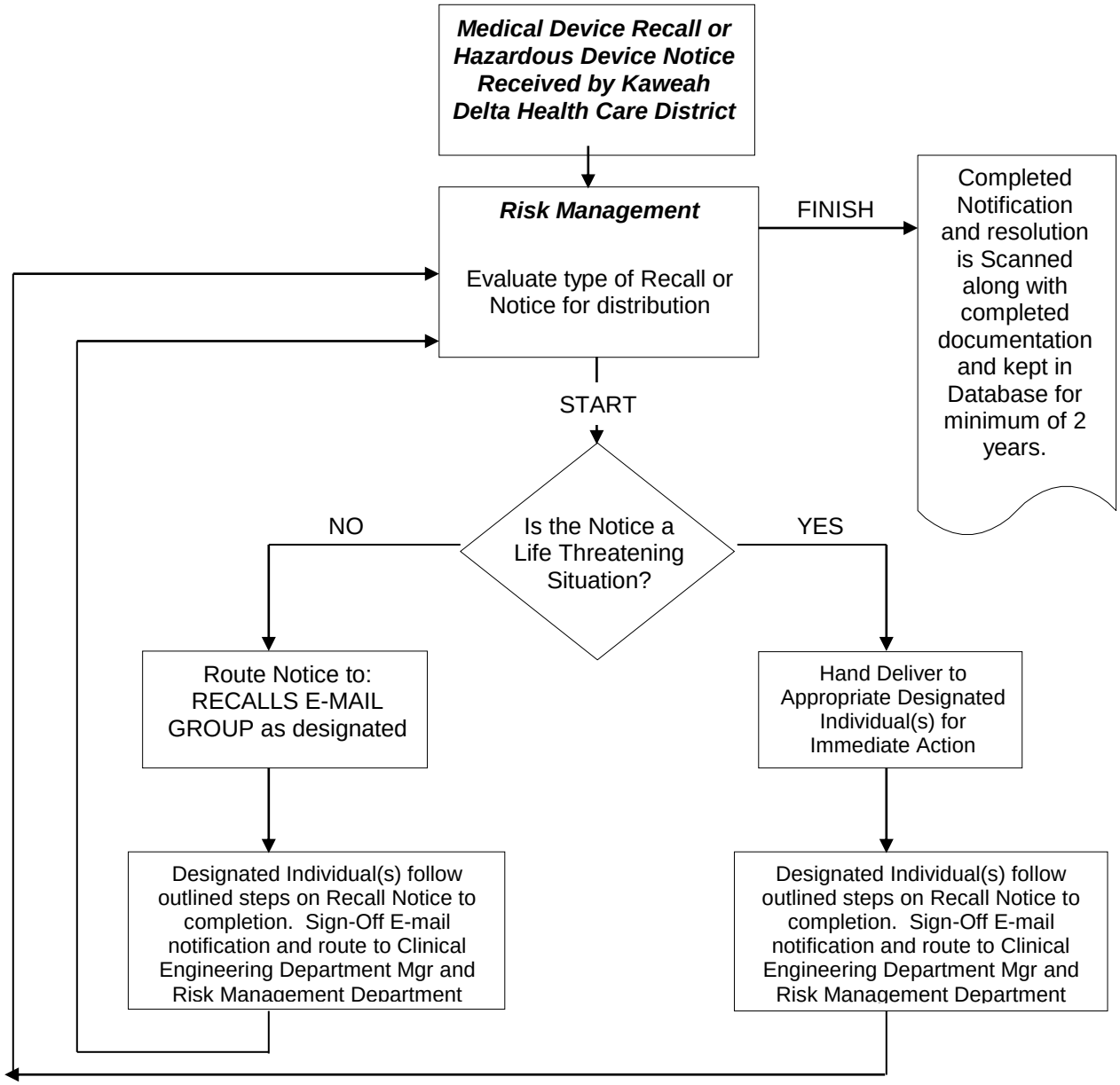
   A. Administration
   B. EOC Committee Chair
   C. Risk Management
   D. Clinical Engineering
   E. Infection Prevention Depts. (If applicable)

F. Central Logistics
G. Performance Improvement
H. Director of Quality and Patient Safety

2. The Risk Manager shall report to the EOC Committee, on a quarterly basis, the current status of any and all completed and outstanding Device Recall and Hazardous Device Notifications.

   A. Documentation shall be maintained to record these reports.

3. Any follow-up action(s) necessary shall be reported to the Environment of Care Committee, or their designee:



Type of Recall/Notification	Responsible Individual

Pharmacy Products Recalls	Director of Pharmacy (Or Designee)
Laboratory Products/Devices Recalls	Director of Laboratory (Or Designee)
Dietary Products	Director of Food Services (Or Designee)
Digital Plates, Barium Products	Director of Imaging & Radiation (Or Designee)
Medical/Surgical Supplies and Equipment	Director of Material Management (or Designee)
O/T Therapy Devices or Products	Director of Rehabilitation Services (Or Designee)
Respiratory Care Products or Devices	Director of Respiratory Svc.(Or Designee)
Engineering Supplies or Equipment	Director of Facilities and Planning Services (Or Designee)
Housekeeping Supplies	Director of Environmental Services (Or Designee)
Medical Devices	Director of Clinical Engineering (Or Designee)
General Product	Director or Financial & Logistical Planning (Or Designee)
General Supplies	Director of Procurement & Logistics (Or Designee)

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."

Subcategories of Department Manuals not selected.

Policy Number: EOC 7001	Date Created: 07/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Plan

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

I. OBJECTIVES

The objectives of the Management Plan for Utility Equipment at Kaweah Delta Health Care District ,herein after referred to as Kaweah Health (KH)are to manage effective, safe, and reliable operations of utility equipment that provides a safe, controlled physical environment for the patients, employees, physicians, and visitors who enter the premises. Inherent in utility equipment processes are operational reliability of utility equipment, the development of a utility equipment inventory and program, and an inspection and maintenance program designed to minimize risks to our patients and the physical environment. Specific programs in place to support the objectives of the utility equipment management plan include the following:

- Preventive Maintenance Program
- Corrective Maintenance Program
- Annual maintenance on inventoried equipment/systems
- User/maintainer training
- Performance indicators
- Annual Evaluation of the Management Plan for Utility Equipment

SCOPE

The scope of the Utility Management Plan applies to KH with the Director of Facilities Planning, overseeing the management of the utility systems, and with broad oversight by the *Environment of Care (EOC)* Committee. With respect to the offsite areas per KH license, the Facilities Planning Director has oversight responsibility for the utility system that provides services to the offsite areas. Each offsite area manager will have the responsibility of the day-to-day operations relating to utility services, which often means working in partnership with a lessor, or building owner if applicable. Utility failure plans are required for each offsite area, and are the responsibility of the offsite manager. Utility issues for the offsite areas may be brought to the attention of the *EOC* Committee.

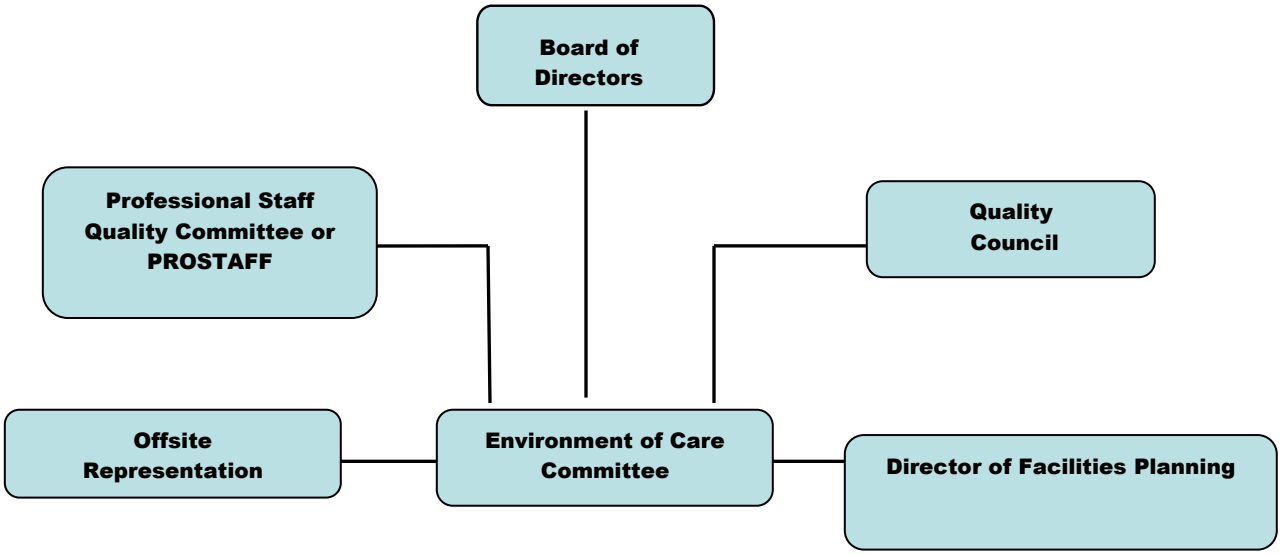
AUTHORITY

The authority for the Management Plan for Utility Equipment is EC. 02.05.01. The authority for overseeing and monitoring the utility equipment plan and program lies in the *EOC* Committee, whose members will ensure activities relating to utility equipment management are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary.

ORGANIZATION

The following represents the organization of the Management Plan for Utility Equipment at KH:

Organization – Management Plan for Utility Equipment



RESPONSIBILITIES

Leadership within Kaweah Health have varying levels of responsibility and work together in the management of utility equipment as identified below:

Board of Directors: The Board of Directors supports the Utility Equipment Management Plan by:

- Review and feedback if applicable of the quarterly and annual *EOC* reports.
- Endorsing budget support as applicable for capital purchases relating to utility equipment.

Quality Council: Reviews annual *EOC* report from the *EOC* Committee, and provides broad direction in the establishment of performance monitoring standards relating to utility equipment risks.

Professional Staff Quality Committee or PROSTAFF: Reviews annual *EOC* report from the *EOC* Committee, providing feedback if applicable.

Administrative Staff: Administrative staff provides active representation on the *EOC* Committee meetings and sets an expectation of accountability for compliance with the Utility Equipment Program

***Environment of Care* Committee:** *EOC* Committee members review and approve the quarterly *EOC* reports, which contain a Utility Equipment component, and oversee any issues relating to the overall utility equipment program.

Directors and Department Managers: These individuals support the Utility Equipment Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to utility equipment risks.
- Communicating recommendations from the *EOC* Committee to affected staff in a timely manner.
- Providing information/in-services to staff that insure compliance with applicable policies of the within the Utility Equipment Management program.
- Serving as a resource for staff on matters of utility equipment usage.

Employees: Employees of Kaweah Health are required to participate in the Utility Equipment Management program by:

- Completing applicable utility equipment training.
- Reporting utility equipment failures to their supervisor and to Facilities

- Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a utility equipment risk, which include, but are not limited to: frayed electrical cords, use of extension cords, overuse of power adaptors, equipment brought in by patients, or any loss of utility power.

Medical Staff: Medical Staff will support the Utility Equipment Management Program by abiding by the Kaweah Health's policies and procedures relating to the use of utility equipment

The [organization] manages risks associated with its utility systems.
EC. 02.05.01-1
EC.02.06.05-1,2

When planning for new, altered or renovated space that will impact utility systems, KH uses one of the following design criteria:
-State rules and regulations, and
-*Guidelines for Design and Construction of Hospitals and Healthcare Facilities*, current edition, published by the American Institute of Architects.
When the above rules, regulations and guidelines do not meet specific design needs, other reputable standards and guidelines are used that provide equivalent design criteria. When planning for demolition, construction or renovation, a pre-construction risk assessment is used that addresses utility requirements that affect care, treatment and services. If any utility-related risks are identified during the pre-construction assessment, KH will take action to minimize the identified utility risks. After construction projects are completed, the Director Facilities Planning will ensure the acquisition of as-built drawings, and in addition will insure that other utility system maps and drawings are updated and current.

KH maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risk for infection, occupant needs, and systems critical to patient care (including all life support systems). Kaweah Health evaluates new types of utility components before initial use to determine whether they should be included in the inventory.
EC.02.05.01-3 through 7
EC.02.05.05, EPs 1through 6

Written Inventory
KH maintains a written inventory of utility systems, which includes (but not limited to) the following:

Water Supply System
Irrigation Water System
Domestic Hot Water System
Hot Water Heat Recovery System
Water Softening System
Patio Storm Drain System
Sewage System
Basement Sump Pump
Natural Gas System
Fuel Oil System
Steam Boilers and Distribution System
Condensate Return
Medical Air System
Medical Vacuum System
Medical Oxygen System
Heating, Ventilation and Air Conditioning System
Electrical System 7 Emergency Generators 7 Transfer Switch
Elevator System
Nurse Call System
Kitchen Fire Extinguishing System
Fire Sprinkler System
MRI Halon Fire Extinguisher System
Fire Alarm Monitoring System – API
Paging System
Telephone System and Telephones

Two-Way Radio System
Pagers
ICU/CCU Monitor System
Master Clock System
Sterilizers
ETO Abator System
Trash Compactor
Bailer

Any new utility equipment purchased for KH is evaluated for inclusion into the written inventory. The utility management program includes equipment that meets the following criteria:

- Equipment maintains the climatic environment in patient care areas.
- Equipment that constitutes a risk to patient life support upon failure.
- Equipment is a part of a building system, which is used for infection control.
- Equipment that is part of the communication system, which may affect the patient or the patient care environment.
- Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment, life support, or infection control.

Inspection and Maintenance Activities

Documentation of inspection, testing and maintenance demonstrates systems and components performance within prescribed limits and adherence to established schedules. The minimum required documentation is exception reporting. This documentation lists all items tested and indicates pass or fail. Those items that fail have additional documentation of repair and subsequent testing indicating performance within standards. As part of utility system operational plans, planned or preventive maintenance is a key factor in assuring the ongoing performance and reliability of utility systems whereby each system is properly identified, operated, and maintained. A system is no more reliable than the individual pieces of equipment, or components, within it. Each component within a system is evaluated to determine the content and frequency of testing procedures, inspections, calibrations, and the servicing and replacement of parts. In the development of preventive maintenance programs, a review is made from various sources of information, such as manufacturers recommendations, codes, standards, and federal, state, and local laws and regulations. The basic sources of information are invaluable as start-up aids; however, over time it is essential that local operating experience be factored in to modify the program. Through this process, initial levels of risk are maintained or reduced.

Minimization of Pathogenic Biological Agents

The Utility Management plan includes processes for activities that will reduce the potential for hospital-acquired illnesses that could be transmitted through the Utility Systems. These include policies and or procedures relating to:

- **Cooling Towers/Open and Closed Water Systems:** Biological and/or chemical treatment(s) and testing or cultures are in place wherein the potential for hospital-acquired illness could occur within Kaweah Health's cooling and heating systems.
- **Domestic Hot and Cold Water Systems:** Periodic biological testing of the hot and cold water systems are in effect as part of the utility management program.
- **Equipment Maintenance - HVAC:** A filter change program is in effect to reduce the risks associated with air borne contaminants within the major air handling systems.
- **Air Pressure Monitoring/Maintenance:** A program is in place in Facilities that allows for the air pressure monitoring, maintenance, and balancing for the following critical areas: surgical operating rooms, critical care areas, including ICU, special procedure rooms, isolation rooms and the labor and delivery suites.
- **Construction.** Protocol and procedures are in place to coordinate Infection Control and construction activities that establishes how an area will be assessed before and during construction for the purpose of minimizing the risks associated with air-borne biological contaminants (e.g., aspergillosis).

The Facilities Planning Director/Safety Officer is responsible for the proper and safe functioning of all equipment within the facility and the general condition of the facility. Facilities management requires written procedures that are developed and specify the action to be taken during the failure of essential equipment and major utility services. The written procedures include a call system for summoning essential personnel and outside assistance when required. The following essential equipment and services are included: Major air conditioning equipment, air handling systems (ventilation, filtration, quantitative exchanges, humidity), boilers, electrical power services, fire alarm and extinguishing systems, water supply, all waste disposal systems, and

medical gas and vacuum systems. Qualified engineering consultative advice is available as needed. In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, then Administration, the Facilities Planning Director and Safety Officer, or their designated representative shall have full authorization to call in an outside resource to correct the situation.

Kaweah Health maps the distribution of its utility systems
EC.02.05.01-17
Layout maps or blueprints for utilities with complicated infrastructures are maintained to enhance troubleshooting effectiveness. Distribution maps are located in Facilities, and are for plumbing, medical gases and electrical.

Kaweah Health labels utility system controls to facilitate partial or complete emergency shutdowns.
EC.02.05.01-9
Controls for Utility Systems are labeled in an efficient manner. Most importantly, controls that are located remotely from related equipment are clearly labeled. The label explains the equipment that is controlled and the power source panel identification. Medical gas valves are clearly labeled as to what areas they isolate. Other plumbing valves are labeled in correspondence with a master valve list.

Kaweah Health has written procedures for responding to utility system disruptions
EC.02.05.01-10
Policies and procedures are in place in Facilities, which identify emergency procedures for utility system disruptions or failures. Systems are in place to mitigate the consequences of a utility failure, such as the emergency generators, battery operated equipment, staff interventions in the event equipment fails and the use of outside vendors for emergency assistance as may be needed.

Kaweah Health's procedures address shutting off the malfunctioning system and notifying staff in affected areas.
EC.02.05.01-11
Staff and employees are notified in affected areas when a partial or total system shutdown is necessary. When a utility system must be shutdown, notification is made to Administration, Nursing, and the Department Director(s)/managers of the affected department(s), and agencies having jurisdiction if applicable.

Kaweah Health's procedures address performing emergency clinical interventions during utility systems disruptions.
EC.02.05.01-12
In the event of a utility system disruption that impacts the flow of electrical-operated medical equipment, clinical interventions are to be provided based upon the scope of practice of the patient care provider, and may include such interventions as:

- Use of portable monitors and ventilators
- Manual bagging of a patient if the patient is on a ventilator that loses power and does not have a battery back-up
- Battery-operated equipment
- Manual intravenous administration in the event IV equipment fails, and does not have battery back-up

Kaweah Health has a reliable emergency electrical power source
EC.02.05.03-1-16
KH provides and maintains a reliable emergency power system that is adequately sized, designed and fueled as required by the LSC occupancy requirements and the services provided, and supplies emergency power to the following areas and systems:

i. Alarm Systems
ii. Egress illumination
iii. Elevator (1)
iv. Emergency Communication Systems
v. Exit Sign Illumination
vi. Blood, Bone and Tissue Storage Units
vii. Emergency Care Areas (Urgent Care)
viii. Intensive Care
ix. Medical Air Compressors

x. Medical/Surgical Vacuum Systems
xi. Newborn Nurseries
xii. OB Delivery Rooms
xiii. Operating Rooms
xiv. Recovery Rooms
xv. Special Care Units
xvi. Lighting at emergency generator locations
xvii. Emergency Rooms
xviii. Dispensing Cabinets
xix. Medication Carousels
xx. Central Medication Robots (if applicable)
xxi. Medication Refrigerators
xxii. Medication Freezers

Kaweah Health inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service, and KH must have access to this documentation.
EC.02.05.05- 2and 4 through 6

On a regular and consistent basis, inspection, testing, and maintenance is part of a process to assure system and component performance. The initial inspection and test are part of the acceptance of new systems and components. Ongoing inspection, testing and maintenance increases reliability, systems and components life, and user confidence. The intervals for inspection, testing and maintenance are based on the needs of the systems and components. The intervals may be less than or more than one year. The exception is the required weekly testing of the emergency generators. If an interval greater than one year is selected, it must be approved by the *EOC* committee. The Facilities Planning Director will apply or obtain professional judgment to set intervals so known risks, hazards and maintenance needs are managed. In Facilities a computerized maintenance system is used to facilitate the scheduling, inspection, testing, maintenance, monitoring, and documentation of equipment for the utilities systems.

Equipment Currently in Inventory:

- Scheduled maintenance work orders are issued on a monthly basis to Facility's staff.
- Maintenance is performed in accordance with the instructions included in the work order. The assigned engineer documents the maintenance, including any pertinent observations, on the work order. When maintenance and documentation are completed, the engineer returns the work order to the Facility's department.
- If scheduled maintenance cannot be performed (i.e., parts not available), the reason is documented on the work order and returned to Facilities. There is a system of evaluation for equipment not serviced within the scheduled time frame.
- If systems' equipment must be removed from the user area for more than one day, the engineer prepares a corrective maintenance work order.
- If scheduled maintenance is to be performed by an outside vendor, the Facility Director or designee contacts the vendor and instructs the vendor to perform the maintenance as detailed in the work order, document the maintenance and any associated work done on the work order. A copy of this documentation is maintained in Facilities.

Incoming Equipment:

- Requests for new equipment are reviewed and approved by the Facilities Planning Director or designee for proper safety features, including electrical needs, drainage needs, ventilation needs and space consideration as required by manufacturer specifications.
- After receipt of new equipment, but prior to its installation, it must be inspected, with electrical and mechanical tests performed, and determined by Facilities that it meets all appropriate safety standards.
- If the equipment fails to pass the required tests and inspection, the engineer will return the equipment to Purchasing unless the deficiency is corrected. The equipment is not assigned an identification number until the equipment has passed all the requirements.
- After passing inspection, and if recommended by manufacturer, the new equipment will be entered on the Preventive Maintenance Database. At this time, the equipment is assigned an identification number, and the engineer performing the inspection will install the respective tag with the assigned equipment number, and then process the necessary data entry of the specific procedures and frequency to be followed during the preventive maintenance as recommended by the manufacturer.

- If the manufacturer does not recommend preventive maintenance to the equipment, i.e., microwave oven, addressograph, the engineer performing the inspection will apply a tag with the date the inspection was performed, and will place the equipment on the Non-Clinical Equipment Inspection Log, and will be subject to visual inspection once a year to verify proper operation.
- In the event that equipment not belonging to Kaweah Health is brought into KH for use, they must be inspected and determined to be safe by the Clinical Engineering Department. This would apply to any items brought by patients, visitors or employees (radios, televisions, coffee makers, etc.). The Facilities Planning Director or designee is authorized to remove any item, which is found to be unsafe for use in the District. This will include any demonstration equipment brought in by any vendor.

Documentation is maintained in the Facilities Department, and includes, but is not limited to the following:

- A current, accurate and separate inventory of utility components identified in this plan
- Performance and safety testing of each critical component before initial use.
    - Maintenance of critical components of High Risk Utility systems/equipment consistent with the maintenance strategies identified in this plan.
    - Maintenance of critical components of infection control utility systems/equipment for consistent with the maintenance strategies identified in this plan.
    - Maintenance of critical components of non-high risk utility systems/equipment on the inventory consistent with maintenance strategies identified in this plan.

Kaweah Health inspects, tests and maintains emergency power systems
EC.02.05.07- 1 through 10

1. At 30-day intervals, a functional test is performed of battery-powered lights required for egress for a minimum duration of 30 seconds. The completion date of the test is documented and maintained in Facilities.
2. Every 12 months, performs a functional test of battery-powered lights required for egress and exit signs for a duration of 1 ½ hours. The completion date of the tests or replacement is documented and maintained in facilities.
3. SEPSS (Stored Electrical Energy Emergency and Standby Power Systems) testing: **Not applicable**.
4. At least weekly, the hospital inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented-**Not applicable**.
5. The generators are tested monthly by Facilities for at least 30 continuous minutes. The completion date of the tests is documented and kept on file in Facilities.
6. The emergency generator tests are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature.
7. Monthly, the automatic transfer switches are tested, and the completion date of the tests is documented and maintained in Facilities.
8. At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented.
9. At least once every 36 months, each emergency generator is tested for a minimum of 4 continuous hours. The completion date of the tests is documented and maintained in Facilities.
10. The 36-month emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature.

    If the required emergency power system test fails, KH will implement measures to protect patients, visitors and staff until necessary repairs or corrections are completed. This is the responsibility of Facilities personnel. If a required emergency power system test fails, Facilities personnel will perform a retest after making the necessary repairs or corrections.

Kaweah Health inspects, tests and maintains medical gas and vacuum systems.
EC.02.05.09-1 through 14

Facilities inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexile connectors, and outlets. The plan for inspecting, testing and maintaining medical gas and vacuum system includes, but is not limited to:

- Annual inspection of alarm panel
- Annual inspection of area alarms

A routine PM schedule is in place for automatic pressure switches, shutoff valves, flexible connectors and outlets (annual testing for patient-care areas, and annual for non-patient care areas).
When the systems are installed, modified, or repaired including cross-connections testing, piping purity testing and pressure testing, a qualified individual (e.g., a contractor/certified licensed technician) insures that the medical gas systems are installed/maintained/repaired. When the installation is completed, or when maintenance or repair work is done, the qualified individual ensures that cross connection testing, piping purity testing and pressure testing are included in the process, and that code requirements are met. The systems will be additionally tested (to ensure it is connected properly so that a sufficient volume is yielded at each outlet) following periods of construction or if there is evidence that the system has been breached.

KH maintains the main supply valve and area shut-off valves of piped medical gas and vacuum systems and ensure they are accessible and clearly labeled. To maintain safety in the event of an emergency, a current and complete set of documents indicating the distribution of the medical gas systems and control for partial or complete shutdown is maintained. The documents include "as-built" drawings, construction or design drawings, line or isometric drawings, shop drawings, or any combination of these if they reflect present conditions.

When the hospital has bulk oxygen systems above ground, they are in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating “OXYGEN – NO SMOKING – NO OPEN FLAMES.”
The hospital’s emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it.

The hospital tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The test results and completion dates are documented.

The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Locations containing only oxygen or medical air have doors labeled "Medical Gases: NO Smoking or Open Flame." Locations containing other gases have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening.”

Ongoing Education for Users and Maintainers

HR.01.05.03-1

The Facility’s Education Department and the department managers hold responsibility for coordinating and implementing the education and training of the utility equipment users jointly.
USER EDUCATION:
Employees will receive a general overview of the Utility Equipment Plan at initial and annual orientation. Department Directors will provide department specific orientation and education to their employees to insure that utility equipment users will be able to describe and/or demonstrate the following items:

1. Basic operating and safety features for users to follow
2. Emergency procedures to follow when utility equipment fails.
3. KH’s process for reporting utility equipment Management problems, failures and user errors (i.e., they are reported to Facilities, who in turn reports this information to the *EOC* Committee.

Maintainer Education

For the maintainers of utility equipment, thorough training about the capabilities and limitations of equipment is made by the manufacturer. Self-assessment can be used annually, through the competency process, to determine the need for additional training. Training may be provided by:

- Formal academic courses
- Seminars, in-service training
- On-the-job training
- Service schools

Information collection system to monitor conditions of the environment.

1. Kaweah Health establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
    - Utility equipment management problems, failures and user errors

Through the *EOC* Committee structure, utility problems, failures and user errors are reported by Facilities, who investigate the issue, and provide corrective actions. Minutes and agendas are kept for each Environment of Care meeting and filed in Performance Improvement.

Annual Evaluation of the Utility Management Plan.
EC.04.01.01-EP-15
On an annual basis *EOC* Committee members evaluate the Management Plan for Utility Equipment, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within KDHCD. Based upon findings, goals and objectives will be determined for the subsequent year. A report will be written and forwarded to the Governing Board. The annual evaluation will include a review of the following:

- The objectives: The objective of the Utility Equipment Management plan will be evaluated to determine continued relevance for KH (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?)
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the utility equipment management plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach applicable employee populations in the off-site areas, and throughout KH?)
- Performance Standards. Specific performance standards for the Utility Equipment Management plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.
- Effectiveness. The overall effectiveness of the objectives, scope and performance standards will be evaluated with recommendations made to continue monitoring, add new indicators if applicable or take specific actions for ongoing review.

KDHCD analyzes identified *EOC* issues.
EC.04.01.03-EP-2
EOC issues relating to utility equipment are identified and analyzed through the *EOC* Committee with recommendations made for resolution. It is the responsibility of the *EOC* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Quarterly Environment of Care reports are communicated to Performance Improvement, the Medical Executive Committee and the Board of Directors.

KDHCD improves its *EOC*
EC.04.01.05-EP1
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of utility equipment management. Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Fire Prevention and Medical equipment management. The standards are approved and monitored by the *EOC* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring~~,~~ and changes in actions that promote an improved performance.

Patient Safety.
Periodically there may be an *EOC* issue that has impact on the safety of our patients relating to utility equipment. This may be determined from *Sentinel Event* surveillance, environmental surveillance, user errors, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue relating to utility equipment emerges, it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

"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."

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 7402	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Emergency Power

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

POLICY:

Kaweah Delta Health Care District herein after referred to as Kaweah Health (KD) shall provide and maintain a reliable, adequate emergency power system to provide electricity to designated areas during interruption of normal utility power.

Areas supplied by emergency power include, but are not limited to:
All Alarm Systems
Blood, Bone and Tissue Storage Units
Egress Illumination and Exit Signs
Elevator (at least one in patient care areas)
Communication Systems (PBX and Paging System)
Medical Air and Medical and Surgical Vacuum Systems
Operating Rooms and Recovery Room
Special Care Units - ICU, CCU, SNF, Emergency Department
Steam Delivery System (at least one boiler)
Delivery Rooms
Newborn Nurseries
Generator Locations

When operating on Emergency Power, the following status will occur:
1. White Electrical Plugs - OFF Red Electrical Plugs - ON
2. Main Phone Switch ON
3. Elevators *

Mineral King Wing

1. Otis Main Visitor	*OFF*	*6. Fresno Employee*	*ON*
2. Otis Main Visitor	*OFF*	*7. Fresno Employee*	*OFF*
3. Otis Surgery	*ON*	*8. US East Expansion*	*ON*
9. US East Expansion	*ON*		
5. Schindler	*ON*		

Acequia Wing

1. Thyssenkrupp Employee	ON	5. Thyssenkrupp Employee	ON
2. Thyssenkrupp Employee	OFF	6. Thyssenkrupp Employee	OFF
3. Thyssenkrupp Visitor	ON	7. Thyssenkrupp Surgery	ON
4. Thyssenkrupp Visitor	OFF	8. Thyssenkrupp Surgery	ON

4. Medical Air, Oxygen, Nitrous, Nitrogen Gases*	ON
5. Medical Vacuum*	ON
6. Water Pumps*	ON
7. Air Conditioning	OFF
8. Computers	ON – terminals on pending availability of Red Plugs.
9. Kronos	OFF
10.Dietary*	Cold Food Only
11. Tube System*	OFF

* If applicable to the campus

"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: EOC 7403	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Emergency Generator Testing and Fuel Levels

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

POLICY:

Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) maintains and tests emergency power generators at: KaweahHealth Medical Center, Kaweah Health Skilled Nursing Services, Kaweah Health Rehabilitation Hospital and Kaweah Health Mental Health Hospital.

PURPOSE:

To ensure adequate operational capability and fuel in the event of a utility power failure.

PROCEDURE:

All emergency diesel generator sets will be inspected weekly and exercised under load conditions for a minimum of 30 continuous minutes, once a month, as per the requirements set forth by *NFPA 110, Standard for Emergency & Stand by Power Systems*.

Each generator will also be tested, annually, using supplemental loads to achieve the requirements set forth by *NFPA 110, Standard for Emergency & Stand by Power Systems*.

Every 36 months, the emergency generators will each be tested for a minimum of 4 continuous hours, using supplemental loads to achieve the requirements set forth by *NFPA 110, Standard for Emergency & Stand by Power Systems*.

In the event an emergency power test is unable to be completed by Patient Care Priorities, such as an operation, the Nursing Supervisor will be consulted for an acceptable re-schedule time that falls within the guidelines set forth by NFPA.

FUEL TANKS:

Each fuel tank will be checked, weekly, for fuel levels. All tanks will maintain, at least, 65% of their fuel capacity. This ensures that each tank will run for a 96 hour minimum.

"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: EOC 8000	Date Created: 07/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Heat and Illness Prevention Program

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

PURPOSE

The purpose of Heat Illness Prevention Plan is to meet the requirements set forth in California Code of Regulations, Title 8, and also to serve as a supplement to the Kaweah Delta Health Care District , herin after referred to Kaweah Health (KH) Injury and Illness Prevention Program (IIPP). This information is intended and must be used in conjunction with the IIPP. The Heat Illness Prevention Plan establishes procedures and provides information, which is necessary to ensure that members of Kaweah Health are knowledgeable in the prevention and recognition of heat stress to ensure their own safety and the safety of others.

PROCEDURE

Heat Cramps

Description:
Heat cramps are the most common type of heat related injury and probably have been experienced by nearly everyone, at one time or another. Heat cramps are muscle spasms, which usually affect the arms, legs, or stomach. They do not usually occur until sometime later after work, at night, or when relaxing. Heat cramps are caused by heavy sweating, especially when water is not replaced quickly enough. Although heat cramps can be quite painful, they usually don't result in permanent damage.

Prevention/First Aid:
Call lead or supervisor immediately. Drink electrolyte solutions such as *Gatorade* or plenty of water during the day and try eating more fruits, such as bananas, to help keep your body hydrated during hot weather.

Heat Exhaustion

Description:
Heat exhaustion is more serious than heat cramps. It occurs when the body's internal temperature regulating system is overworked, but has not completely shut down. In heat exhaustion, the surface blood vessels and capillaries, which originally enlarged to cool the blood, collapse from loss of body fluids and necessary minerals. This happens when you do not drink enough fluids to replace what you are sweating away.

Symptoms Include:
Headache, heavy sweating, intense thirst, dizziness, fatigue, loss of coordination, nausea, impaired judgment, loss of appetite, hyperventilation, tingling in hands or feet, anxiety, cool moist skin, weak and rapid pulse (120-200), and low to normal blood pressure.

Prevention/First Aid:

Call Ext. 44 and ask for the House Supervisor, if the person becomes non-responsive, refuses water, vomits, or loses consciousness dial 911 or transport to Emergency Department. The employee suffering these symptoms should be moved to a cool location, such as a shaded area or air-conditioned building. Have them lie down with their feet slightly elevated. Loosen their clothing, apply cool, wet cloths or fan them. Have them drink water or electrolyte drinks. Try to cool them down, and have them checked by medical personnel. Victims of heat exhaustion should avoid strenuous activity for at least a day and they should continue to drink water to replace lost body fluids.

Heat Stroke

Description:
Heat stroke is a life threatening illness with a high death rate. It occurs when the body has depleted its supply of water and salt and the victim's core body temperature rises to deadly levels. A heat stroke victim may first suffer heat cramps and/or heat exhaustion before progressing into the heat stroke stage, but this is not always the case. It should be noted that, on the job, heat stroke is sometimes mistaken for a heart attack. It is therefore very important to be able to recognize the signs and symptoms of heat stroke - and to check for them anytime an employee collapses while working in a hot environment.

Symptoms Include:
A high body temperature (103 degrees F); a distinct absence of sweating (usually); hot red or flushed dry skin; rapid pulse; difficulty breathing; constricted pupils; any/all the signs or symptoms of heat exhaustion such as dizziness, headache, nausea, vomiting, or confusion, and possibly more severe systems including; bizarre behavior; and high blood pressure. Advance symptoms may be seizure or convulsions, collapse, loss of consciousness, and a body temperature of over 108 degrees F.

Prevention/First Aid:
Call Ext 44 and transport to Emergency Department immediately. It is vital to lower a heat stroke victim's body temperature. Quick actions can mean the difference between life and death. Pour water on them, fan them, or apply cold packs.

PRECAUTIONS TO PREVENT HEAT ILLNESSES

Condition yourself for working in hot environments. Start slowly then build up to more physical work. Allow your body to adjust over a few days (acclimatization).

Drink plenty of liquids. Hydration is a continuous process. Don’t wait until you’re thirsty!
By then, there’s a good chance that you’re already on your way to being dehydrated.
Electrolyte drinks are good for replacing both water and minerals lost through sweating.
Never drink alcohol, and avoid caffeinated beverages like coffee and soda as these liquids can have the opposite effect and can actually increase the level of dehydration.

Take frequent breaks, especially if you notice you’re getting a headache or you start feeling overheated. Assure that adequate water and shade are available at the job site before work is to begin. Wear lightweight, light colored clothing when working out in the sun. You should immediately report all unsafe conditions and/or concerns to your supervisor or area manager.

Provisions of Water
Water is a key preventive measure to minimize the risk of heat related illnesses.
3395 (c) Employees shall have access to potable drinking water meeting the requirements of Sections 1524, 3363, and 3457, as applicable. Where the supply of water is not plumbed or otherwise continuously supplied, water shall be provided in sufficient quantity at the beginning of the work shift to provide one quart per employee per hour for drinking for the entire shift. Employers may begin the shift with smaller quantities of water if they have effective procedures for replenishment during the shift as needed to allow employees to drink one quart or more per hour. The frequent drinking of water, as described in 3395 (e), shall be encouraged.

Access to Shade

Access to rest and shade or other cooling measures are important preventive steps to minimizing the risk of heat related illnesses. 3395 (d) Employees suffering from heat illness or believing a preventative recovery period is needed, shall be provided access to an area with shade that is either open to the air or provided with ventilation or cooling for a period of no less than five minutes. Such access to shade shall be permitted at all times. Except for employers in the agriculture industry, cooling measures other than shade (e.g., use of misting machines) may be provided in lieu of shade if the employer can demonstrate that these measures are at least as effective as shade in allowing employees to cool.

Training
Training is critical to help reduce the risk of heat related illnesses and to assist with obtaining emergency assistance without delay.

3395 (e) (1) Employee training: training in the following topics shall be provided to all supervisory and non-supervisory employees:

- The environmental and personal risk factors for heat illness;
- The employer's procedures for complying with the requirements of this standard;
- The importance of frequent consumption of small quantities of water, up to 4 cups per hour, when the work environment is hot and the employees are likely to be sweating more than usual in the performance of their duties.
- The importance of acclimatization;
- The different types of heat illness and the common signs and symptoms of heat illness;
- The importance to employees of immediately reporting to the employer, directly or through the employee's supervisor, symptoms or signs of heat illness in themselves, or in co-workers.
- The employer's procedures for responding to symptoms of possible heat illness, including how emergency medical services will be provided should they become necessary;
- The employer's procedures for contacting emergency medical services, and if necessary, for transporting employees to a point where they can be reached by an emergency medical service provider.
- The employer's procedures for ensuring that, in the event of an emergency, clear and precise directions to the work site can and will be provided as needed to emergency responders.

Note: T8 CCR 3203 (a)(3) requires that communication for employees shall be in a form readily understandable by all affected employee.

Departments with employees whose job duties require them to work in the outdoors or indoors during summer months in elevated heat conditions will take the following steps:.

- All employees, upon hire and annually thereafter, will receive training regarding Heat Illness Prevention Procedures. All newly hired workers will be assigned a buddy or experienced coworker to ensure that they understood the training and follow the company procedures.

- Water is available in the department at all times. There is a water fountain and cold water through the refrigerator.

- Fluids will be easily accessible for all employees and located in the employee break room.

- Frequent (hourly) waters breaks will be taken by all employees, when needed, and when the temperature exceeds 95 degrees F. An air-conditioned break room is available for this purpose.

- Shift leads will provide frequent reminders to employees to drink frequently, and more water breaks will be provided.

"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."

Kaweah Health

Provider Name: _____ Date: _____

Please Print

NURSE PRACTITIONER / PHYSICIAN ASSISTANT

Assignment: ☐ ICU ☐ ICCU ☐ Cardiac Services ☐ Through-Put ☐ OB/GYN ☐ Pediatric ☐ Psychiatry ☐ Radiology

☐ Adult Hospitalists ☐ Surgery ☐ Orthopedic ☐ Neurosurgery ☐ Family Medicine ☐ Internal Medicine ☐ Employee Health

☐ KHMC – Ben Maddox

Initial Criteria
Physician Assistant: Completion of an ARC-PA approved program; Current certification by the NCCPA (***Obtain certification within one year of completion of PA program or granting of privileges***); Current licensure to practice as a PA by the California Physician Assistant Board; **OR** **Nurse Practitioner:** Completion of an advanced nursing program accredited by the Commission of Collegiate of Nursing Education (CCNE) or National League for Nursing Accrediting Commission (NLNAC) with emphasis on the NP's specialty area; current certification by the ANCC or AANP ***(Obtain certification within one year of completion of advanced nursing program); AND*** ***Additional Certifications:*** BLS or ACLS and full schedule California DEA **Clinical Experience:** Documentation of patient care for 50 patients in the past two years OR completion of training program within the last 12 months **Renewal Criteria:** Documentation of patient care for 50 patients in the past 2 years **AND** maintenance of current certification by NCCPA, ANCC, or AANP (For PA's granted privileges prior to March 2016 that are not certified by the NCCPA: Must provide 100 CMEs within the last 2 year period, 50 of which must be category I, as defined by the NCPPA for Certification); **AND** current BLS or ACLS and full schedule California DEA **FPPE:** A minimum of 5 cases by Direct Observation and Retrospective Chart Review at the supervising physician's discretion.

Request	GENERAL CORE PRIVILEGES Includes procedures on the following list and such other procedures that are extensions of the same techniques and skills (may include telehealth):	Approve
☐	• Apply, remove, and change dressings and bandages; Perform debridement and general care for superficial wounds and minor superficial surgical procedures • Counsel and instruct patients, families, and caregivers as appropriate • Direct care as specified by medical staff-approved protocols; Make daily rounds on hospitalized patients, as appropriate; Initiate appropriate referrals; • Implement palliative care and end-of-life care through evaluation, modification, and documentation according to the patient's response to therapy, changes in condition, and to therapeutic interventions • Implement therapeutic intervention for specific conditions when appropriate • Insert and remove nasogastric tube; provide tracheostomy care • Order and initial interpretation of diagnostic testing and therapeutic modalities; • Perform field infiltrations of anesthetic solutions; incision and drainage of superficial abscesses; • Perform History & Physical/ MSE; • Perform other emergency treatment • Prescribe & Administer medications per formulary of designated certifying board • Record progress notes; • Removal of drains, sutures, staples, & packing • Remove arterial catheters, central venous catheters, chest tubes; • Short-term and indwelling urinary bladder catheterization; venous punctures for blood sampling, cultures, and IV catheterization; superficial surgical procedures • Write Discharge Summaries and Instructions	☐
☐	Adult: Patients >18 years of age	☐
☐	Pediatric: Well newborn up to 18 years of age	☐
☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__Dinuba __Exeter __Lindsay __Tulare __Woodlake __ KHMC - Willow __Dialysis Clinic __Hospice __Specialty Clinic __Wound Care Center __ Cardiology Center __Neuroscience Center __ KHMC - Ben Maddox**	☐
	ADVANCED INPATIENT PRIVILEGES	

Kaweah Health

Provider Name: _____ Date: _____

Please Print

Initial FPPE is deemed to have been satisfied based on succesful completion of a preceptorship at Kaweah Health within 6 months prior to the grant of clinical privileges					
Request	**Procedure**	**Criteria**	**Renewal Criteria**	**FPPE**	**Approve**
☐	Bronchoscopy	20 procedures in the last 2 years	10 procedures in the last 2 years	Minimum of 5 concurrent	☐
☐	Cerebral Spinal Fluid (CSF Shunt Tap)	2 in the last 2 years	1 in the last 2 years	2 concurrent	☐
☐	Endotracheal tube placement	10 in the last 2 years	8 in the last 2 years	Minimum of 3	☐
☐	Insertion of Arterial Lines	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Insertion of central venous access or dialysis catheters	5 in the last 2 years	5 in the last 2 years	Minimum of 2 -any site	☐
☐	Insertion of Chest Tubes	5 in the last 2 years	5 in the last 2 years	Minimum of 3	☐
☐	Joint Injection	Documentation of training and 5 procedures in the last 2 years (Use of Sim Lab acceptable for up to 2)	2 procedures in the last 2 years (Sim Lab procedures not accepted)	A minimum of 1	☐
☐	Laceration Repair – Complex and Layered	3 in the last 2 years	3 in the last 2 years	3 concurrent	☐
☐	Lumbar Puncture	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Myelogram	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Orthopedic Advanced Privileges to include Open fracture superficial closure – loose approximation of open fracture closure under direct supervision (prior to definitive surgical closure by the surgeon in the OR) and the following procedures: ___ Joint Injection & Arthrocentesis ___ Fracture Reduction ___ Dislocation Reduction ___ Hematoma and Digital Blocks	5 Joint Injections or Arthrocentesis in the last 2 years AND 5 Fracture Reductions in the last 2 years AND 3 Dislocation reductions in the last 2 years AND 3(including 1 of each) Hematoma and Digital Blocks in the last 2 years	15 procedures in the last 2 years	A minimum of 1	☐
☐	Paracentesis	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Perform pharmacological and non-pharmacological stress tests	10 in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Placement of External Ventricular Drainage Device	3 in the last 2 years	3 the last 2 years	2 concurrent	☐
☐	Placement of Intracranial Monitoring Devices	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Radiologic procedures to include CT, Fluoroscopy, and Ultrasound of deep & superficial organs and organ systems (including aspirations, biopsies, drainages, or injections)	25 in the last 2 years	25 in the last 2 years	5 concurrent	☐
☐	Removal of Intra-Aortic Balloon Pump	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Removal of Intra-cardiac lines or temporary Epicardial Pacer Wires	2 in the last 2 years	2 in the last 2 years	2 concurrent	☐
☐	Remove & reinsert PEG tube	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Replacement of tracheostomy tubes >1 month since time of tracheostomy	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐

Formatted: Left

Kaweah Health

Provider Name: _____ Date: _____

Please Print

☐	Surgical Assistant *(may not perform opening and/or closing surgical procedures at or below the fascia on a patient under anesthesia without the personal presence of a supervising physician and surgeon).*	10 in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Thoracentesis	5 in the last 2 years	5 in the last 2 years	Minimum of 2	☐
☐	Tilt Table	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Uncomplicated Ventilator Management	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐

ADVANCED OUTPATIENT PRIVILEGES

FPPE requirement waived if provider has successfully completed training (preceptorship) at Kaweah Health within the last 6 months

Request	Procedure	Criteria	Renewal Criteria	FPPE	Approve
☐	Colposcopy	Documentation of training and 10 procedures in the last 2 years.	10 procedures in the last 2 years.	A minimum of 1	☐
☐	Complex Wound Care (Wound debridement, application of skin substitutes, complicated management and wound biopsy) (Wound Care Center Only)	20 procedures in the last 2 years	20 procedures in the last 2 years	First 2 concurrent cases	☐
☐	Hospice: Rounding on home-bound patients enrolled in KDHCD Hospice Services	Initial Criteria for Core Privileges	20 patient contacts in the last 2 years.	2 concurrent or retrospective chart reviews.	☐
☐	Hyperbaric Oxygen Therapy Pre-requisite: Hyperbaric Course approved by the Undersea and Hyperbaric Medical Society (UHMS) or the American College of Hyperbaric Medicine (ACHM) (Wound Care Center Only)	Completion of 40 hour Hyperbaric Course **and** documentation of 20 cases in the last 2 years.	20 procedures **AND** documentation of 10 CME in wound care/hyperbaric medicine in the last 2 years	2 direct observation & 2 retrospective chart reviews	☐
☐	Joint Injection	Documentation of training and 5 procedures in the last 2 years (Use of Sim Lab acceptable for up to 2)	2 procedures in the last 2 years (Sim Lab procedures not accepted)	A minimum of 1	☐
☐	Nephrology: Changing dry weight, checking declots (Dialysis Centers Only)	Initial Criteria for Core Privileges	20 nephrology patient contacts in the last 2 years	2 concurrent or retrospective chart reviews.	☐
☐	OB Care: Prenatal and post-partum care	Documentation of training and 20 prenatal/ post-partum cases in the last 2 years. **AND** Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted **AND** Completion of an Implicit Bias Training prior to or within 30 days of privilege granted	20 prenatal/ post-partum cases in the last 2 years. **AND** Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months **AND** Completion of an Implicit Bias Training within the last 24 months	2 concurrent or retrospective chart reviews.	☐
☐	OB ultrasonography: Evaluation of fetal presentation, number, confirmation of cardiac activity, position and placental placement	Completion of Basic Obstetric Ultrasound course in limited U/S and 10 in the last 2 years.	10 in the last 2 years.	3 concurrent and/or retrospective chart reviews	☐
☐	Paragard and Mirena IUD insertion/removal	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Nexplanon insertion	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Pelvic examinations, including pap smears	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐

Kaweah Health

Provider Name: _____ Date: _____

Please Print

☐	Endometrial Biopsy	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Biopsy of the cervix	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Perform pharmacological and non-pharmacological stress tests	10 procedures in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Radiation Oncology: Assist with simulations; high dose rate brachytherapy, intravenous radioactive therapy, oral radioactive administration and atrontium beta-irradiation application	A minimum of 3-month training period with a radiation oncologist OR previous experience.	10 in the last 2 years	A minimum of 10 (including Core)	☐

ADDITIONAL PRIVILEGES					
Request	**Procedure**	**Initial Criteria**	**Renewal Criteria**	**FPPE**	**Approve**
☐	Use of fluoroscopy equipment (or supervision of other staff using the equipment)	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐
☐	Image-guided techniques as an adjunct to privileged procedures	Documentation of training and 10 procedures in the last 2 years.	10 procedures in the last 2 years.	None	☐
☐	Administration of Moderate Sedation	Successful completion of Kaweah Health sedation exam	Successful completion of Kaweah Health sedation exam	None	☐

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and; I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) I may participate in the Kaweah Health Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.

(c) **Emergency Privileges –** In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

_____ _____

Advanced Practice Provider Signature *Date*

_____ _____

Supervising/Collaborating Physician Signature *Date*

DEPARTMENT CHAIR SIGNATURE(S) :

_____ _____

Department of Cardiovascular Services *Date*

_____ _____

Department of Critical Care, Pulmonary & Adult Hospitalist *Date*

_____ _____

Department of Family Medicine *Date*

_____ _____

Kaweah Health

Provider Name: _____ Date: _____
Please Print

Department of Internal Medicine *Date*

_____ _____
Department of OB/GYN *Date*

_____ _____
Department of Pediatrics *Date*

_____ _____
Department of Psychiatry & Neurosciences *Date*

_____ _____
Department of Radiology *Date*

_____ _____
Department of Surgery *Date*

September 18, 2023

Attached are the Medical Staff Approved Proposed Bylaws & Rules and Regulations Revisions forwarded to the Board of Directors

Vote Statistics:

Sent to Active & Active-Voting Medical Staff Members (355)

Bylaws 3.B.2

Approve	89.66%	78
Not Approve	6.90%	6
Abstain	3.45%	3

Bylaws 5.B.1

Approve	91.36%	74
Not Approve	4.94%	4
Abstain	3.70%	3

Rules & Regulations 3.2.g

Approve	87.65%	71
Not Approve	1.23%	1
Abstain	11.11%	9

Rules & Regulations 3.2.r

Approve	84.52%	71
Not Approve	7.14%	6
Abstain	8.33%	7

Rules & Regulations 3.4.a.2

Approve	76.19%	64
Not Approve	19.05%	16
Abstain	4.76%	4

Rules & Regulations 3.4.b

Approve	78.57%	66
Not Approve	14.29%	12
Abstain	7.14%	6

Rules & Regulations 3.4.c

Approve	76.74%	66
Not Approve	16.28%	14
Abstain	6.98%	6

3.B. ACTIVE NON-VOTING STAFF

3.B.1 Qualifications:

The Active Non-Voting Staff shall consist of physicians, dentists, oral surgeons, podiatrists, and psychologists who:

(a) meet the general qualifications for membership as set forth in section 2.A.1; and

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

3.B.2 Prerogatives and Responsibilities:

Active Non-Voting Staff members:

(a) may attend and participate in Medical Staff, department, and division meetings (without vote);

(b) may not hold office or serve as department chairs, division chairs, or committee chairs (unless waived by the MEC);

(c) may be invited to serve on committees (with vote);

(d) shall cooperate in the professional practice evaluation and performance improvement processes, including the evaluation of new members of the Medical Staff;~~;~~

~~(d)~~(e) shall accept inpatient consultations when requested by another member of the Medical Staff;

~~(e)~~(f) ~~shall~~ may exercise such clinical privileges as are granted to them; and

~~(f)~~(g) shall pay application fees, dues, and assessments.

Rationale: Clarifying responsibilities of Active Non-Voting members to match Active-Voting for privileging.

5.B TEMPORARY CLINICAL PRIVILEGES

5.B.1 Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO, upon recommendation of the Department Chair, Chief of Staff, and Chief Medical Officer, under the following conditions:

(1) the applicant has submitted a complete application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no pending or previous adverse action against the applicant's license or DEA registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

~~(4) the Chief of Staff determines that extenuating circumstances exist and that an urgent patient care need supports the need to grant temporary privileges for the new applicant;~~

~~(5)~~(4) the application is pending review by the MEC and the Board, following a favorable recommendation ~~by the Credentials Committee after considering the~~ and evaluation ~~of~~from the department chair; and

~~(6)~~(5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.

Rationale: Urgent Patient Care need is not required for a temporary application that is clean and only waiting for committee approval per The Joint Commission; the Credentials Committee is unlikely to have a different recommendation for a clean applicant and waiting for this committee may cause a delay in receiving privileges.

3.2 (g) Vaginal Delivery Report ~~Content~~: The delivery report will be documented by the obstetrician, family physician or nurse midwife responsible for the delivery and must be on the chart at 24 hours. If the delivery occurred without a provider in attendance, then the provider performing the inspection for lacerations and/or the delivery of the placenta shall complete the report. The delivery report will include certain elements as listed in the current MEC approved Required Elements of Delivery Report.

Rationale: To ensure compliance with the required delivery note elements and clearly define who is responsible for the report

3.2. Content and Timeliness of Medical Record Documentation:

(r) Outpatient Testing: Outpatient tests will be read by the provider and a report will be available in the medical record within 24 hours if it is urgent or preoperative testing and within 7 days if it is routine testing.

Rationale: The inability to access this report can cause a delay in patient care, unnecessary repeat testing, and can cause a billing delay.

3.4. Delinquent Medical Records:

(a) General Requirements:

(1) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the District. If the patient care and/or discharge happened when a resident physician was covering, then the ultimate responsibility for record completion resides with the supervising physician. Non-compliance of medical record completion includes the use of unapproved abbreviations, incomplete PRN medication orders, incomplete/missing documentation, and illegible documentation.

(2) The following documents must be available in the electronic medical record (or on the paper chart when the electronic medical record is experiencing downtime), authenticated, and co-signed (if applicable) within the following time frames:

(i) History and physical: within 24 hours of admission.

(ii) Brief operative/procedure note: before patient moves to the next level of care (not needed if a full operative report is typed and ready before patient moves to the next level of care).

(iii) Full operative/procedure report: within 24 hours of procedure.

(iv) Consultation report: within 24 hours of the documented request for consultation.

(v) Discharge/Death summary (acute care hospital): preferably on the day of discharge and no later than five days from discharge.

(vi) Discharge/Death summary (long-term care): 30 days from discharge.

(vii) Verbal/Telephone orders for medications: 48 hours

(viii) Progress Note (acute care hospital): daily before midnight

(ix) Progress Note (long-term care): every other week

(x) Ambulatory Care Documentation: 48 hours

(xi) Resident Co-Signature: 24 hours from the resident signature

(xii) Pre-anesthesia Evaluation: before the start of surgery

(xiii) Post-Anesthesia Evaluation: 48 hours or before discharge whichever is shorter

(~~i~~xiv) Answering Queries: 72 hours

(xv) Emergency Department documentation: immediately following discharge/transfer of the patient from the ED

(xvi) Dictated documents shall be signed within 24 hours of being available for signature

**All documentation must be in the Electronic Medical Record in the above time frames, and electronically signed within 24 hours of being available for signature

(b) Notification: If a medical record is incomplete as defined in Article 3 of Medical Staff Rules and Regulations, ~~the~~the ~~-~~HIM Department ~~HIM Department~~ will notify the practitioner by email ~~in writing~~ of the delinquency and that his or her clinical privileges are at risk of automatic ~~administrativeutomatic~~ suspension in accordance with the Medical Staff Bylaws and the Suspension Policy.

(c) Enforcement: : Failure to complete medical records within the time frames specified in Section 3.4(a)(2) will trigger the process set forth in the Suspension Policy, which can result in administrative suspension and termination of Medical S~~f~~taff membership and/or privileges following issuance of the notices required by the Suspension Policy.

~~Failure to complete medical records within seven5 days of being notified will result in automatic suspension of all certainclinical privileges to admit new patients, schedule, or perform elective procedures and surgeries, in accordance with the Suspension PolicyMedical Staff Bylaws, Section 8.E.1. Thereafter, if the delinquent medical records are not completed within seven days, all the practitioner's clinical privileges will be administratively suspended in accordance with the Suspension Policy. Thereafter, if the delinquent medical records are not completed within 14 days of the full suspension, the practitioner's Medical Staff membership and clinical privileges will be automatically terminated in accordance with the Suspension Policy.~~

~~(d) Automatic Suspension Procedures: In the event that an automatic suspension occurs, tThe HIM Department, under the direction of the HIM Committee, is responsible for issuing all notices of delinquent medical records and administrative suspensions and terminations to the practitioner, with copies to practitioner's Department Chair, Medical Staff Services Department, and any applicable Medical Director, in accordance with the Suspension Policy. The HIM Department is also will be responsible for notifying the Chief of Staff, the Emergency Department, nursing administration, and other key departments of all automatic suspensions. In the case of administrative suspensions and terminations, Tthe practitioner will be responsible for transferring the care of any patients that he or she may have in the Medical Center District to a practitioner withwho has appropriate clinical privileges. If the practitioner is unable or fails to appropriately transfer the care of his or her patients, the Chief of Staff will assign the care of such patients to a practitioner(s) withwho has appropriate clinical privileges.~~

~~(e) Reinstatement After Suspension: Any practitioner who has his or her clinical privileges suspended as a result of medical record delinquencies must complete all delinquent and pending delinquent medical records. The practitioner must notify the HIM Department of completion of all records. Once HIM verifies all medical records have been completed, a reinstatement will be processed in accordance with the Suspension Policy.~~

~~(f) If the medical record deficiencies are not resolved within 60 days of notification of the individual has not requested reinstatement within 60 days of the date of the automatic suspension, the individual shall be deemed to have voluntarily resigned from the Medical Staff. Special Notice of the voluntary resignation shall be given to the affected individual, and regular notice of this occurrence will be given to the MEC, CEO, and Board.~~

Diversion Prevention

Evelyn McEntire and Shannon Cauthen

Bluesight Optimization

- Full use of IRIS (Individualized Risk Identification Score)-> Investigations now completed by Nurse Managers (NMs)
- Investigation Questionnaire drafted and provided to NMs
- 1:1 meetings between Pharmacy Leaders and NMs about how to complete investigations
- Guidance tool created for NMs: outlines expectations for response times to daily variances and IRIS investigations and how to apply Just Culture follow-up when repeated variances are created by the same user.

Kaweah Health
MORE THAN MEDICINE. LIFE.

Diversion Prevention Sub-Committee

{1st Weekers}

- Meets the first week of the month (hence the name ☺)
- Review IRIS investigations that were completed by NMs on staff who have had 2 or more elevated IRIS scores within 6 months
- Spot check any other areas of concern in investigations
- Follow up regarding leader response timeliness, non-clinical leaders reviewing variances etc.

Kaweah Health

Audit Review

- Following the Plan of Correction in May of 2021, a number of pharmacy audits were reviewed and reported up through DPC for compliance monitoring. All of the reviewed audits achieved 100% compliance and have since been modified or completed from our audit review.

- In an effort to provide safe patient care and full transparency, on-going reviews include:
  - Pharmacy team and Dr. Romo review 10 short cases per month.
  - Dr. Romo reviews one case per provider per quarter. Approximately 60 Anesthesia providers are reviewed each quarter.
  - When Dr. Romo's cases are reviewed, a second provider reviews that case independent of Dr. Romo.
  - Concerns are notated in an excel spreadsheet and follow up is tracked and completed by Dr. Romo and Pharmacy.

Education

- Booth at Patient Safety Fair
- “Strange” Education: shared org-wide
- Continued education at time of hire and annually via Mandatory Annual Training (MAT)

Next Steps

- Meetings changed from monthly to quarterly (QIC approved)
- QIC recommends moving the work to Patient Care Med Safety Committee and then P&T
- DPC Leaders attending 6-week Bluesight Webinar series to learn about how to grow our Diversion Prevention Program

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

FY 2024 Strategic Plan

Patient Experience and Community Engagement

September 27, 2023

World-Class Service Champion: Keri Noeske

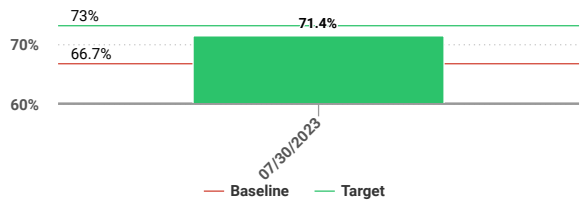
Objective: *Develop strategies that provide our health care team the tools they need to deliver a world-class health care experience.*

Plan

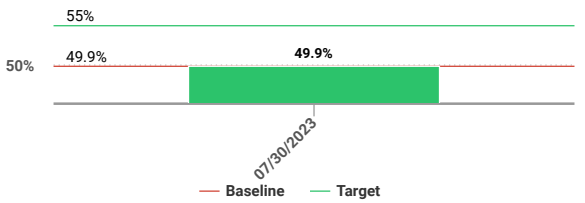
#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.1.1	Objective	Provide trainings & tools to team members on how to deliver world-class service.	07/01/2023	06/30/2024	Keri Noeske	On Track	Collecting of patient stories for editing and integration into weekly communications organization wide. Plan to use short stories focused on compassion, customer service and human connections to educate and adjust culture for compassionate service expectations. Stories to be shared with organization leaders by October 19, 2023 for implementation into weekly communications and huddles.
6.1.2	Objective	Enhance patient navigation across the health care continuum.	07/01/2023	06/30/2024	Deborah Volosin	On Track	Project assigned to Jacob Kennedy to initiate review and plans for patient navigation across continuum. Assessment of opportunities, development of interventions and implementation of changes planned over next 12 months.
6.1.3	Objective	Patient Wayfinding	07/01/2023	06/30/2024	Deborah Volosin	On Track	A community wayfinding exercise took place at the main campus during the month of August. "Secret shoppers" were assigned destinations (or units) and asked to answer questions during that assignment on various areas of focus. (Facilities, cleanliness, directions, friendliness of staff, website, parking, etc.) On September 6th, we had an in-person meeting with the participants and the Patient Experience Steering Committee. This committee is comprised of the directors of EVS, Food Services, Security, Facilities, Marketing, Community Engagement; and the Chief Nursing Officer. After that focus group, the directors over the surveyed areas met and were assigned the tasks of coming up with action plans based on the survey results. Those action plans are due at the end of September. We will be presenting the results of the survey and the action plans to the Board of Directors at the October Board of Directors meeting. The goal of this exercise was to better understand the needs of patients and visitors and to get a glimpse of our facility through the community's eyes.
6.1.4	Outcome	Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey	07/01/2023	06/30/2024	Keri Noeske	On Track	July 2023 Score 71.4
6.1.5	Outcome	Achieve Patient Feedback Score Goal on ED Survey	07/01/2023	06/30/2024	Keri Noeske	Off Track	Patient Experience Steering committee requested progress and action plan updates to address patient experience score decline. Sending education on scripting care and communication to providers, working with clinical and EVS staff on appearance of department.
6.1.6	Outcome	Achieve the 75th Percentile in HCAHPS Care Transitions Score	07/01/2023	06/30/2024	Keri Noeske	On Track	July 2023 score - Patient Experience project focused on care transitions initiated in August 2023 with the Patient Navigation team. Analyzing opportunities to develop specific action items for improvement.
6.1.7	Outcome	Improve Net Promoter Score (NPS) Clinics - Would Recommend Provider	07/01/2023	06/30/2024	Keri Noeske	On Track	Continue focused efforts in the clinics to address needs as they come up with real time surveys.
6.1.8	Outcome	Achieve overall Organization Net Promoter Score of 83.2 (October 2023 - June 2024)	07/01/2023	06/30/2024	Keri Noeske	On Track	

World-Class Service Champion: Keri Noeske

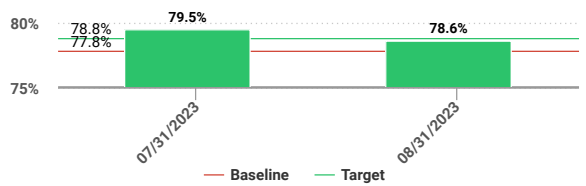
Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey



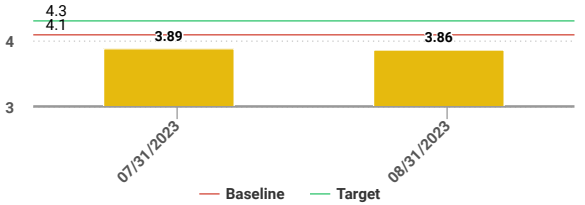
Achieve the 75th Percentile in HCAHPS Care Transitions



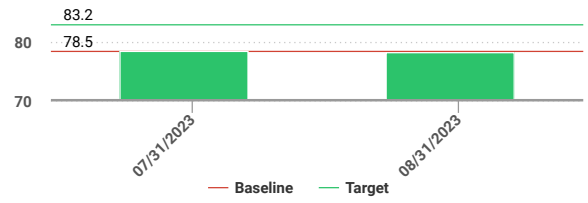
Improve Net Promoter Score Clinics - Would Recommend Provider



Achieve 4.3 Patient Feedback Score Goal on ED Survey



Achieve overall Organization Net Promoter Score of 83.2 (October 2023 - June 2024)



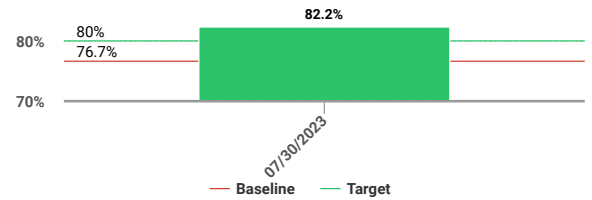
Increase Compassionate Communication Champions: Keri Noeske

Objective: *Improve physician and nursing communication and responsiveness of staff.*

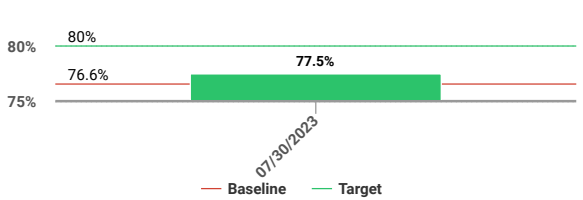
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.2.1	Objective	Develop an expectation for best practice provider and team communication (training and coaching)	07/01/2023	06/30/2024	Keri Noeske	Not Started	Assigned to Patient Experience Committee objectives for FY24.
6.2.2	Objective	Bedside Rounds - Health Care Team Rounds Implemented in all Med Surg and Critical Care areas	07/01/2023	06/30/2024	Keri Noeske	On Track	Rounds in place in all med/surg areas. Next steps to validate continued use of rounds to communicate with care team and the patient or family each day, including plan of care and discharge needs.
6.2.3	Outcome	Achieve the 60th Percentile in Physician Communication Score	07/01/2023	06/30/2024	Keri Noeske	On Track	Developing training for physician and nursing communication to maintain progress and develop consistent habits with workforce. Planning meeting scheduled for 9/19 - Patient Experience Committee and Org Development collaborating on curriculum and implementation.
6.2.4	Outcome	Achieve the 60th Percentile in Nursing Communication Score	07/01/2023	06/30/2024	Keri Noeske	On Track	Developing training for physician and nursing communication to maintain progress and develop consistent habits with workforce. Planning meeting scheduled for 9/19 - Patient Experience Committee and Org Development collaborating on curriculum and implementation.
6.2.5	Outcome	Achieve the 70th Percentile in Responsiveness of Staff to Patients and Among Internal Teams	07/01/2023	06/30/2024	Keri Noeske	On Track	Developing training for physician and nursing communication to maintain progress and develop consistent habits with workforce. Planning meeting scheduled for 9/19 - Patient Experience Committee and Org Development collaborating on curriculum and implementation.

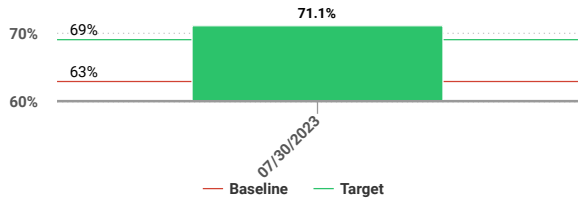
Achieve the 60th Percentile on Physician Communication Scores



Achieve the 60th Percentile on Nursing Communication Scores



Achieve the 70th Percentile in Responsiveness of Staff to Patients and Internal Teams



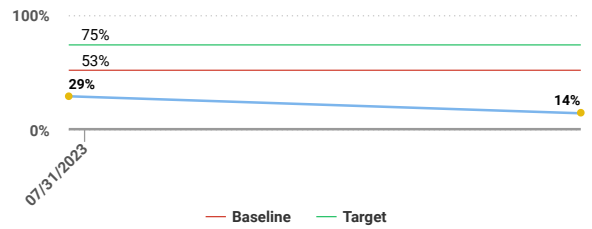
Enhancement of Environment Champion: Deborah Volosin

Objective: *To create a secure, warm and welcoming environment for patients and the community.*

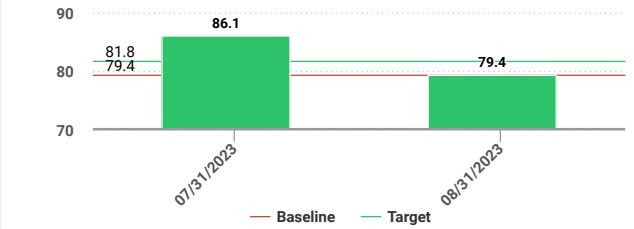
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.3.1	Objective	Environmental Rounds: Identify and Respond to Environmental Needs	07/01/2023	06/30/2024	Deborah Volosin	On Track	Marc Mertz, Dianne Cox, Kevin Morrison and Tendai Zinyemba have started monthly rounds at the main campus identifying things that need to be fixed or updated. As a result of these rounds changes have been or are going to be made to the following areas: 3 West, Acequia Wing main hallway, 4 South nurse station, and 4 Center restroom. The Green Committee met in June and brainstormed ideas for making Kaweah a more environmentally friendly organization. Ideas included refillable water bottle stations, composting food waste, drought tolerant landscaping, recycling program, biodegradable silverware, and battery recycling. These ideas are being vetted at the Director level to determine if they are financially feasible.
6.3.2	Outcome	Reunite 75% of Lost Belongings with Owners	07/01/2023	06/30/2024	Keri Noeske	Off Track	Lost belongings reports reviewed by executive leaders, details taken to Patient Care Management. Changing investigation approach and processes in areas where highest incident of lost belongings occurring. Opportunity in the ED to improve keeping belongings with patient during movement.
6.3.3	Outcome	Improve the Cleanliness of Clinic Environment	07/01/2023	06/30/2024	Keri Noeske	On Track	August 2023 Score is 79.4 with NRC benchmark of 81.8. Clinic team and EVS team aware of feedback and collaborating to address project action item identification and implementation.
6.3.4	Outcome	Achieve the 50th Percentile in HCAHPS Cleanliness Survey Score (Inpatient)	07/01/2023	06/30/2024	Keri Noeske	Off Track	Cleanliness and Quietness score combined in HCAHPS. Feedback from wayfinding survey being used to develop action plans on addressing cleanliness in acute hospital.

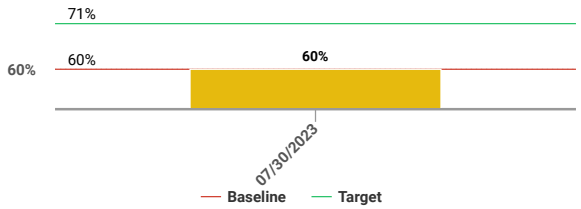
Reunite 75% of Lost Belongings with Owners



Improve Cleanliness of Clinic Environment



Achieve the 50th Percentile in HCAHPS Cleanliness Score (Inpatient)



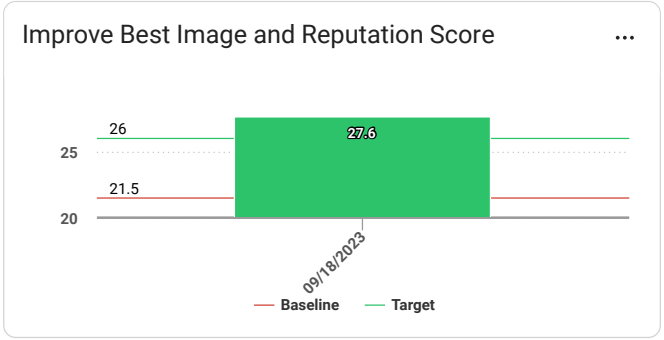
Community Engagement Champion: Deborah Volosin and Keri Noeske

Objective: *To provide an environment where community members and patients are able to assist staff in co-designing safe, high quality, and world-class care and services.*

Plan

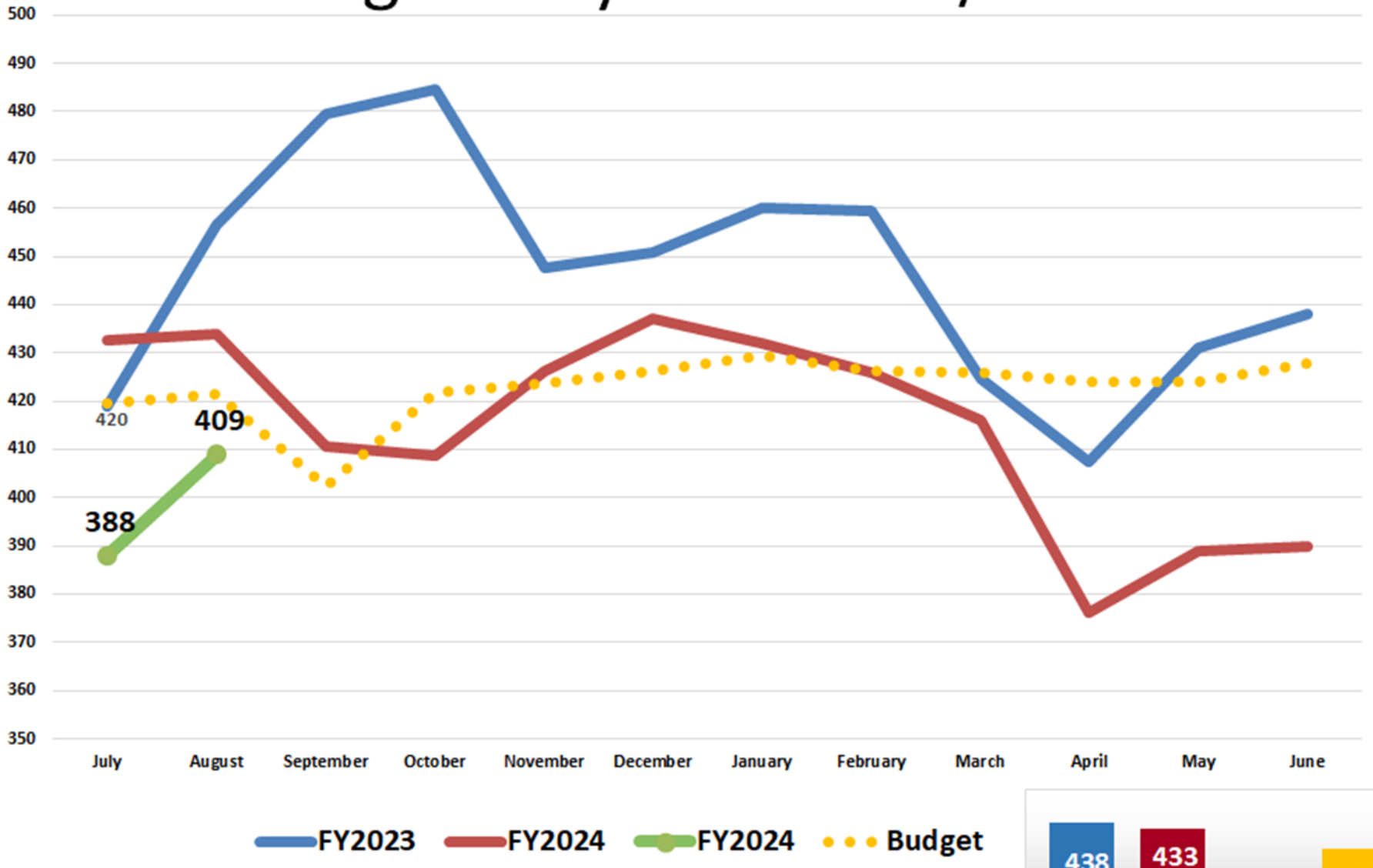
#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.4.1	Objective	Report on Community Engagement Activities	07/01/2023	06/30/2024	Deborah Volosin	On Track	We continue to meet monthly with the five advisory councils and the employee ambassador group. In the month of August we had a Community Ambassador Meeting. We have connected a new leader with a service club, which gives us a total of 14 leaders in local community service clubs. We sponsored several community events and participate monthly in the VEDC, Industrial Park Roundtable, Tulare Kings Hispanic Chamber of Commerce Ambassador Roundtable, and Visalia Chamber of Commerce Ambassador roundtable. . We had a booth at the Tulare County Fair and were able to advertise our Maternal Child Health services, the Lifestyle Center programs, the Rapid Response Team, and the services available at the Kaweah Health Outpatient Clinics.
6.4.2	Objective	Continue to meet with Community Advisory Councils and Ambassador groups to gain community and employee insights and support	07/01/2023	06/30/2024	Deborah Volosin	On Track	We meet monthly with five advisory councils. (Healthcare for Today and Tomorrow, Diversity/Community Relations, Emergency Department Advisory Council, Patient Family Advisory Council, Employee Ambassadors) We met in August with the Community Ambassador group and educated them on the Hospitalist Program.
6.4.3	Objective	Explore ways to collaborate on modernization efforts with other health care districts, Central Valley Healthcare Alliance, and the County of Tulare	07/01/2023	06/30/2024	Deborah Volosin	On Track	Leaders from Kaweah Health and Sierra View have been meeting to discuss and prioritize opportunities to revitalize CVHA, including operational and clinical opportunities. These efforts have taken on new importance given SB525.
6.4.4	Objective	Promote Community Engagement program with new membership, new Councils, and a new onboarding program	07/01/2023	06/30/2024	Deborah Volosin	On Track	The Diversity Ambassadors merged with Community Relations and that has invigorated the group. In the last two months we have added one new member to the EDAC and two new members to the Diversity/CR Council. Seven new members were added to the Employee Ambassador Group in September. We will be kicking off a recruitment campaign in November for new membership and are working with Marketing and Media Relations to develop the media/marketing plan around this recruitment effort.
6.4.5	Objective	Continue to promote Speakers Bureau	07/01/2023	06/30/2024	Deborah Volosin	On Track	Ryan Gates and Ivan Jara attended the August VEDC meeting and the Industrial Park Roundtable to discuss the Industrial Park Clinic and to get feedback on the services needed at that location. We are currently scheduling multiple programs for the Downtown Rotary.
6.4.6	Objective	Continue to monitor legislation around seismic regulations and financial implications related to replacing the Mineral King Wing and keep the community engagement participants informed of the legislative updates. If needed, plan community webinars, town halls, social media posts, and other communicative methods if these updates are concerning or have a significant impact to Kaweah Health.	07/01/2023	06/30/2024	Deborah Volosin	Not Started	
6.4.7	Objective	Kick off a new Foundation fundraising campaign	07/01/2023	06/30/2024	Deborah Volosin	Not Started	The Kaweah Health Foundation's current campaign, Caring for our Caregivers, will run through June of 2024. They have a lot of activities in the month of October, mainly focused around Breast Cancer Awareness Month.
6.4.8	Outcome	Improve Best Image and Reputation Score (26)	07/01/2023	06/30/2024	Deborah Volosin	On Track	The Best Image/Reputation score is at 27.6 for the third quarter of 2023.

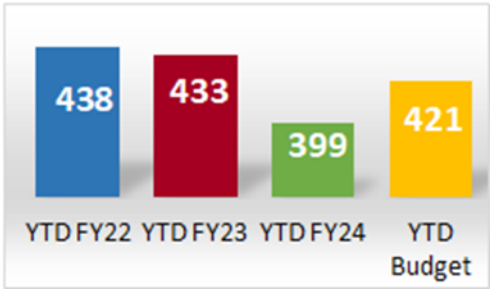
Community Engagement Champion: Deborah Volosin and Keri Noeske



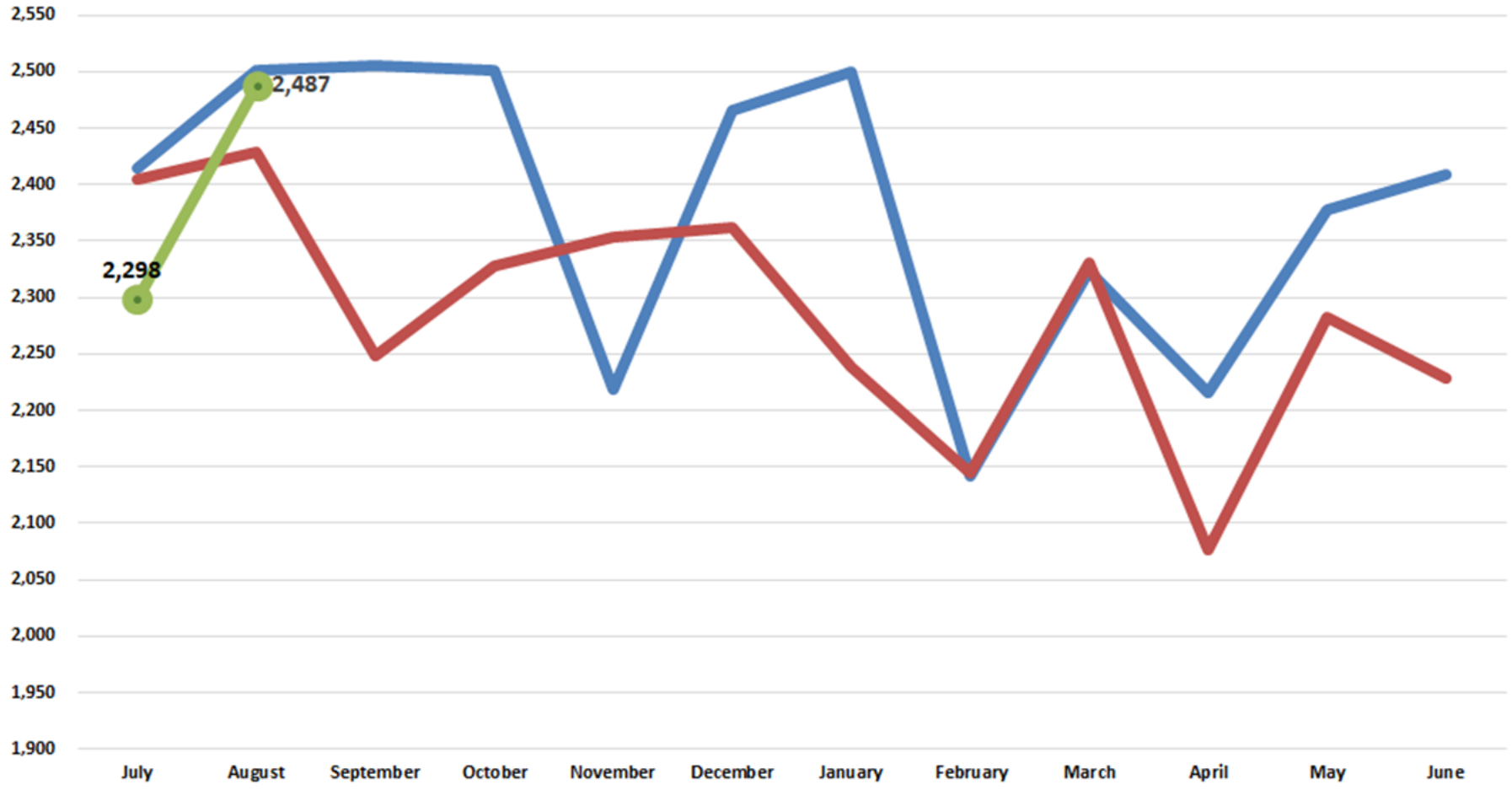
CFO Financial Report
Financials
Month Ending August 2023

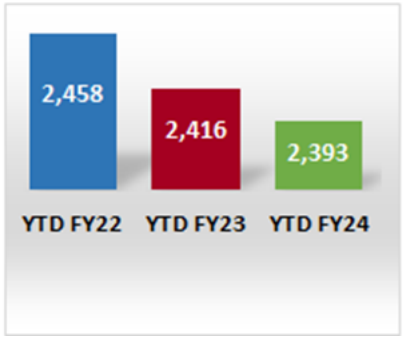
Average Daily Census w/o TCS



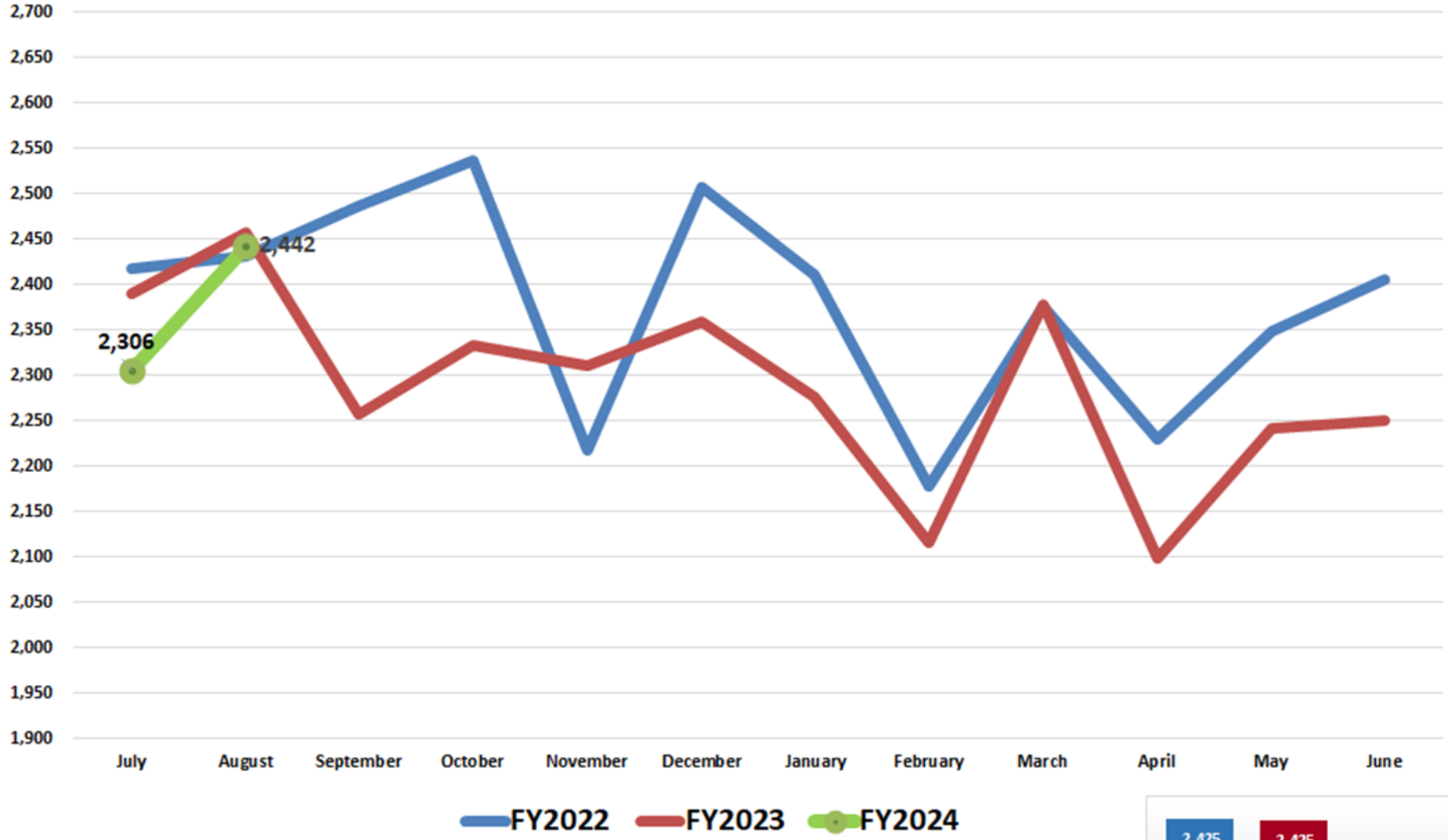


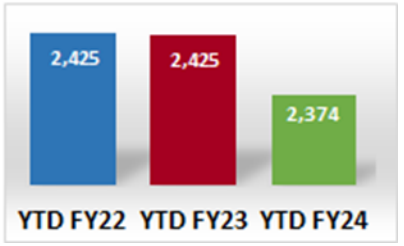
Admissions


2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,487
2,298
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024


2,458
2,416
2,393
YTD FY22
YTD FY23
YTD FY24

Discharges

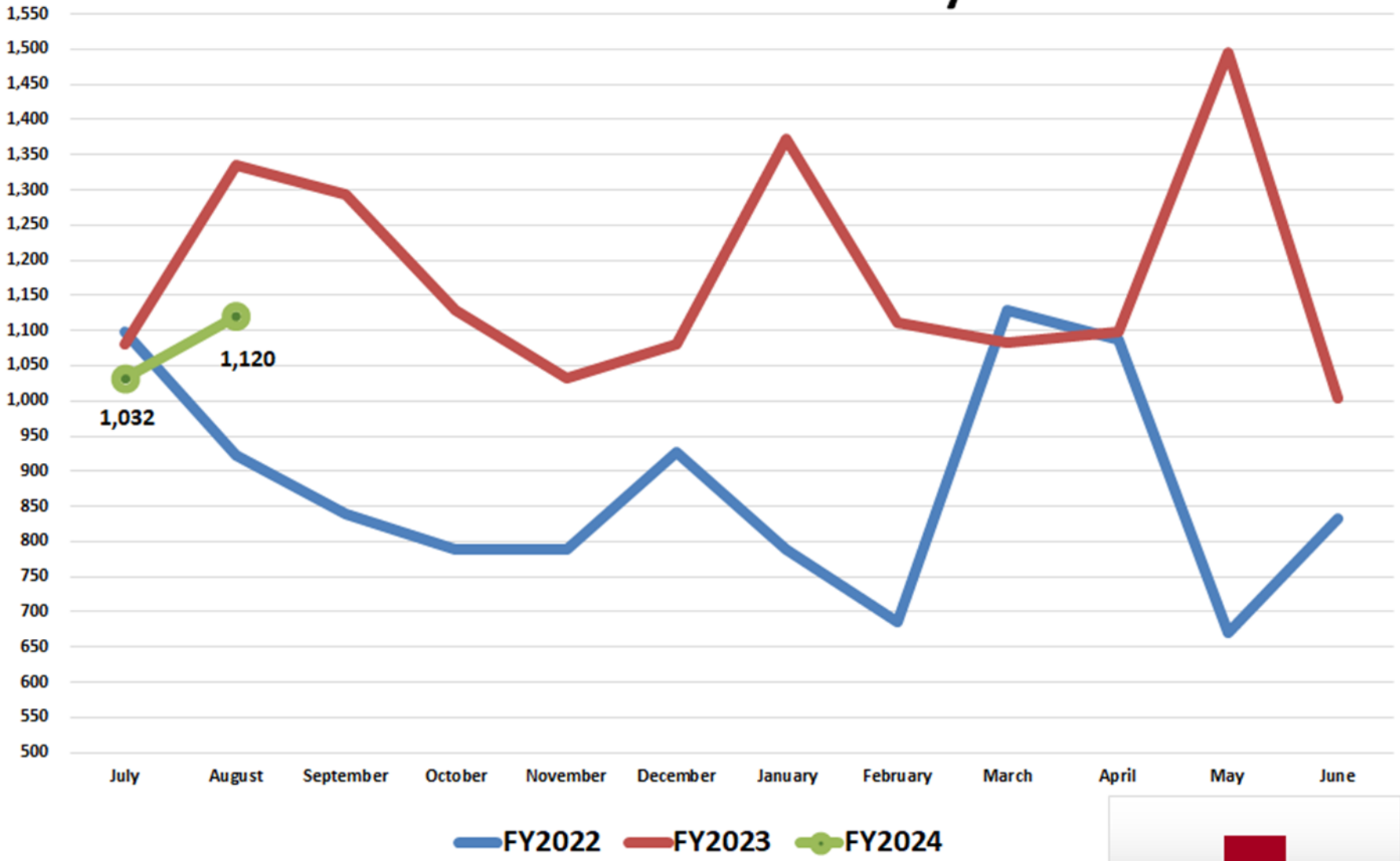

2,700
2,650
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,442
2,306
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024

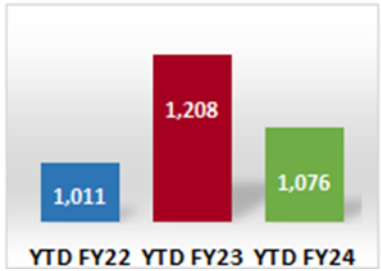

2,425
2,425
2,374
YTD FY22
YTD FY23
YTD FY24

Average Length of Stay versus National Average (GMLOS)

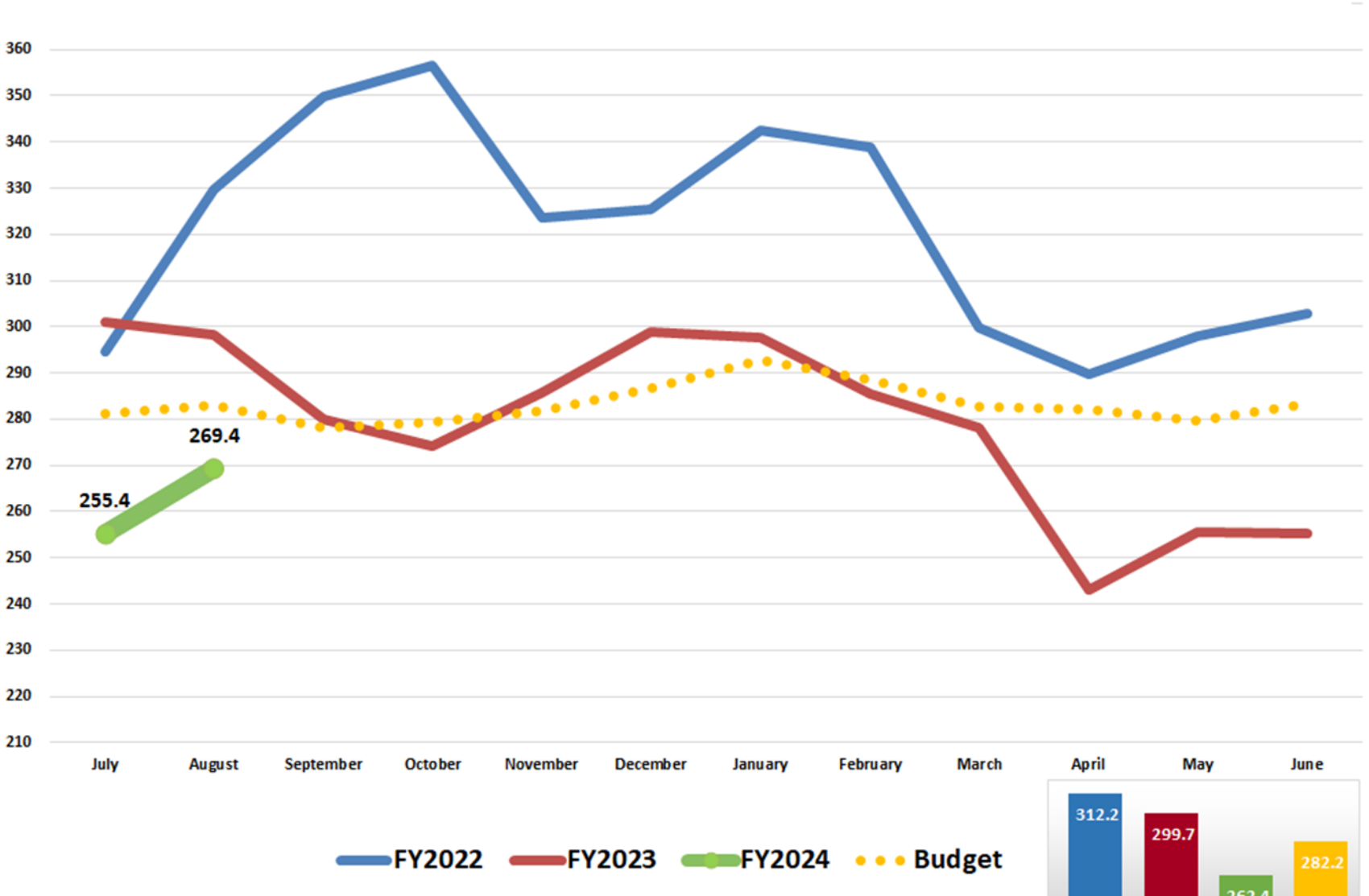
	Including COVID Patients			Excluding COVID Patients				
	ALOS	GMLOS	GAP	ALOS	GMLOS	GAP	Gap Diff	%
Aug-21	6.25	4.39	1.86	5.95	4.05	1.90	(0.04)	-2%
Sep-21	6.72	4.52	2.20	5.89	4.08	1.81	0.39	18%
Oct-21	6.51	4.38	2.13	5.33	4.00	1.33	0.80	38%
Nov-21	7.00	4.37	2.63	5.75	3.95	1.80	0.83	32%
Dec-21	6.82	4.23	2.59	6.12	3.98	2.14	0.45	17%
Jan-22	6.09	4.26	1.83	5.96	3.96	2.00	(0.17)	-9%
Feb-22	6.61	4.23	2.38	5.86	3.83	2.03	0.35	15%
Mar-22	6.61	4.02	2.59	5.68	3.89	1.79	0.80	31%
Apr-22	5.79	3.99	1.80	5.67	3.98	1.69	0.11	6%
May-22	5.99	3.94	2.05	5.63	3.89	1.74	0.31	15%
Jun-22	6.11	3.97	2.14	5.62	3.88	1.74	0.40	19%
Jul-22	5.93	4.06	1.87	5.66	3.90	1.76	0.11	6%
Aug-22	5.95	3.94	2.01	5.62	3.82	1.80	0.21	10%
Sep-22	6.57	4.02	2.55	6.32	3.95	2.37	0.18	7%
Oct-22	5.83	3.97	1.86	5.62	3.91	1.71	0.15	8%
Nov-22	5.93	3.77	2.16	5.87	3.74	2.13	0.03	1%
Dec-22	6.13	4.01	2.12	5.68	3.92	1.76	0.36	17%
Jan-23	6.80	4.05	2.75	6.28	3.94	2.34	0.41	15%
Feb-23	6.59	4.09	2.50	6.39	4.04	2.35	0.15	6%
Mar-23	5.68	3.99	1.69	5.55	3.93	1.62	0.07	4%
Apr-23	5.34	3.99	1.35	5.06	3.94	1.12	0.23	17%
May-23	5.37	3.94	1.43	5.15	3.91	1.24	0.19	13%
Jun-23	5.38	3.89	1.49	5.32	3.86	1.46	0.03	2%
Jul-23	5.48	3.84	1.64	5.46	3.82	1.64	-	0%
Aug-23	5.27	3.81	1.46	5.21	3.77	1.44	0.02	1%
Average	**5.97**	**4.11**	**1.85**	**5.52**	**3.95**	**1.57**	**0.28**	**15%**

Observation Days

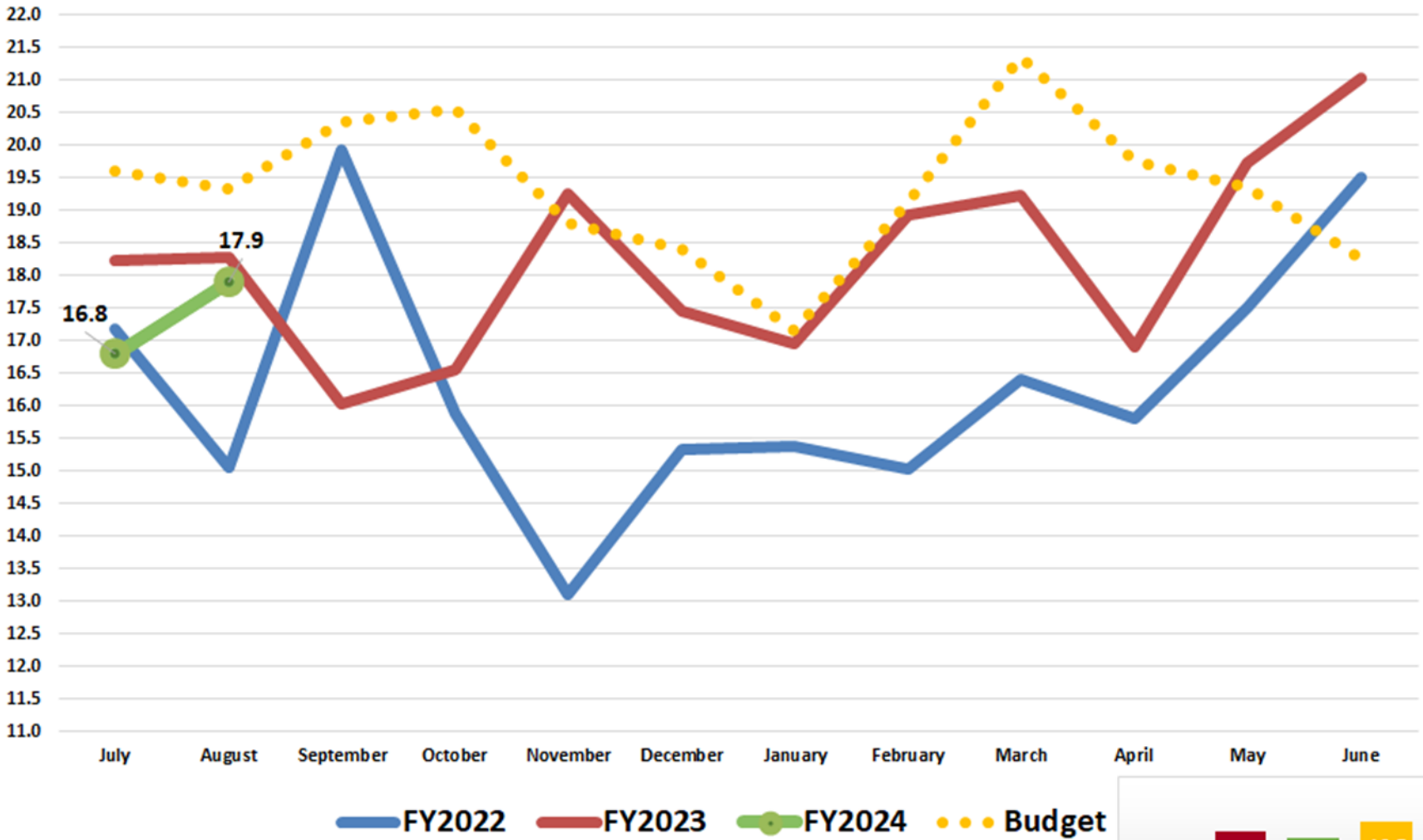


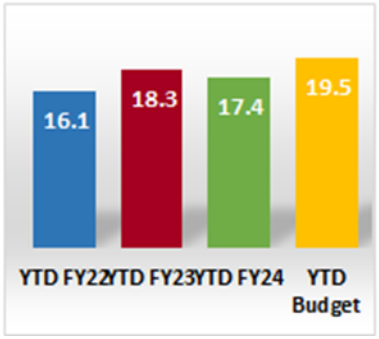


Medical Center (Avg Patients Per Day)

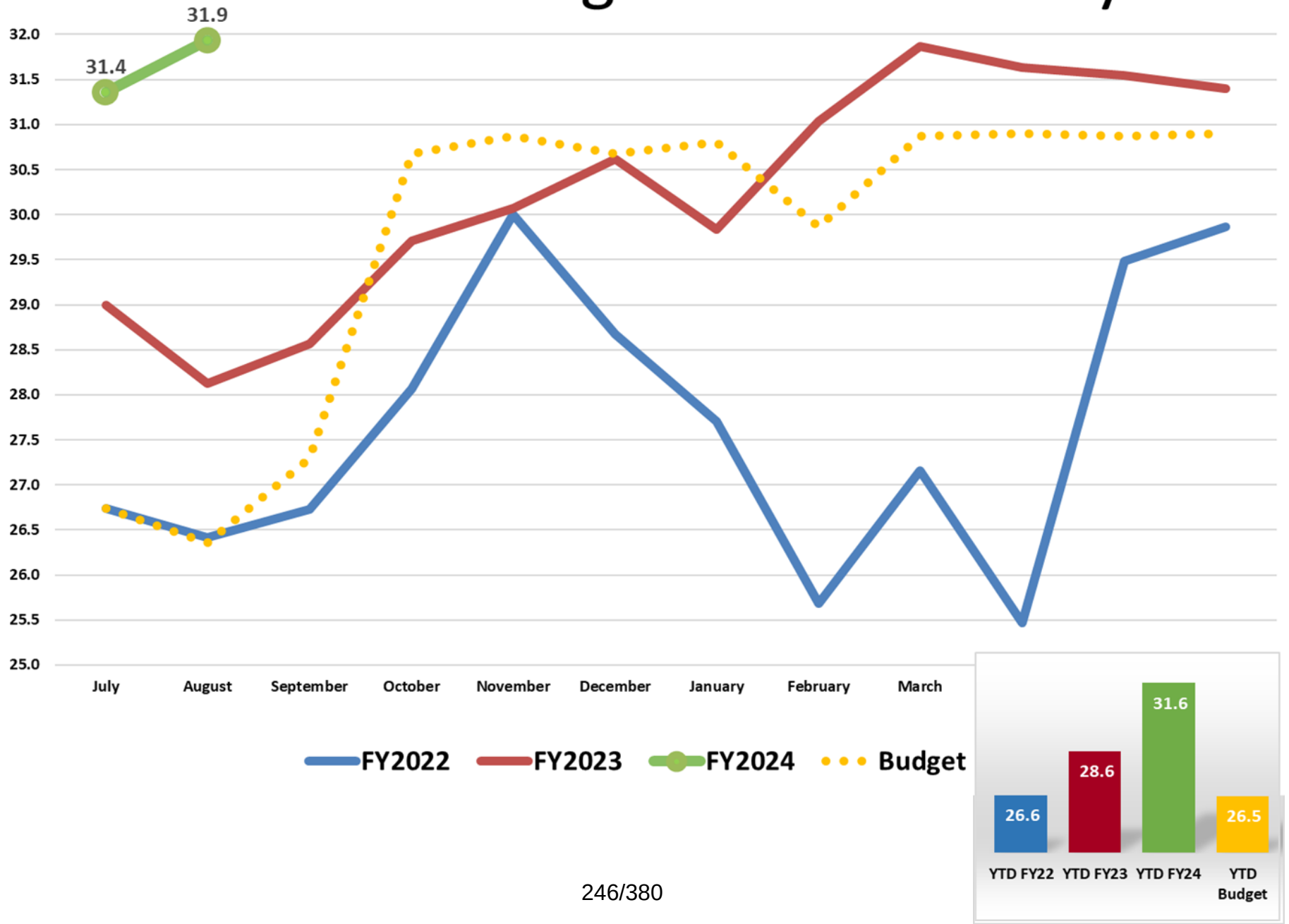


Rehabilitation Hospital - Avg Patients Per Day

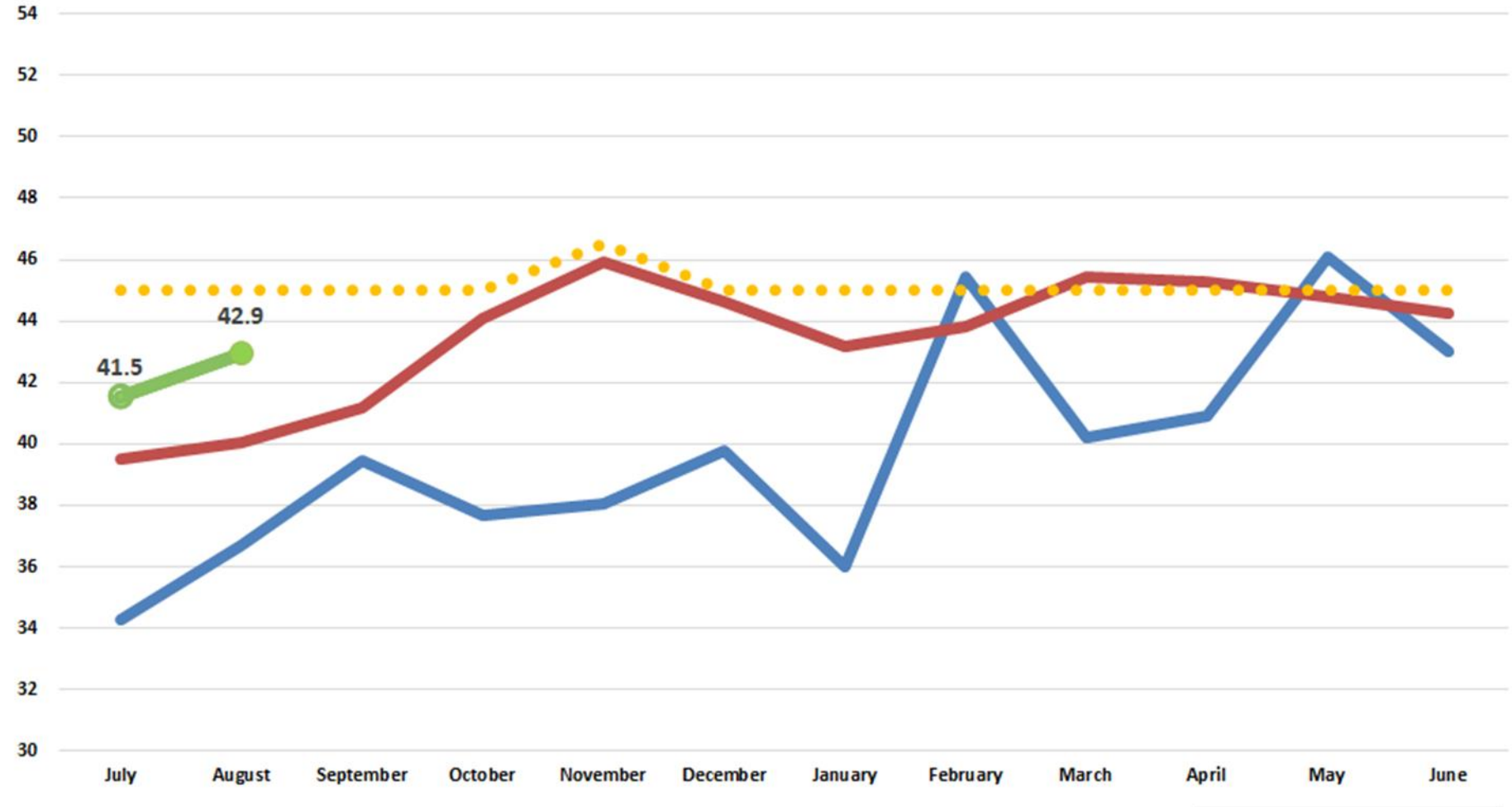


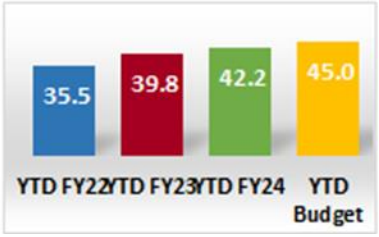


Sub-Acute - Avg Patients Per Day

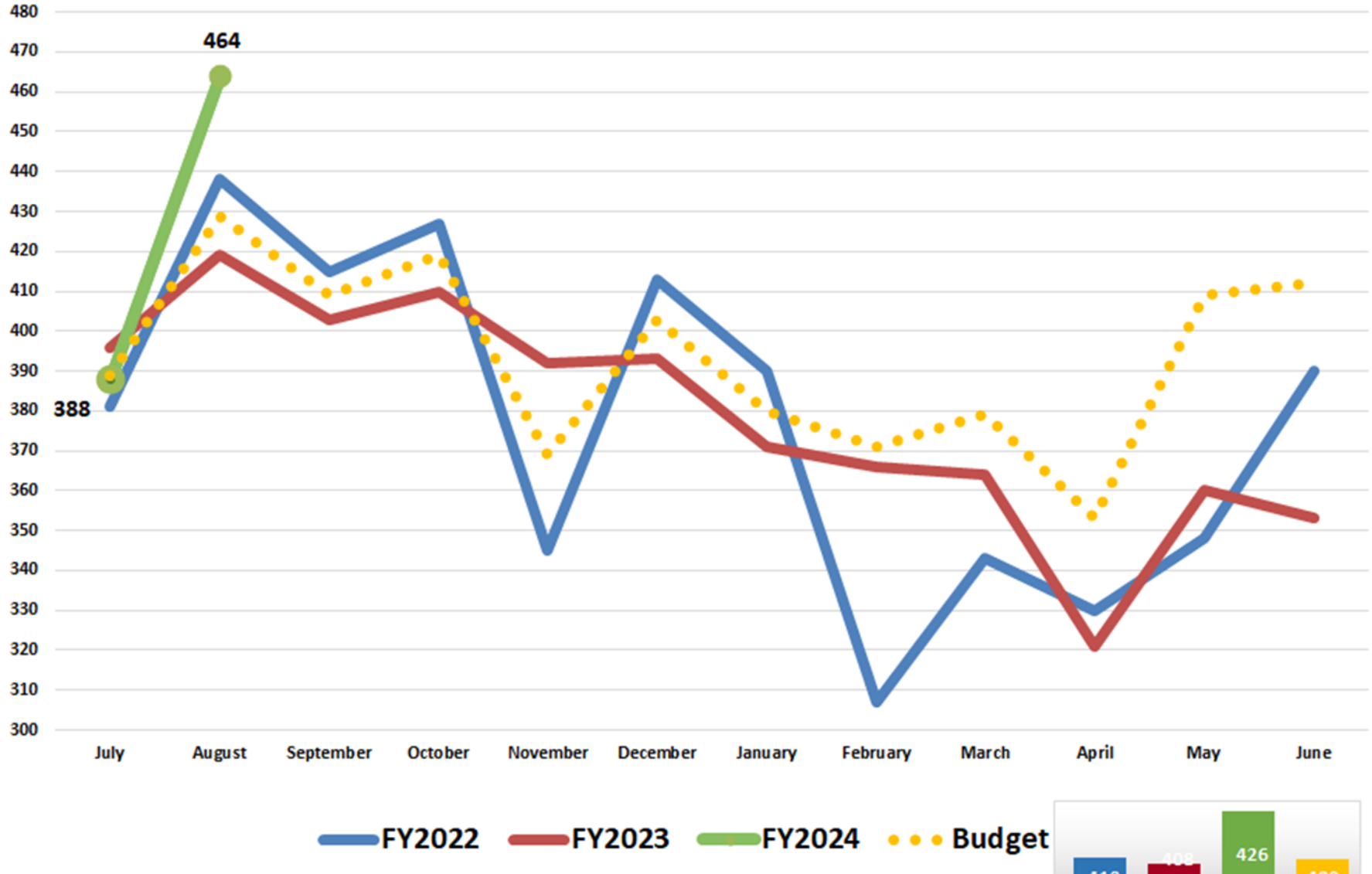


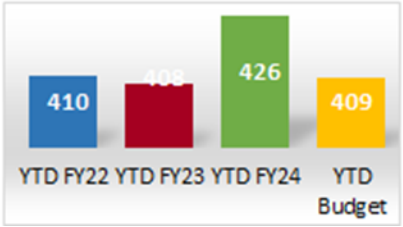
Acute I/P Psych (Avg Patients Per Day)



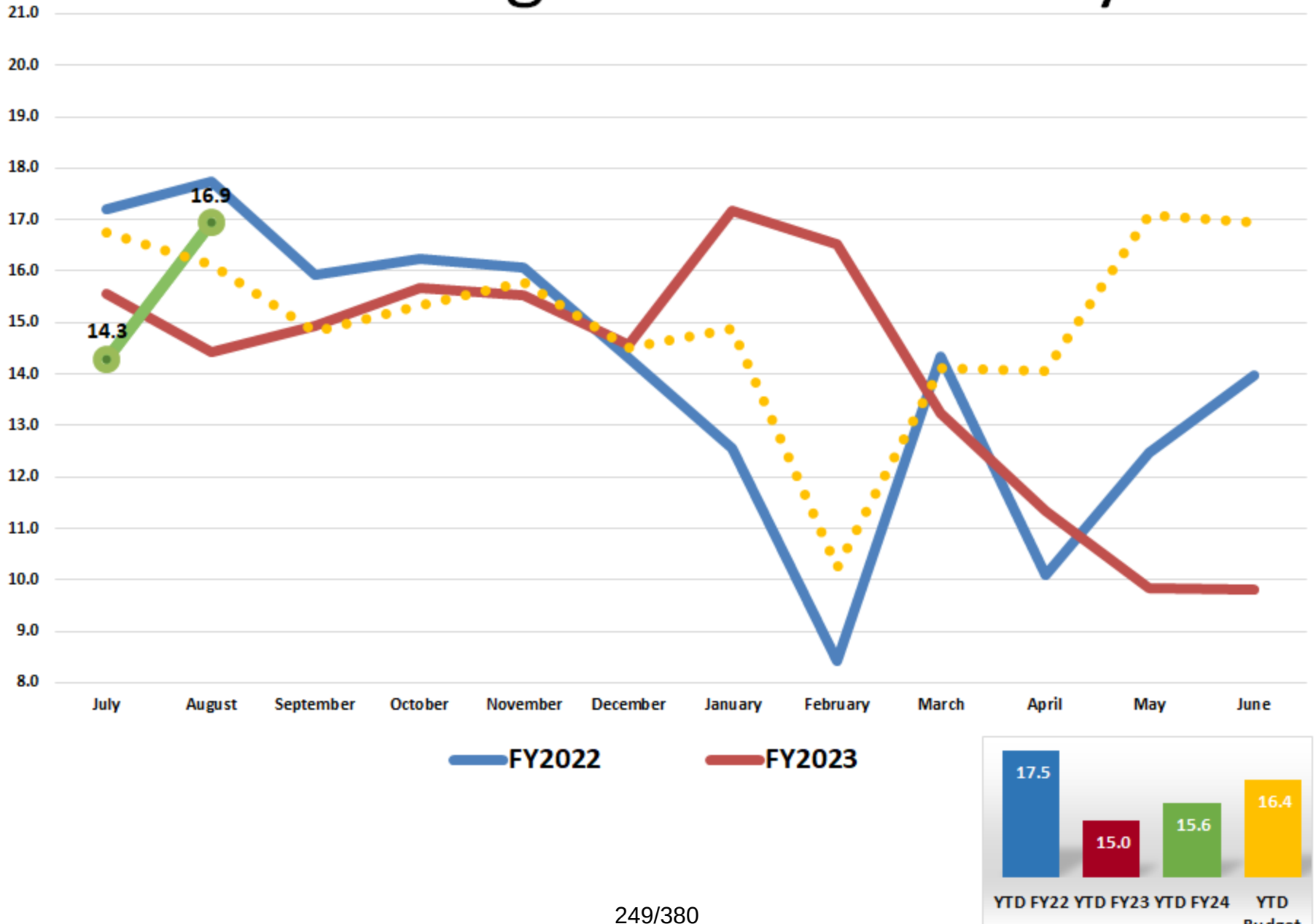


Deliveries

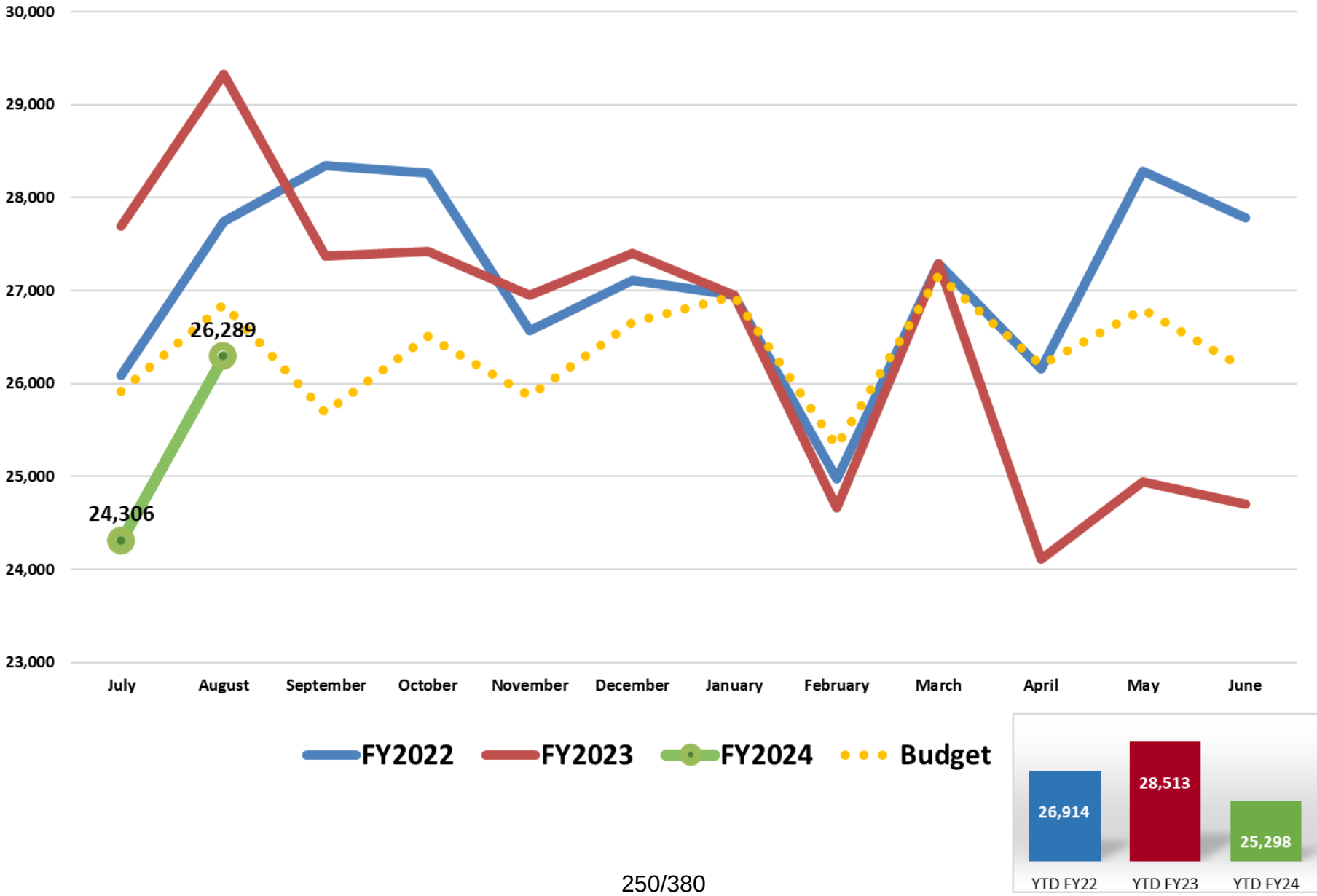

480
470
460
450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
464
388
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024
Budget


410
408
426
409
YTD FY22
YTD FY23
YTD FY24
YTD Budget

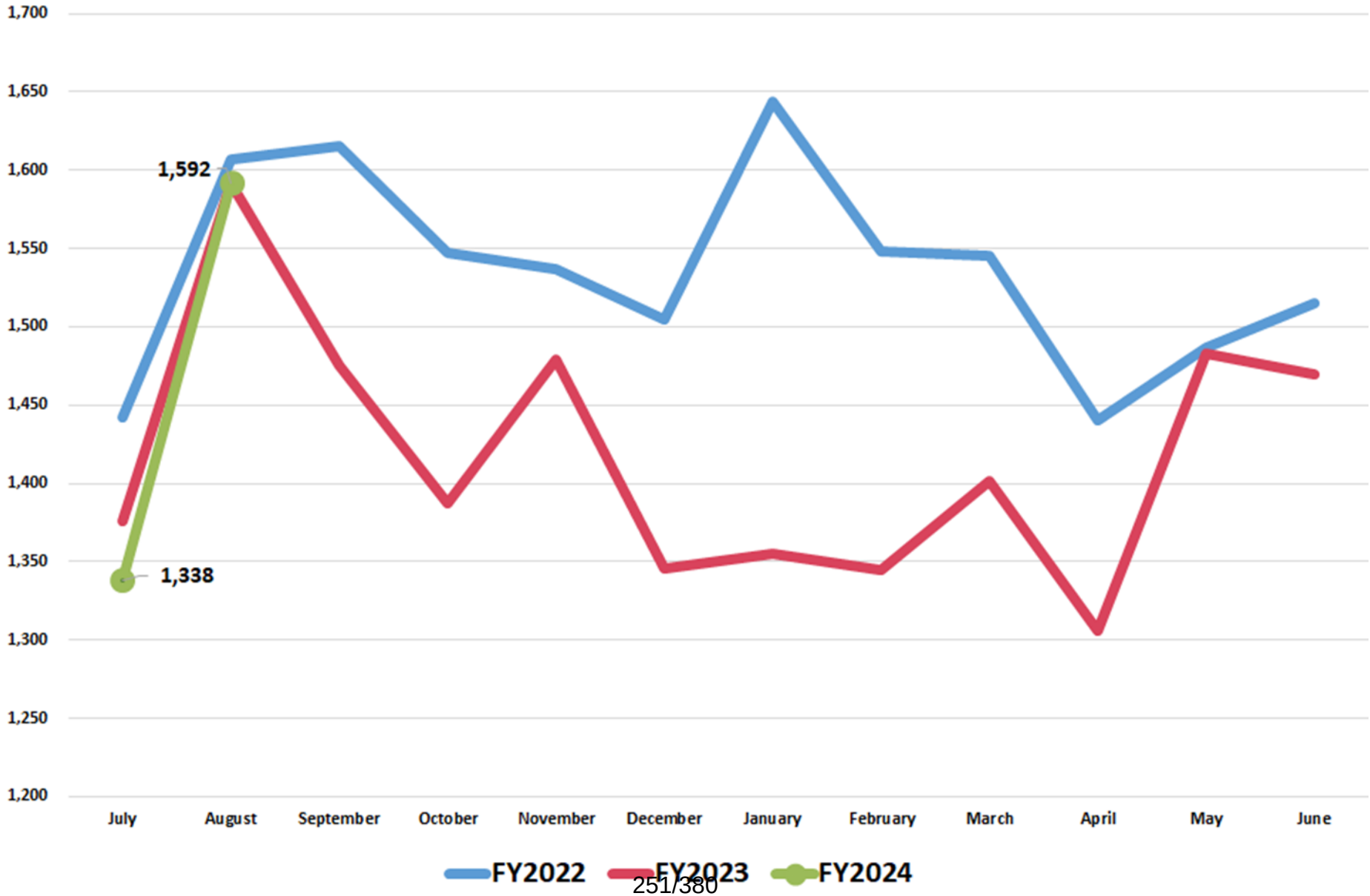
NICU - Avg Patients Per Day



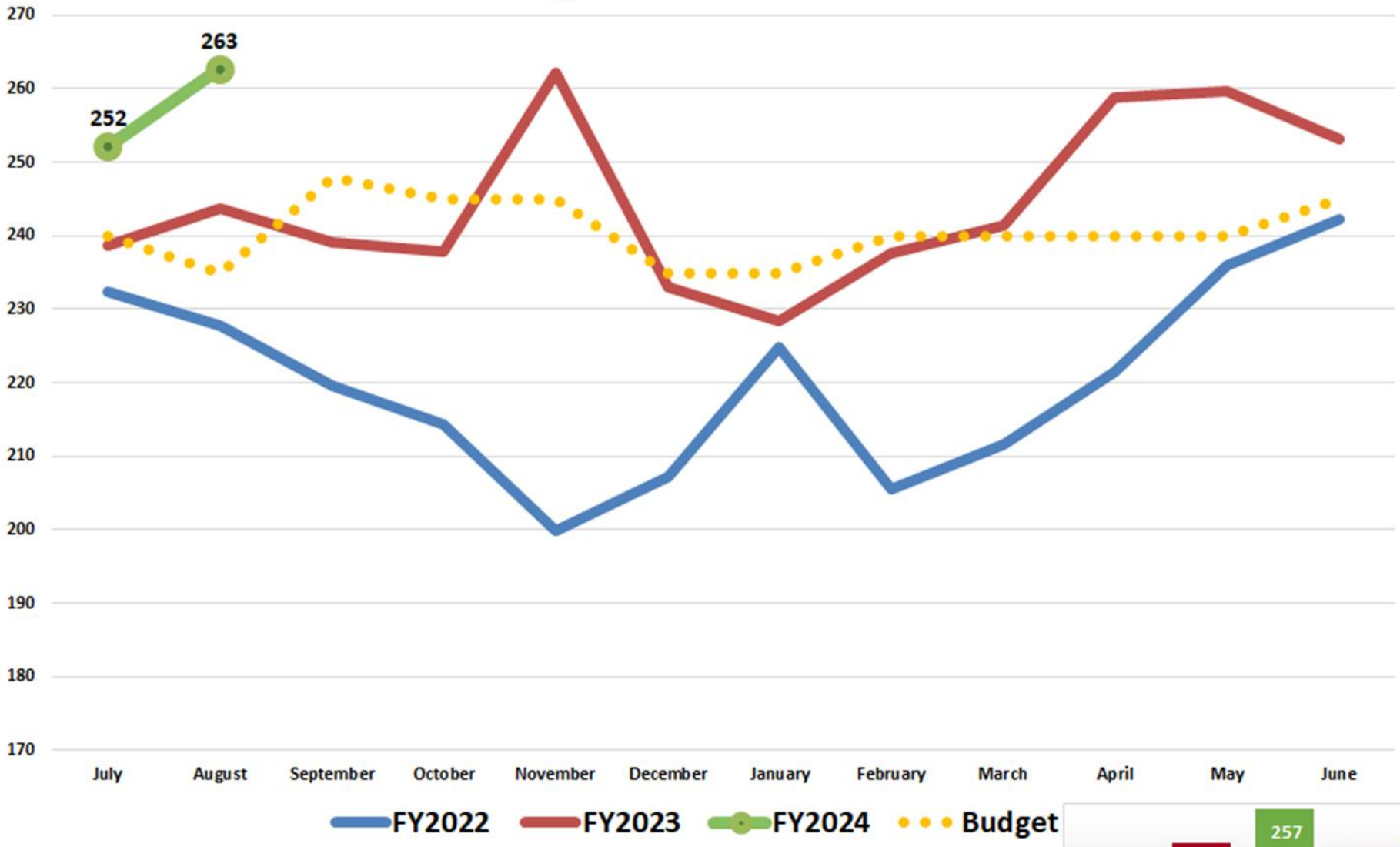
Adjusted Patient Days

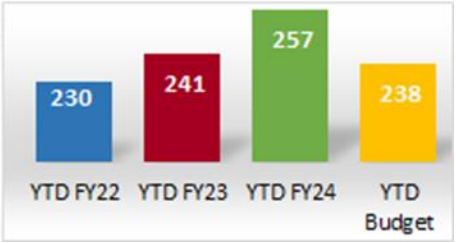


Outpatient Registrations Per Day

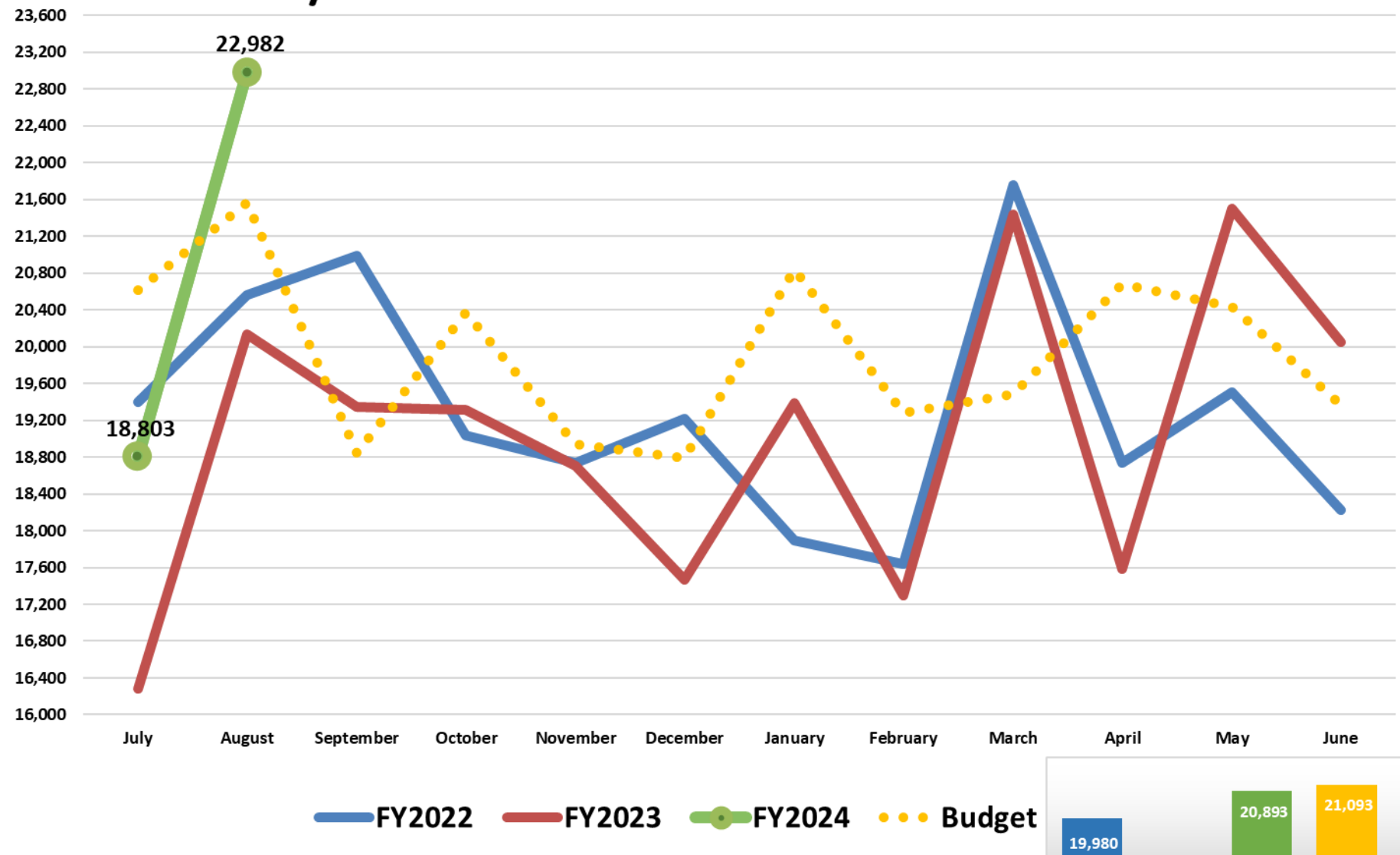


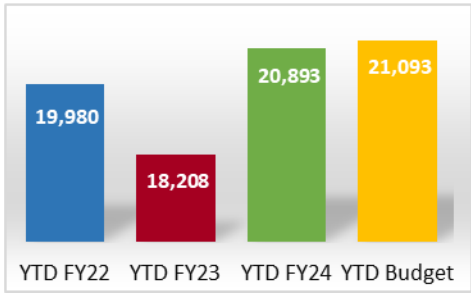
ED - Avg Treated Per Day



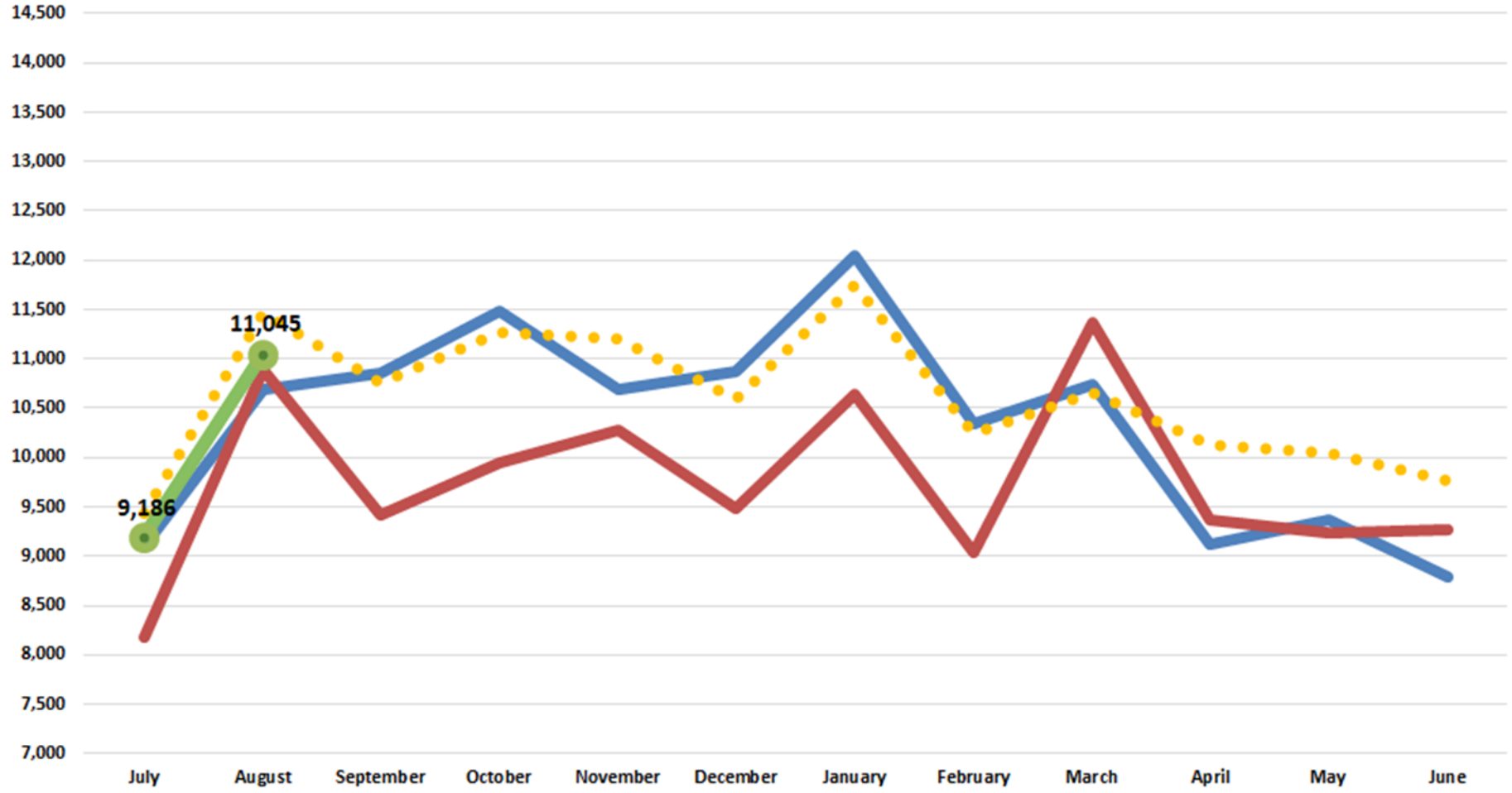


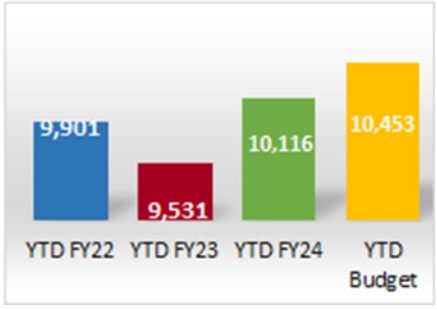
All O/P Rehab Svcs Across District



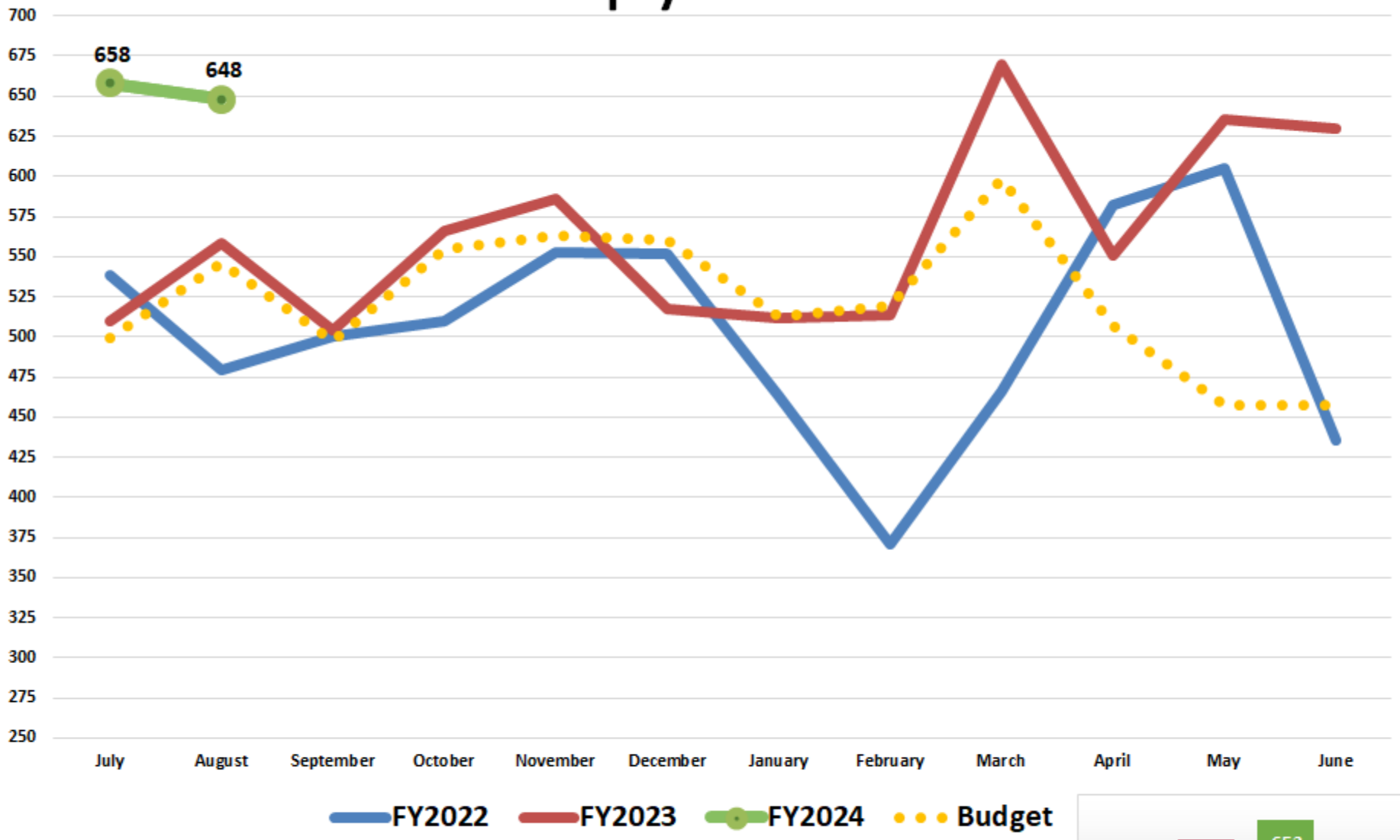


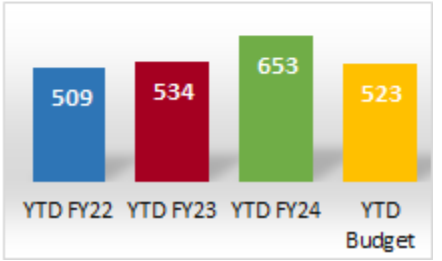
Rural Health Clinics Registrations



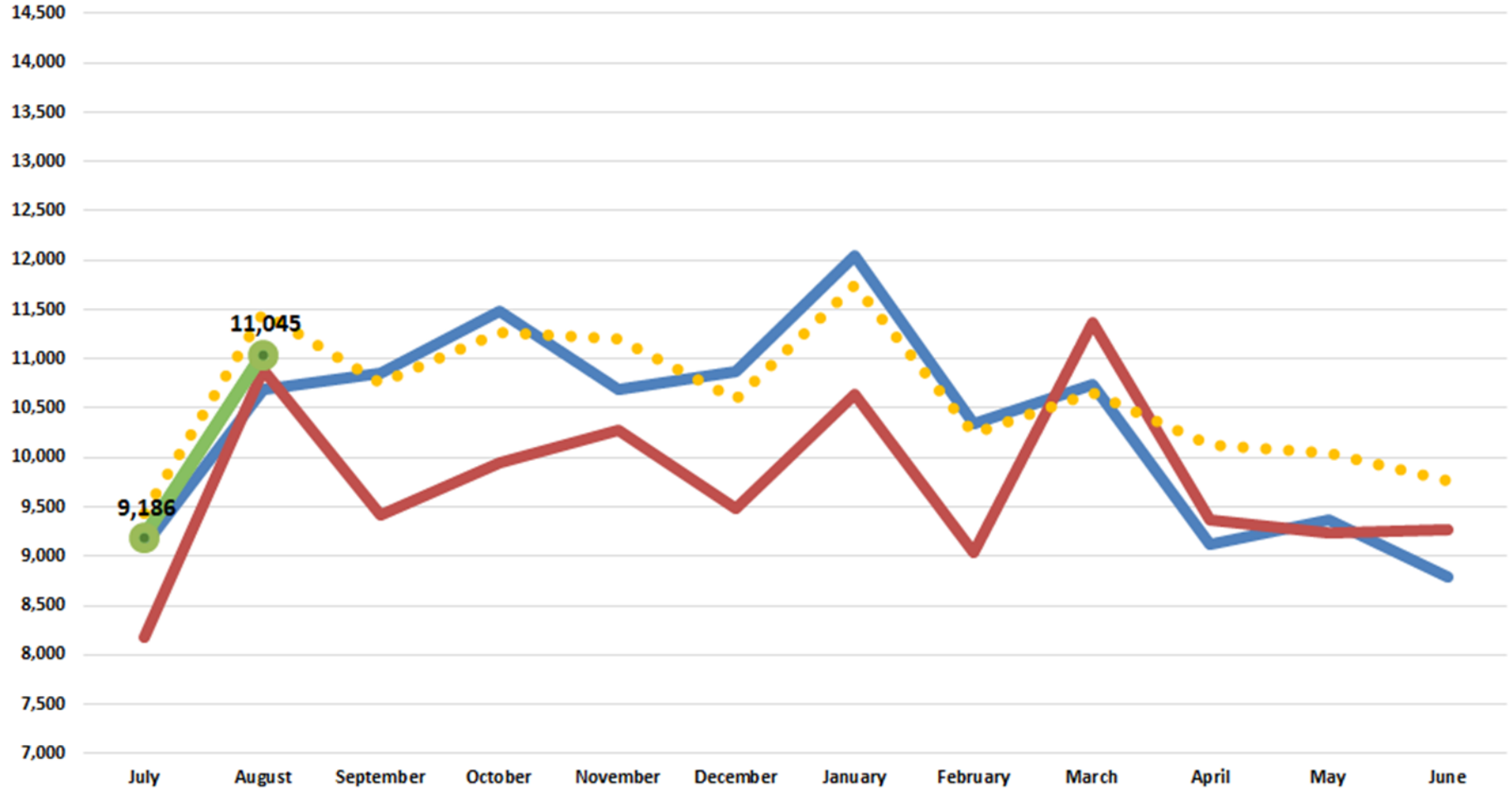


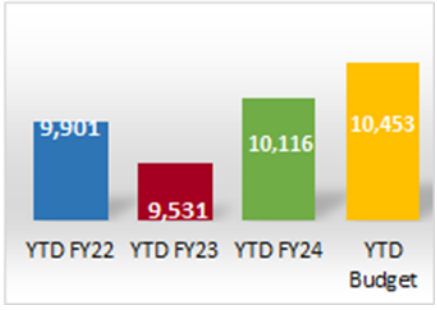
Endoscopy Procedures



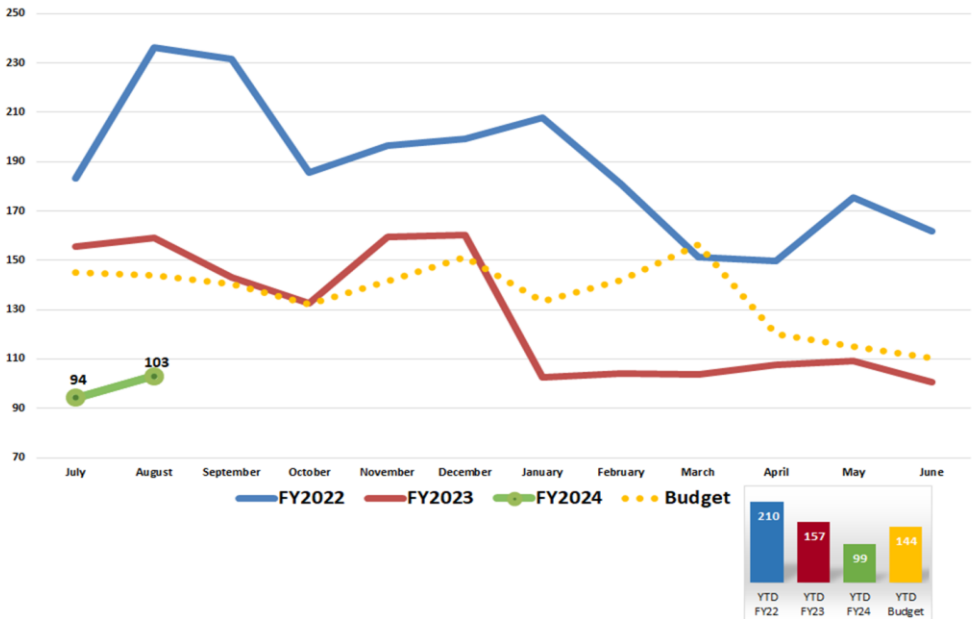


Rural Health Clinics Registrations

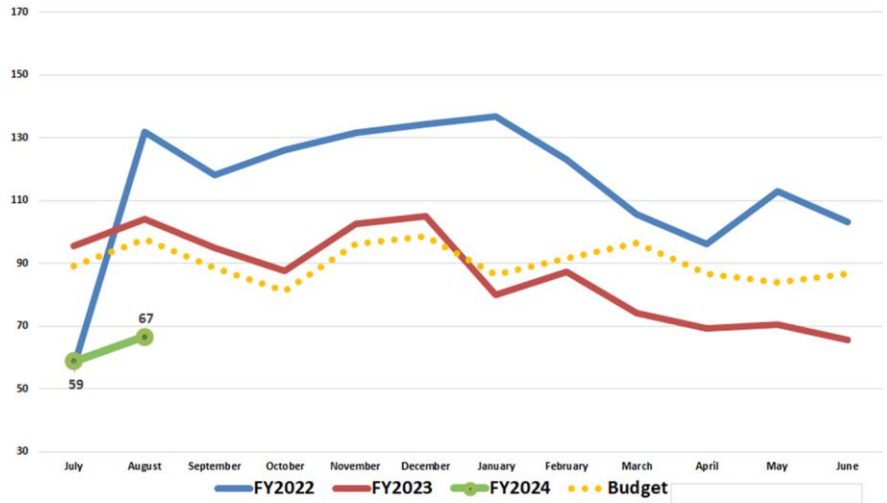




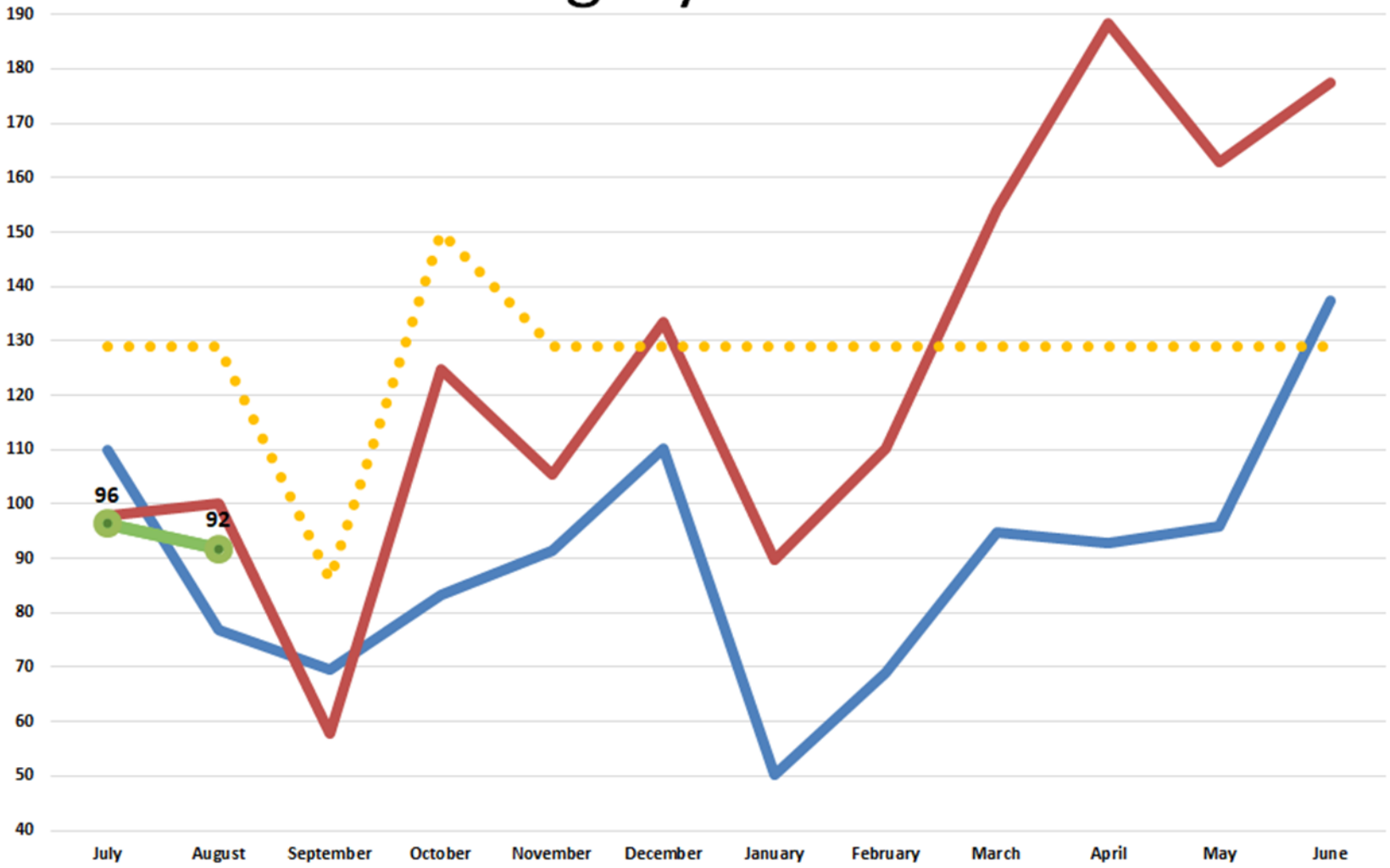
Urgent Care – Court Avg Visits Per Day

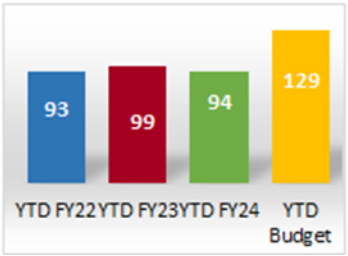


Urgent Care – Demaree Avg Visits Per Day

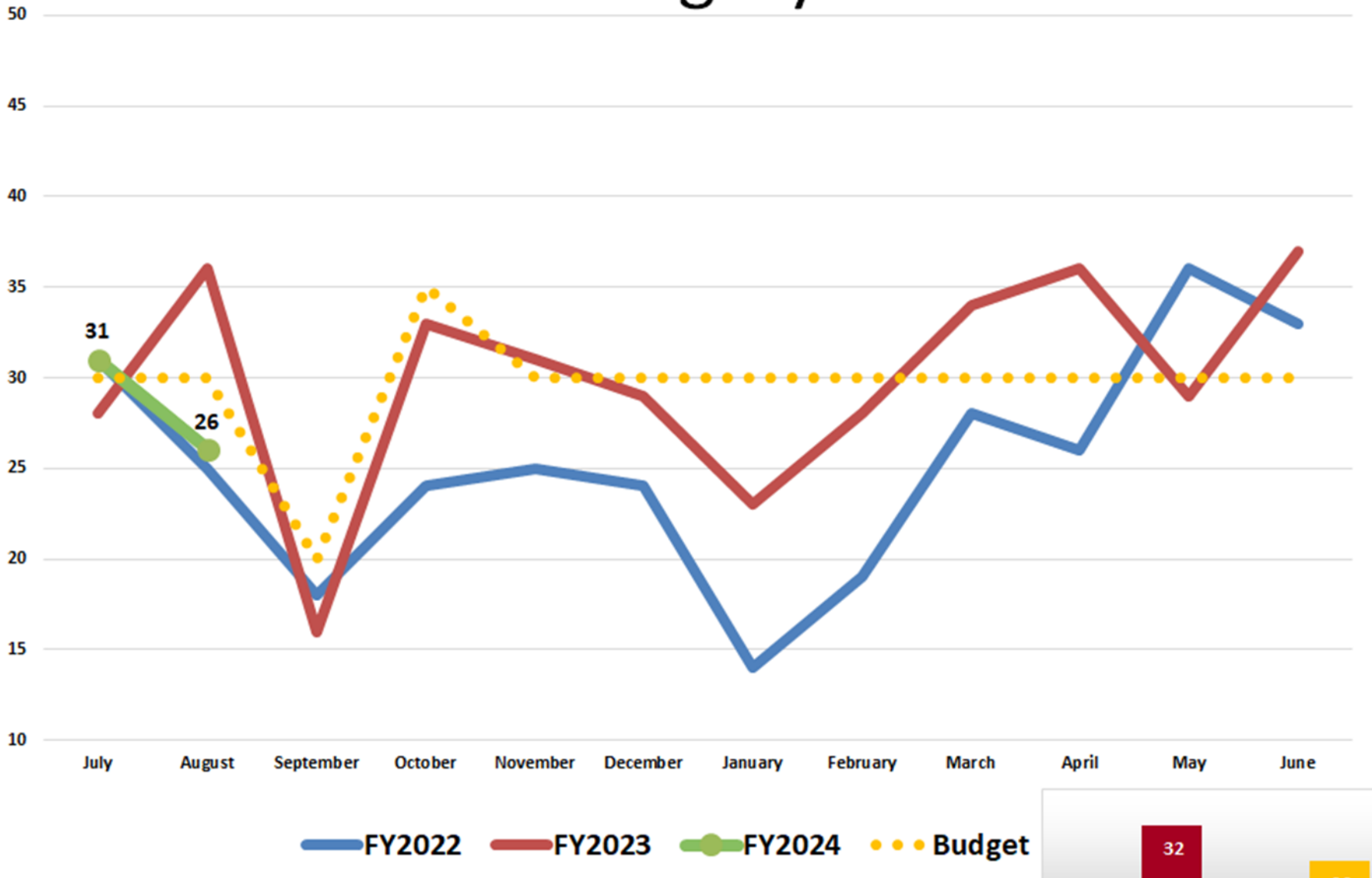


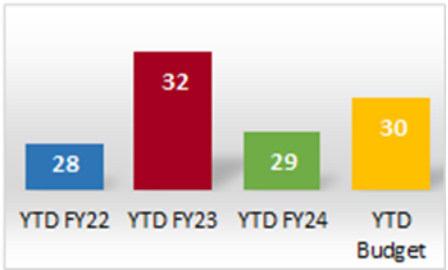
Cardiac Surgery - 100 Min Units



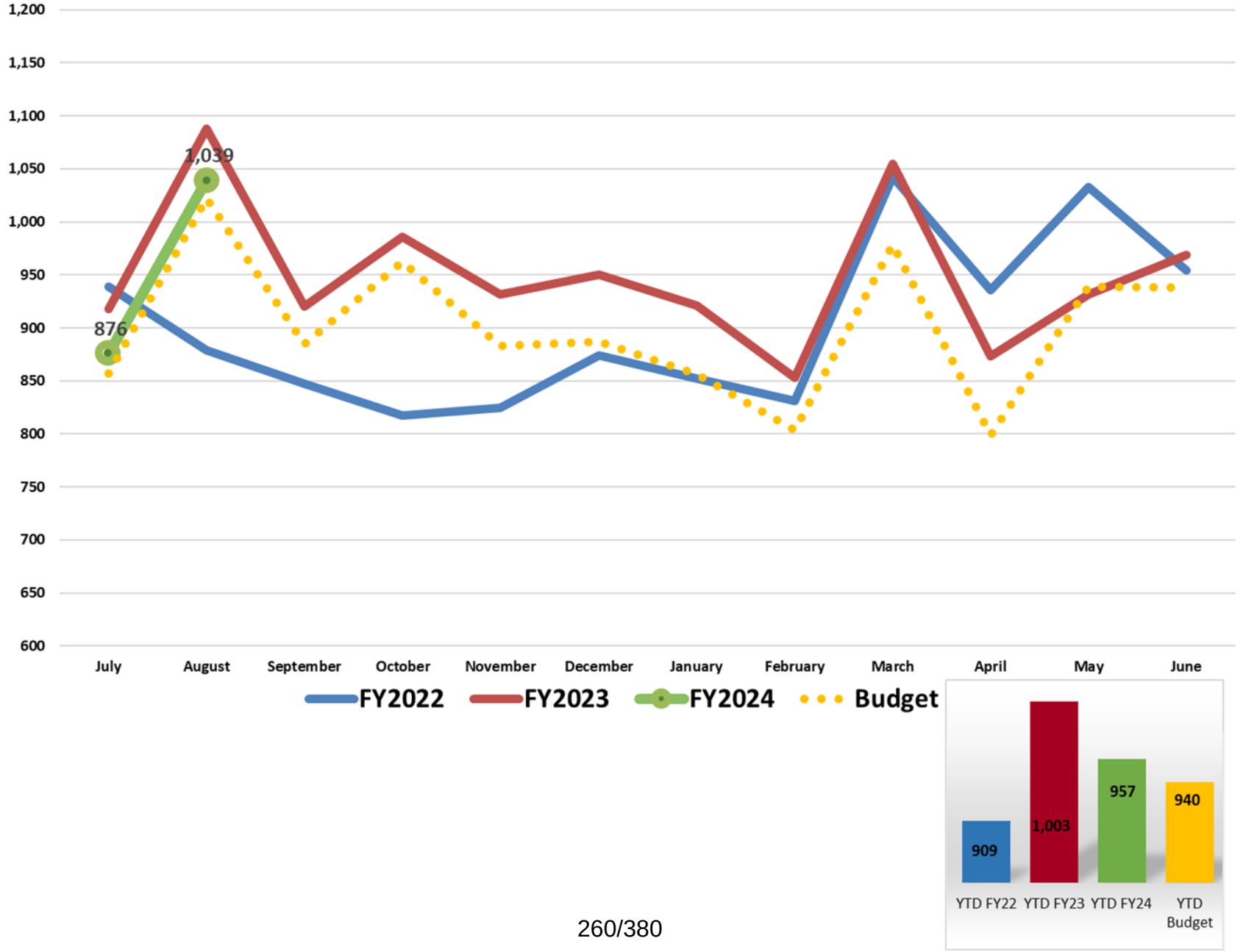


Cardiac Surgery Cases

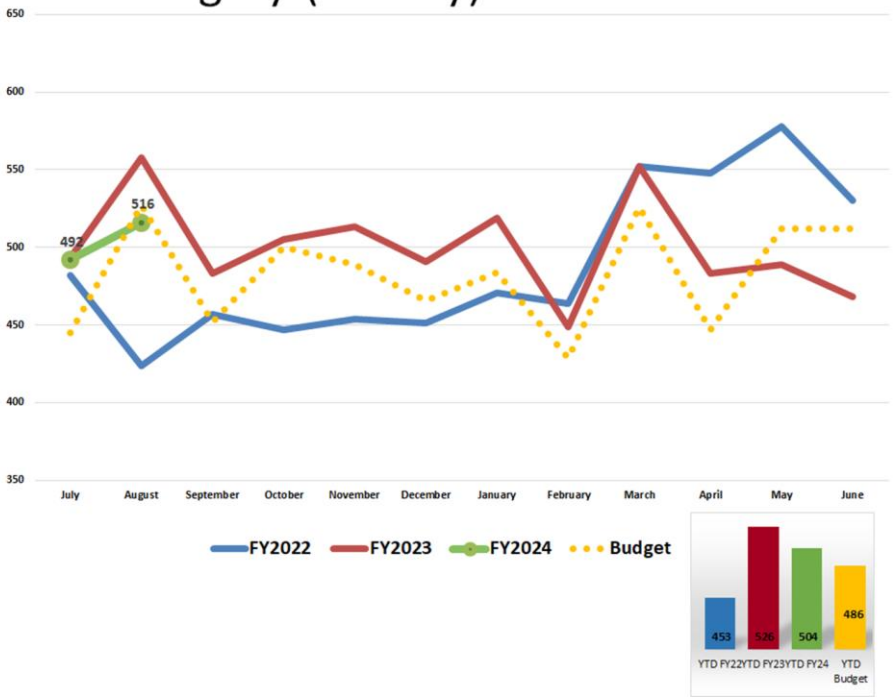




Surgery (IP & OP) – 100 Min Units

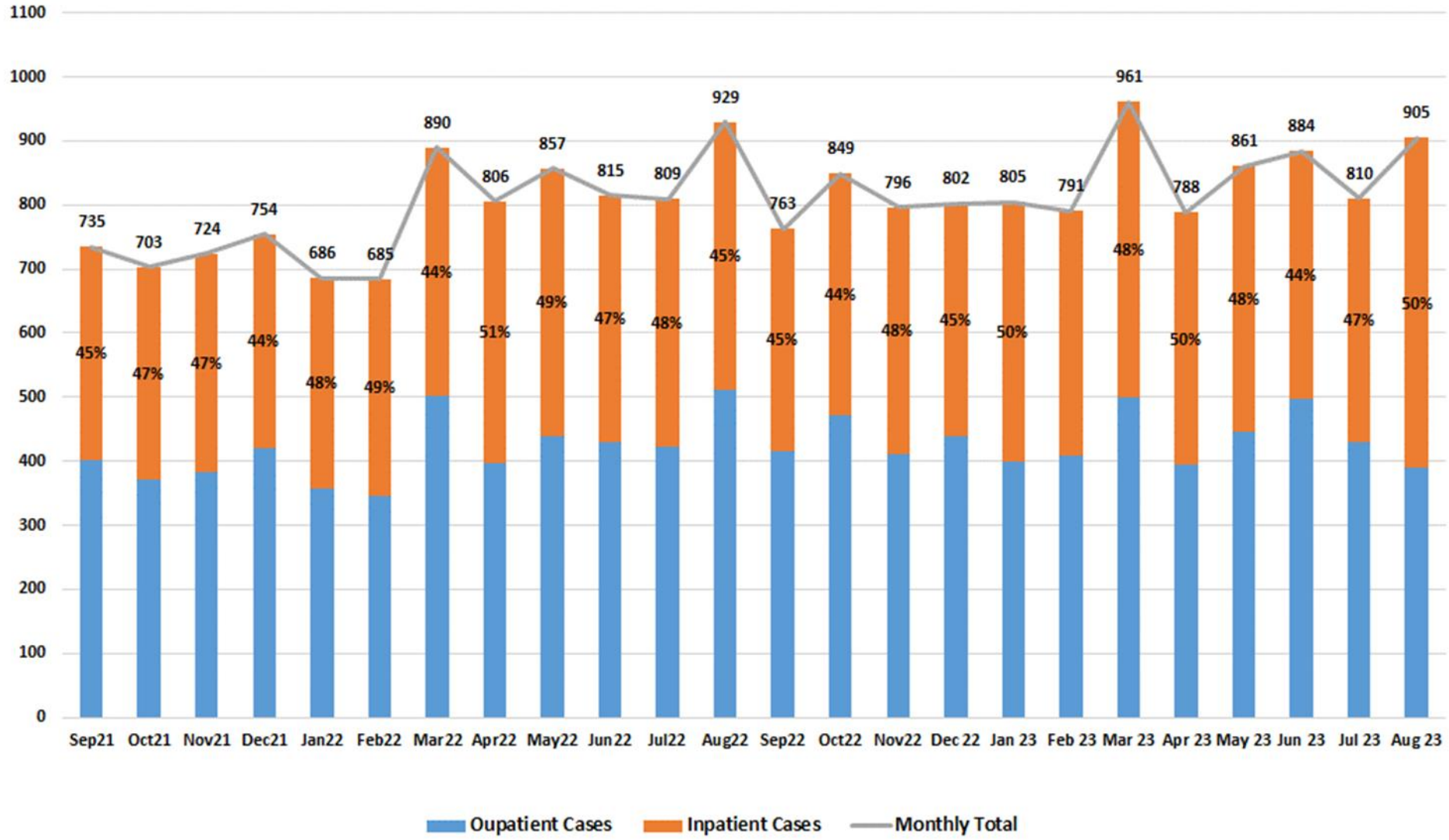


Surgery (IP Only) - 100 Min Unit

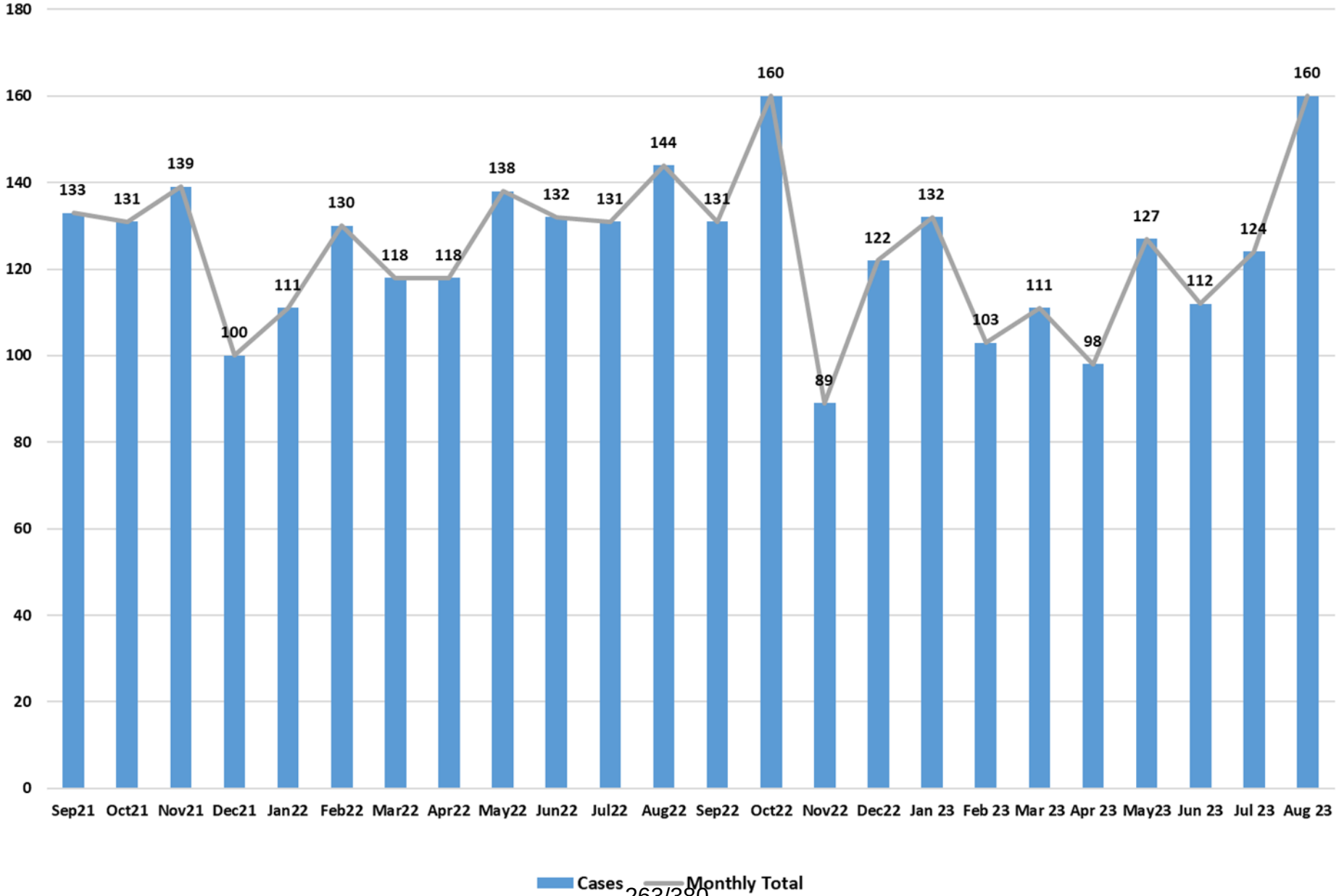


Surgery (OP Only) - 100 Min Units

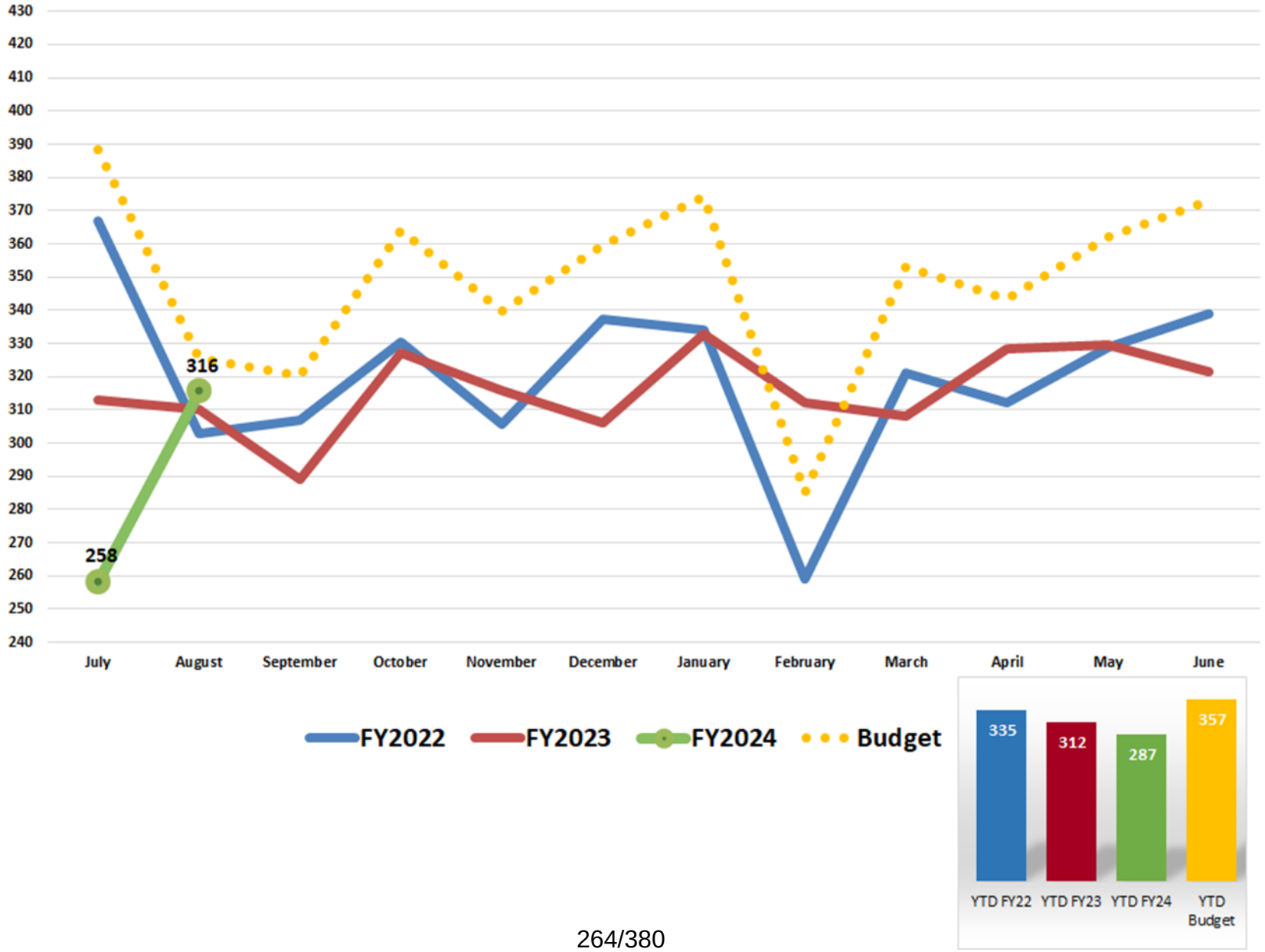
Surgery Cases (IP & OP)



OB Cases


180
160
140
120
100
80
60
40
20
0
133
131
139
100
111
130
118
118
138
132
131
144
131
160
89
122
132
103
111
98
127
112
124
160
Sep21
Oct21
Nov21
Dec21
Jan22
Feb22
Mar22
Apr22
May22
Jun22
Jul22
Aug22
Sep22
Oct22
Nov22
Dec22
Jan 23
Feb 23
Mar 23
Apr 23
May23
Jun 23
Jul 23
Aug 23
Cases
Monthly Total

Cath Lab (IP & OP) – 100 Min Units



Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results			Budget	Budget Variance	
	Aug 2022	Aug 2023	% Change	Aug 2023	Change	% Change
Average Daily Census	**447**	**409**	**(8.6%)**	**421**	**(12)**	**(3.0%)**
KDHCD Patient Days:						
Medical Center	9,249	8,351	(9.7%)	8,778	(427)	(4.9%)
Acute I/P Psych	1,242	1,331	7.2%	1,395	(64)	(4.6%)
Sub-Acute	872	990	13.5%	817	173	21.2%
Rehab	567	555	(2.1%)	599	(44)	(7.3%)
TCS-Ortho	424	344	(18.9%)	419	(75)	(17.9%)
TCS	504	0	(100.0%)	0	0	0.0%
NICU	447	525	17.4%	500	25	5.0%
Nursery	560	587	4.8%	558	29	5.2%
Total KDHCD Patient Days	**13,865**	**12,683**	**(8.5%)**	**13,066**	**(383)**	**(2.9%)**
Total Outpatient Volume	**49,352**	**47,585**	**(3.6%)**	**42,641**	**4,944**	**11.6%**

Statistical Results – Fiscal Year Comparison (Jul-Aug)

	Actual Results			Budget	Budget Variance	
	FYTD 2023	FYTD 2024	% Change	FYTD 2024	Change	% Change
Average Daily Census	**448**	**399**	**(11.0%)**	**421**	**(22)**	**(5.2%)**
KDHCD Patient Days:						
Medical Center	18,580	16,267	(12.4%)	17,499	(1,232)	(7.0%)
Acute I/P Psych	2,467	2,619	6.2%	2,790	(171)	(6.1%)
Sub-Acute	1,771	1,962	10.8%	1,646	316	19.2%
Rehab	1,132	1,076	(4.9%)	1,207	(131)	(10.9%)
TCS-Ortho	792	751	(5.2%)	832	(81)	(9.7%)
TCS	1,008	0	(100.0%)	0	0	0.0%
NICU	929	968	4.2%	1,019	(51)	(5.0%)
Nursery	1,096	1,072	(2.2%)	1,079	(7)	(0.6%)
Total KDHCD Patient Days	**27,775**	**24,715**	**(11.0%)**	**26,072**	**(1,357)**	**(5.2%)**
Total Outpatient Volume	**92,008**	**89,063**	**(3.2%)**	**85,281**	**3,782**	**4.4%**

Other Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results				Budget	Budget Variance	
	Aug 2022	Aug 2023	Change	% Change	Aug 2023	Change	% Change
Adjusted Patient Days	**29,148**	**26,289**	**(2,859)**	**(9.8%)**	**26,848**	**(559)**	**(2.1%)**
Outpatient Visits	**49,352**	**47,585**	**(1,767)**	**(3.6%)**	**42,641**	**4,944**	**11.6%**
Infusion Center	336	451	115	**34.2%**	386	65	**16.8%**
Radiology/CT/US/MRI Proc (I/P & O/P)	17,247	20,330	3,083	**17.9%**	19,615	715	**3.6%**
Endoscopy Procedures (I/P & O/P)	558	648	90	**16.1%**	546	102	**18.7%**
O/P Rehab Units	20,139	22,982	2,843	**14.1%**	21,565	1,417	**6.6%**
OB Deliveries	419	464	45	**10.7%**	429	35	**8.2%**
ED Total Registered	7,702	8,259	557	**7.2%**	7,285	974	**13.4%**
Home Health Visits	3,078	3,223	145	**4.7%**	3,111	112	**3.6%**
Cath Lab Minutes (IP & OP)	310	316	6	**1.9%**	326	(10)	**(3.1%)**
RHC Registrations	10,890	11,045	155	**1.4%**	11,463	(418)	**(3.6%)**
Hospice Days	3,970	4,017	47	**1.2%**	3,748	269	**7.2%**
Physical & Other Therapy Units	18,875	18,091	(784)	**(4.2%)**	18,187	(96)	**(0.5%)**
Dialysis Treatments	1,560	1,444	(116)	**(7.4%)**	1,550	(106)	**(6.8%)**
Surgery Minutes-General & Robotic (I/P & O/P)	1,215	1,119	(96)	**(7.9%)**	1,095	24	**2.2%**
Radiation Oncology Treatments (I/P & O/P)	2,339	1,717	(622)	**(26.6%)**	2,161	(444)	**(20.5%)**
Urgent Care - Court	4,928	3,197	(1,731)	**(35.1%)**	4,457	(1,260)	**(28.3%)**
Urgent Care - Demaree	3,226	2,065	(1,161)	**(36.0%)**	3,026	(961)	**(31.8%)**

Other Statistical Results – Fiscal Year Comparison (Jul-Aug)

	Actual Results				Budget	Budget Variance	
	FY 2023	FY 2024	Change	% Change	FY 2024	Change	% Change
Adjusted Patient Days	**56,858**	**50,595**	**(6,263)**	**(11.0%)**	**52,768**	**(2,173)**	**(4.1%)**
Outpatient Visits	**92,008**	**89,063**	**(2,945)**	**(3.2%)**	**85,281**	**3,782**	**4.4%**
Infusion Center	625	832	207	**33.1%**	722	110	**15.2%**
Endoscopy Procedures (I/P & O/P)	1,068	1,306	238	**22.3%**	1,045	261	**25.0%**
O/P Rehab Units	36,416	41,785	5,369	**14.7%**	42,186	(401)	**(1.0%)**
Home Health Visits	5,599	6,022	423	**7.6%**	6,216	(194)	**(3.1%)**
ED Total Registered	15,195	16,143	948	**6.2%**	14,725	1,418	**9.6%**
Radiology/CT/US/MRI Proc (I/P & O/P)	33,211	35,262	2,051	**6.2%**	33,868	1,394	**4.1%**
RHC Registrations	19,061	20,231	1,170	**6.1%**	20,905	(674)	**(3.2%)**
OB Deliveries	815	852	37	**4.5%**	818	34	**4.2%**
Dialysis Treatments	3,024	3,099	75	**2.5%**	3,100	(1)	**(0.0%)**
Hospice Days	7,796	7,875	79	**1.0%**	7,544	331	**4.4%**
Physical & Other Therapy Units	37,222	35,908	(1,314)	**(3.5%)**	36,374	(466)	**(1.3%)**
Surgery Minutes-General & Robotic (I/P & O/P)	2,229	2,061	(168)	**(7.5%)**	2,015	46	**2.3%**
Cath Lab Minutes (IP & OP)	623	574	(49)	**(7.9%)**	714	(140)	**(19.6%)**
Radiation Oncology Treatments (I/P & O/P)	3,976	3,360	(616)	**(15.5%)**	4,260	(900)	**(21.1%)**
Urgent Care - Court	9,751	6,122	(3,629)	**(37.2%)**	8,953	(2,831)	**(31.6%)**
Urgent Care - Demaree	6,193	3,888	(2,305)	**(37.2%)**	5,793	(1,905)	**(32.9%)**

Payer Trend by Gross Charges (Through August 2024)

	Gross Charges				Patient Cases %			
Payers Grouped	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Medicare	$1,024,403,992	$1,062,397,956	$1,095,034,342	$181,203,792	43.3%	42.0%	43.0%	42.3%
Medi-Cal	$762,517,252	$834,888,178	$836,590,614	$136,581,085	32.2%	33.0%	32.9%	31.9%
Commercial/Other	$526,692,820	$567,541,720	$561,498,885	$97,605,623	22.2%	22.5%	22.1%	22.8%
Other	$54,702,674	$63,029,160	$51,511,313	$12,488,311	2.3%	2.5%	2.0%	2.9%
Grand Total	**$2,368,316,738**	**$2,527,857,014**	**$2,544,635,154**	**$427,878,810**	**100%**	**100%**	**100%**	**100%**

	Gross Charges				Patient Cases %			
Payers - Add'l Breakout	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Medicare	$722,820,858	$719,315,129	$719,791,278	$111,754,356	30.5%	28.5%	28.3%	26.1%
Medi-Cal Managed Care	$564,282,466	$631,191,685	$656,293,721	$109,041,089	23.8%	25.0%	25.8%	25.5%
Commercial/Other	$526,692,820	$567,541,720	$561,498,885	$97,605,623	22.2%	22.5%	22.1%	22.8%
Medicare Managed Care	$301,583,134	$343,082,828	$375,243,065	$69,449,436	12.7%	13.6%	14.7%	16.2%
Medi-Cal	$198,234,786	$203,696,493	$180,296,892	$27,539,995	8.4%	8.1%	7.1%	6.4%
Cash Pay	$31,071,034	$37,377,691	$31,813,260	$8,817,796	1.3%	1.5%	1.3%	2.1%
Work Comp	$22,307,951	$24,705,998	$18,444,527	$3,558,356	0.9%	1.0%	0.7%	0.8%
Tulare County	$1,323,688	$945,471	$1,253,525	$112,159	0.1%	0.0%	0.0%	0.0%
Grand Total	**$2,368,316,738**	**$2,527,857,014**	**$2,544,635,154**	**$427,878,810**	**100%**	**100%**	**100%**	**100%**

Excludes those service lines not on Cerner: Home Health, Home Care, Home Infusion, Hospice and Open Arms

Payer Trend by Patient Volume (Through August 2024)

	Patient Cases				Patient Cases %			
	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021	FY 2022	FY 2023	FY 2024
Inpatient								
Medi-Cal Managed Care	8,035	8,533	8,754	1,573	28.3%	29.6%	31.6%	32.8%
Commercial/Other	6,491	6,770	6,420	1,117	22.8%	23.4%	23.2%	23.3%
Medicare	6,844	6,491	6,015	983	24.1%	22.5%	21.7%	20.5%
Medicare Managed Care	2,799	2,993	3,034	552	9.8%	10.4%	10.9%	11.5%
Medi-Cal	3,830	3,711	3,129	478	13.5%	12.9%	11.3%	10.0%
Cash Pay	237	215	213	74	0.8%	0.7%	0.8%	1.5%
Work Comp	122	114	90	19	0.4%	0.4%	0.3%	0.4%
Tulare County	74	49	58	7	0.3%	0.2%	0.2%	0.1%
Total Inpatient	**28,432**	**28,876**	**27,713**	**4,803**	**100%**	**100%**	**100%**	**100%**
Outpatient								
Commercial/Other	177,378	185,520	172,082	28,501	34.2%	33.0%	32.3%	32.3%
Medi-Cal Managed Care	156,270	186,731	170,094	26,309	30.1%	33.2%	31.9%	29.8%
Medicare	100,401	96,894	94,155	16,101	19.3%	17.2%	17.7%	18.2%
Medicare Managed Care	46,719	51,242	60,156	10,901	9.0%	9.1%	11.3%	12.3%
Medi-Cal	24,833	23,911	22,950	3,799	4.8%	4.3%	4.3%	4.3%
Cash Pay	10,338	14,381	9,644	1,784	2.0%	2.6%	1.8%	2.0%
Work Comp	3,204	3,387	3,920	918	0.6%	0.6%	0.7%	1.0%
Tulare County	1		1		0.0%	0.0%	0.0%	0.0%
Total Outpatient	**519,144**	**562,066**	**533,002**	**88,313**	**100%**	**100%**	**100%**	**100%**

Excludes those service lines not on Cerner: Home Health, Home Care, Home Infusion, Hospice and Open Arms

August Financial Comparison without KHMG (000's)

	Comparison to Budget - Month of August				Comparison to Prior Year - Month of August			
	Budget Aug-2023	Actual Aug-2023	$ Change	% Change	Aug-2022	Aug-2023	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$48,988**	**$49,531**	**$543**	**1.1%**	**$50,999**	**$49,531**	**($1,468)**	**-3.0%**
Supplemental Gov't Programs	$6,483	$6,383	($100)	-1.6%	$5,042	$6,383	$1,341	21.0%
Prime Program	$835	$822	($13)	-1.6%	$743	$822	$79	9.6%
Premium Revenue	$7,931	$7,930	($0)	0.0%	$5,927	$7,930	$2,004	25.3%
Management Services Revenue	$3,439	$3,621	$182	5.0%	$3,797	$3,621	($176)	-4.9%
Other Revenue	$2,505	$3,702	$1,197	32.3%	$2,096	$3,702	$1,606	43.4%
Other Operating Revenue	$21,192	$22,458	$1,265	5.6%	$17,604	$22,458	$4,853	21.6%
Total Operating Revenue	**$70,180**	**$71,989**	**$1,809**	**2.5%**	**$68,603**	**$71,989**	**$3,385**	**4.7%**
Operating Expenses								
Salaries & Wages	$29,334	$28,197	($1,138)	-4.0%	$28,420	$28,197	($223)	-0.8%
Contract Labor	$1,786	$2,121	$335	15.8%	$7,124	$2,121	($5,003)	-235.8%
Employee Benefits	$6,781	$6,547	($234)	-3.6%	$5,374	$6,547	$1,172	17.9%
Total Employment Expenses	**$37,901**	**$36,864**	**($1,037)**	**-2.8%**	**$40,918**	**$36,864**	**($4,053)**	**-11.0%**
Medical & Other Supplies	$10,677	$10,518	($158)	-1.5%	$10,798	$10,518	($280)	-2.7%
Physician Fees	$6,665	$6,793	$128	1.9%	$7,173	$6,793	($380)	-5.6%
Purchased Services	$1,471	$2,031	$560	27.6%	$1,062	$2,031	$970	47.7%
Repairs & Maintenance	$2,370	$1,434	($936)	-65.3%	$2,238	$1,434	($803)	-56.0%
Utilities	$1,001	$1,007	$7	0.7%	$940	$1,007	$68	6.7%
Rents & Leases	$165	$156	($10)	-6.1%	$140	$156	$15	9.8%
Depreciation & Amortization	$2,914	$2,841	($73)	-2.6%	$2,778	$2,841	$62	2.2%
Interest Expense	$587	$604	$18	3.0%	$592	$604	$12	2.0%
Other Expense	$2,171	$1,788	($383)	-21.4%	$1,897	$1,788	($109)	-6.1%
Humana Cap Plan Expenses	$3,701	$4,331	$629	14.5%	$3,831	$4,331	$500	11.5%
Management Services Expense	$3,641	$3,571	($70)	-2.0%	$3,660	$3,571	($88)	-2.5%
Total Other Expenses	**$35,363**	**$35,076**	**($287)**	**-0.8%**	**$35,108**	**$35,076**	**($33)**	**-0.1%**
Total Operating Expenses	**$73,264**	**$71,940**	**($1,324)**	**-1.8%**	**$76,026**	**$71,940**	**($4,086)**	**-5.7%**
Operating Margin	**($3,084)**	**$48**	**$3,132**		**($7,423)**	**$48**	**$7,471**	
Stimulus/FEMA	**$1,610**	**$1,610**	**$0**		**$0**	**$1,610**	**$1,610**	
Operating Margin after Stimulus/FEMA	**($1,474)**	**$1,658**	**$3,133**		**($7,423)**	**$1,658**	**$9,081**	
Nonoperating Revenue (Loss)	$484	$602	$117		$326	$602	$275	
Excess Margin	**($990)**	**$2,260**	**$3,250**		**($7,096)**	**$2,260**	**$9,356**	

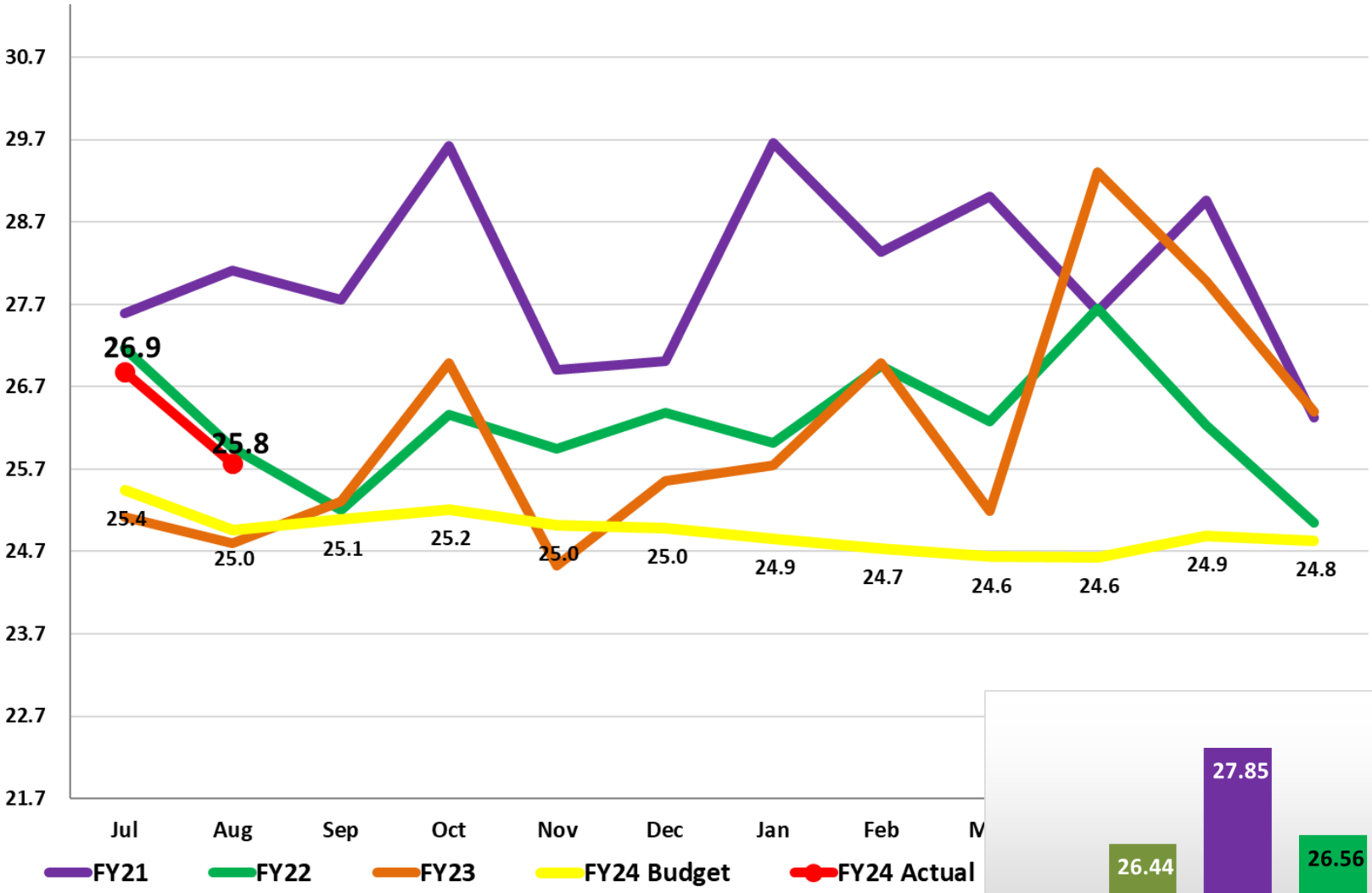
FYTD July and August: Financial Comparison without KHMG (000's)

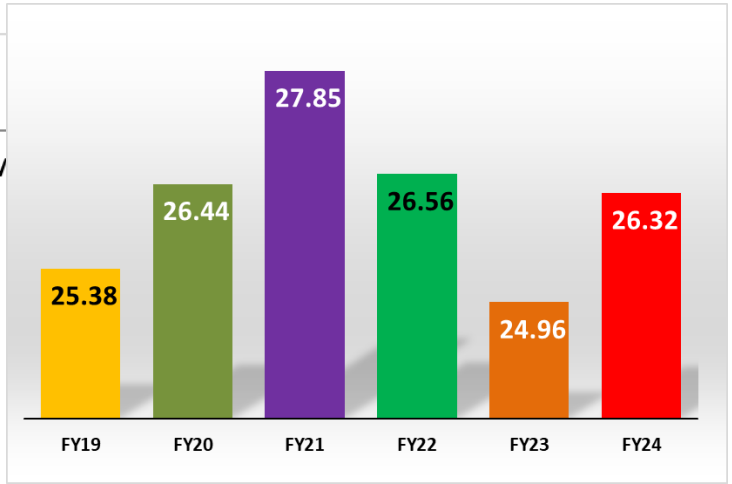
	Comparison to Budget - YTD August				Comparison to Prior Year - YTD August			
	Budget FYTD 2024	Actual FYTD 2024	$ Change	% Change	FYTD 2023	FYTD 2024	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$96,764**	**$95,010**	**($1,754)**	**-1.8%**	**$99,745**	**$95,010**	**($4,735)**	**-5.0%**
Supplemental Gov't Programs	$12,965	$12,765	($200)	-1.6%	$10,084	$12,765	$2,682	21.0%
Prime Program	$1,670	$1,643	($27)	-1.6%	$1,485	$1,643	$158	9.6%
Premium Revenue	$15,861	$15,861	($0)	0.0%	$11,828	$15,861	$4,033	25.4%
Management Services Revenue	$6,878	$6,899	$21	0.3%	$6,729	$6,899	$170	2.5%
Other Revenue	$5,009	$6,449	$1,440	22.3%	$5,535	$6,449	$914	14.2%
Other Operating Revenue	$42,384	$43,618	$1,234	2.8%	$35,661	$43,618	$7,957	18.2%
Total Operating Revenue	**$139,148**	**$138,628**	**($520)**	**-0.4%**	**$135,407**	**$138,628**	**$3,222**	**2.3%**
Operating Expenses								
Salaries & Wages	$58,233	$56,344	($1,889)	-3.4%	$56,612	$56,344	($268)	-0.5%
Contract Labor	$3,787	$3,742	($45)	-1.2%	$12,988	$3,742	($9,246)	-247.1%
Employee Benefits	$13,461	$12,831	($630)	-4.9%	$11,445	$12,831	$1,386	10.8%
Total Employment Expenses	**$75,480**	**$72,916**	**($2,564)**	**-3.5%**	**$81,045**	**$72,916**	**($8,129)**	**-11.1%**
Medical & Other Supplies	$20,840	$20,910	$70	0.3%	$19,795	$20,910	$1,115	5.3%
Physician Fees	$13,330	$13,828	$497	3.6%	$13,855	$13,828	($28)	-0.2%
Purchased Services	$2,942	$3,400	$458	13.5%	$3,920	$3,400	($521)	-15.3%
Repairs & Maintenance	$4,741	$3,625	($1,116)	-30.8%	$4,237	$3,625	($612)	-16.9%
Utilities	$1,926	$1,770	($156)	-8.8%	$1,601	$1,770	$169	9.5%
Rents & Leases	$330	$248	($82)	-33.0%	$248	$248	$0	0.1%
Depreciation & Amortization	$5,828	$5,665	($163)	-2.9%	$5,559	$5,665	$106	1.9%
Interest Expense	$1,173	$1,190	$17	1.4%	$1,184	$1,190	$6	0.5%
Other Expense	$4,349	$3,444	($906)	-26.3%	$3,441	$3,444	$3	0.1%
Humana Cap Plan Expenses	$7,403	$8,203	$800	9.7%	$8,235	$8,203	($33)	-0.4%
Management Services Expense	$7,026	$6,395	($631)	-9.9%	$6,581	$6,395	($186)	-2.9%
Total Other Expenses	**$69,888**	**$68,676**	**($1,212)**	**-1.8%**	**$68,657**	**$68,676**	**$20**	**0.0%**
Total Operating Expenses	**$145,368**	**$141,593**	**($3,776)**	**-2.7%**	**$149,702**	**$141,593**	**($8,109)**	**-5.7%**
Operating Margin	**($6,220)**	**($2,964)**	**$3,256**		**($14,296)**	**($2,964)**	**$11,331**	
Stimulus/FEMA	**$3,219**	**$3,220**	**$1**		**$97**	**$3,220**	**$3,123**	
Operating Margin after FEMA	**($3,001)**	**$256**	**$3,256**		**($14,198)**	**$256**	**$14,454**	
Nonoperating Revenue (Loss)	$969	$1,219	$250		$781	$1,219	$438	
Excess Margin	**($2,032)**	**$1,475**	**$3,507**		**($13,417)**	**$1,475**	**$14,892**	

Month of August- Budget Variances

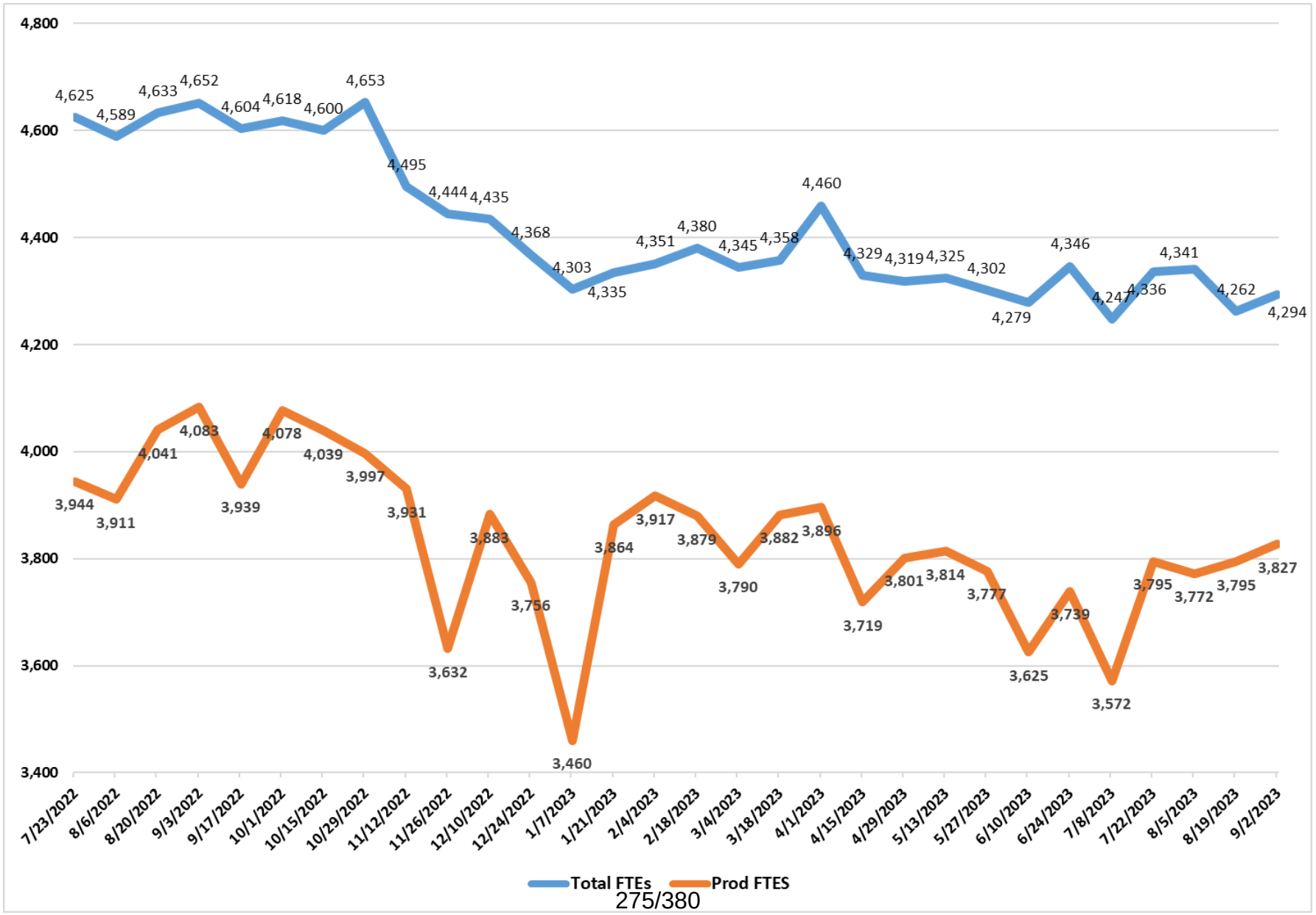
- **Net Patient Revenues:** August patient revenue was 1.1%, $543K higher than budget primarily due to higher than budgeted revenue in the Emergency Department, Subacute Hospital, Endoscopy Service Line, NICU/OB and our Radiology Modalities (CT, MRI, PET, Xray)
- **Other Revenue:** Other revenue was $2.2M over budget primarily due to grant funds recognized and higher than budgeted retail pharmacy revenue.
- **Employment expenses**: Employment expense is slightly less than budget. August employment expense was 2.8%, $1M less than budget.

Productivity: Worked Hours/Adjusted Patient Days

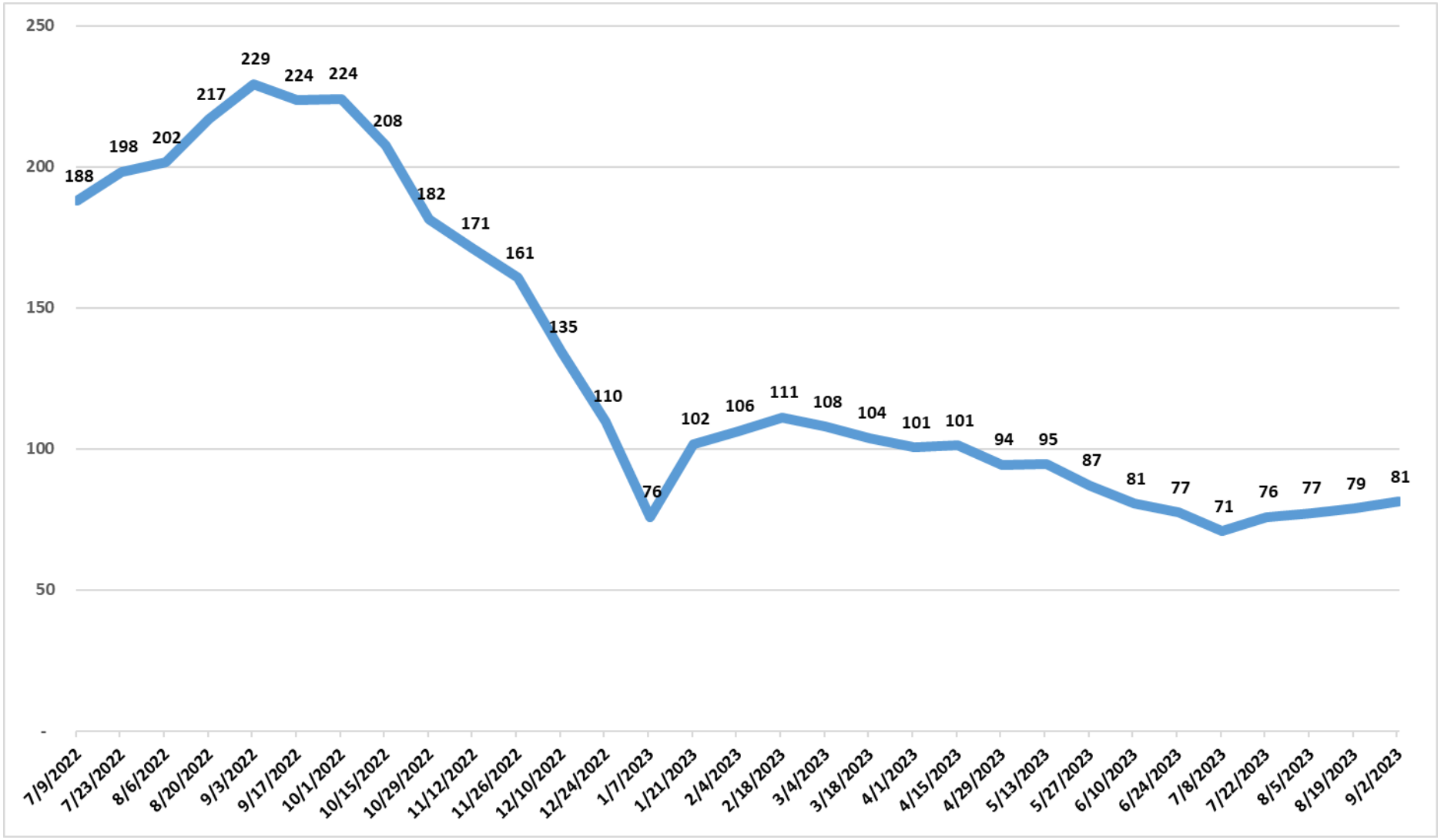




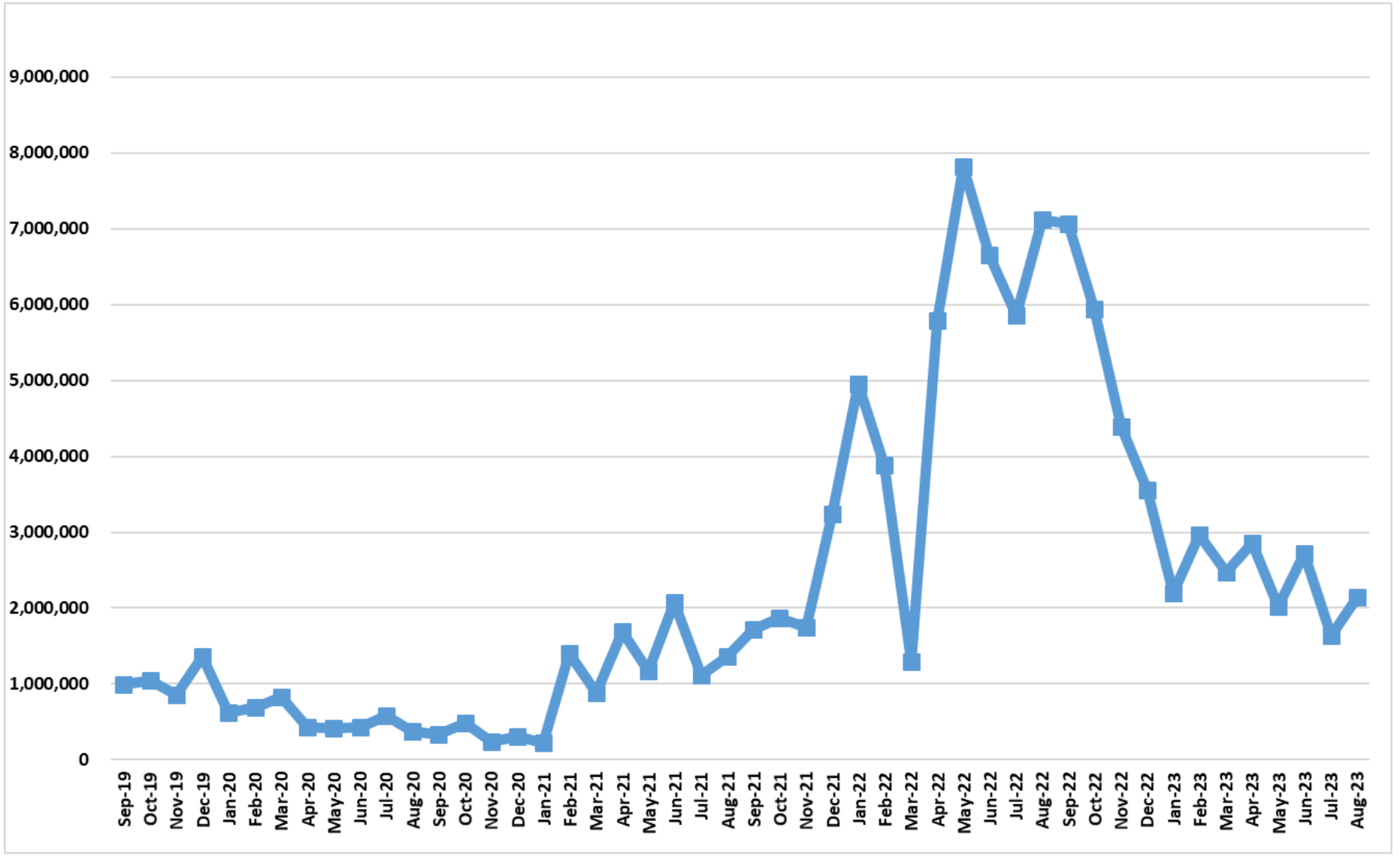
Productive and Total FTEs without KHMG



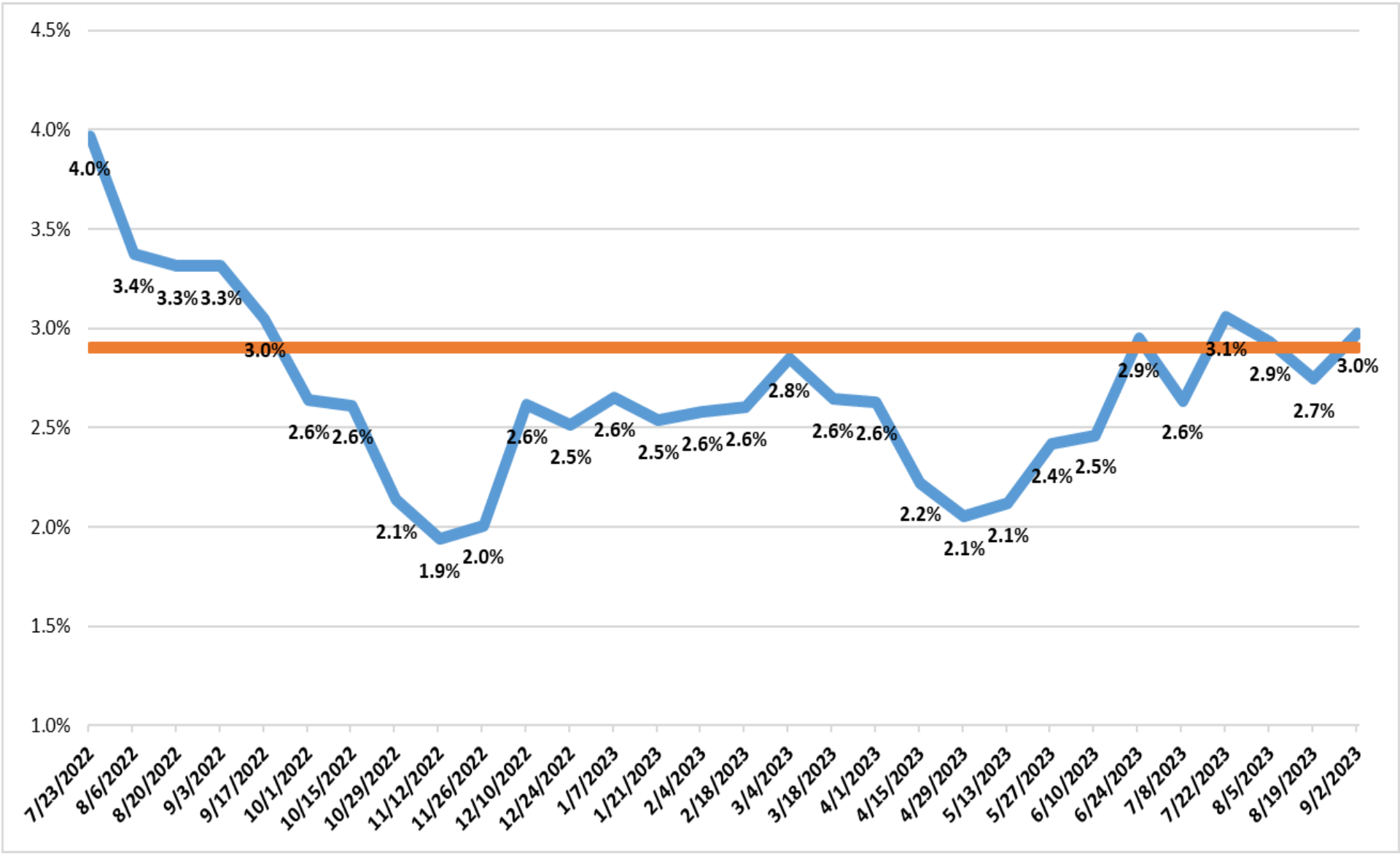
Contract Labor Full Time Equivalents (FTEs)

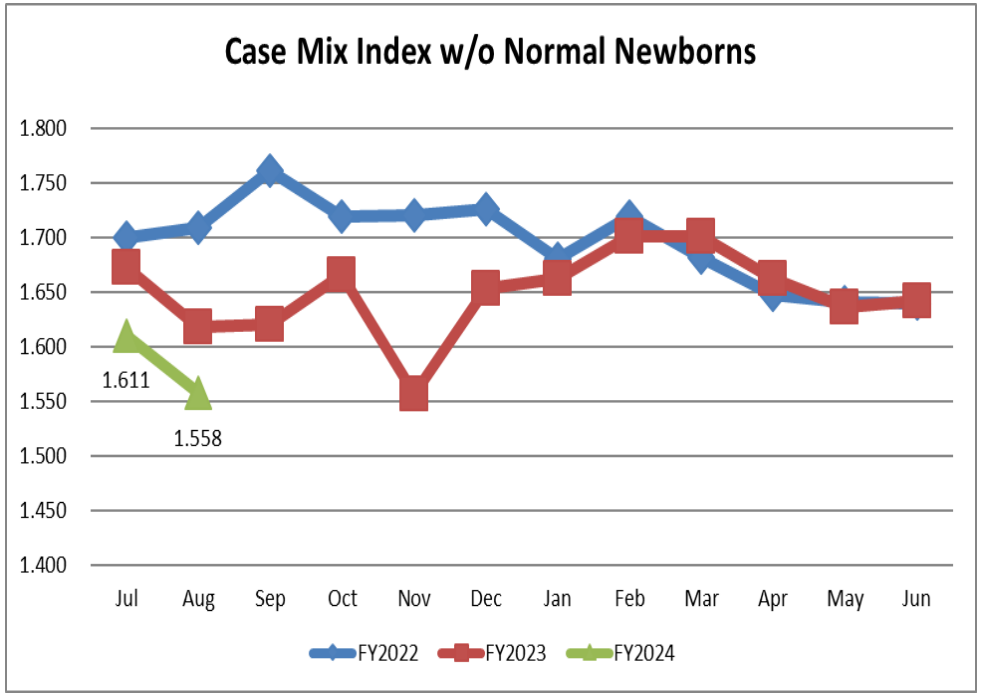


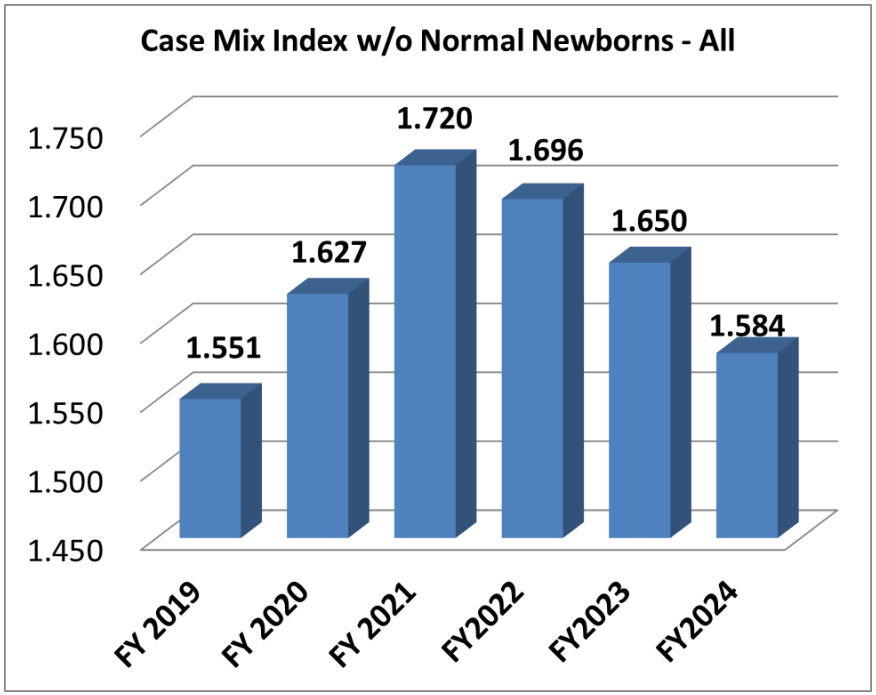
Contract Labor Expense

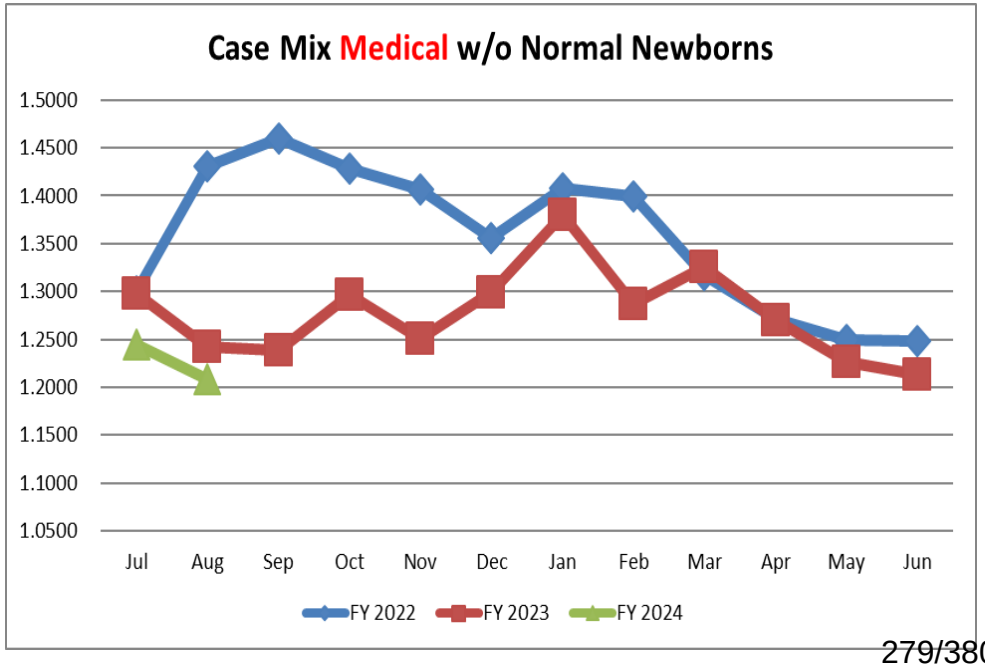


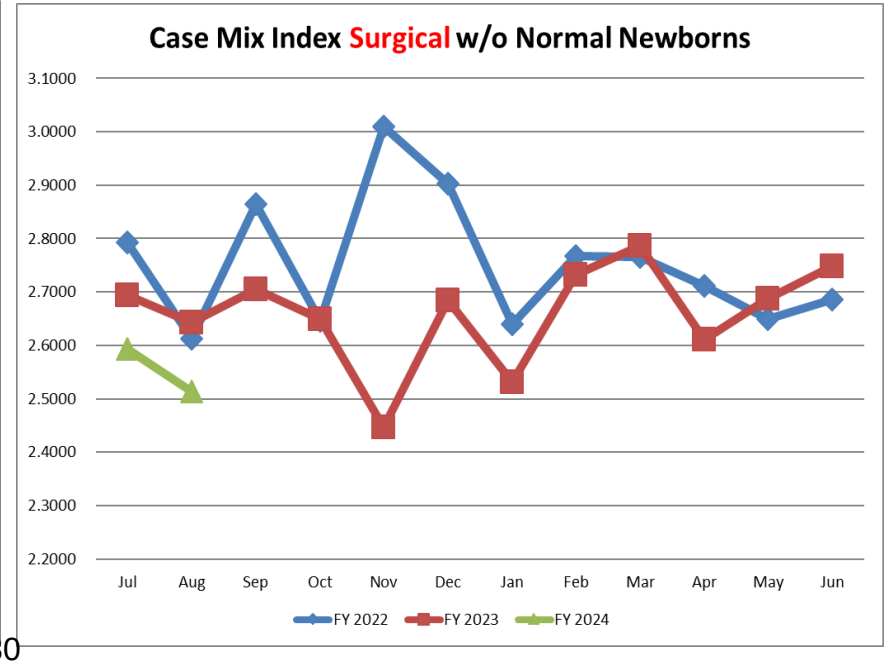
Overtime as a % of Productive Hours and $



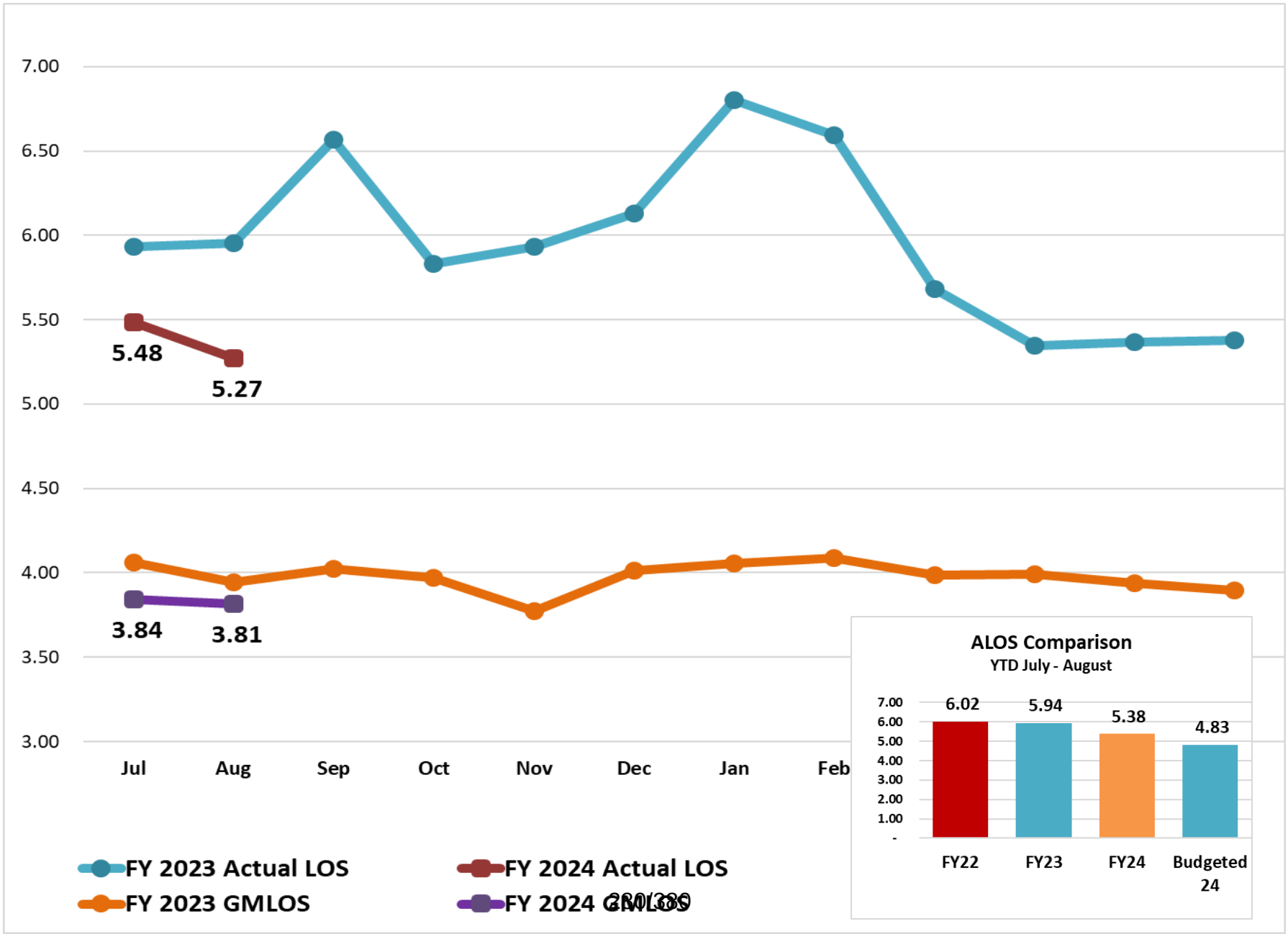

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.611
1.558
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2022
FY2023
FY2024


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.551
1.627
1.720
1.696
1.650
1.584
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024


Case Mix Medical w/o Normal Newborns
1.5000
1.4500
1.4000
1.3500
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2022
FY 2023
FY 2024

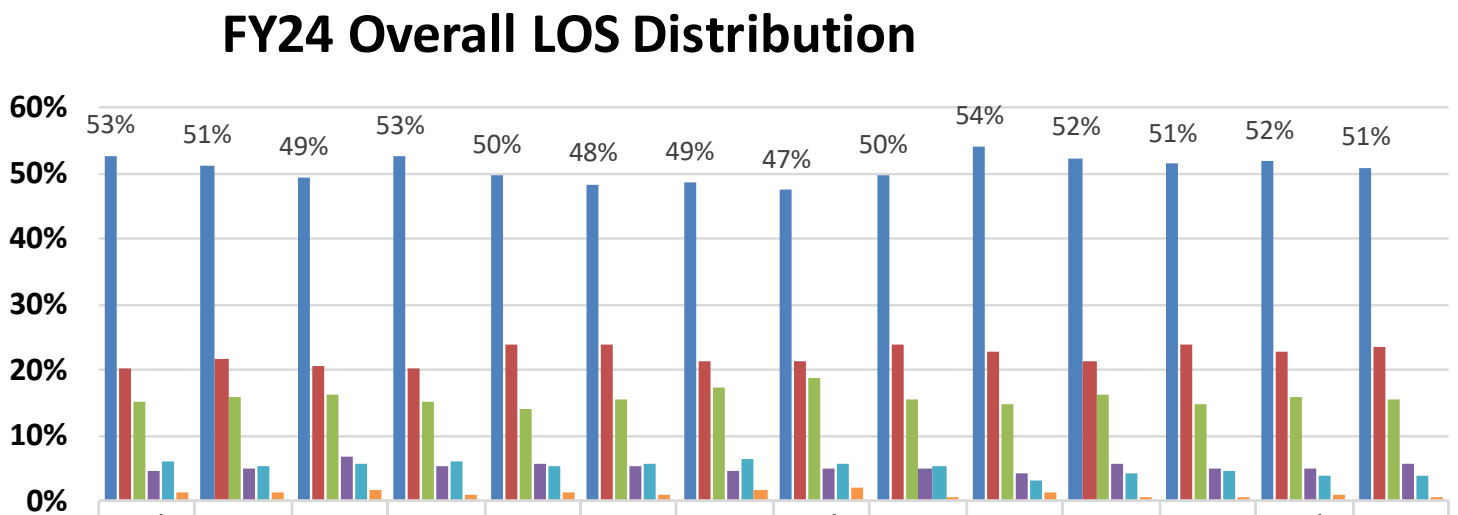

Case Mix Index Surgical w/o Normal Newborns
3.1000
3.0000
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2022
FY 2023
FY 2024

Average Length of Stay versus National Average (GMLOS)



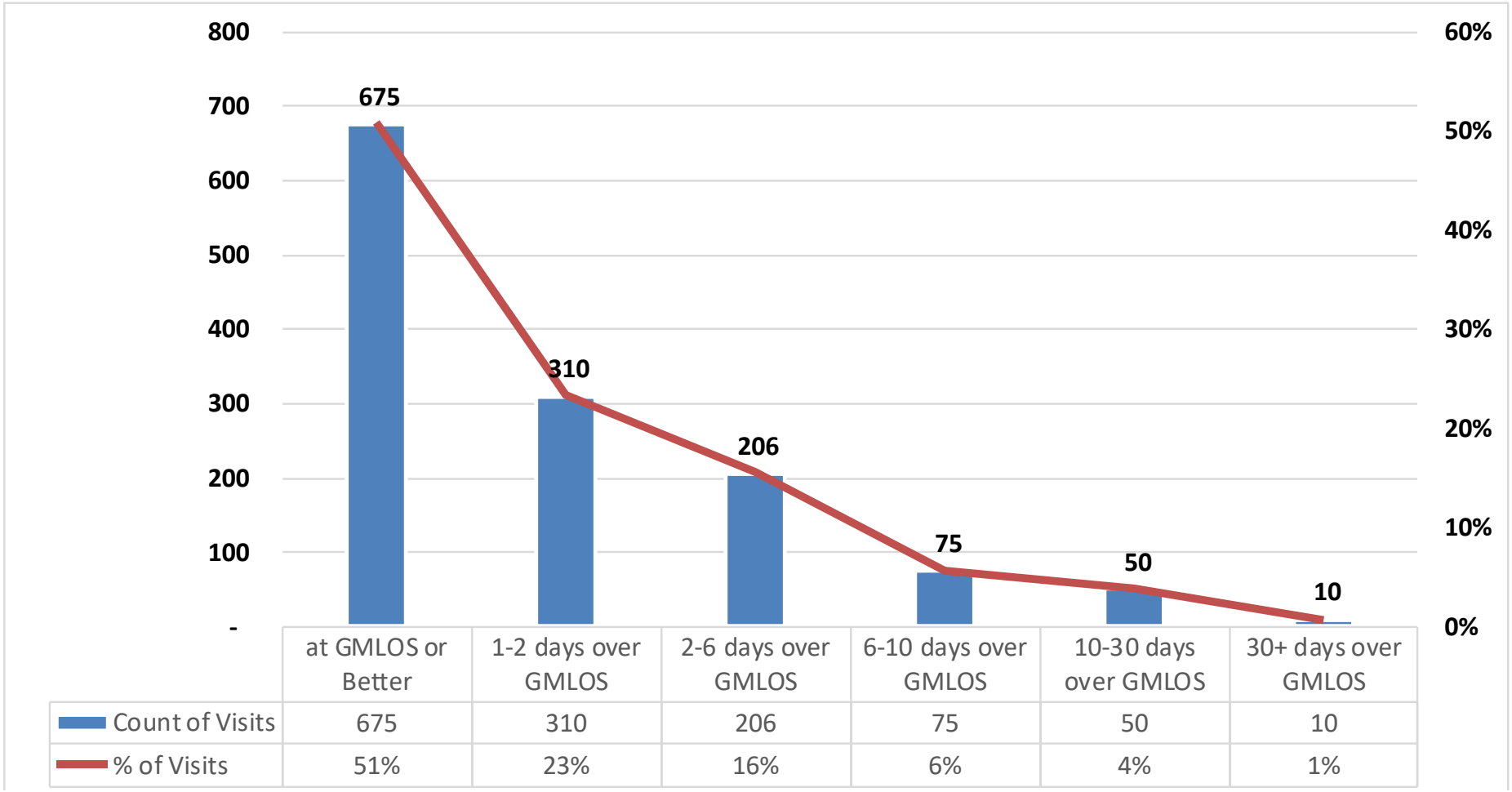
Average Length of Stay Distribution

Overall



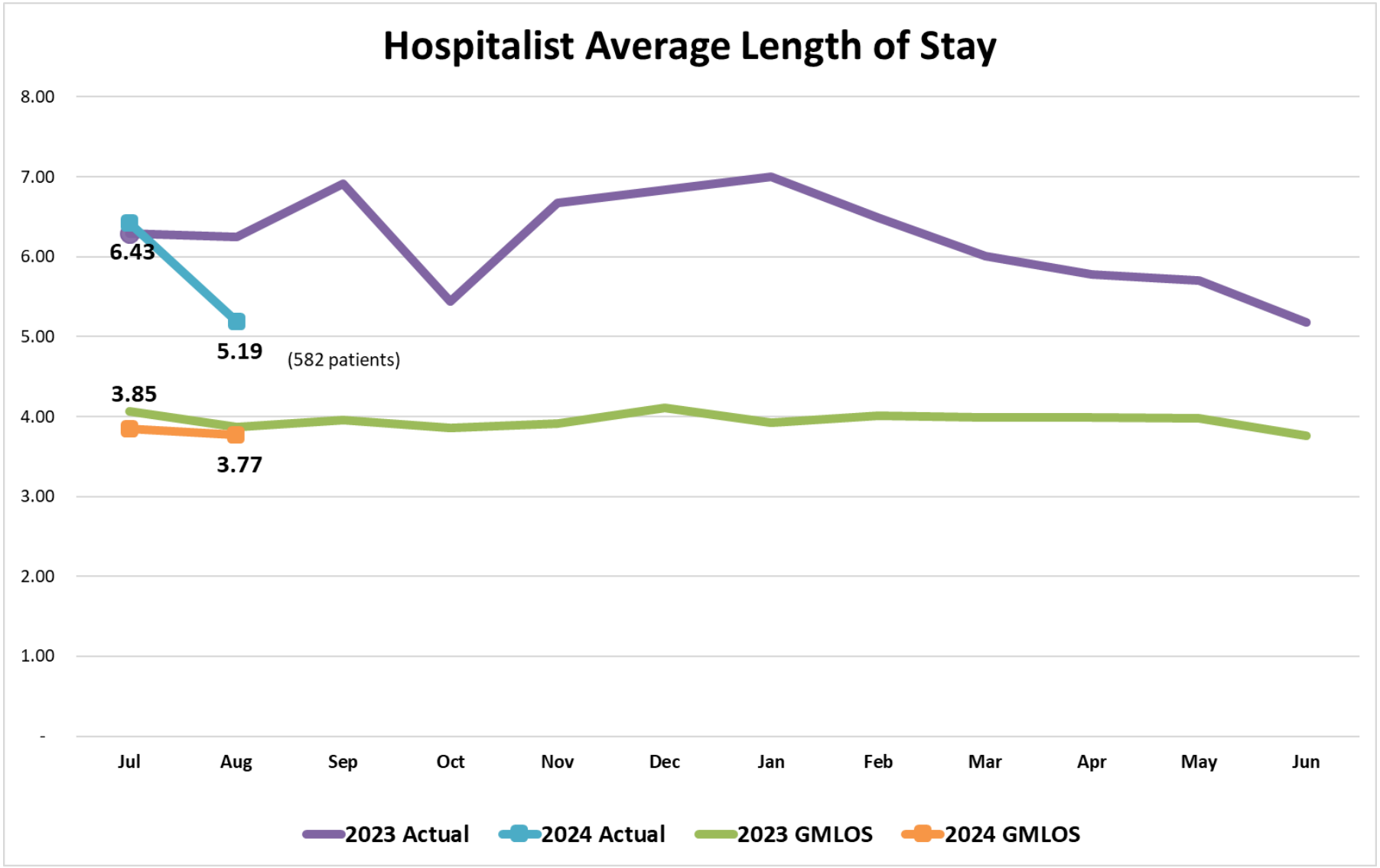
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
	2023												2024	
at GMLOS or Better	53%	51%	49%	53%	50%	48%	49%	47%	50%	54%	52%	51%	52%	51%
1-2 days over GMLOS	20%	22%	20%	20%	24%	24%	21%	21%	24%	23%	21%	24%	23%	23%
2-6 days over GMLOS	15%	16%	16%	15%	14%	16%	17%	19%	16%	15%	16%	15%	16%	16%
6-10 days over GMLOS	5%	5%	7%	5%	6%	5%	5%	5%	5%	4%	6%	5%	5%	6%
10-30 days over GMLOS	6%	5%	6%	6%	5%	6%	7%	6%	5%	3%	4%	5%	4%	4%
30+ days over GMLOS	1.2%	1.2%	1.7%	1.0%	1.2%	1.1%	1.6%	2.0%	0.5%	1.2%	0.5%	0.8%	0.9%	0.8%

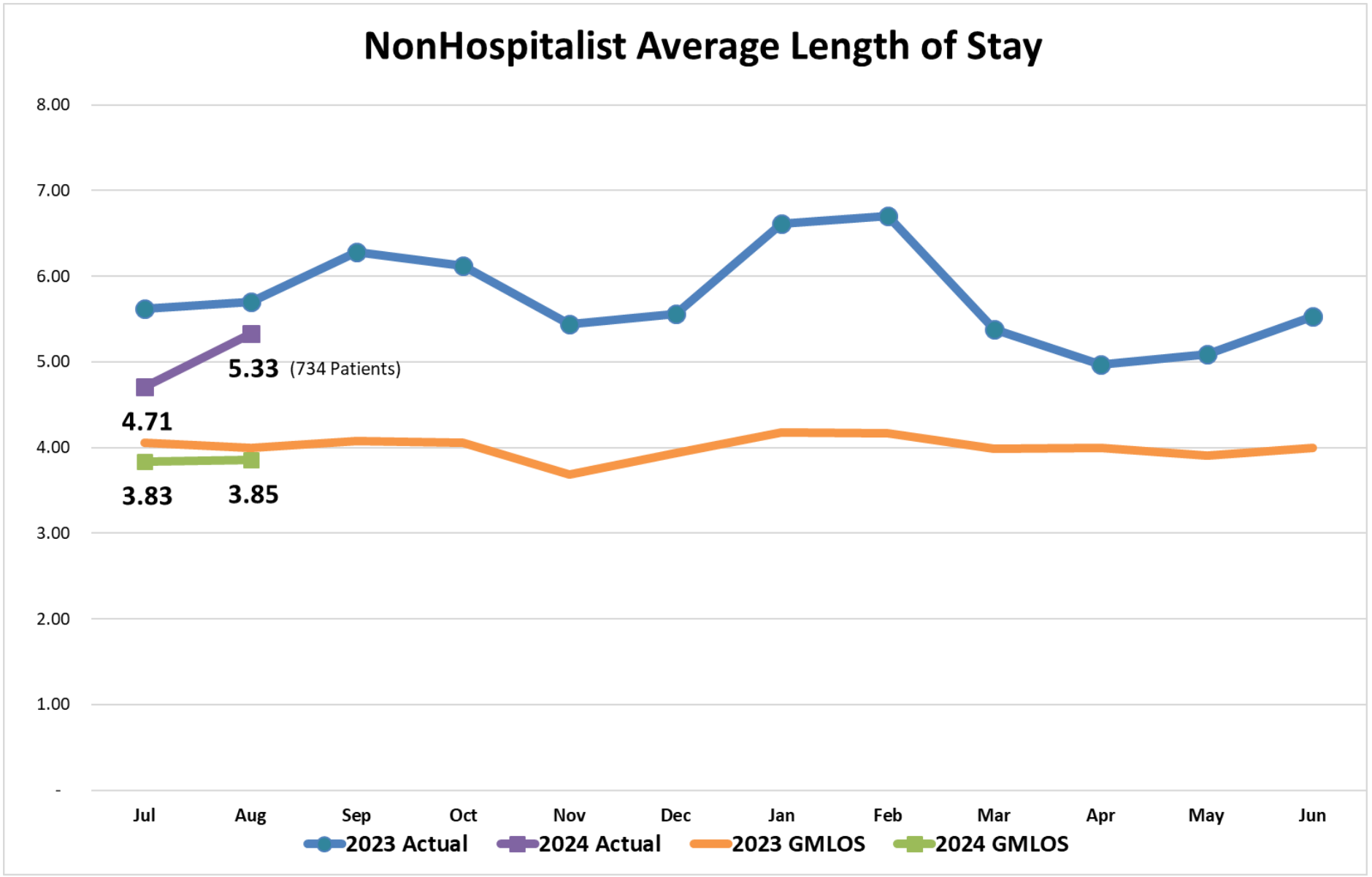
Average Length of Stay Distribution



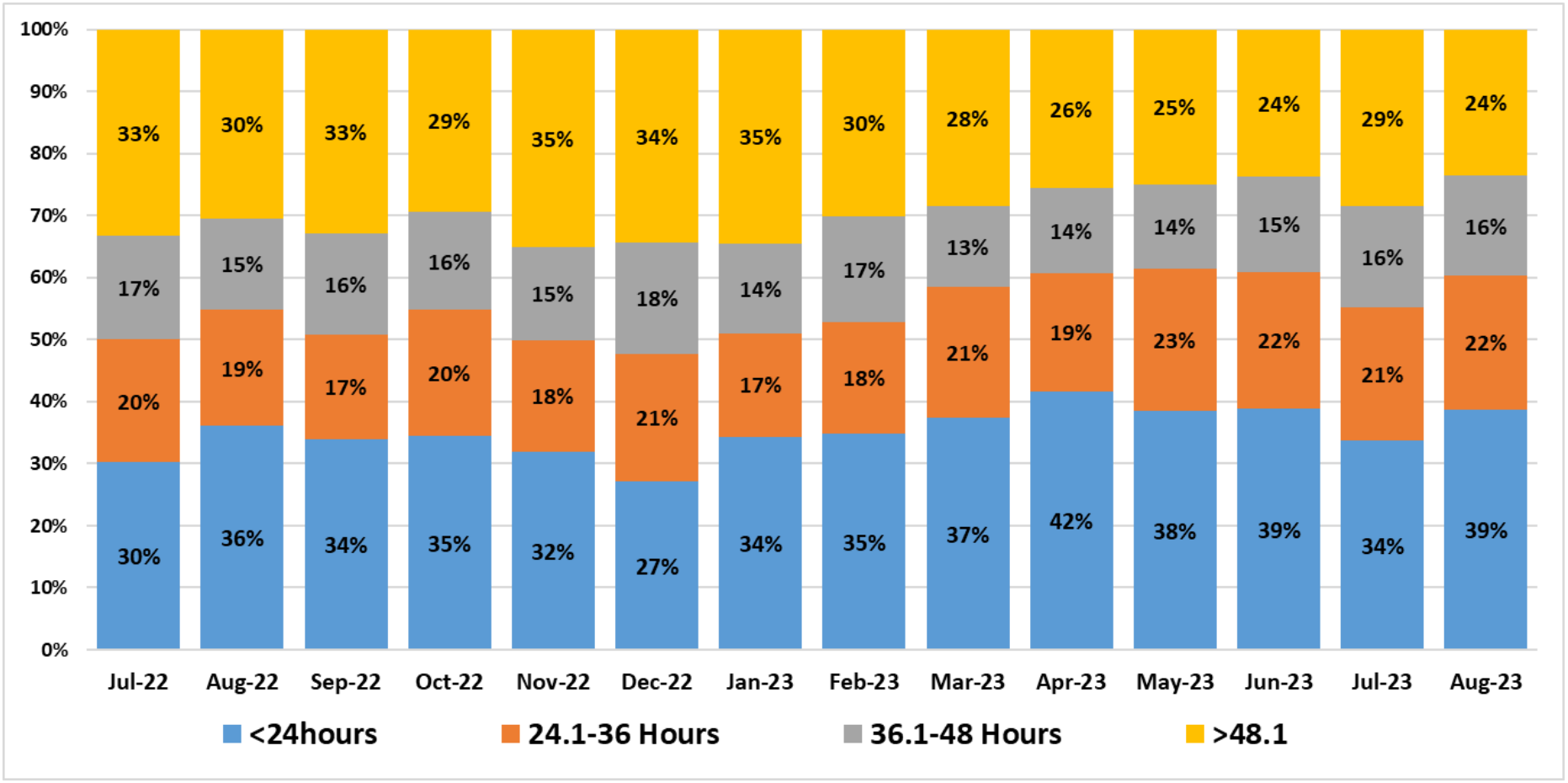
	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS	30+ days over GMLOS
Count of Visits	675	310	206	75	50	10
% of Visits	51%	23%	16%	6%	4%	1%

Opportunity Cost of Reducing LOS to National Average - $82M FY22

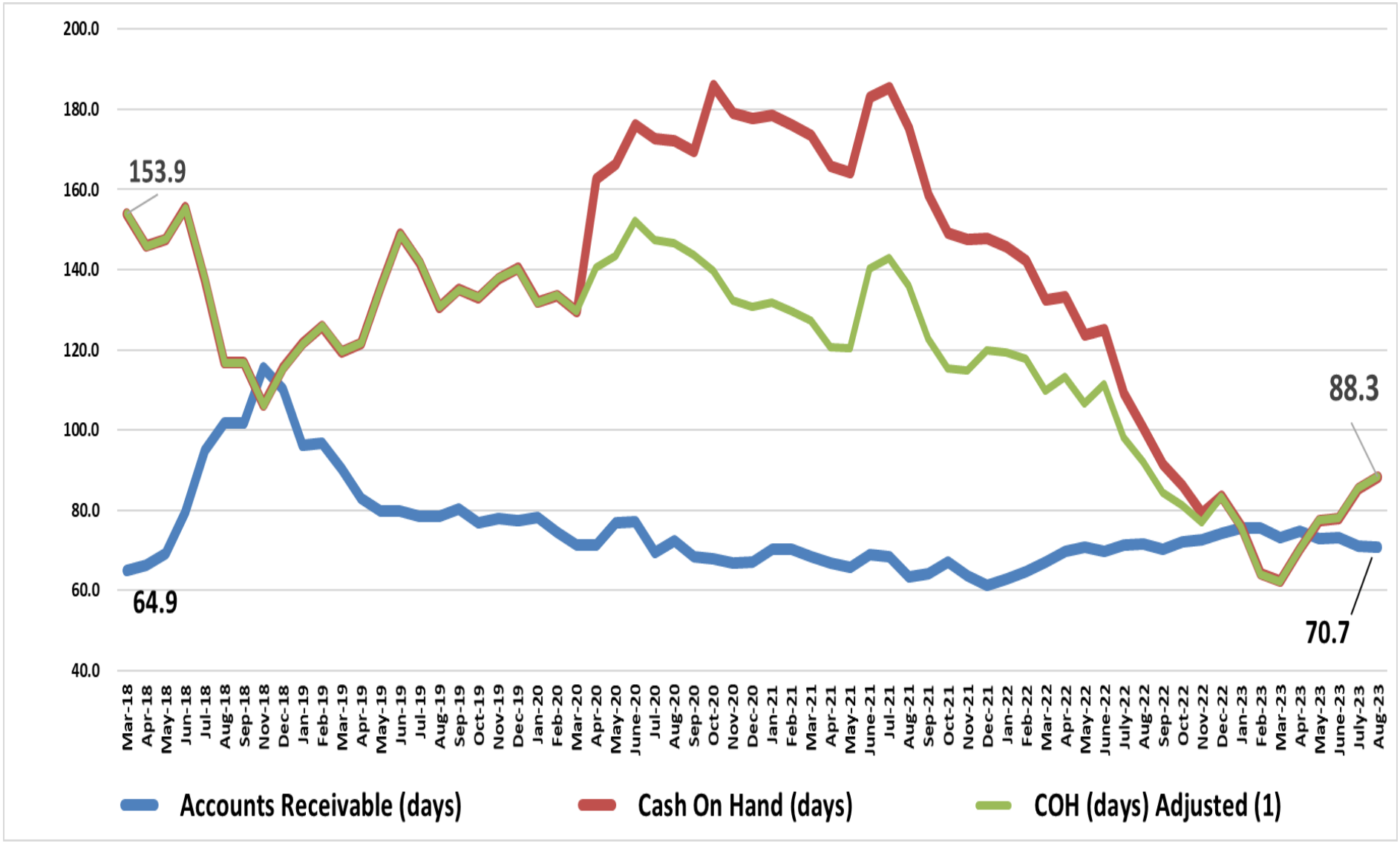

Hospitalist Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
6.43
5.19
(582 patients)
3.85
3.77
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2023 Actual
2024 Actual
2023 GMLOS
2024 GMLOS


NonHospitalist Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.33 (734 Patients)
4.71
3.83
3.85
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2023 Actual
2024 Actual
2023 GMLOS
2024 GMLOS

Monthly Discharges of Observation Patients by their Length of Stay



Trended Liquidity Ratios



Ratio Analysis Report

	Current Month Value	Prior Month Value	June 30, 2023 Unaudited Value	2021 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	3.3	3.3	3.2	1.4	**1.7**	1.6
Accounts Receivable (days)	70.7	71.0	72.7	48.3	**48.3**	47.5
Cash On Hand (days)	88.3	85.9	78.0	341.3	**268.4**	206.5
Cushion Ratio (x)	10.7	10.2	10.3	52.4	**31.5**	19.9
Average Payment Period (days)	42.4	40.8	38.1	97.6	**86.4**	94.0
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	95.4%	91.3%	91.8%	323.4%	**220.4%**	170.1%
Debt-To-Capitalization	33.2%	33.0%	32.9%	20.6%	**29.1%**	36.3%
Debt-to-Cash Flow (x)	4.3	6.9	(63.3)	2.1	**2.6**	3.3
Debt Service Coverage	2.6	1.6	(0.2)	9.6	**6.0**	4.5
Maximum Annual Debt Service Coverage(x)	2.6	1.6	(0.2)	8.2	**5.5**	3.9
Age Of Plant (years)	14.6	14.7	13.3	10.8	**12.4**	13.5
PROFITABILITY RATIOS						
Operating Margin	(2.1%)	(4.5%)	(6.6%)	4.1%	**3.1%**	2.2%
Excess Margin	1.0%	(1.1%)	(5.2%)	8.1%	**6.7%**	4.8%
Operating Cash Flow Margin	2.8%	0.7%	(1.5%)	9.6%	**8.8%**	7.5%
Return on Assets	1.0%	(1.1%)	(5.5%)	5.8%	**4.9%**	3.9%

Consolidated Statements of Net Position (000's)

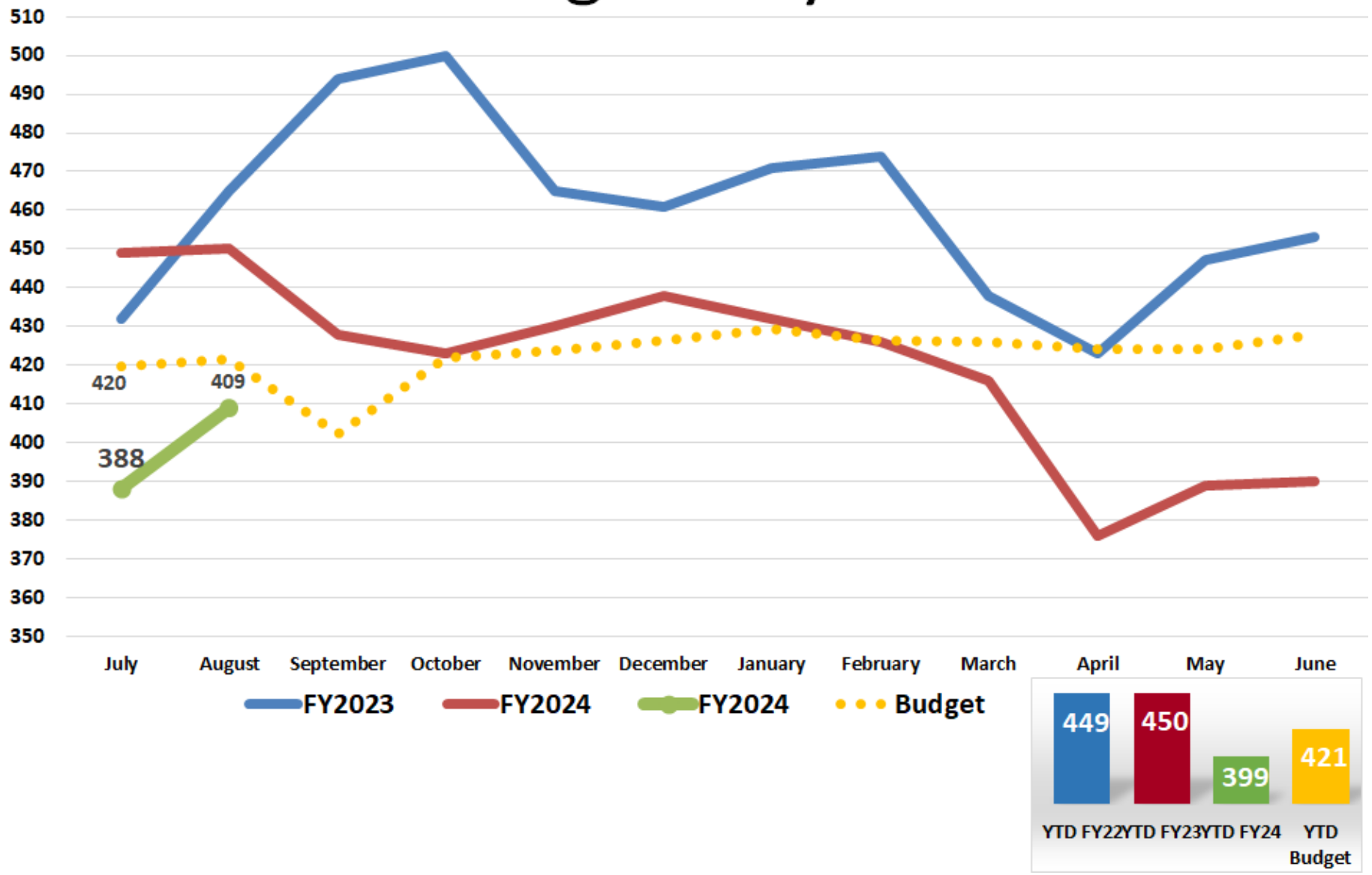
	Aug-23	Jul-23	Change	% Change
ASSETS AND DEFERRED OUTFLOWS				
CURRENT ASSETS				
Cash and cash equivalents	$ 20,283	$ 7,063	$ 13,220	187.17%
Current Portion of Board designated and trusted assets	14,931	13,560	1,372	10.12%
Accounts receivable:		-		
Net patient accounts	124,968	126,340	(1,372)	-1.09%
Other receivables	28,002	31,859	(3,857)	-12.11%
	152,970	158,199	(5,230)	-3.31%
Inventories	14,007	12,856	1,151	8.95%
Medicare and Medi-Cal settlements	88,376	88,471	(95)	-0.11%
Prepaid expenses	13,484	12,567	917	7.30%
Total current assets	304,051	292,716	11,335	3.87%
NON-CURRENT CASH AND INVESTMENTS - less current portion				
Board designated cash and assets	164,403	169,226	(4,824)	-2.85%
Revenue bond assets held in trust	18,806	18,806	-	0.00%
Assets in self-insurance trust fund	963	959	4	0.40%
Total non-current cash and investments	184,171	188,991	(4,820)	-2.55%
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	12,866	11,202	1,664	14.86%
CAPITAL ASSETS				
Land	20,544	17,542	3,002	17.11%
Buildings and improvements	426,230	427,105	(875)	-0.20%
Equipment	323,988	328,663	(4,675)	-1.42%
Construction in progress	24,324	25,714	(1,390)	-5.41%
	795,087	799,025	(3,938)	-0.49%
Less accumulated depreciation	485,326	487,985	(2,660)	-0.55%
	309,761	311,039	(1,279)	-0.41%
Property under capital leases - less accumulated amortization	(691)	(691)	-	0.00%
Total capital assets	309,069	310,348	(1,279)	-0.41%
OTHER ASSETS				
Property not used in operations	1,913	1,529	384	25.13%
Health-related investments	2,497	2,752	(255)	-9.28%
Other	13,761	13,760	1	0.01%
Total other assets	18,170	18,040	130	0.72%
Total assets	828,328	821,297	7,031	0.86%
DEFERRED OUTFLOWS	33,769	33,802	(33)	-0.10%
Total assets and deferred outflows	289/380 **$ 862,097**	**$ 855,099**	**$ 6,998**	**0.82%**

Consolidated Statements of Net Position (000's)

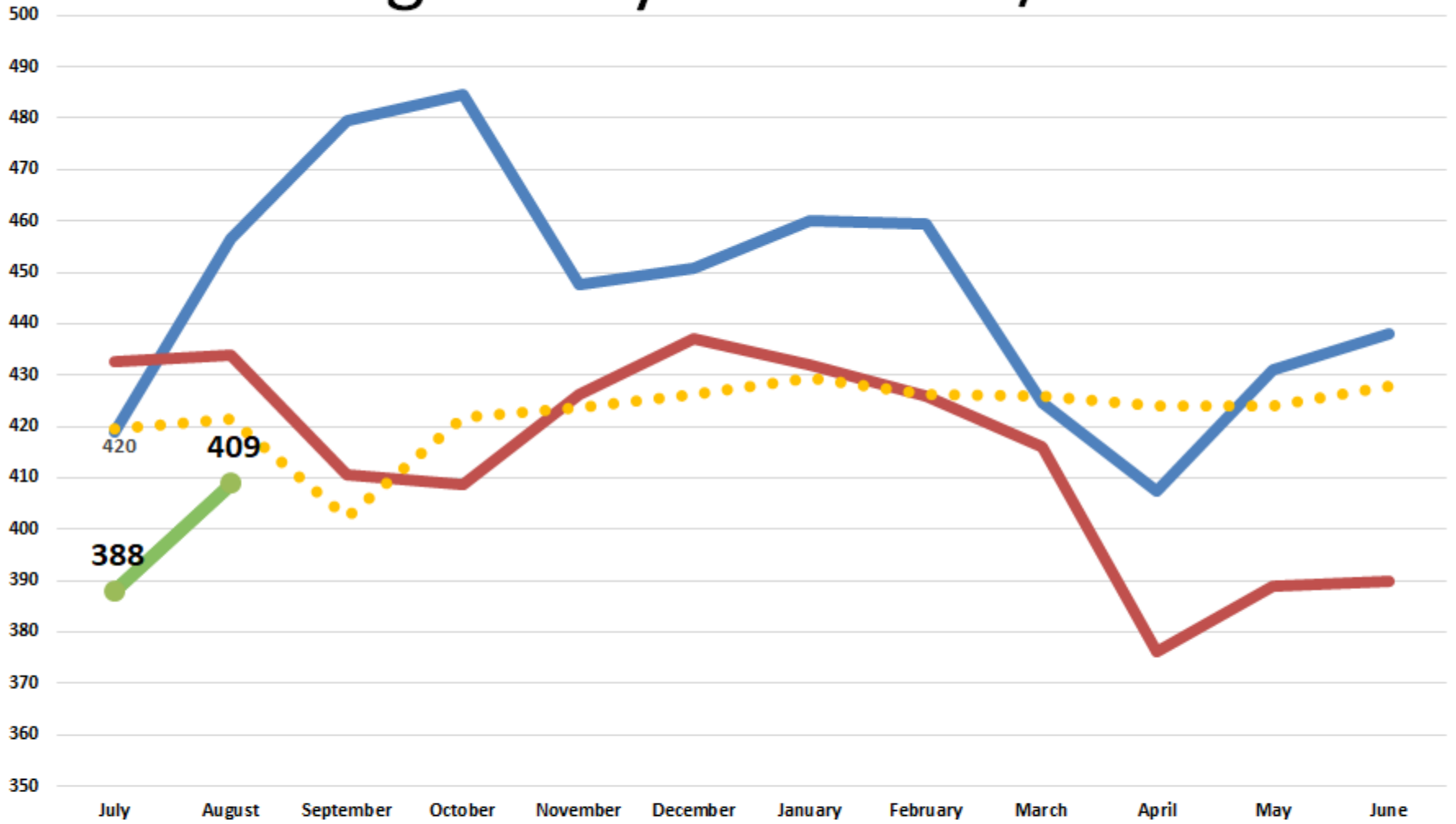
	Aug-23	Jul-23	Change	% Change
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts payable and accrued expenses	$ 32,148	$ 28,863	$ 3,285	11.38%
Accrued payroll and related liabilities	52,775	50,910	1,865	3.66%
Long-term debt, current portion	8,051	8,051	-	0.00%
Total current liabilities	92,974	87,824	5,150	5.86%
LEASE LIABILITY, net of current portion	13,043	11,354	1,689	14.88%
LONG-TERM DEBT, less current portion				
Bonds payable	229,419	229,426	(7)	0.00%
Capital leases	-	-	-	0.00%
Notes payable	17,745	17,745	-	0.00%
Total long-term debt	247,164	247,170	(7)	0.00%
NET PENSION LIABILITY	53,200	52,276	924	1.77%
OTHER LONG-TERM LIABILITIES	31,835	30,853	983	3.18%
Total liabilities	438,216	429,477	8,739	2.03%
NET ASSETS				
Invested in capital assets, net of related debt	56,916	58,220	(1,305)	-2.24%
Restricted	50,150	48,669	1,481	3.04%
Unrestricted	316,816	318,732	(1,917)	-0.60%
Total net position	423,881	425,621	(1,740)	-0.41%
Total liabilities and net position	**$ 862,097**	**$ 855,099**	**$ 6,998**	**0.82%**

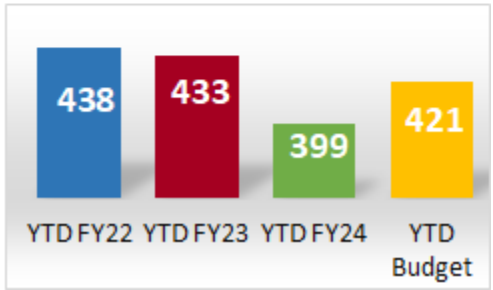
Statistical Report
August 2023

Average Daily Census

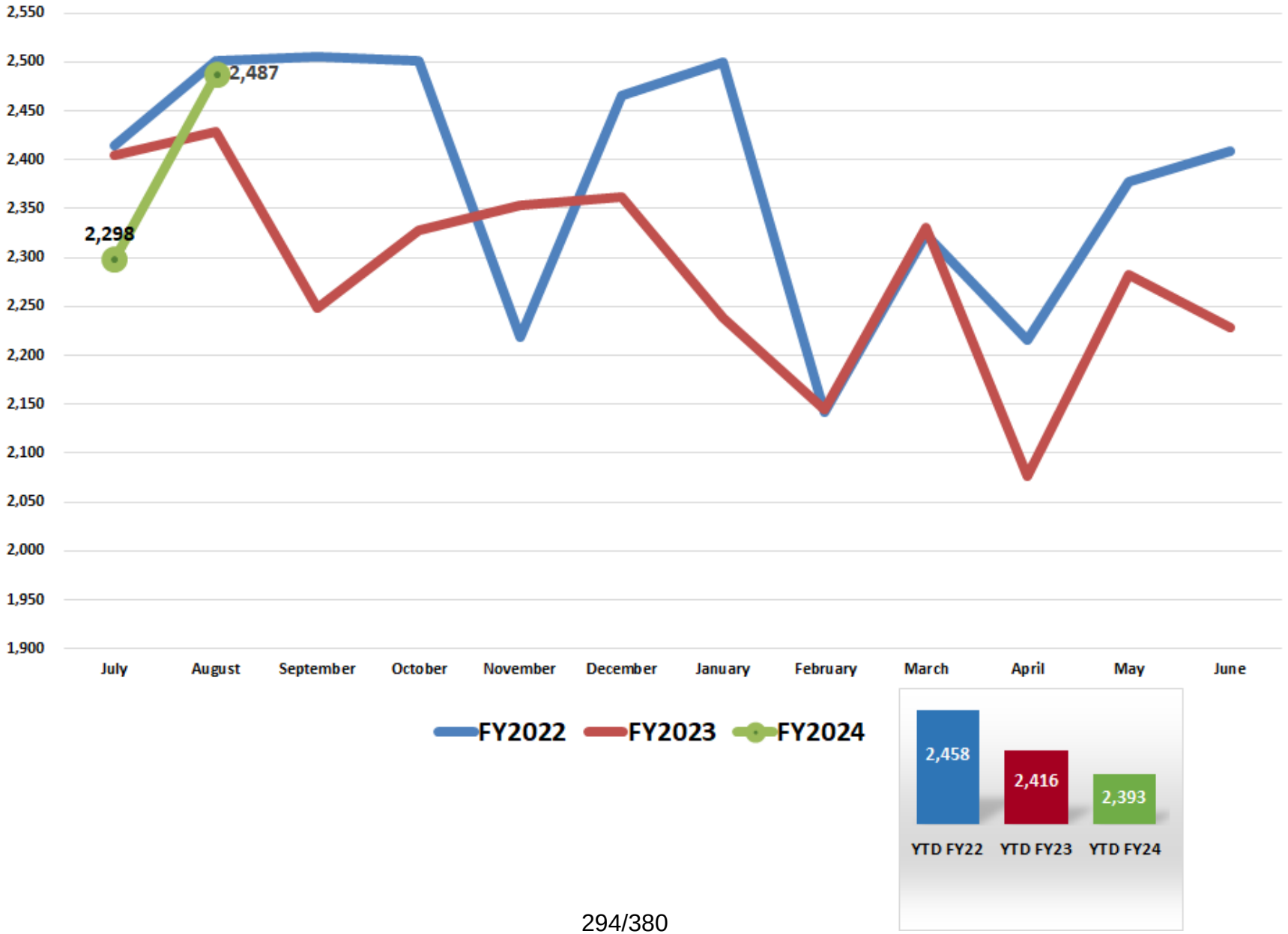


Average Daily Census w/o TCS

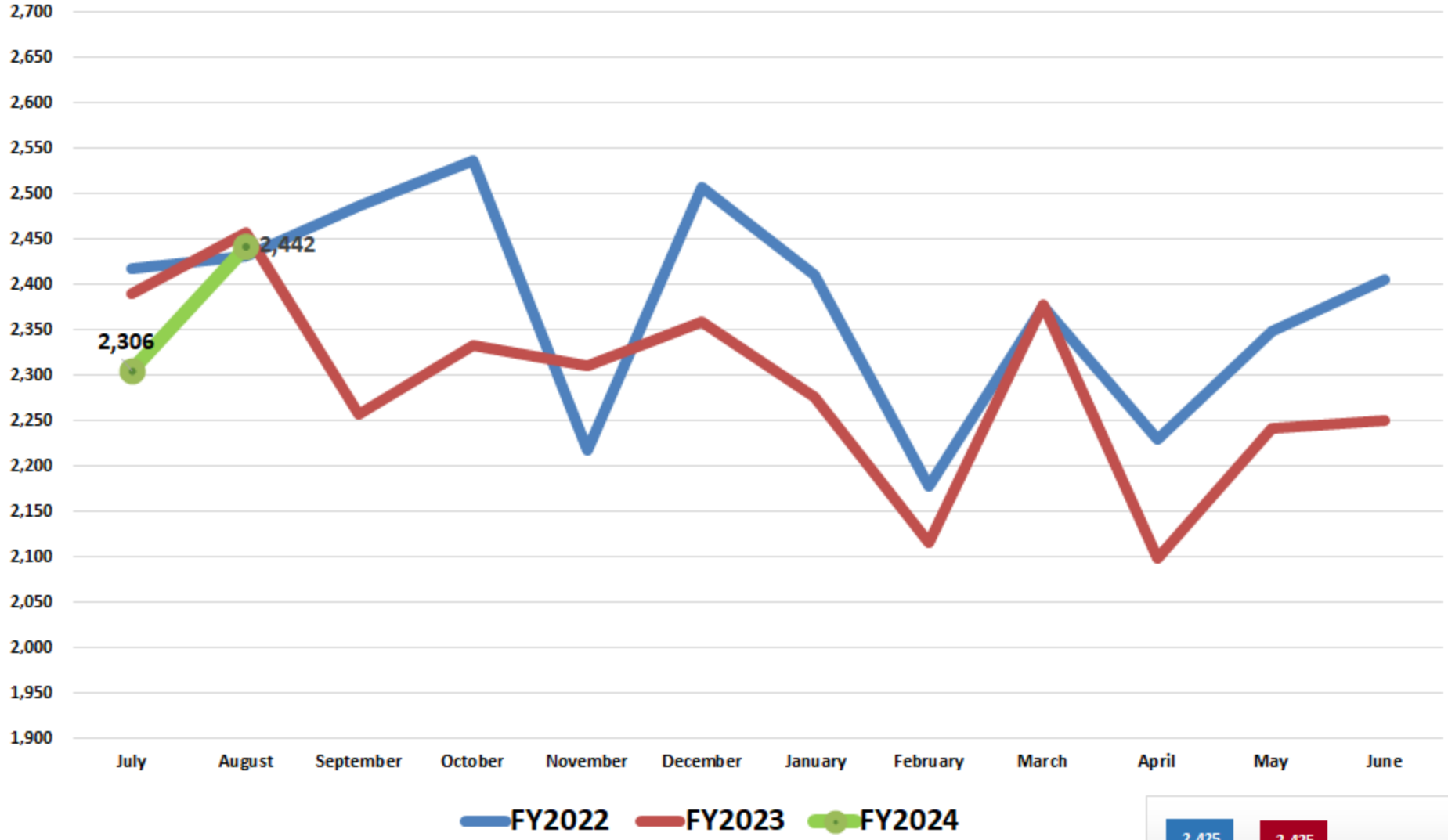


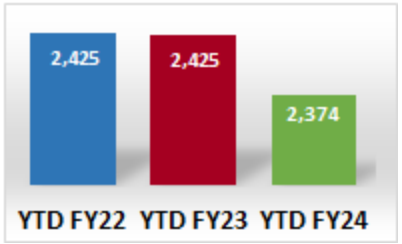


Admissions

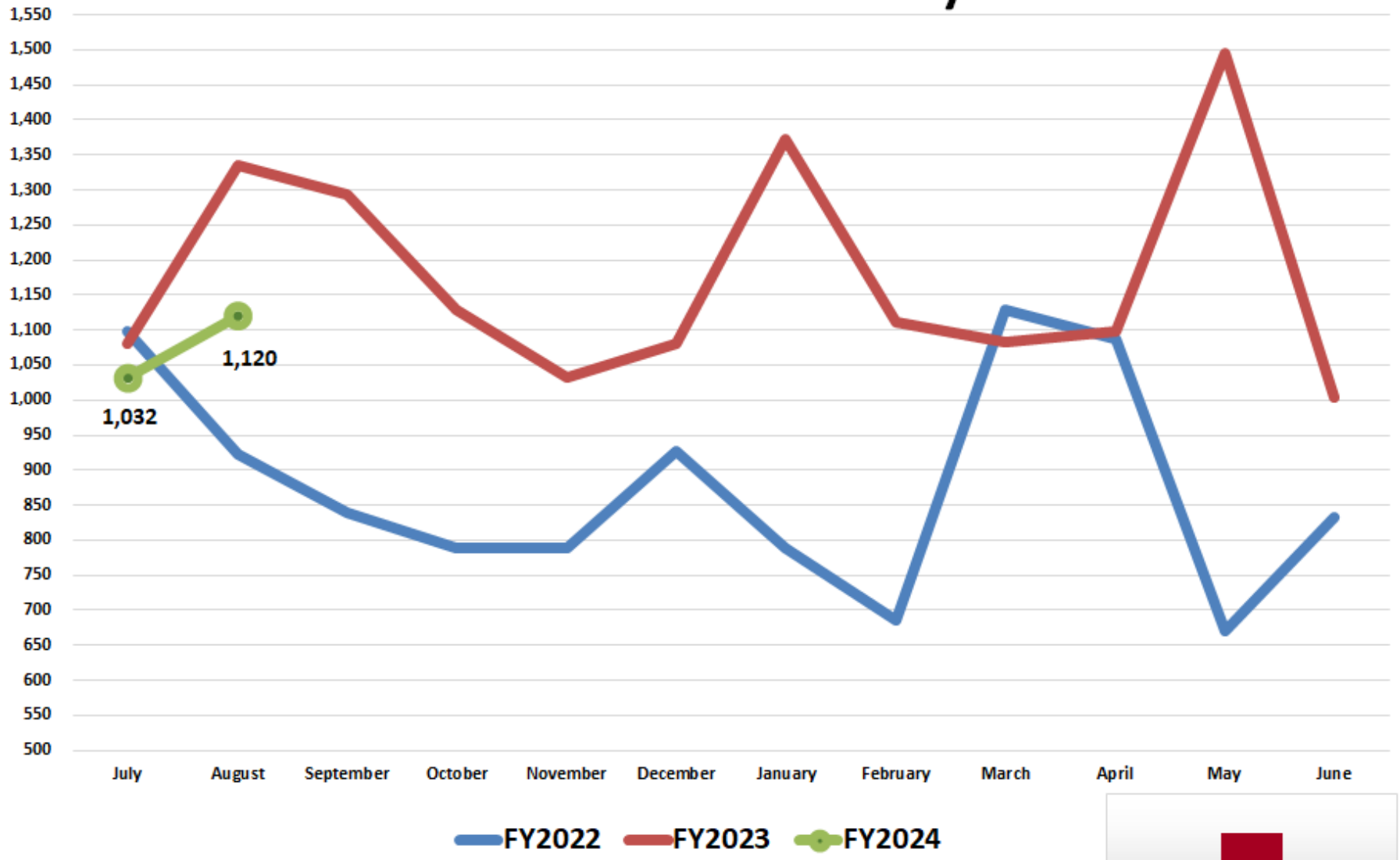

2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,487
2,298
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024
2,458
2,416
2,393
YTD FY22
YTD FY23
YTD FY24

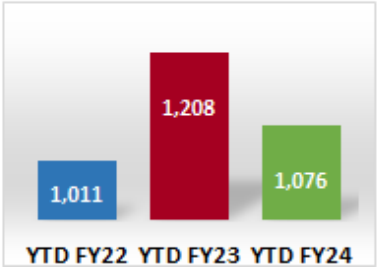
Discharges


2,700
2,650
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,442
2,306
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024

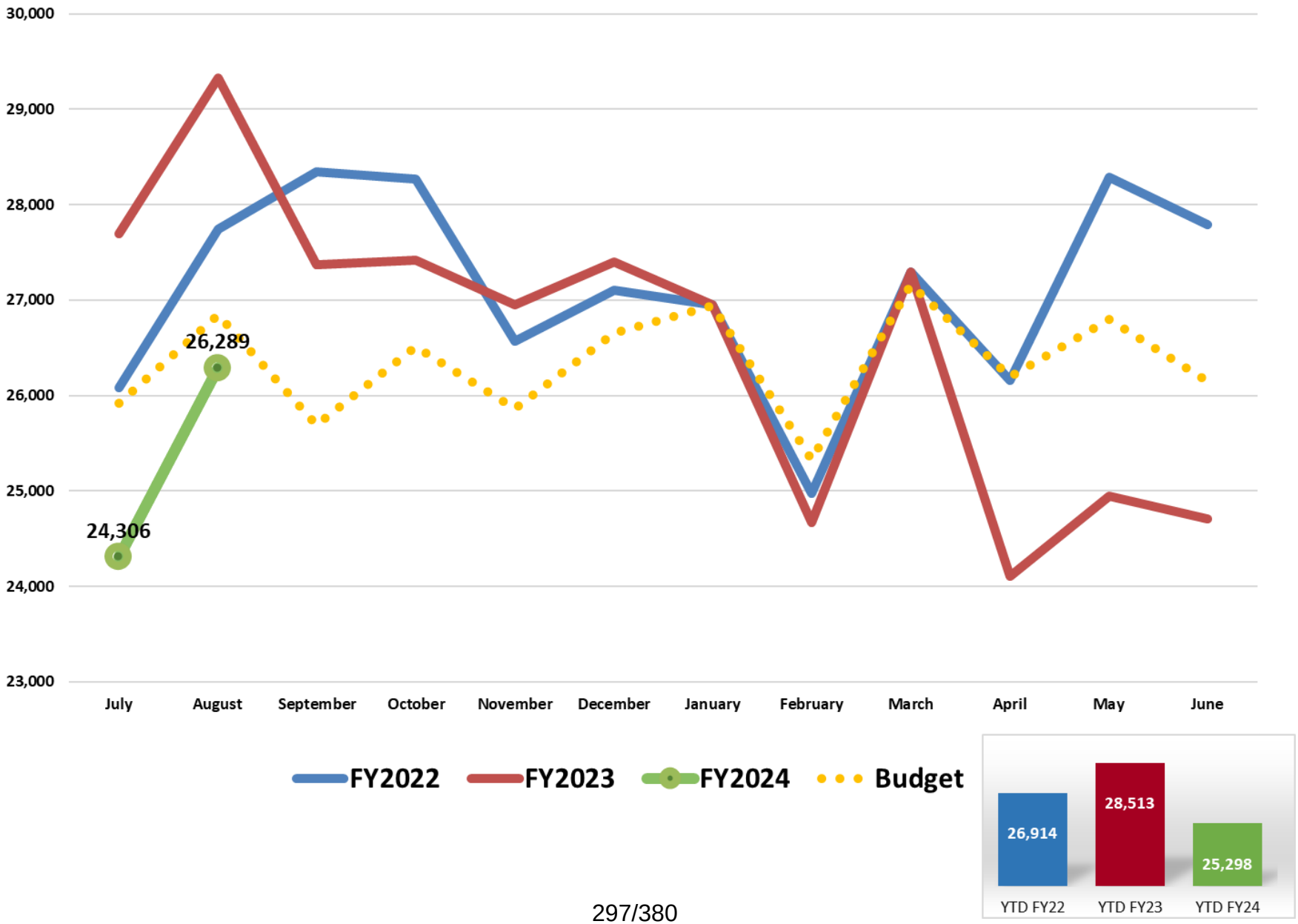

2,425
2,425
2,374
YTD FY22
YTD FY23
YTD FY24

Observation Days

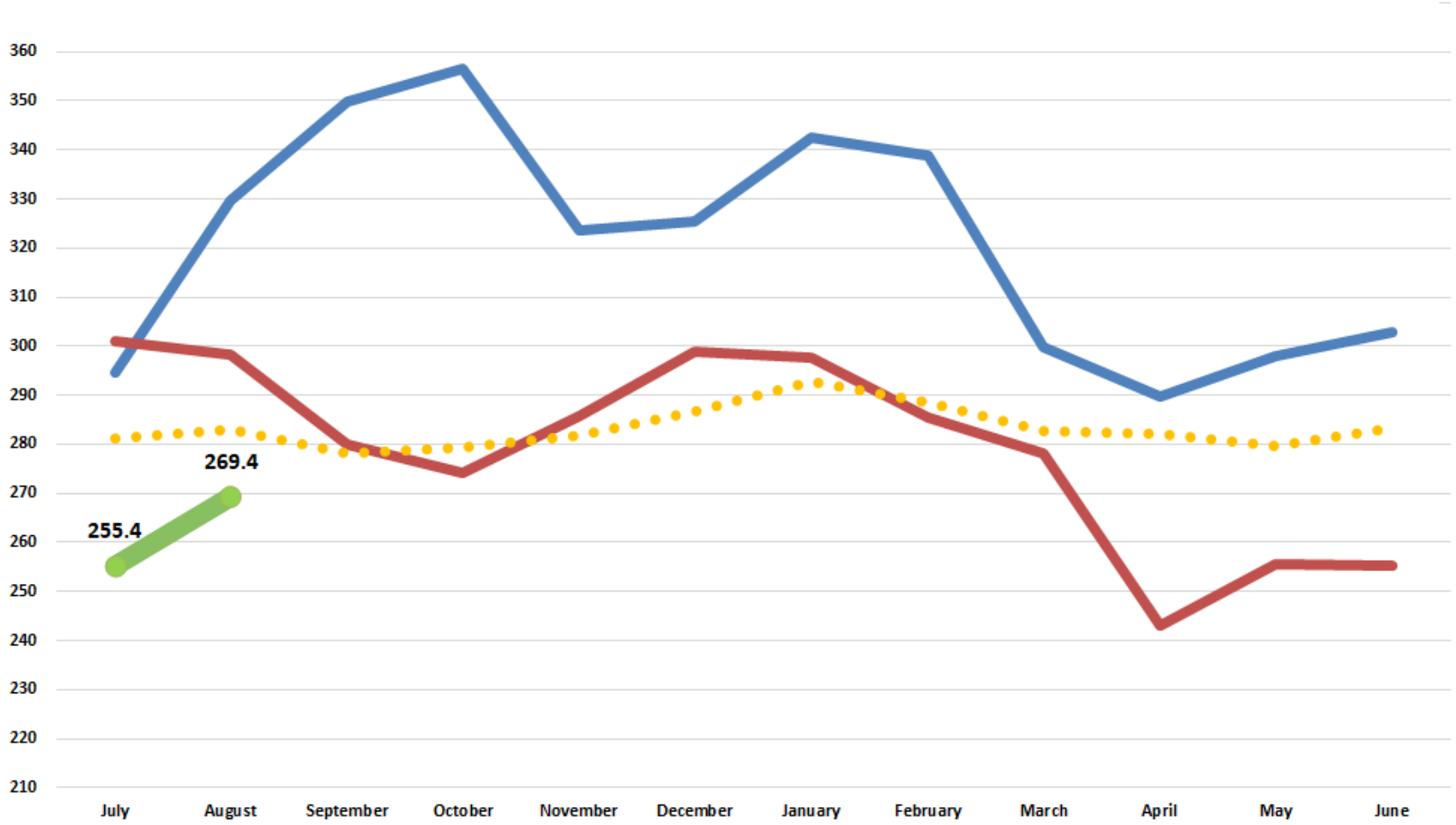


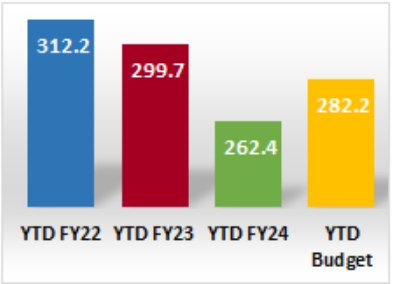


Adjusted Patient Days

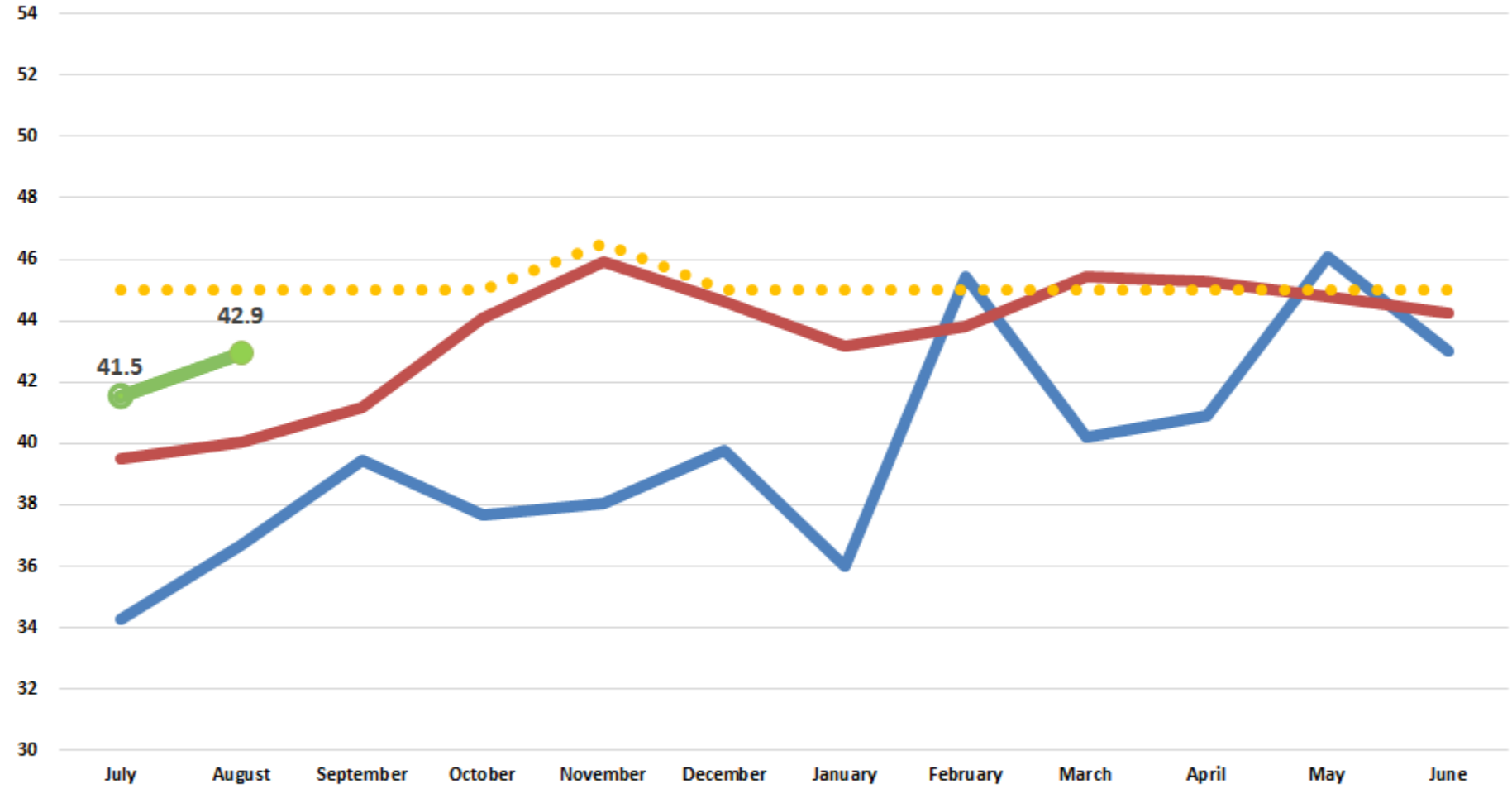


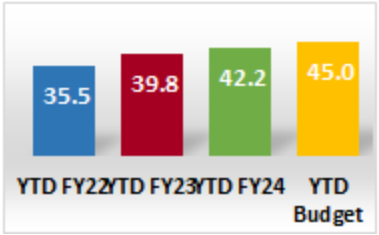
Medical Center (Avg Patients Per Day)



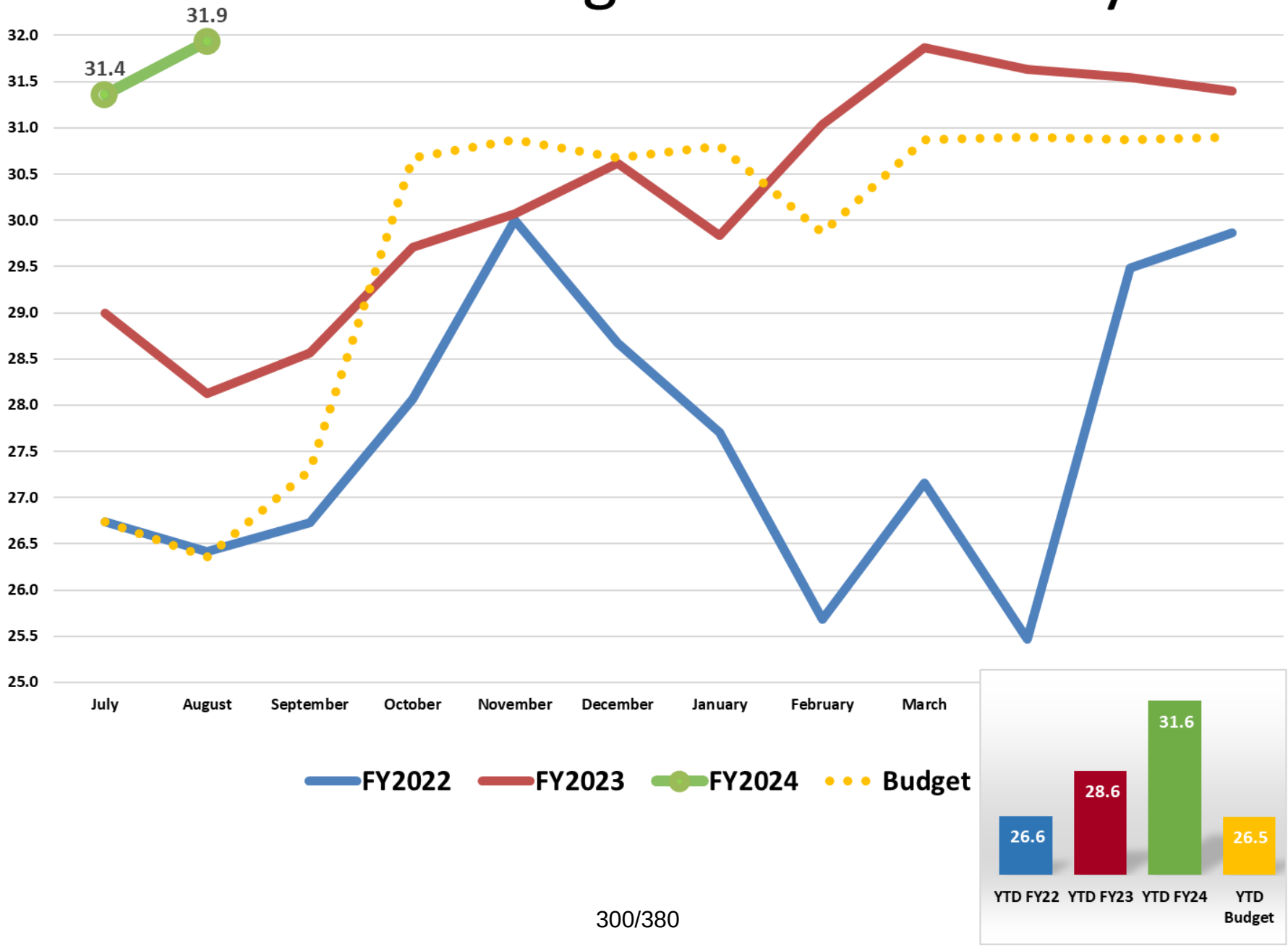


Acute I/P Psych (Avg Patients Per Day)

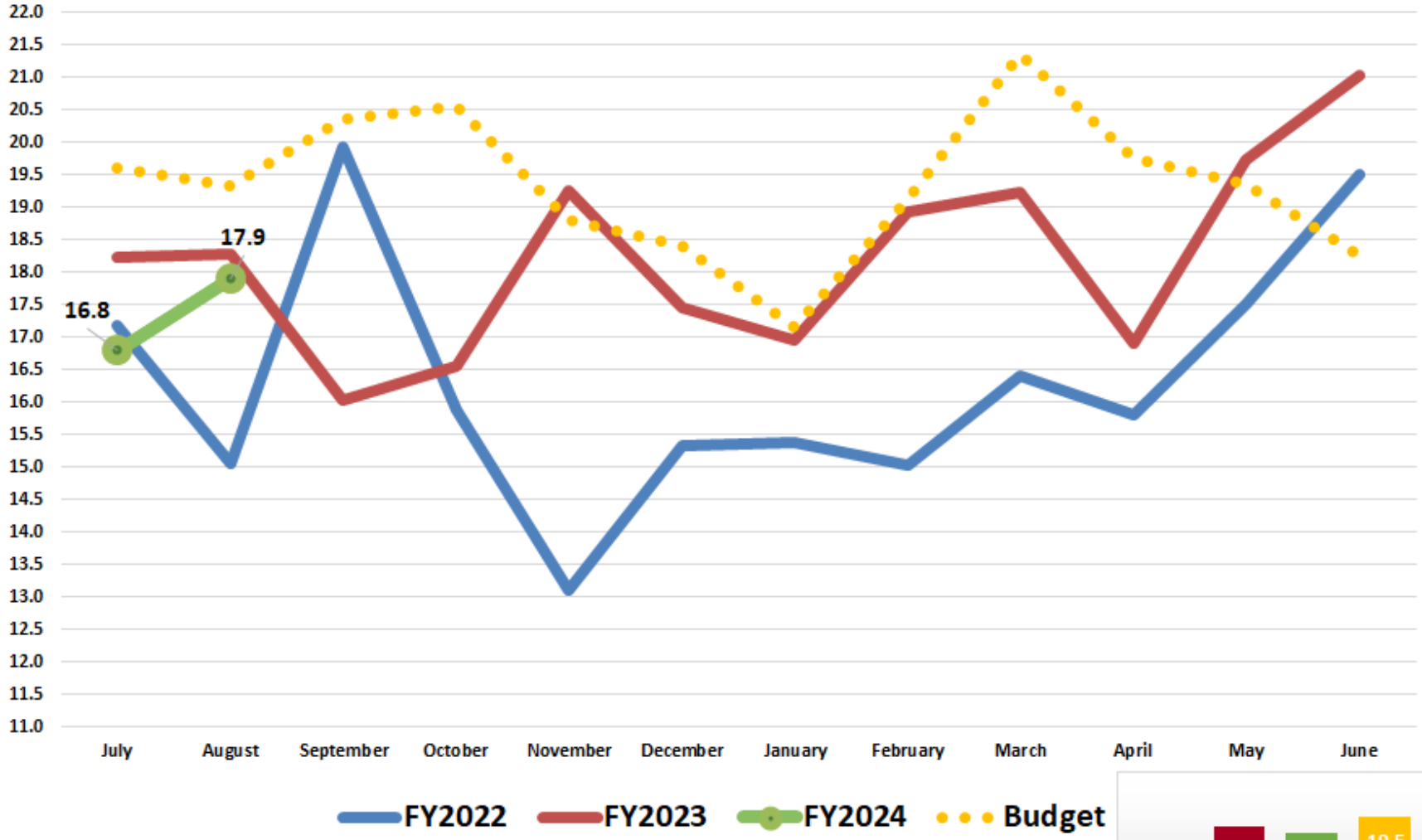


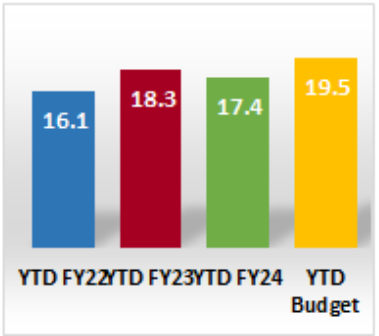


Sub-Acute - Avg Patients Per Day

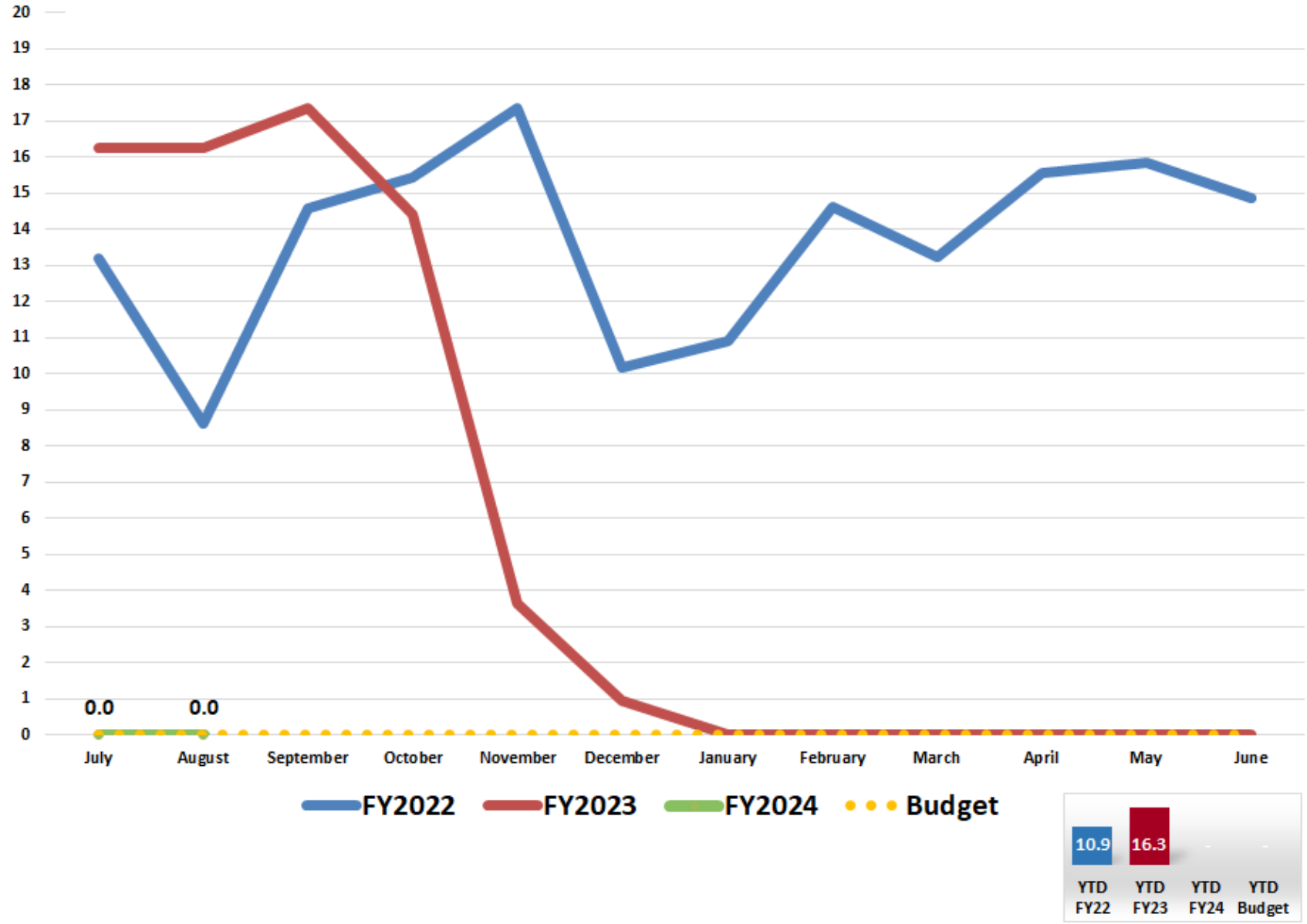


Rehabilitation Hospital - Avg Patients Per Day

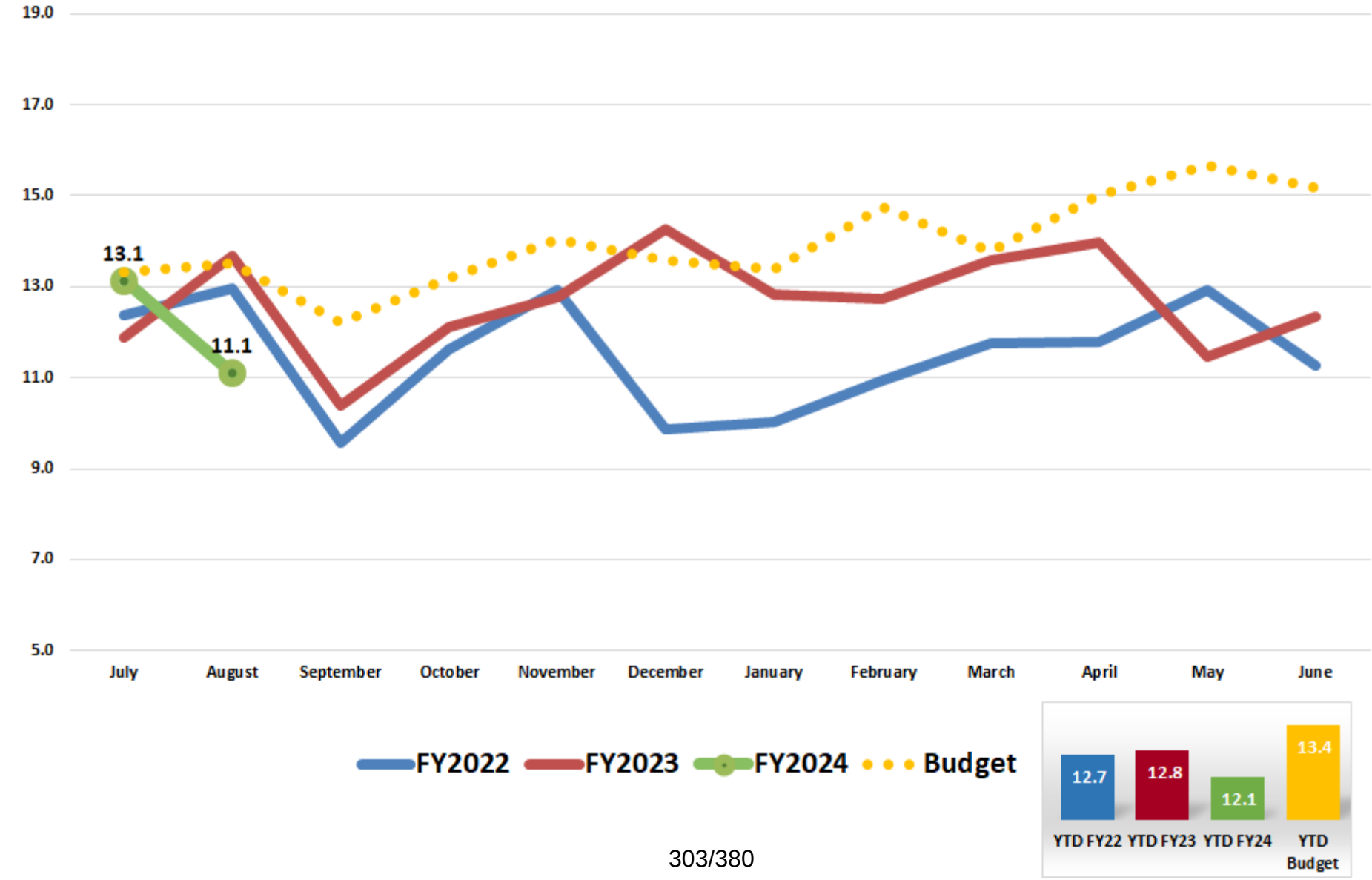




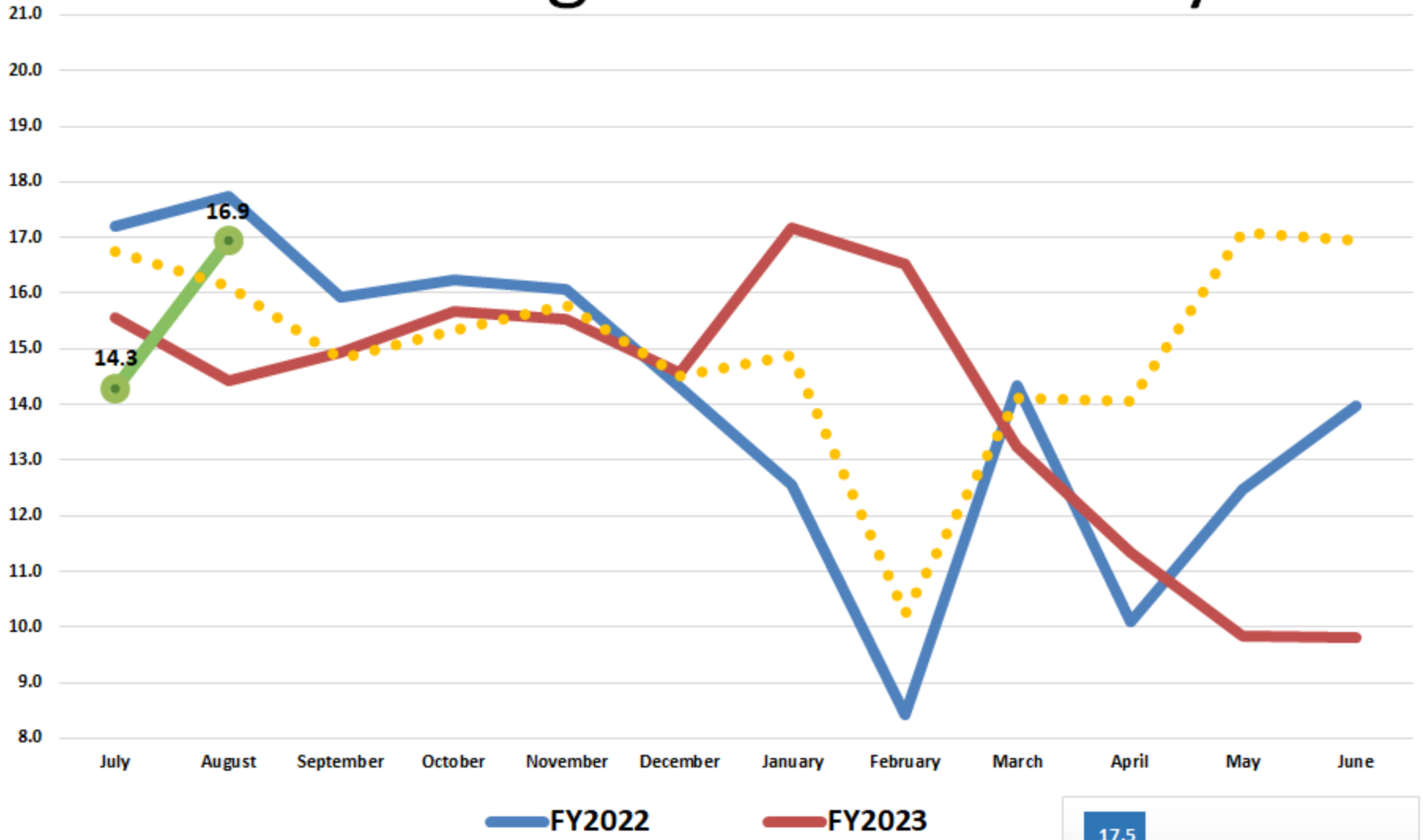
Transitional Care Services (TCS) - Avg Patients Per Day

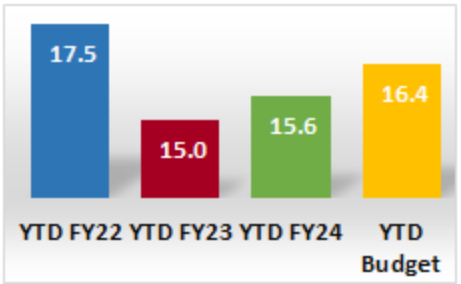


TCS Ortho - Avg Patients Per Day

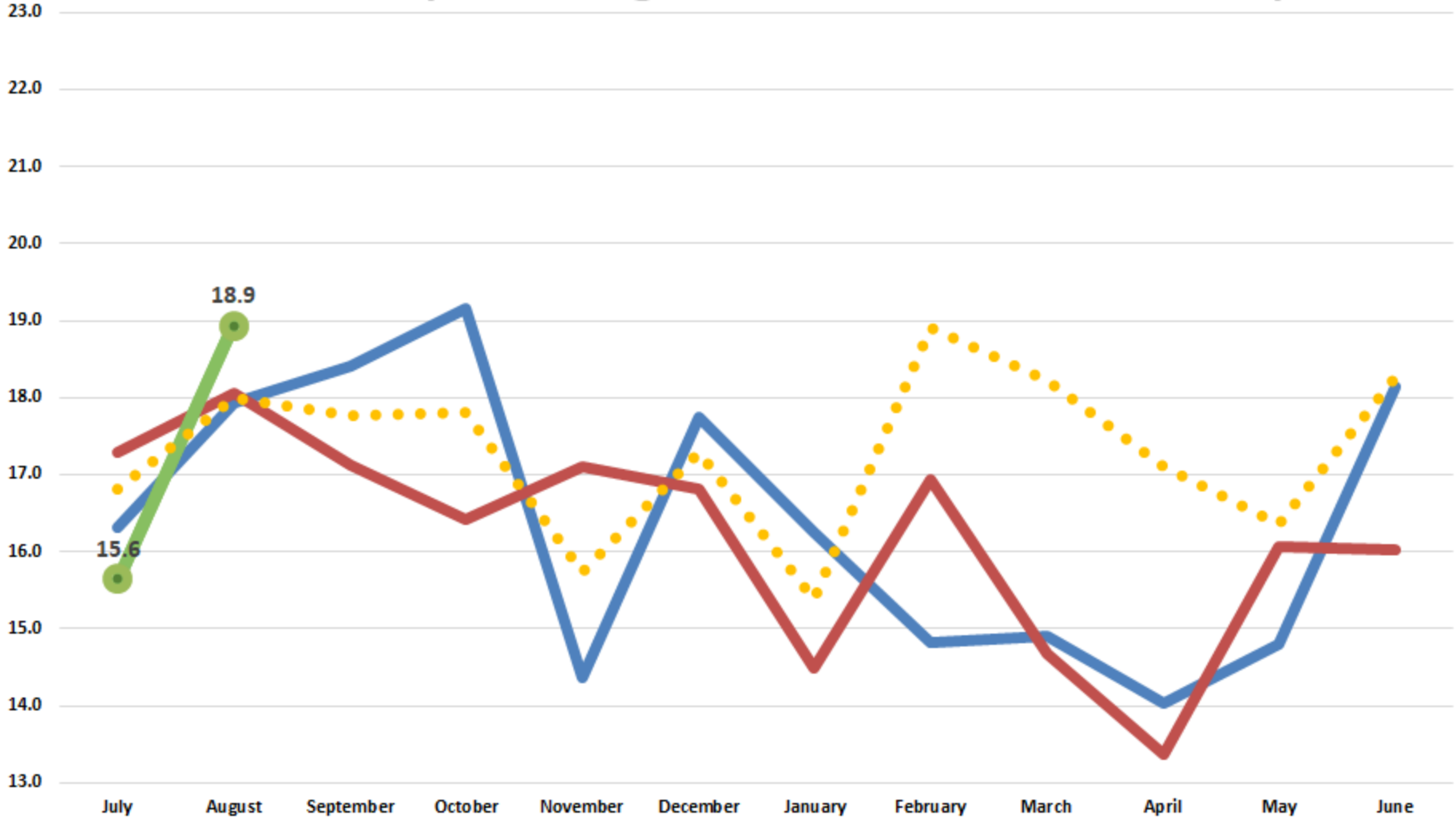


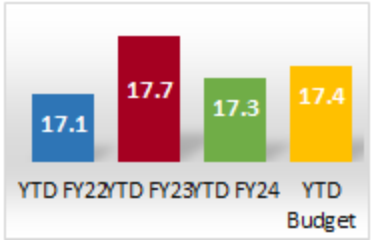
NICU - Avg Patients Per Day



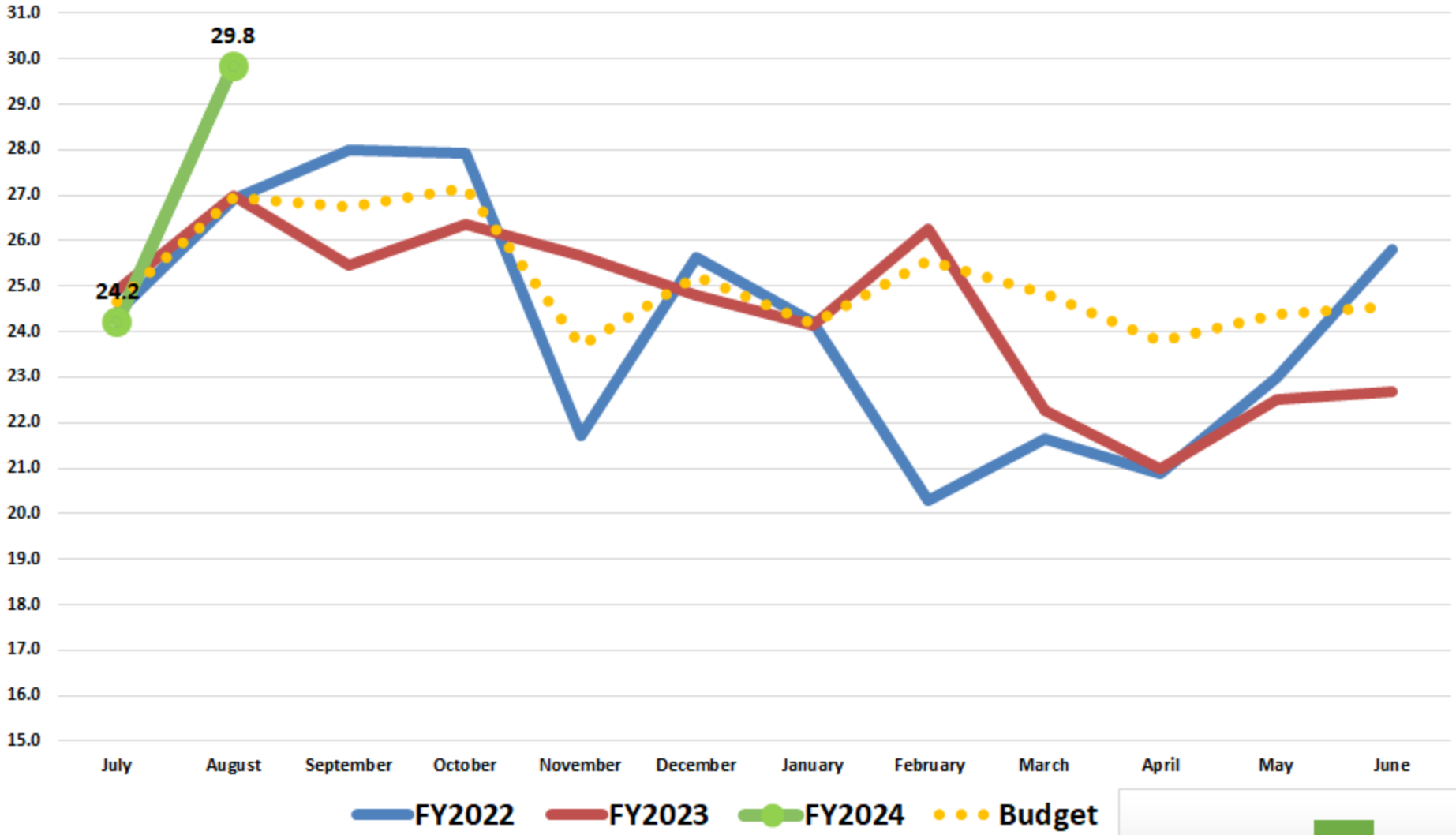


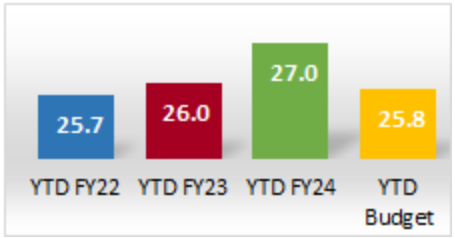
Nursery - Avg Patients Per Day



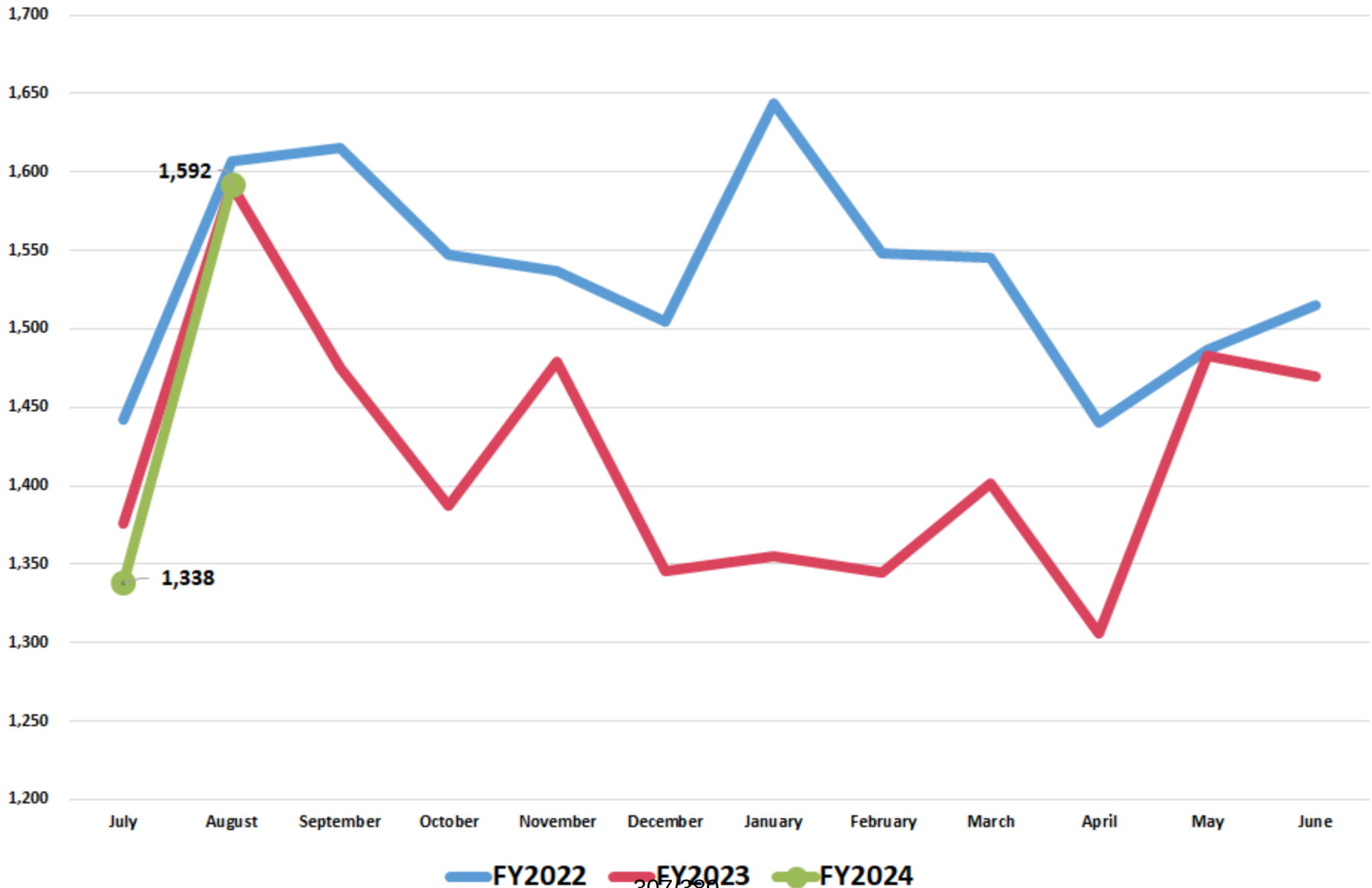


Obstetrics - Avg Patients Per Day

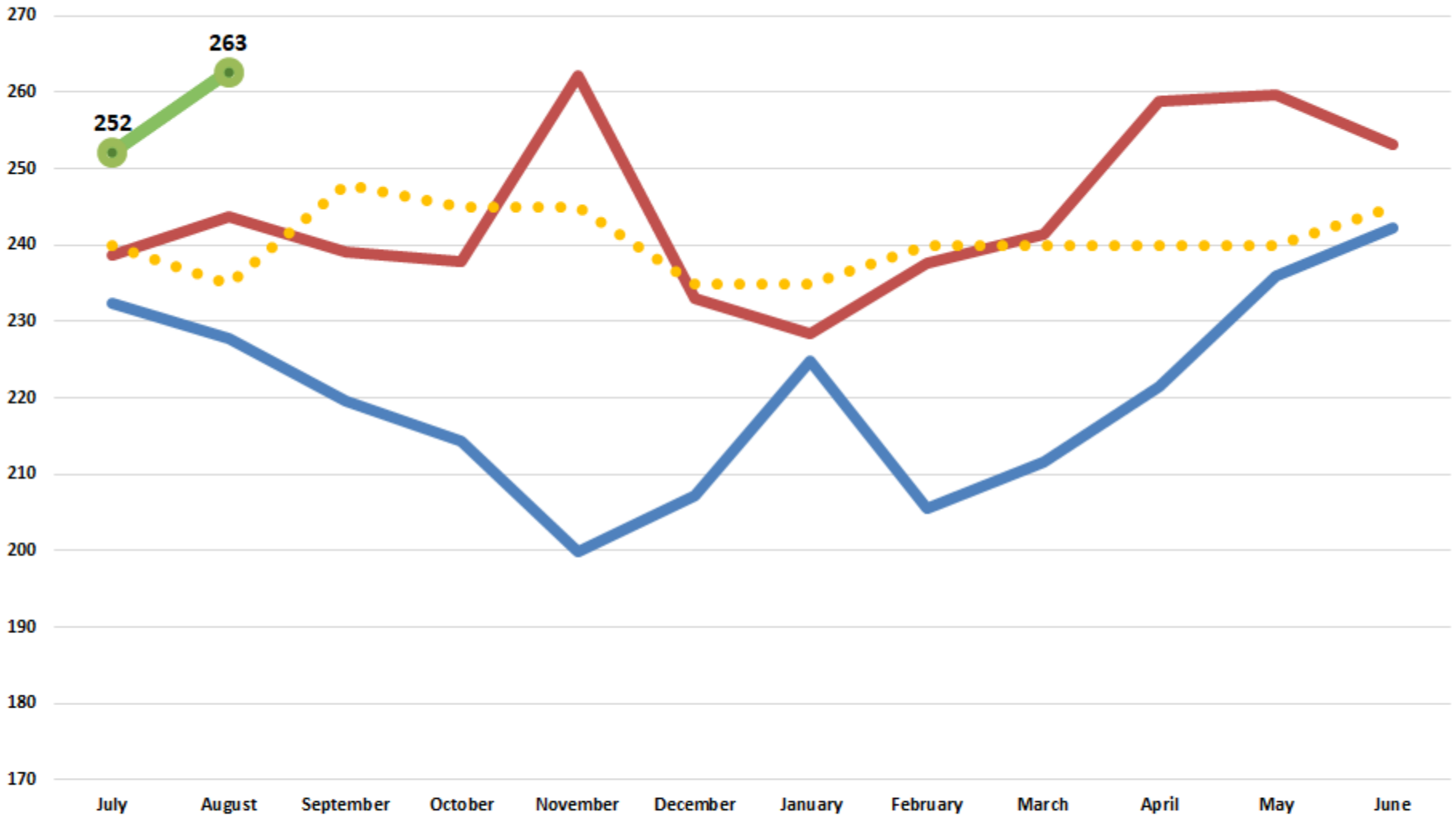


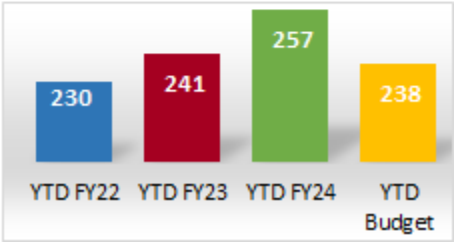


Outpatient Registrations Per Day

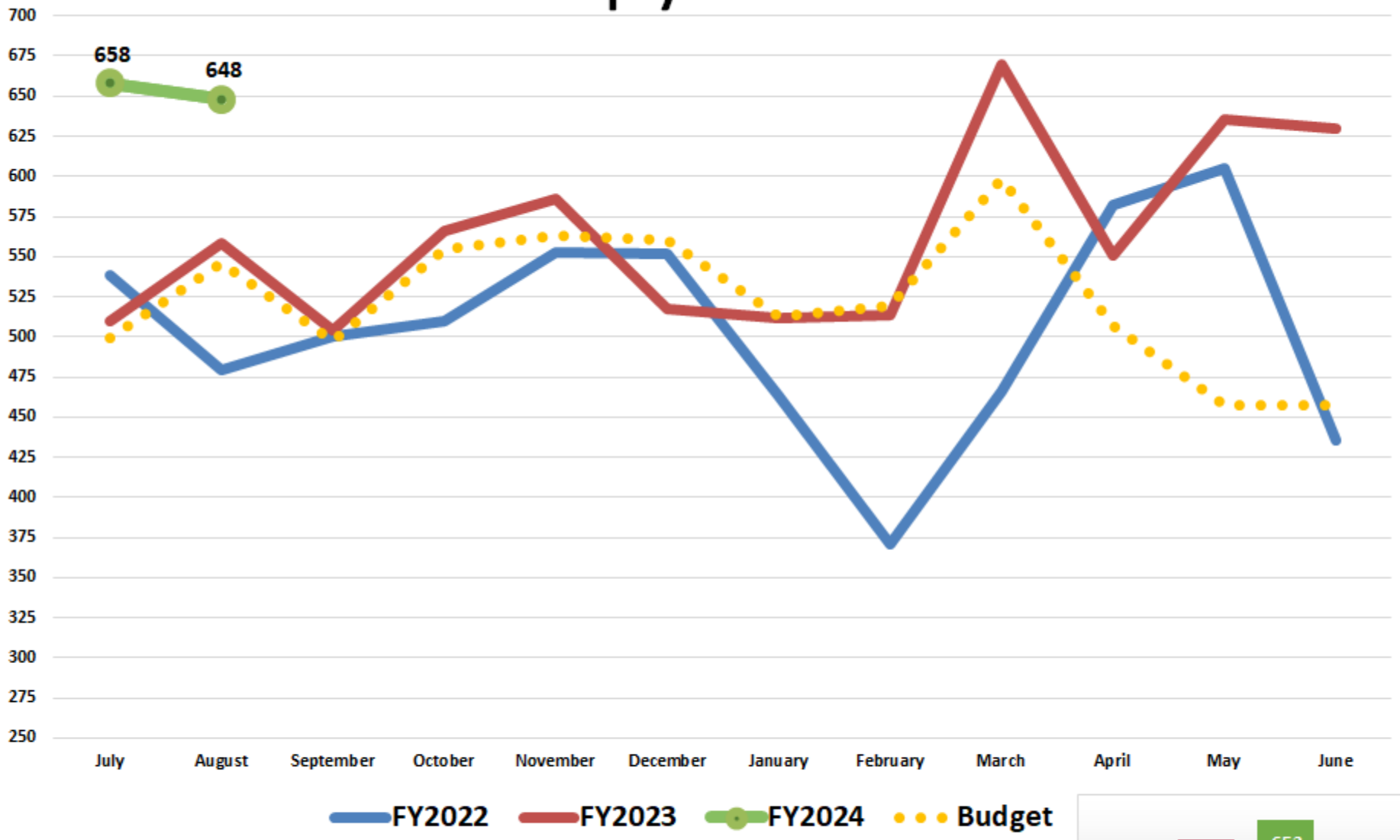


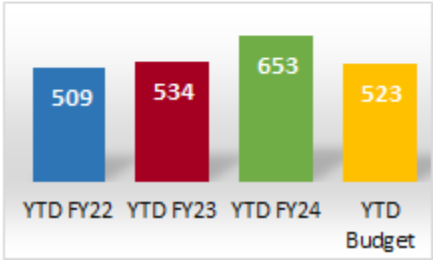
ED - Avg Treated Per Day



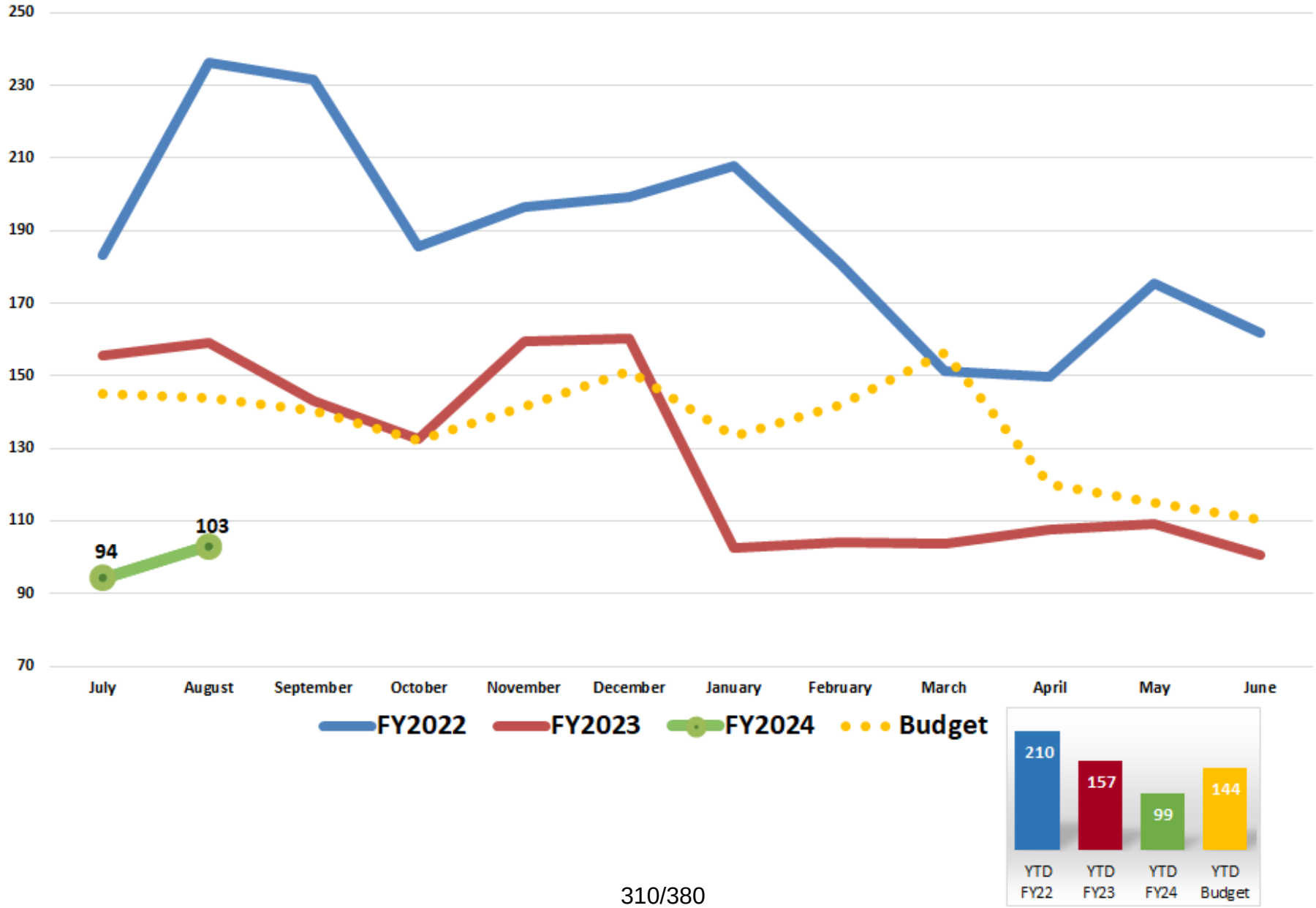


Endoscopy Procedures

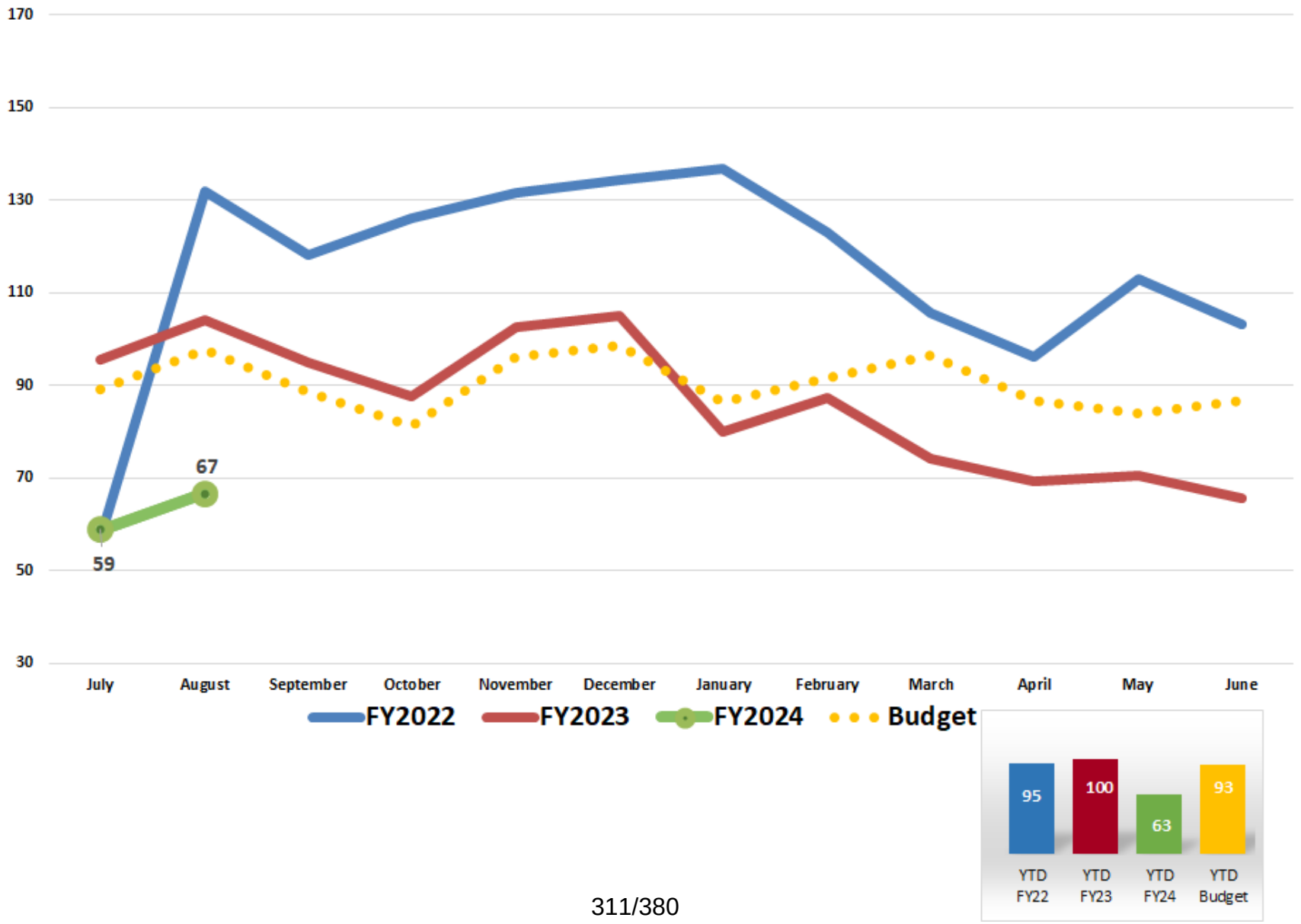




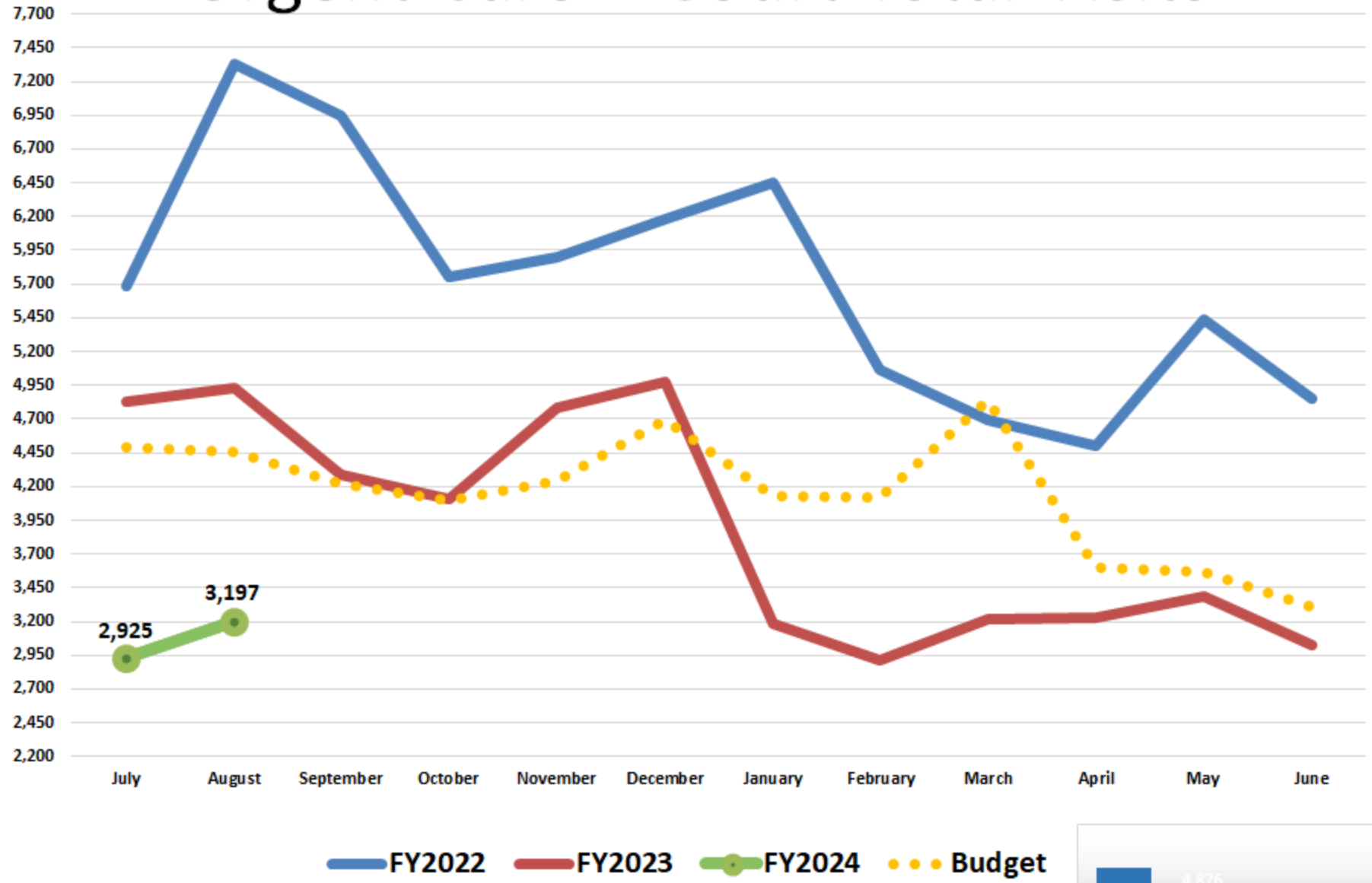
Urgent Care – Court Avg Visits Per Day



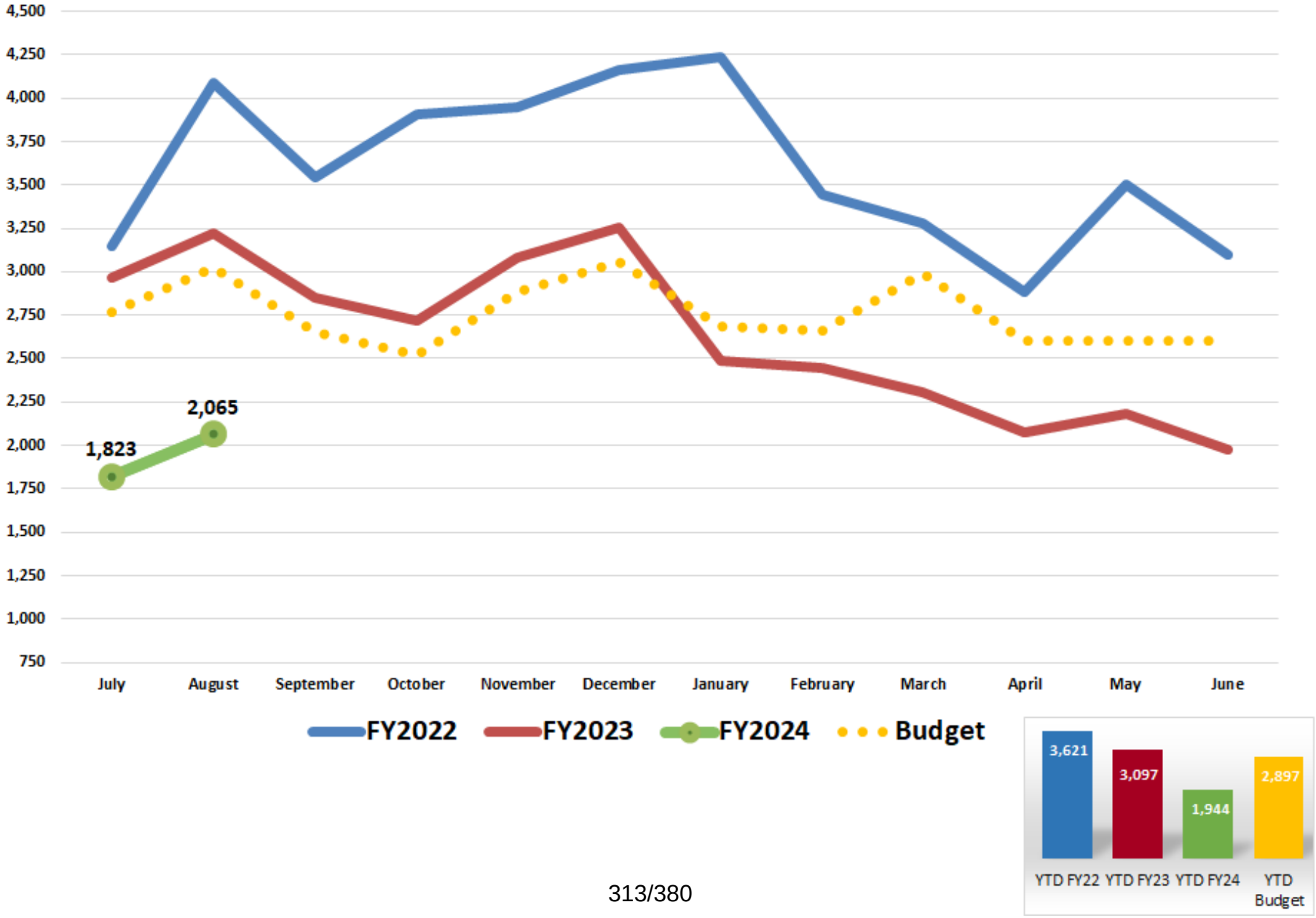
Urgent Care – Demaree Avg Visits Per Day



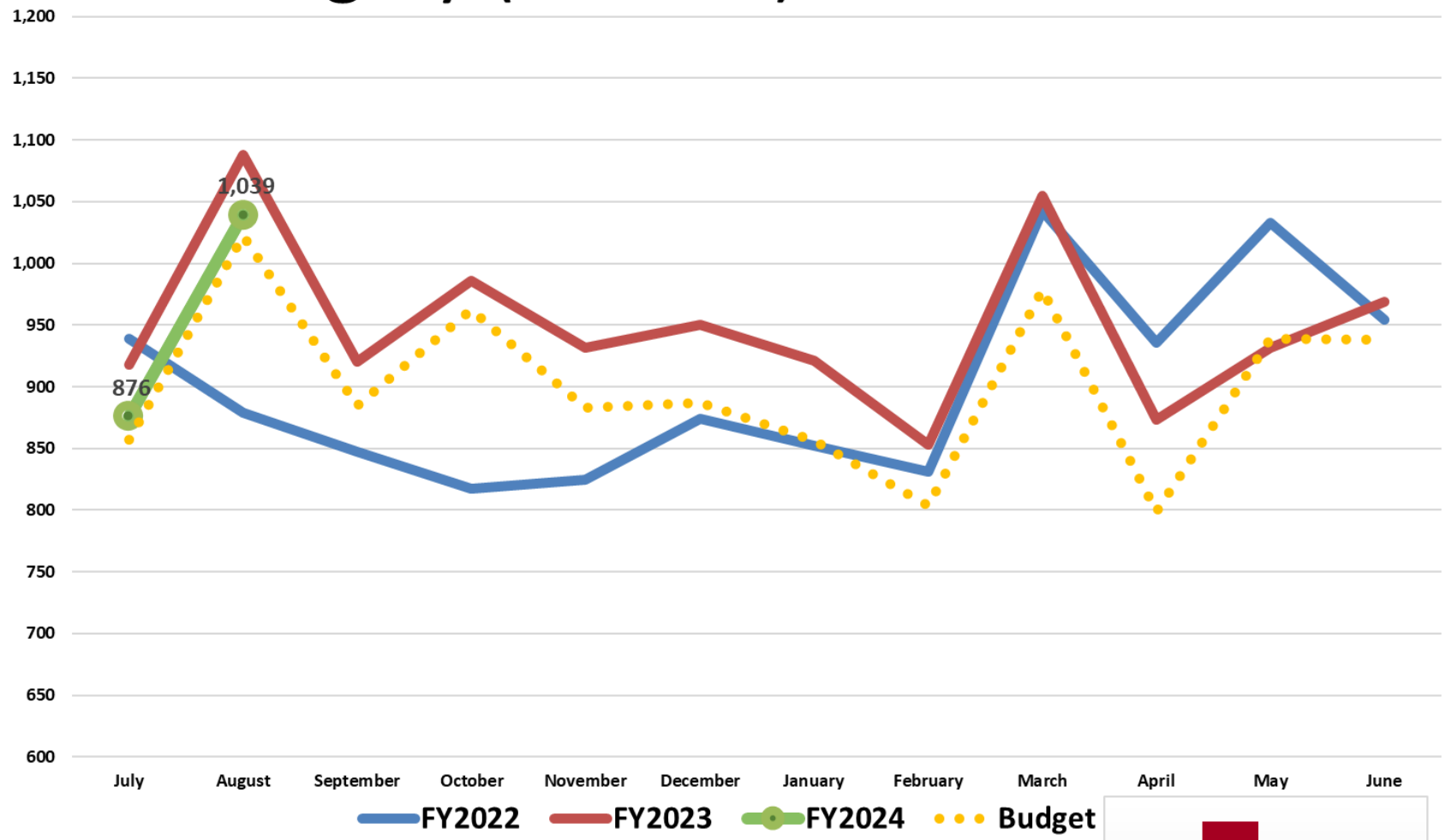
Urgent Care – Court Total Visits

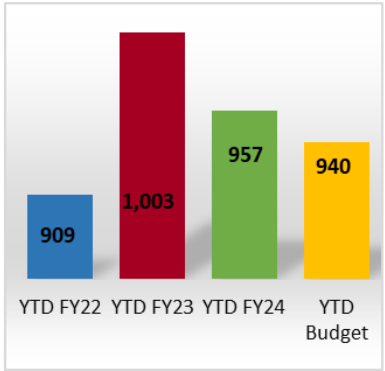


Urgent Care – Demaree Total Visits

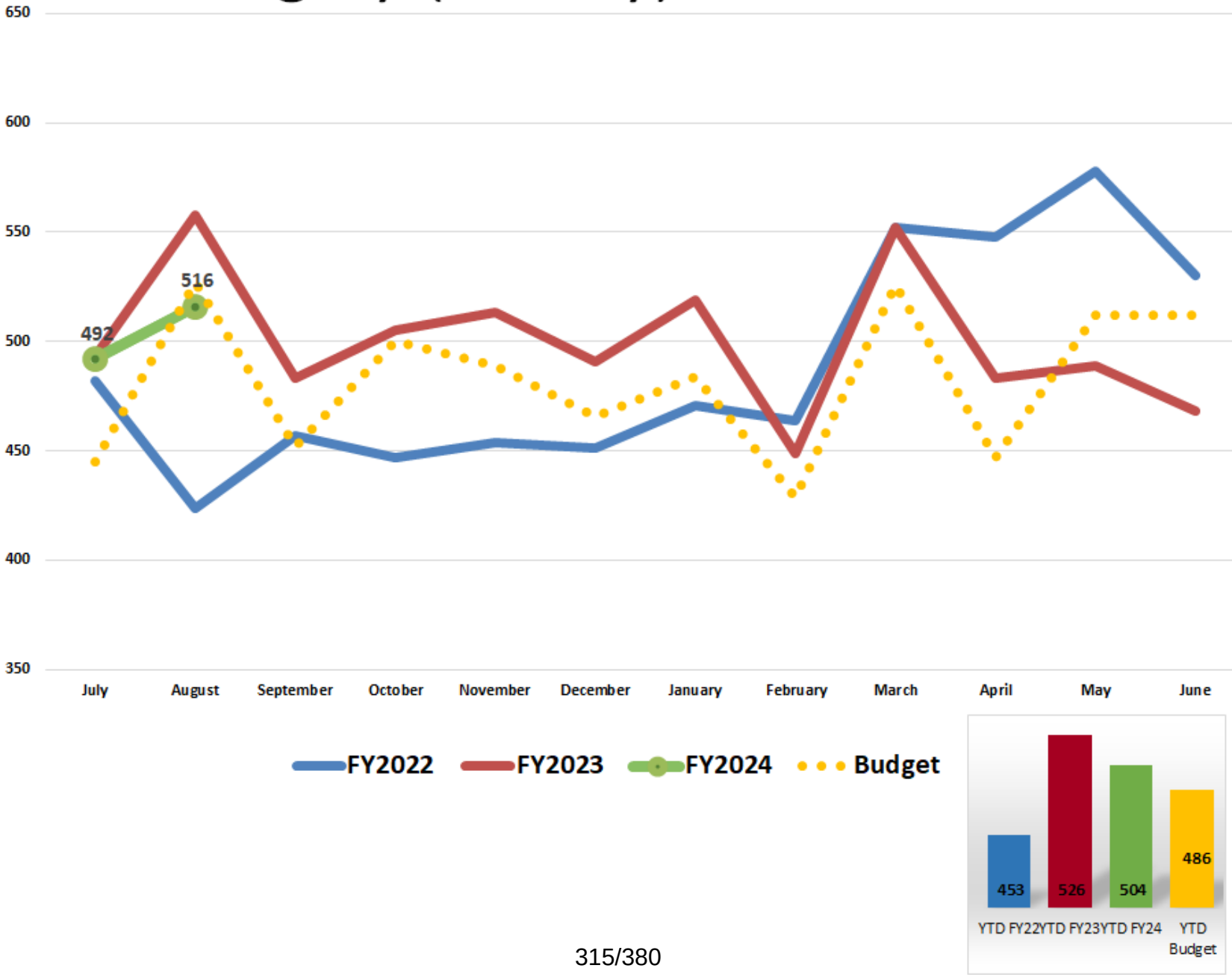


Surgery (IP & OP) – 100 Min Units

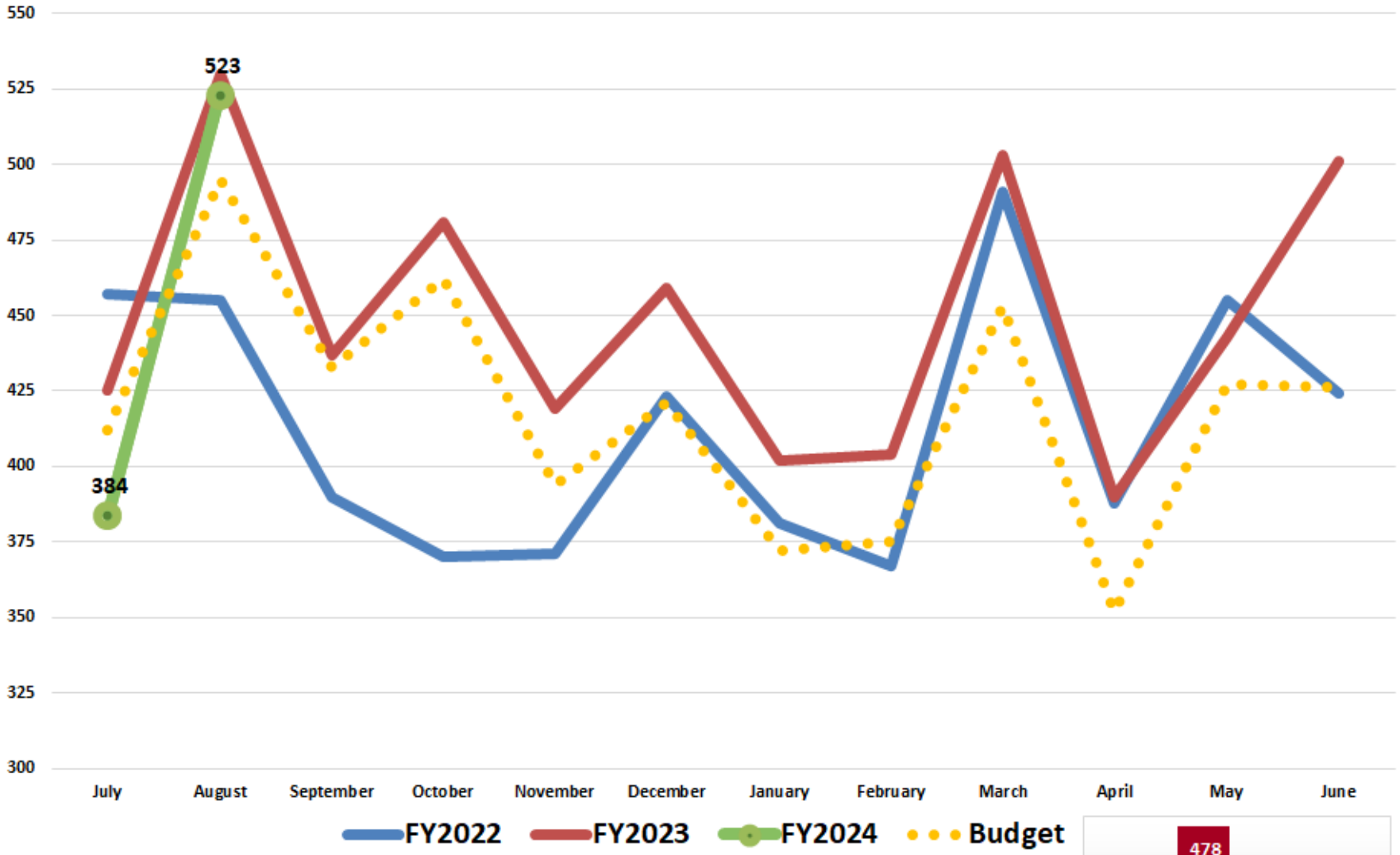


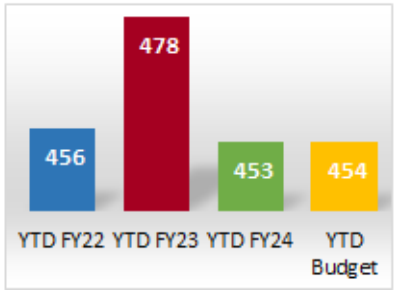


Surgery (IP Only) - 100 Min Unit

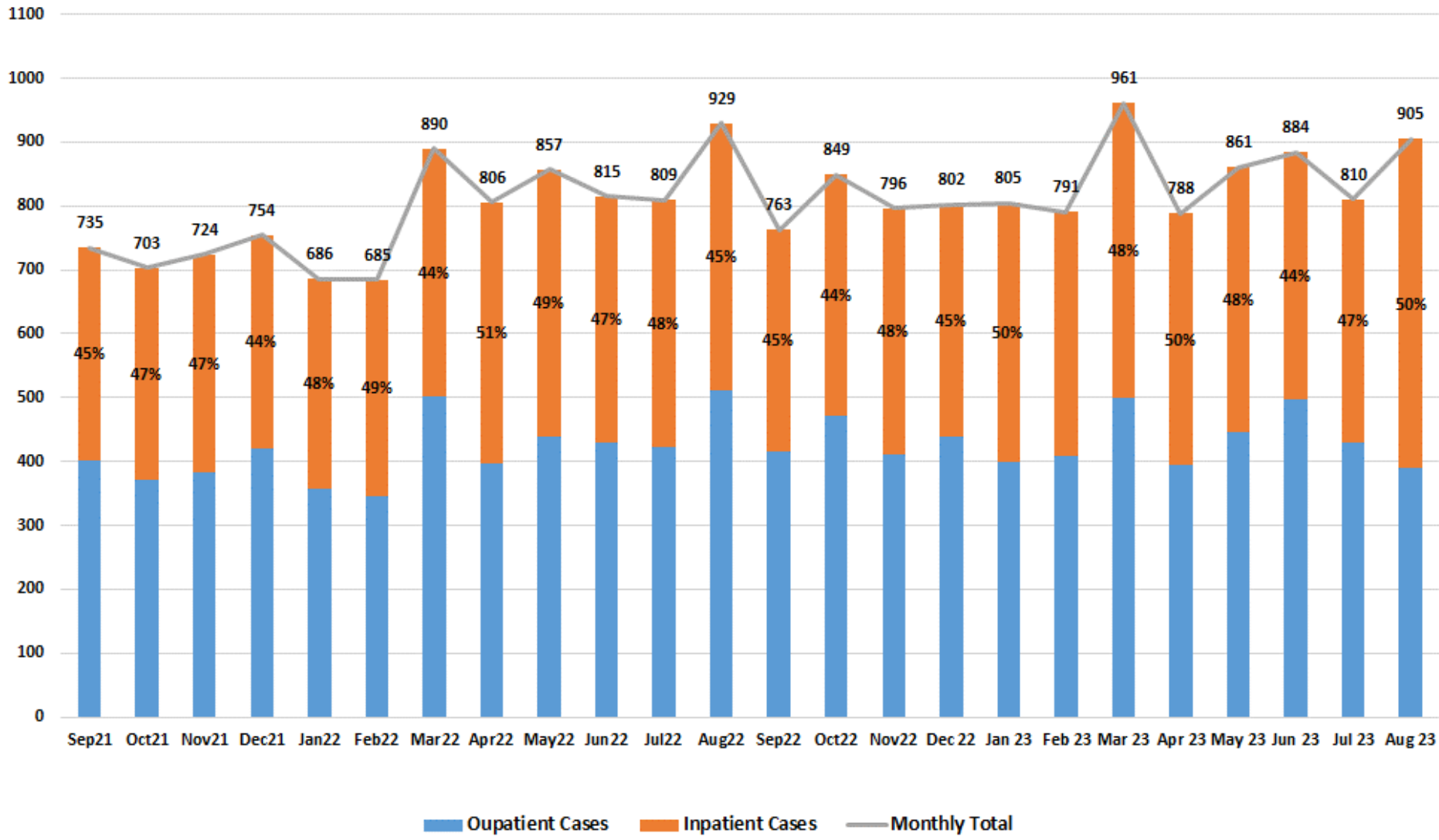


Surgery (OP Only) - 100 Min Units

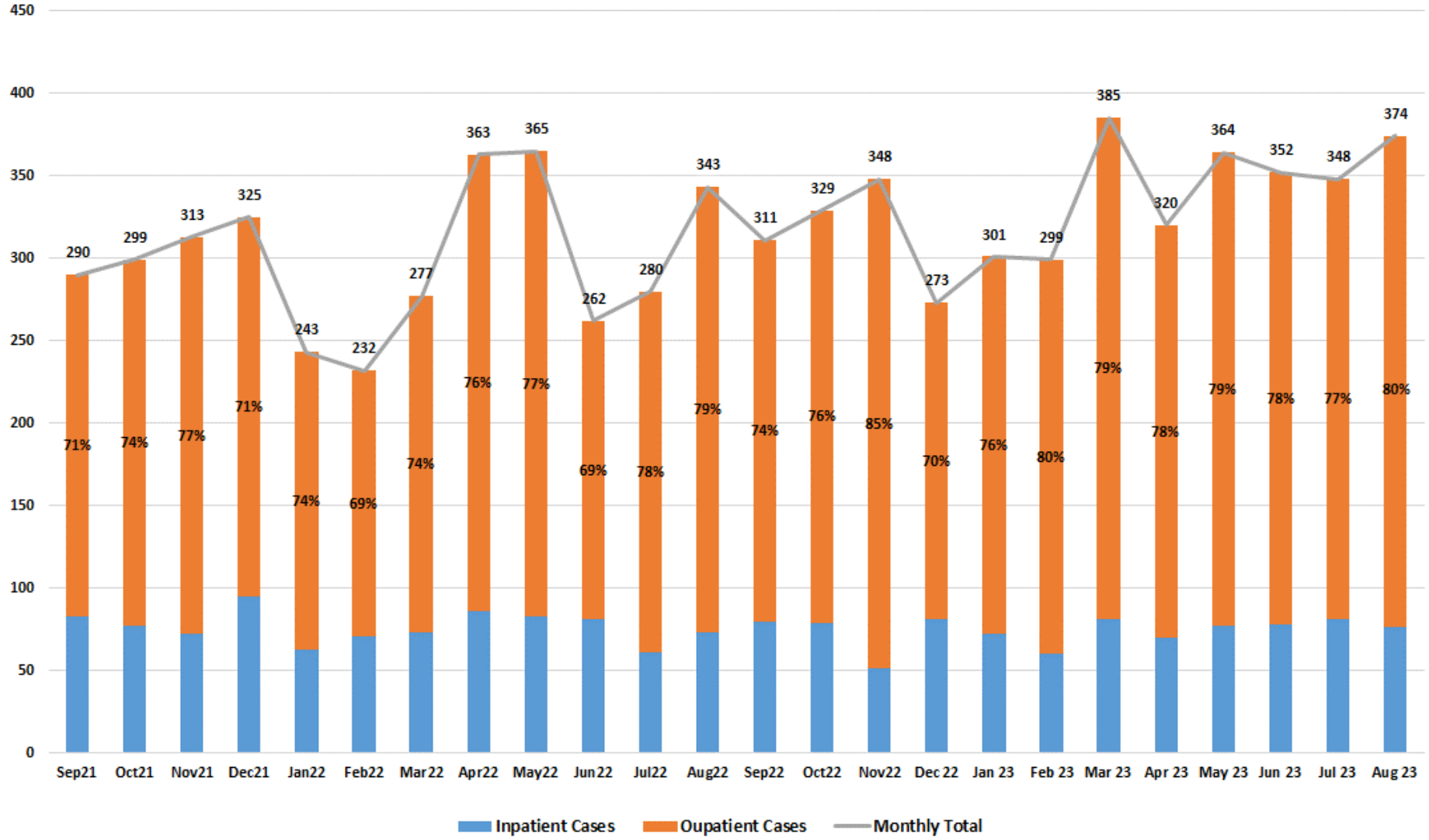




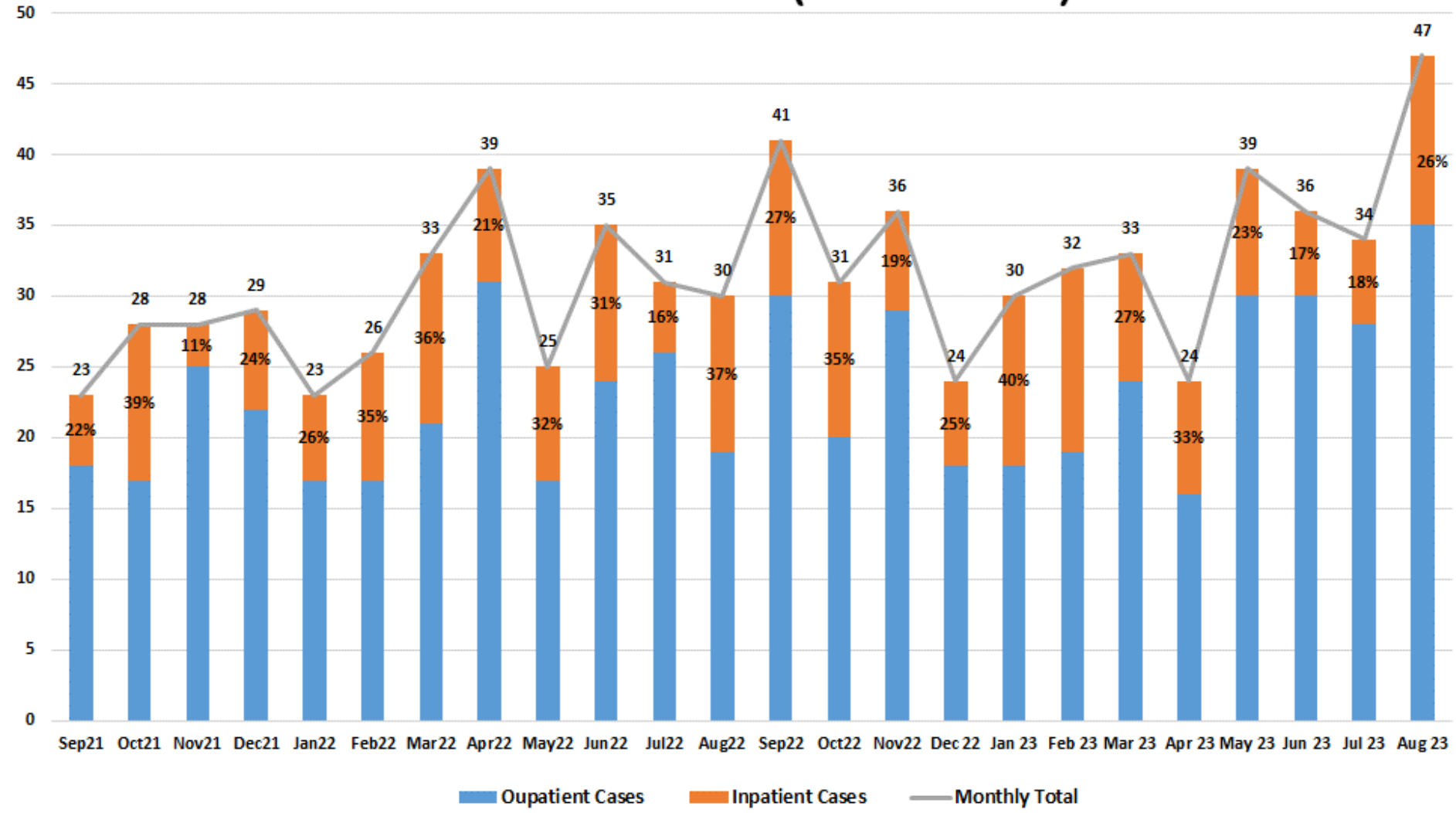
Surgery Cases (IP & OP)



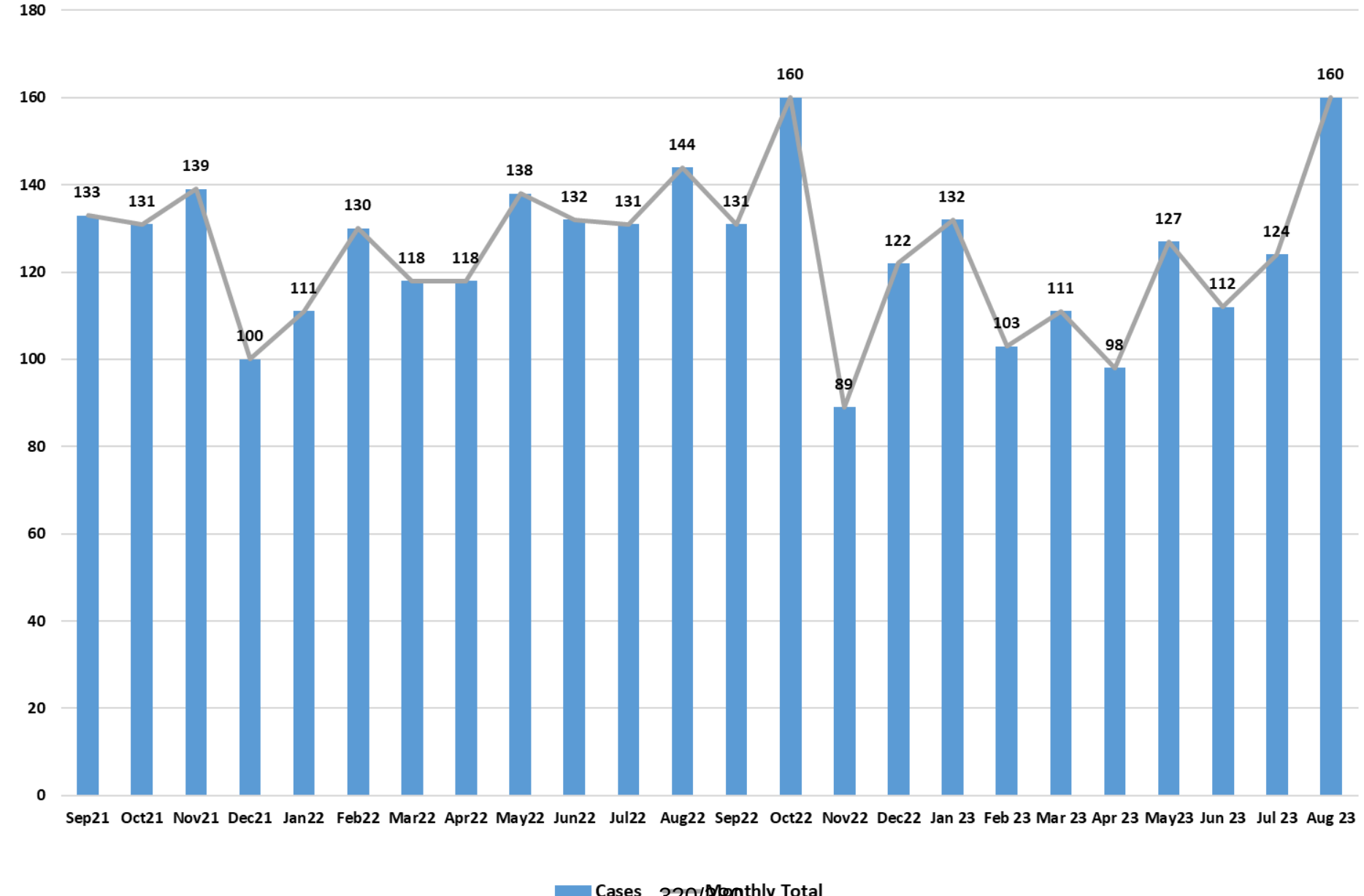
Endo Cases (Endo Suites)



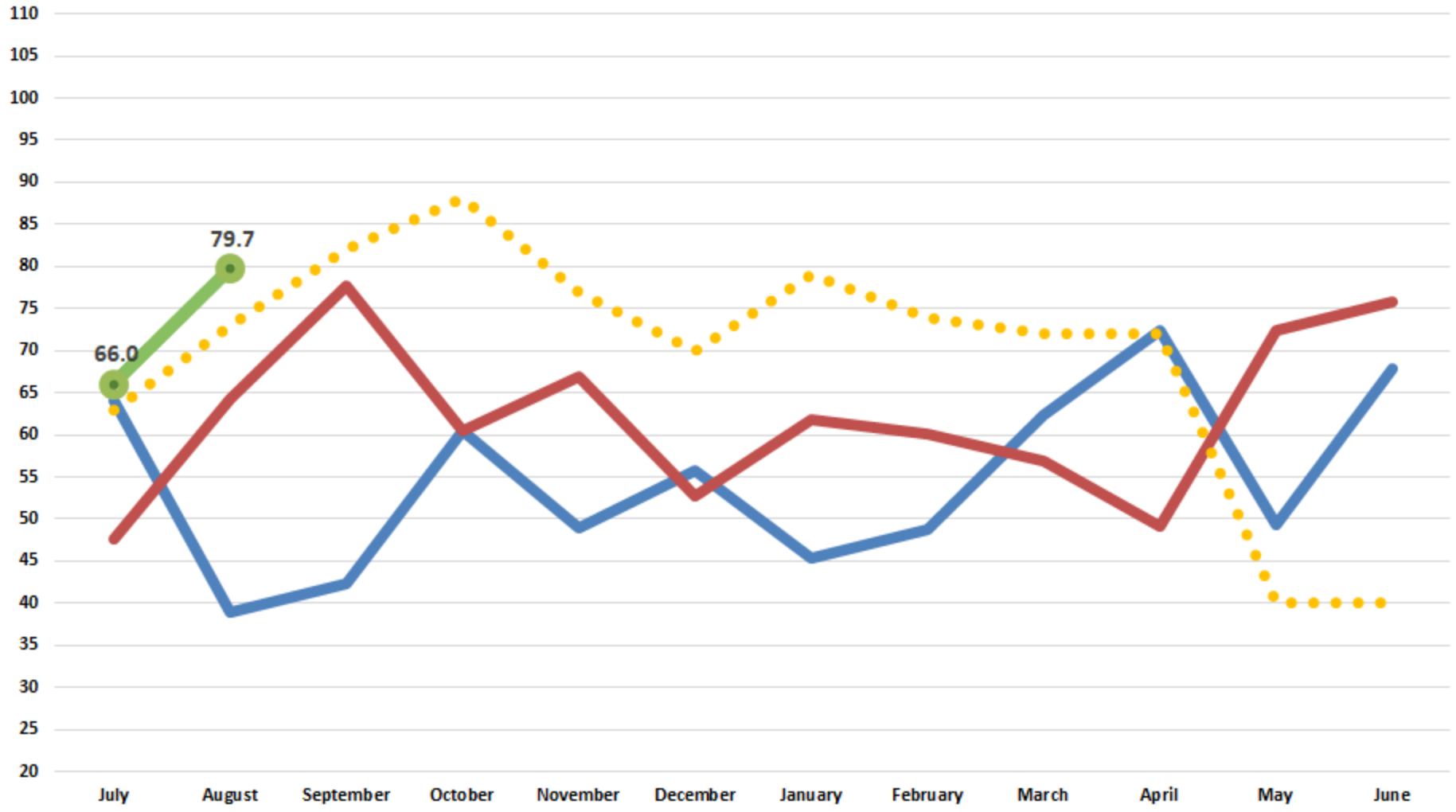
Robotic Cases (IP & OP)

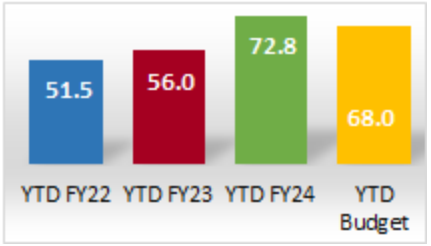


OB Cases

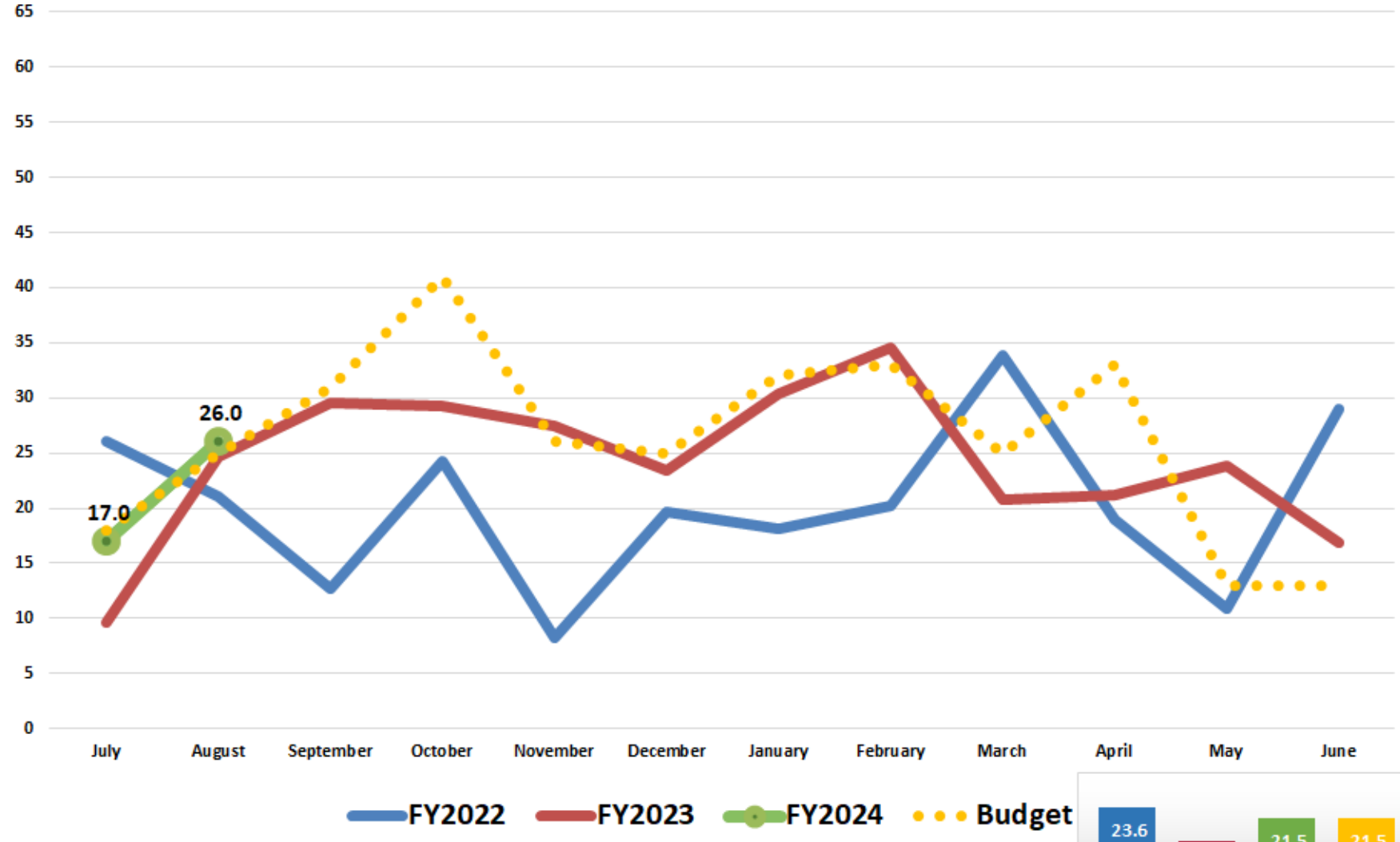

180
160
140
120
100
80
60
40
20
0
133
131
139
100
111
130
118
118
138
132
131
144
131
160
89
122
132
103
111
98
127
112
124
160
Sep21
Oct21
Nov21
Dec21
Jan22
Feb22
Mar22
Apr22
May22
Jun22
Jul22
Aug22
Sep22
Oct22
Nov22
Dec22
Jan 23
Feb 23
Mar 23
Apr 23
May23
Jun 23
Jul 23
Aug 23
Cases
Monthly Total

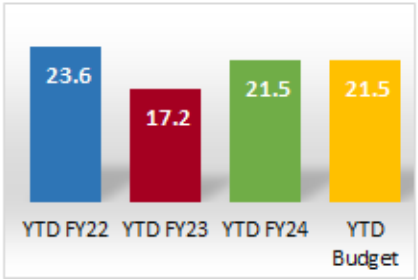
Robotic Surgery (IP & OP) - 100 Min Units



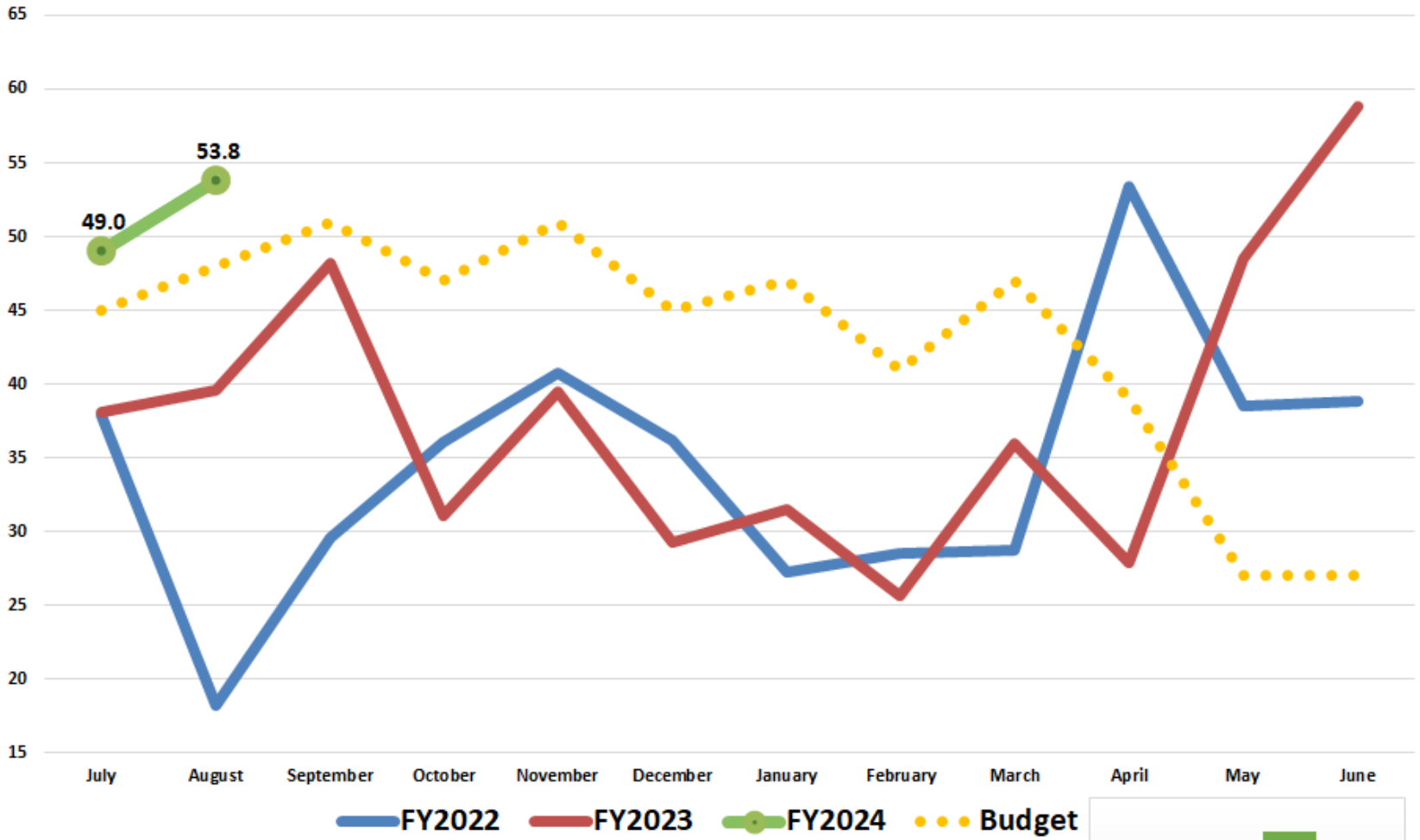


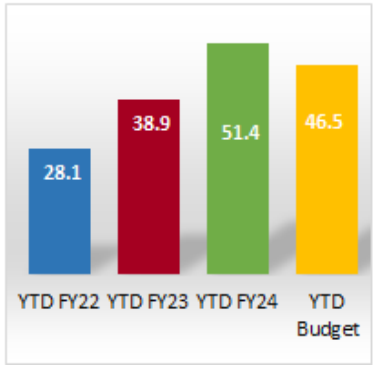
Robotic Surgery Minutes (IP Only)



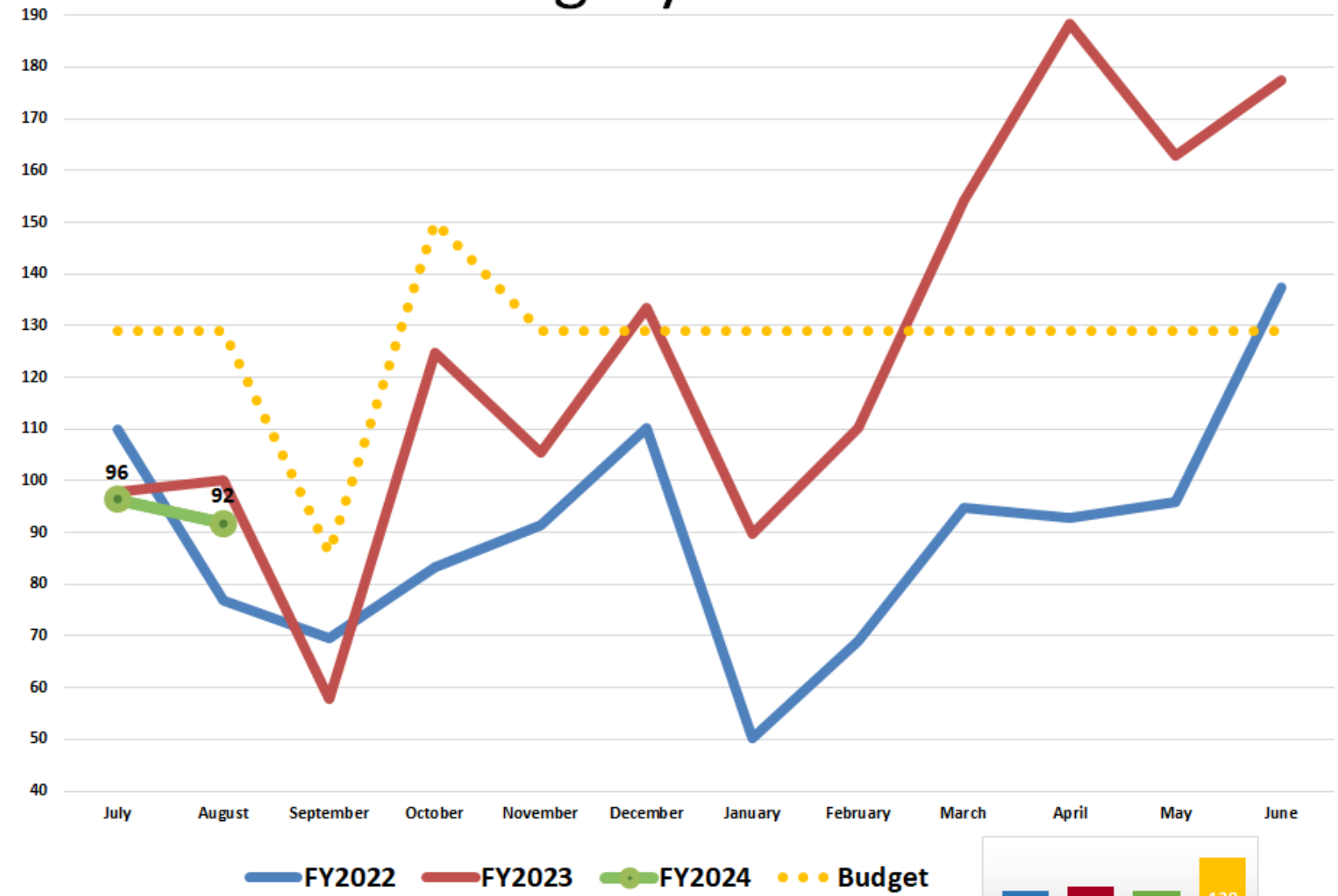


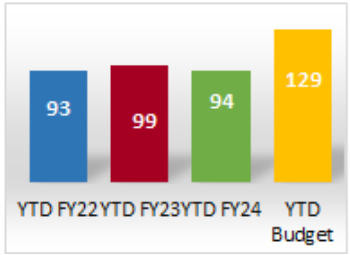
Robotic Surgery Minutes (OP Only)



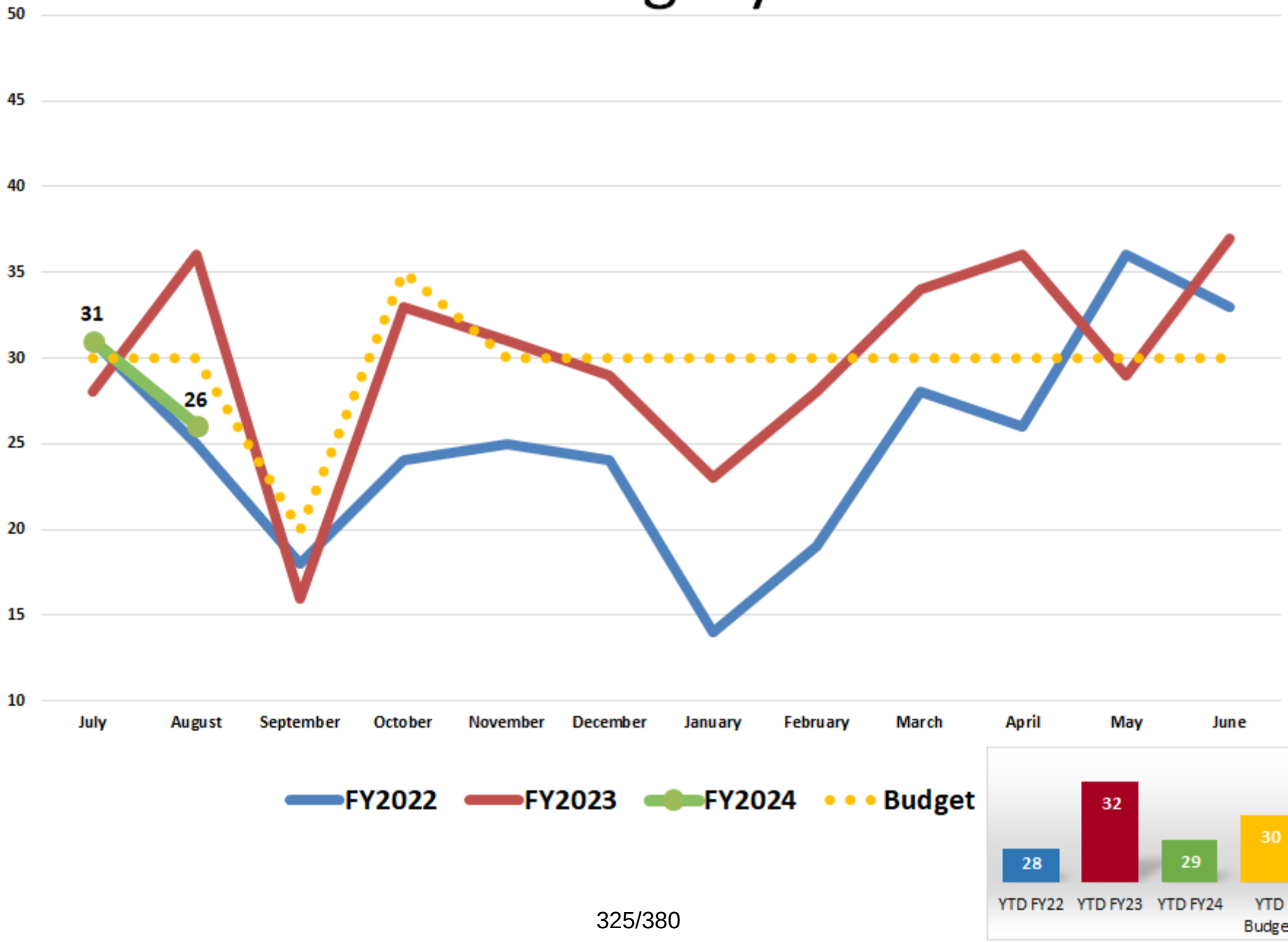


Cardiac Surgery - 100 Min Units

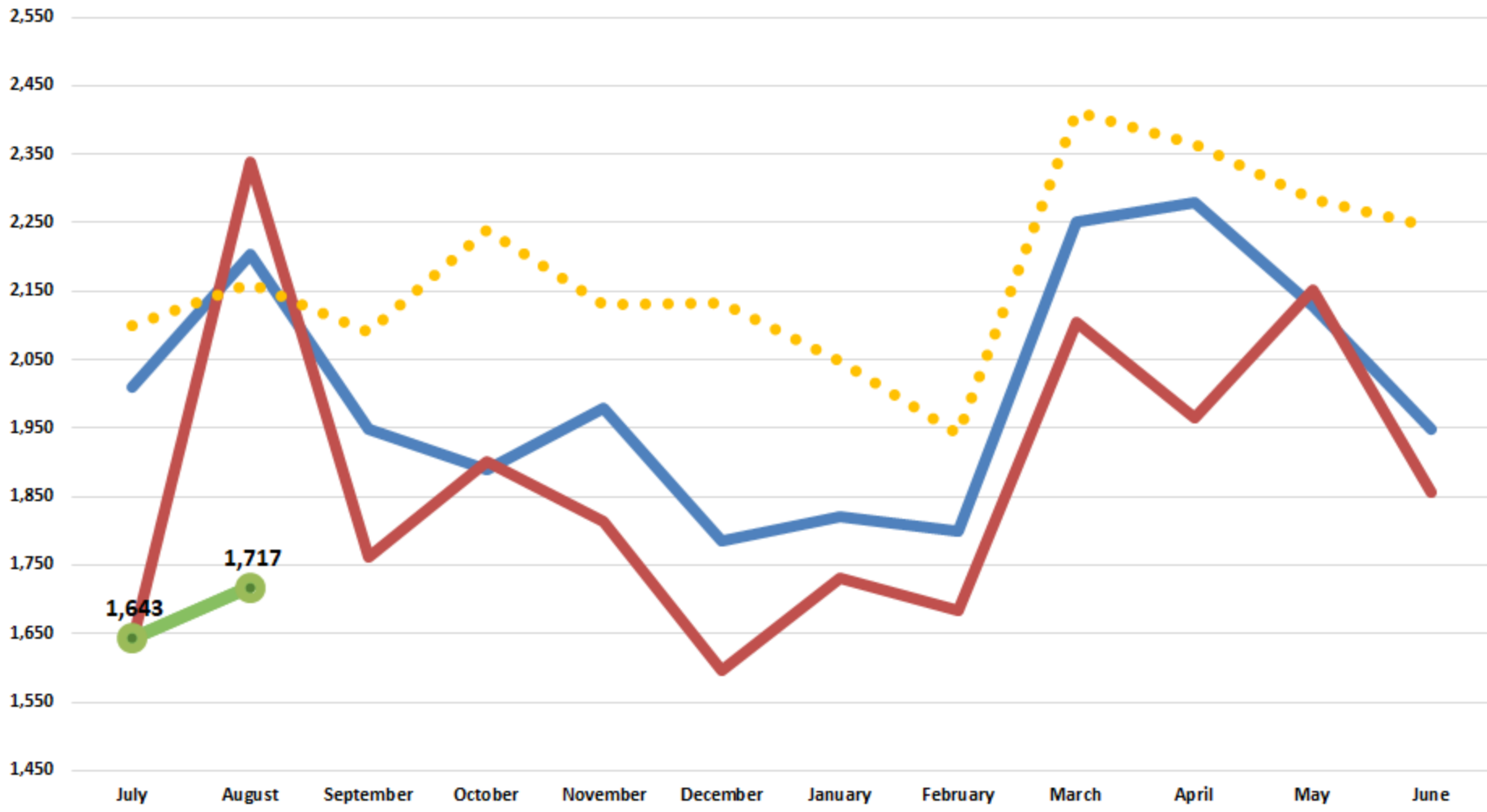


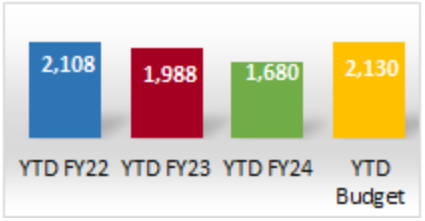


Cardiac Surgery Cases

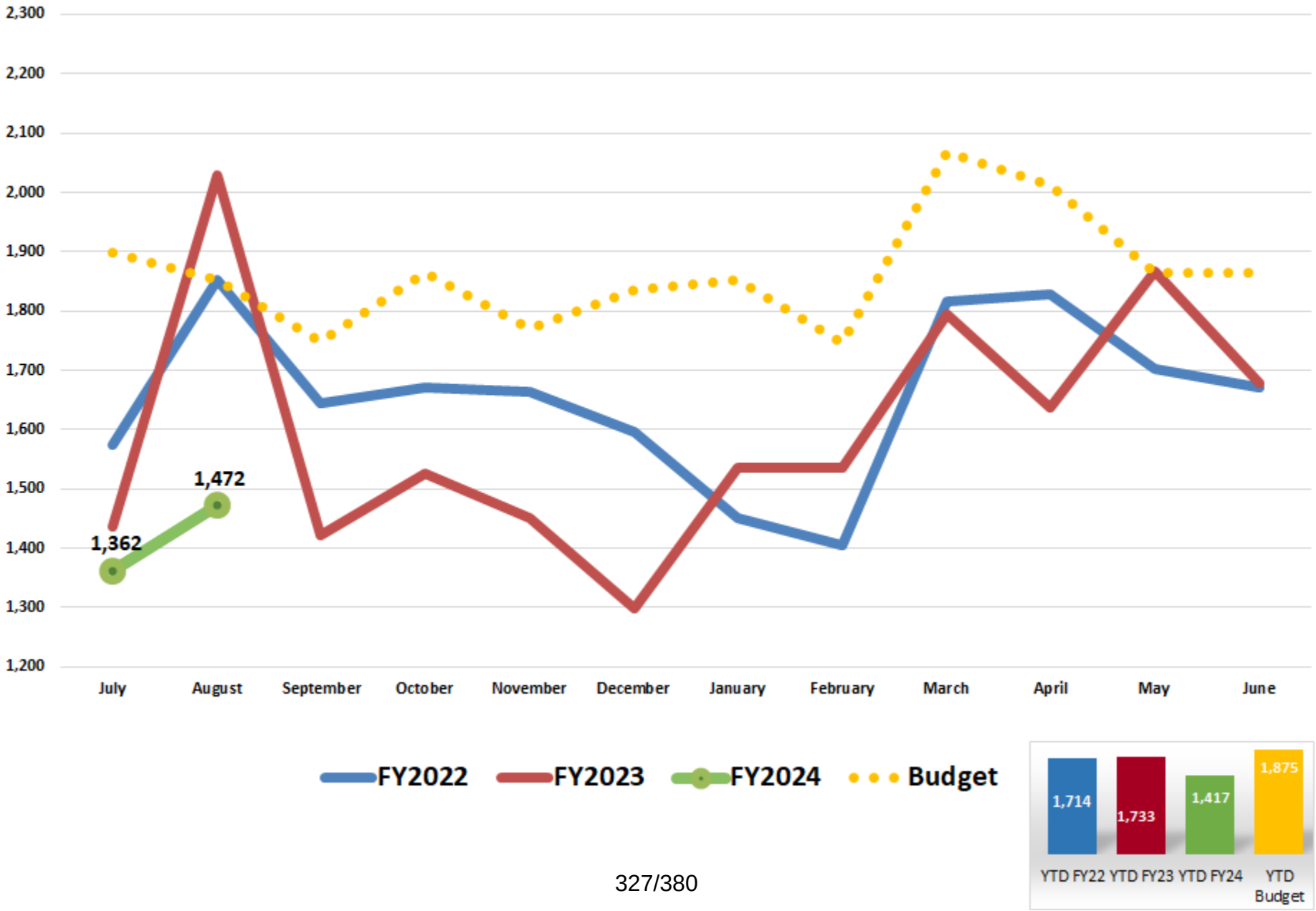


Rad Onc Treatments (Vis. & Hanf.)

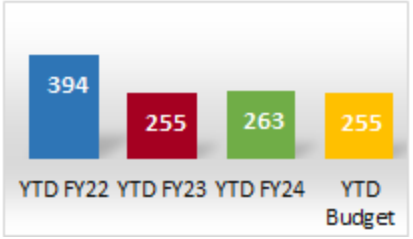




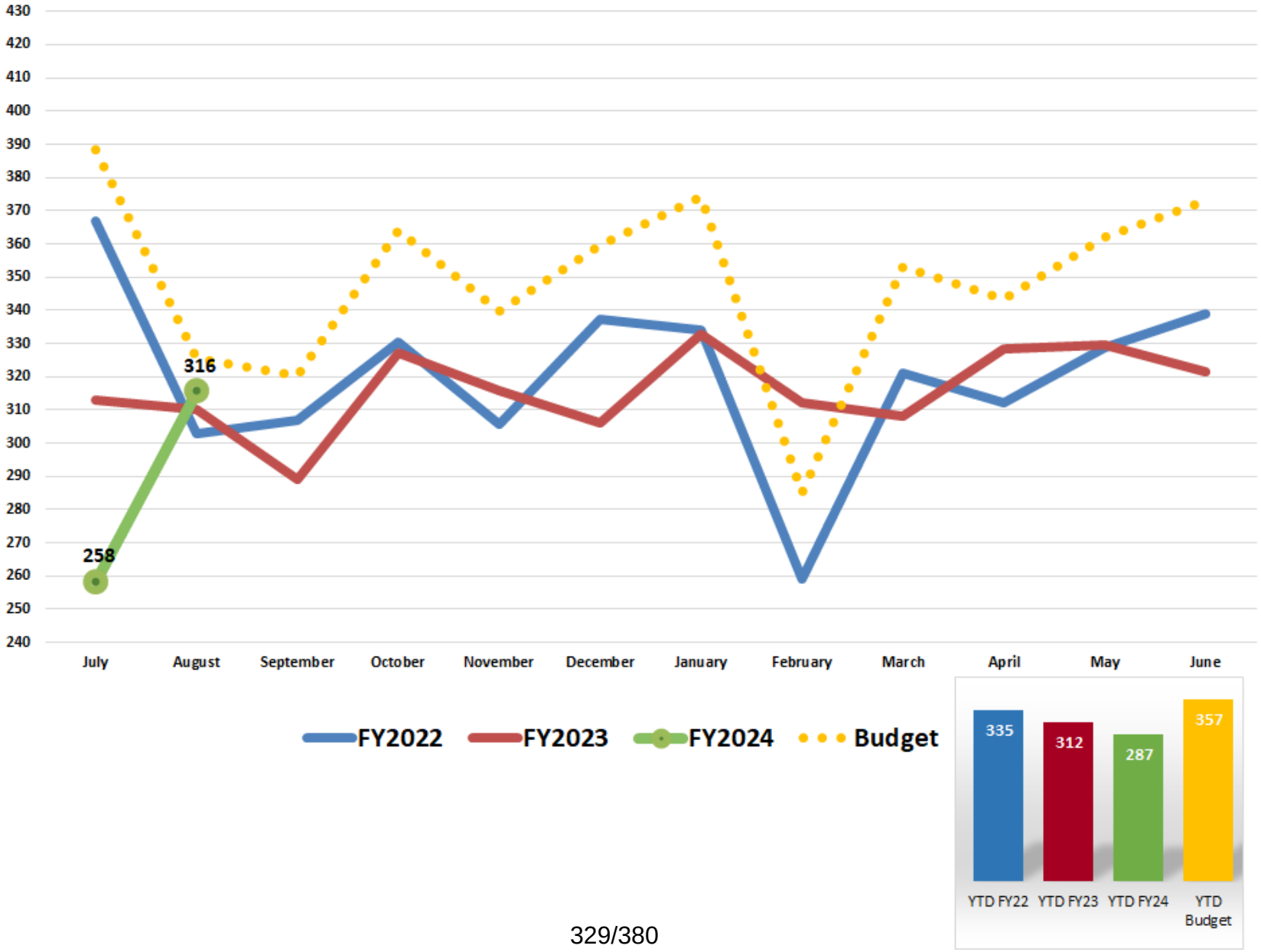
Rad Onc Visalia



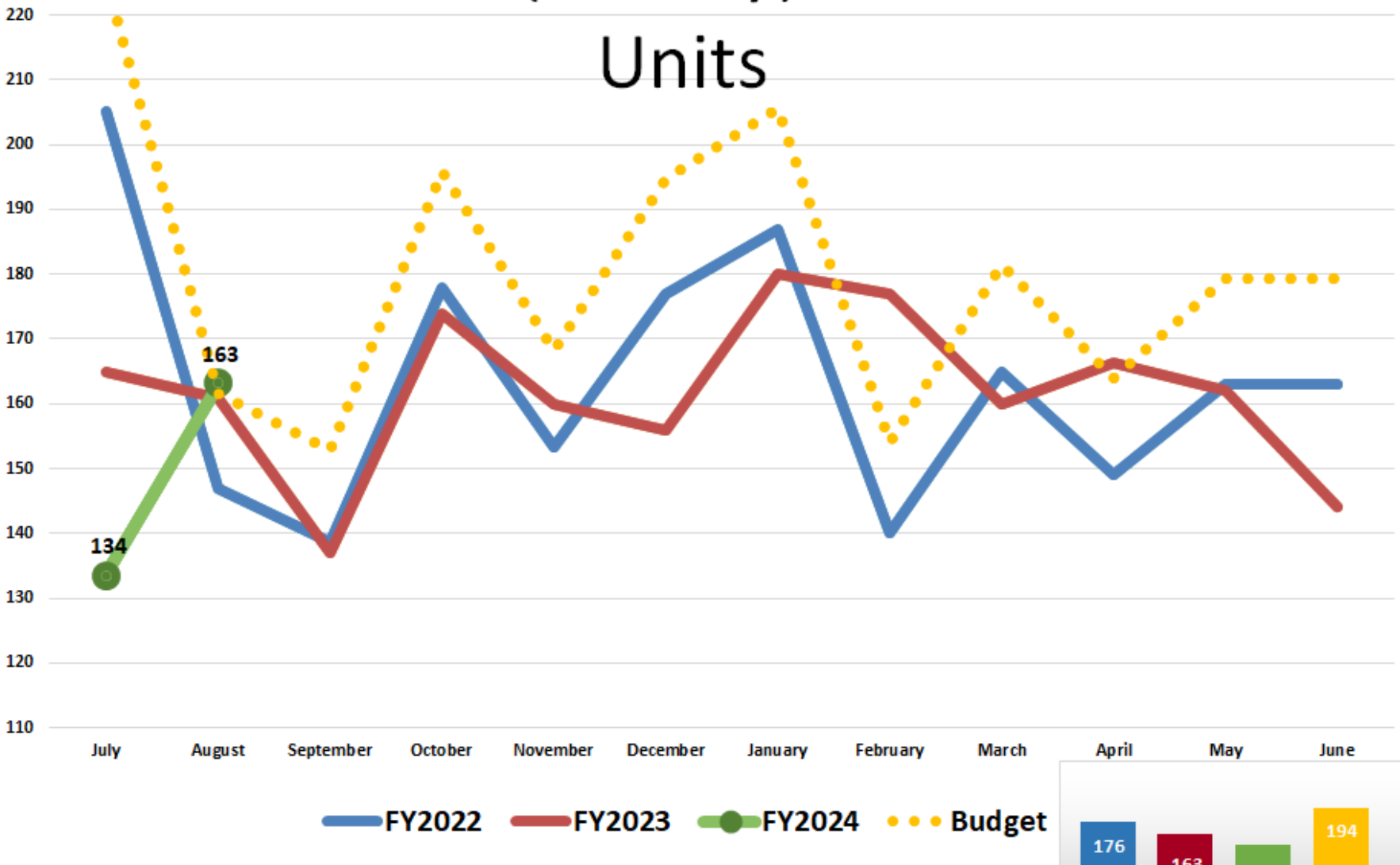
Rad Onc Hanford

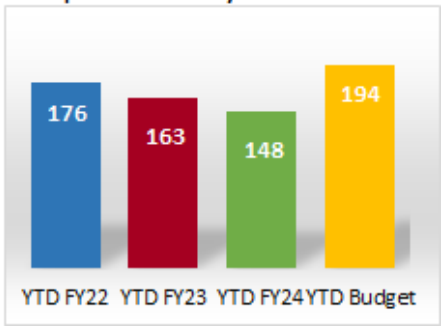


Cath Lab (IP & OP) – 100 Min Units

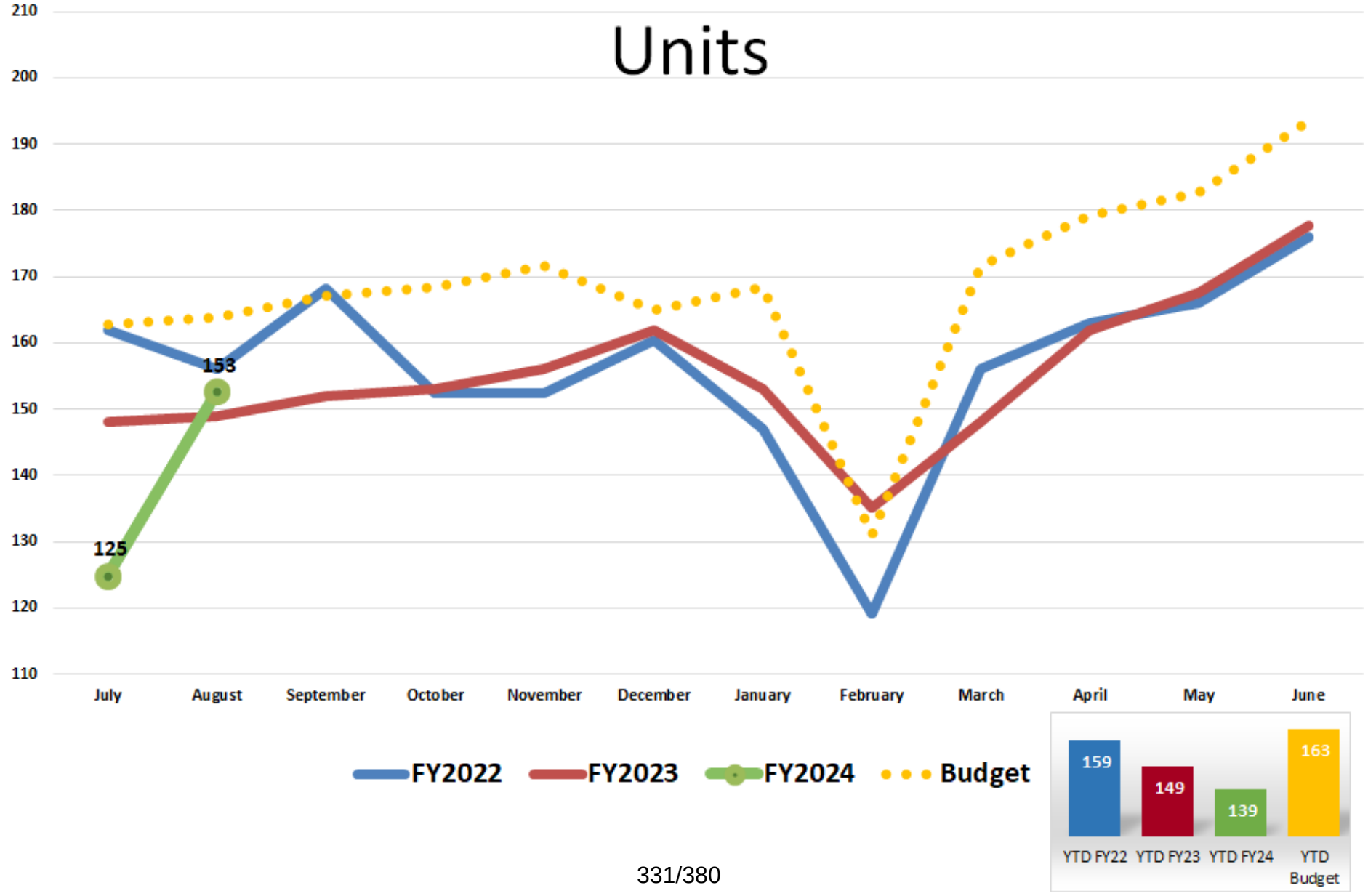


Cath Lab (IP Only) – 100 Min Units

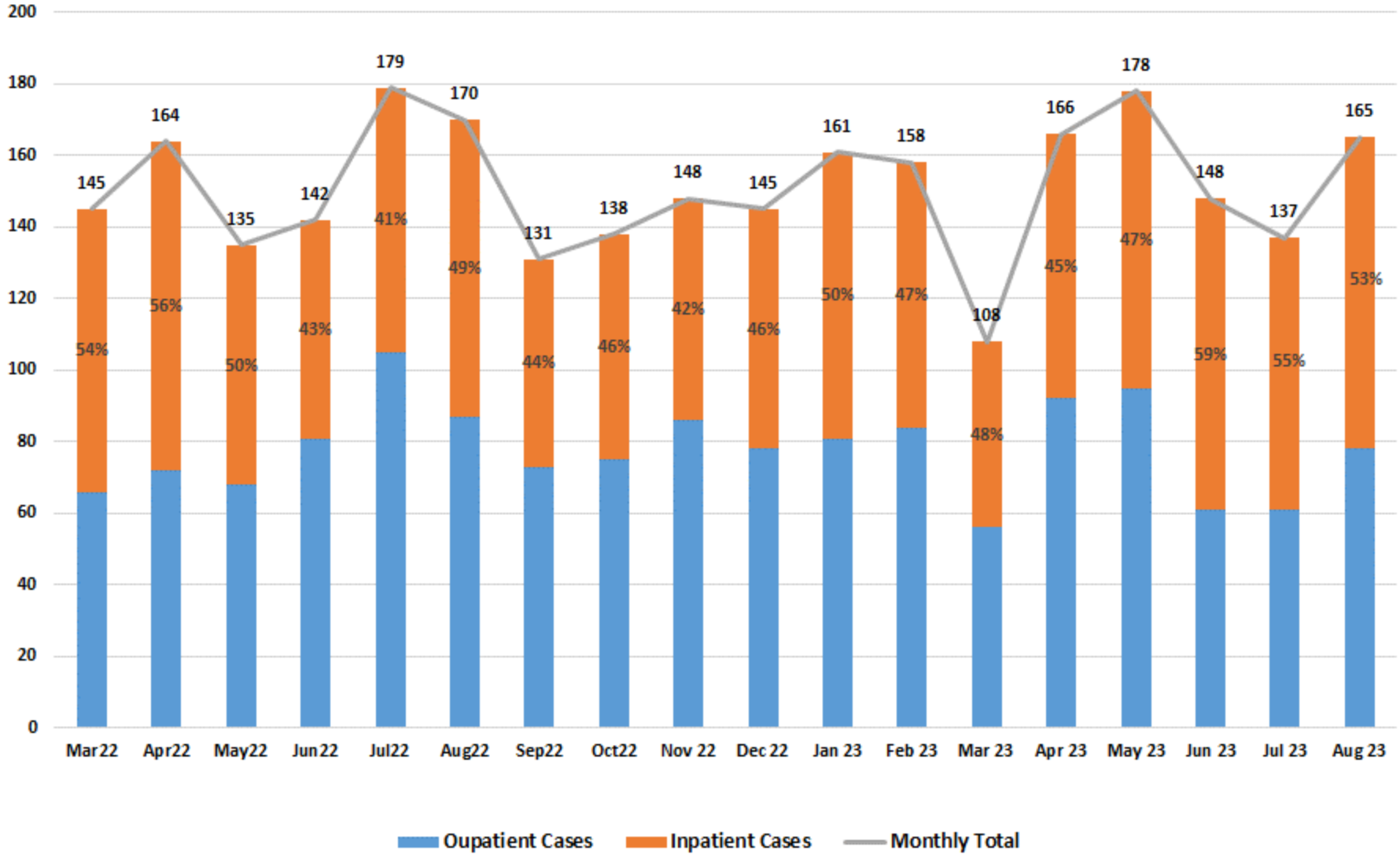




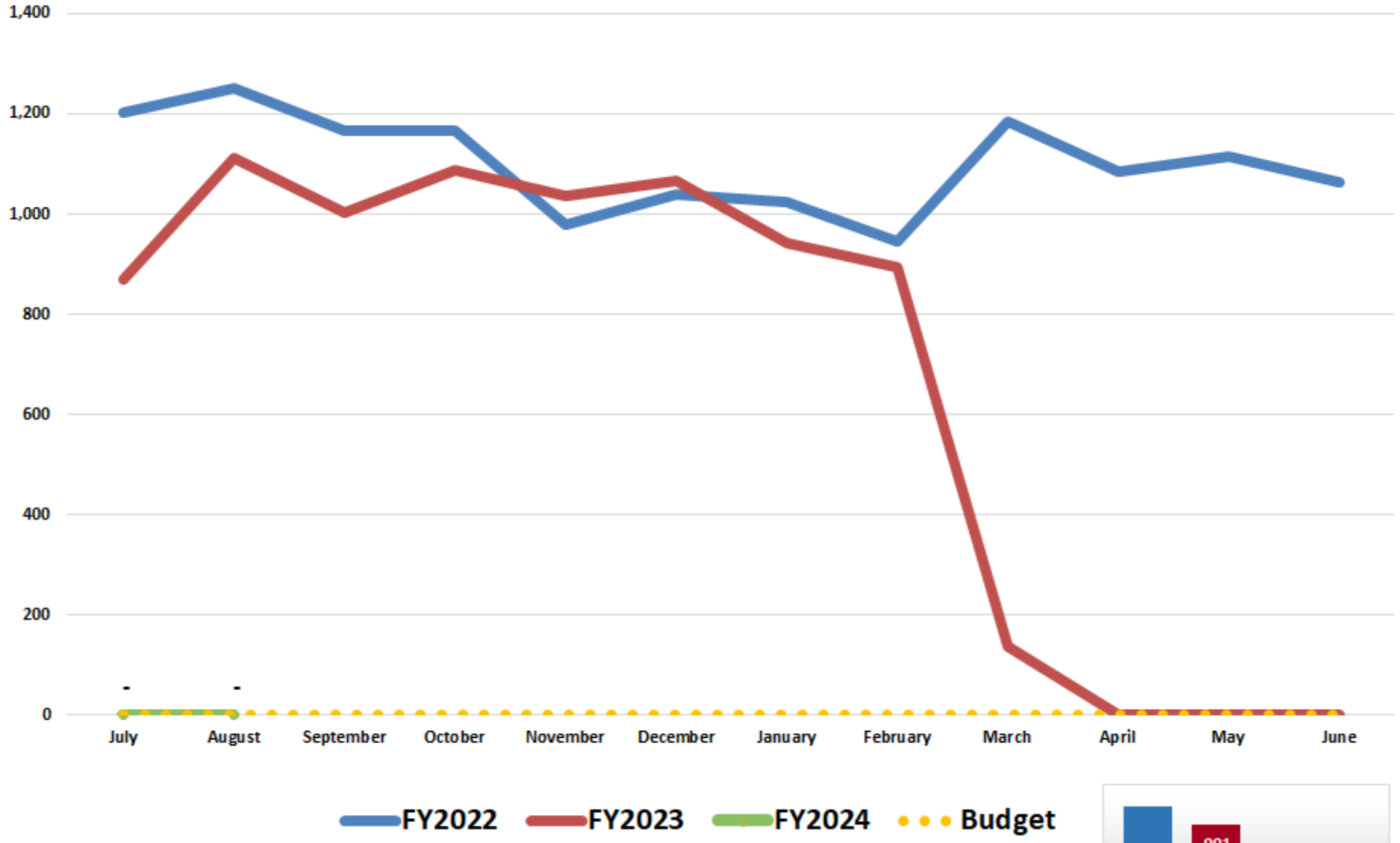
Cath Lab (OP Only) – 100 Min Units

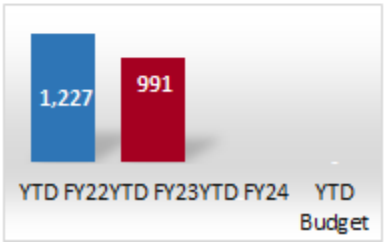


Cath Lab Patients (IP & OP)

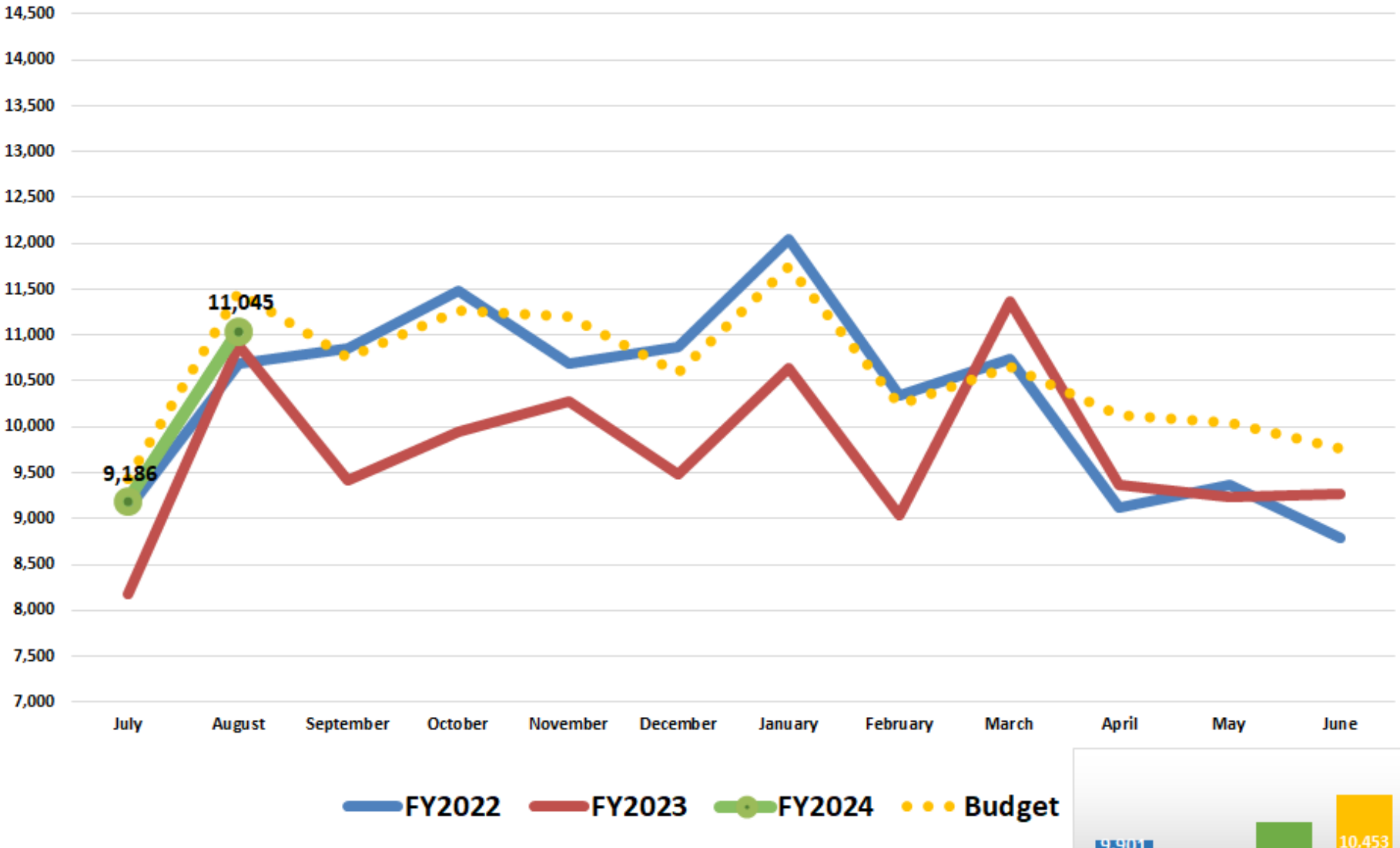


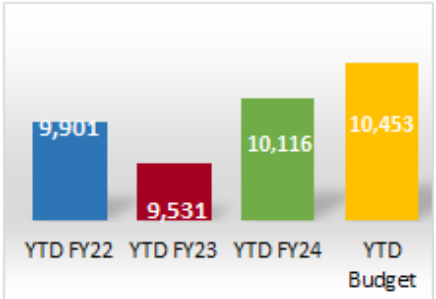
GME Family Medicine Clinic Visits



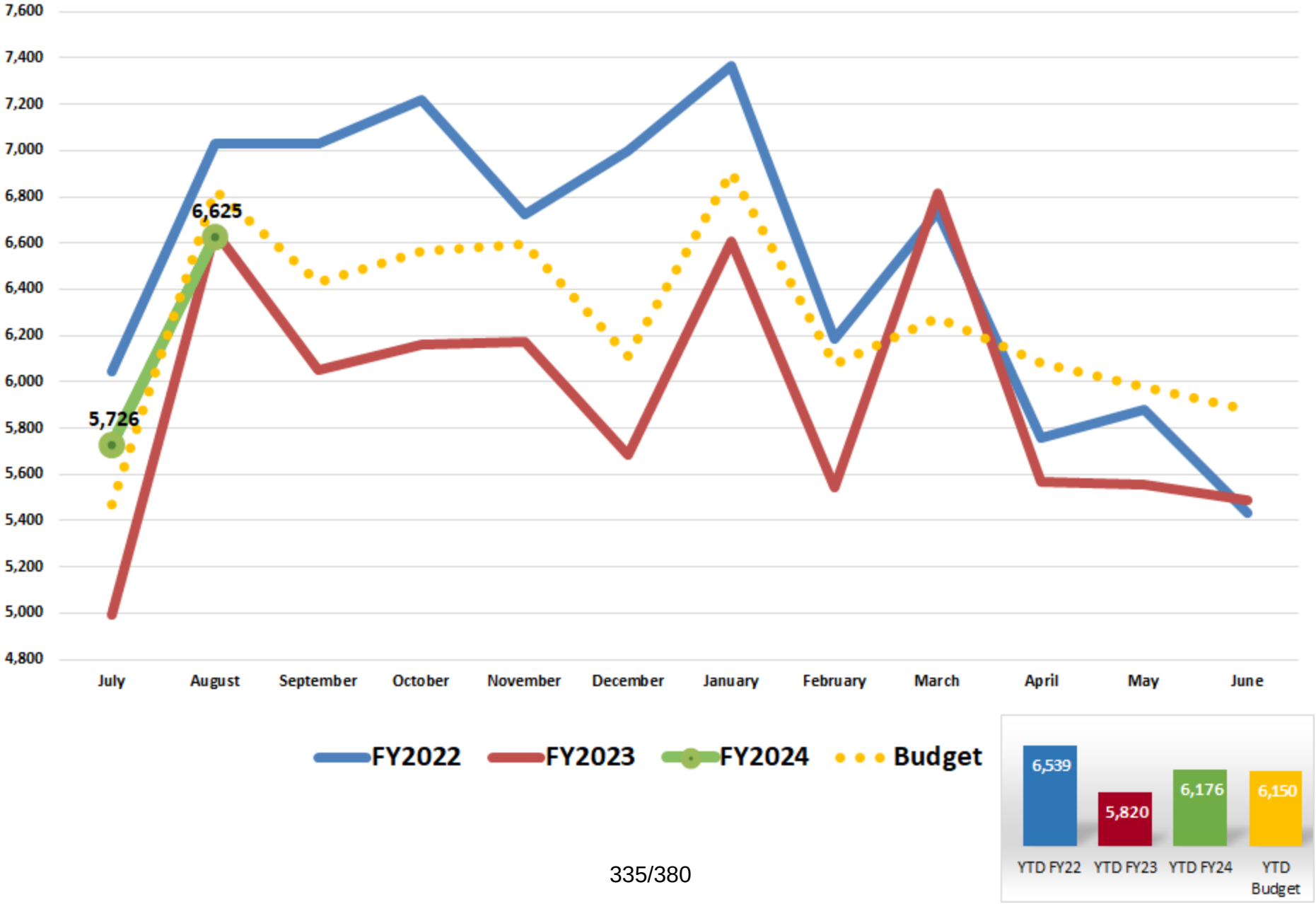


Rural Health Clinics Registrations

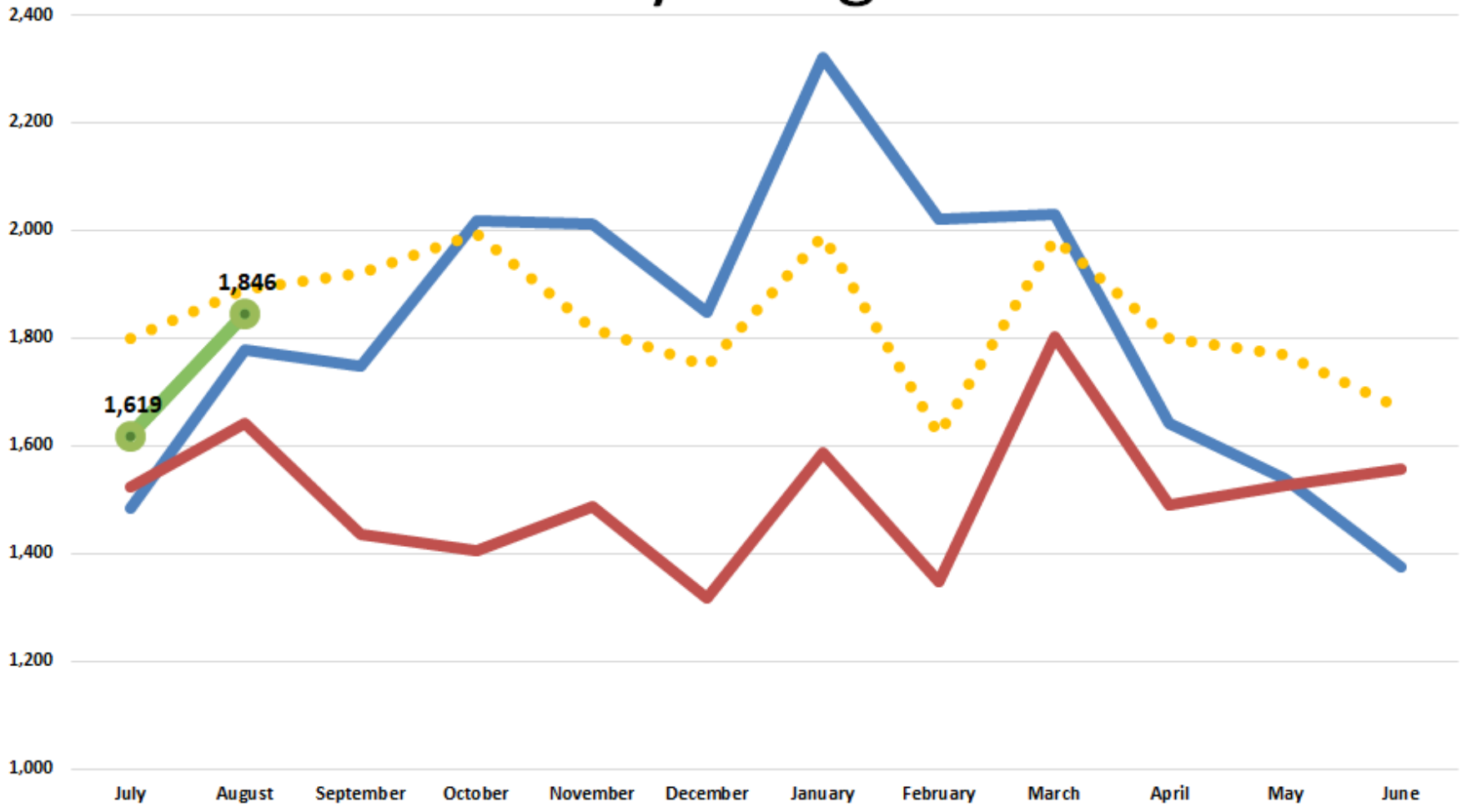


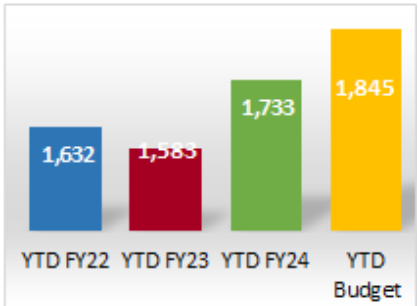


RHC Exeter - Registrations

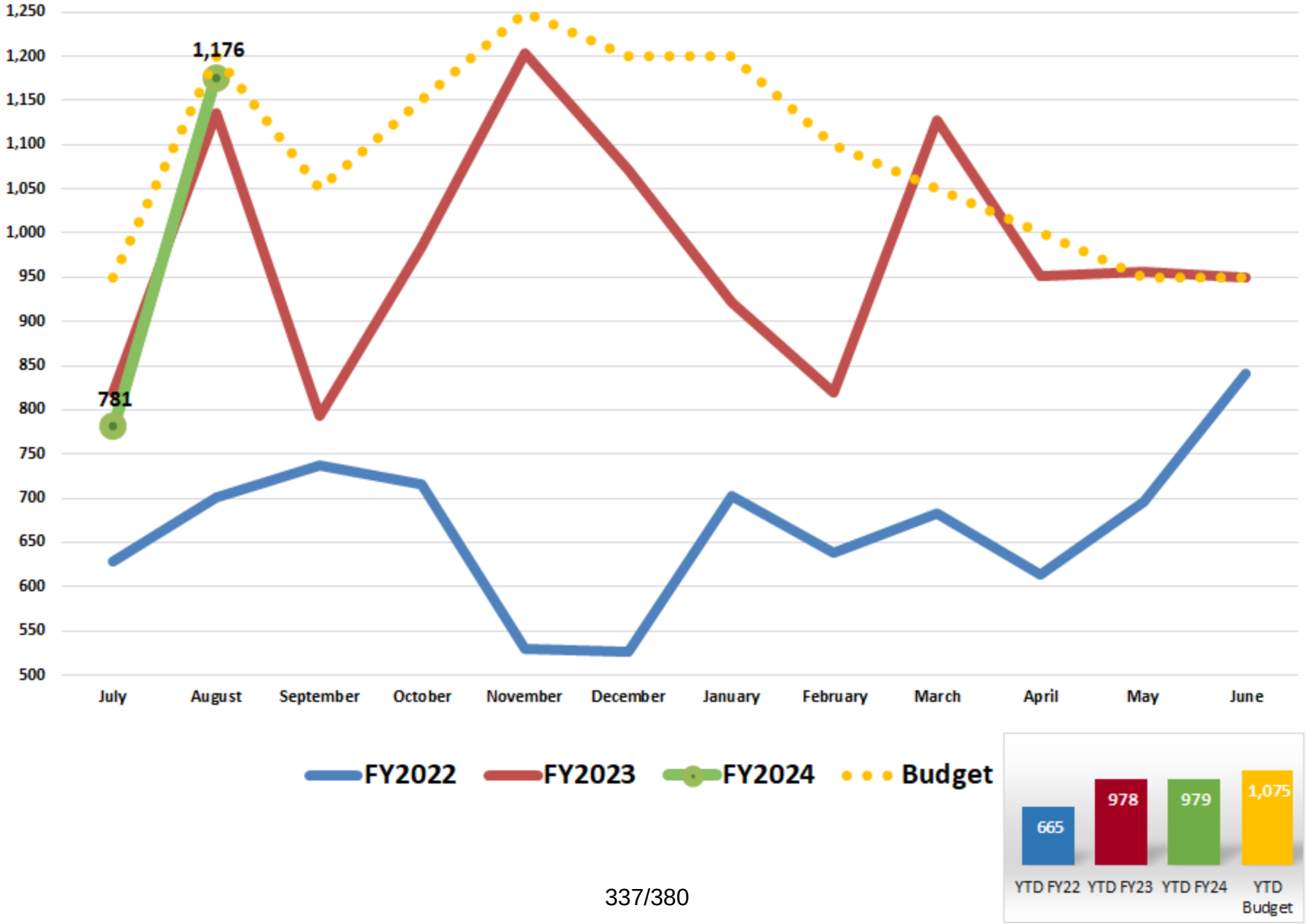


RHC Lindsay - Registrations

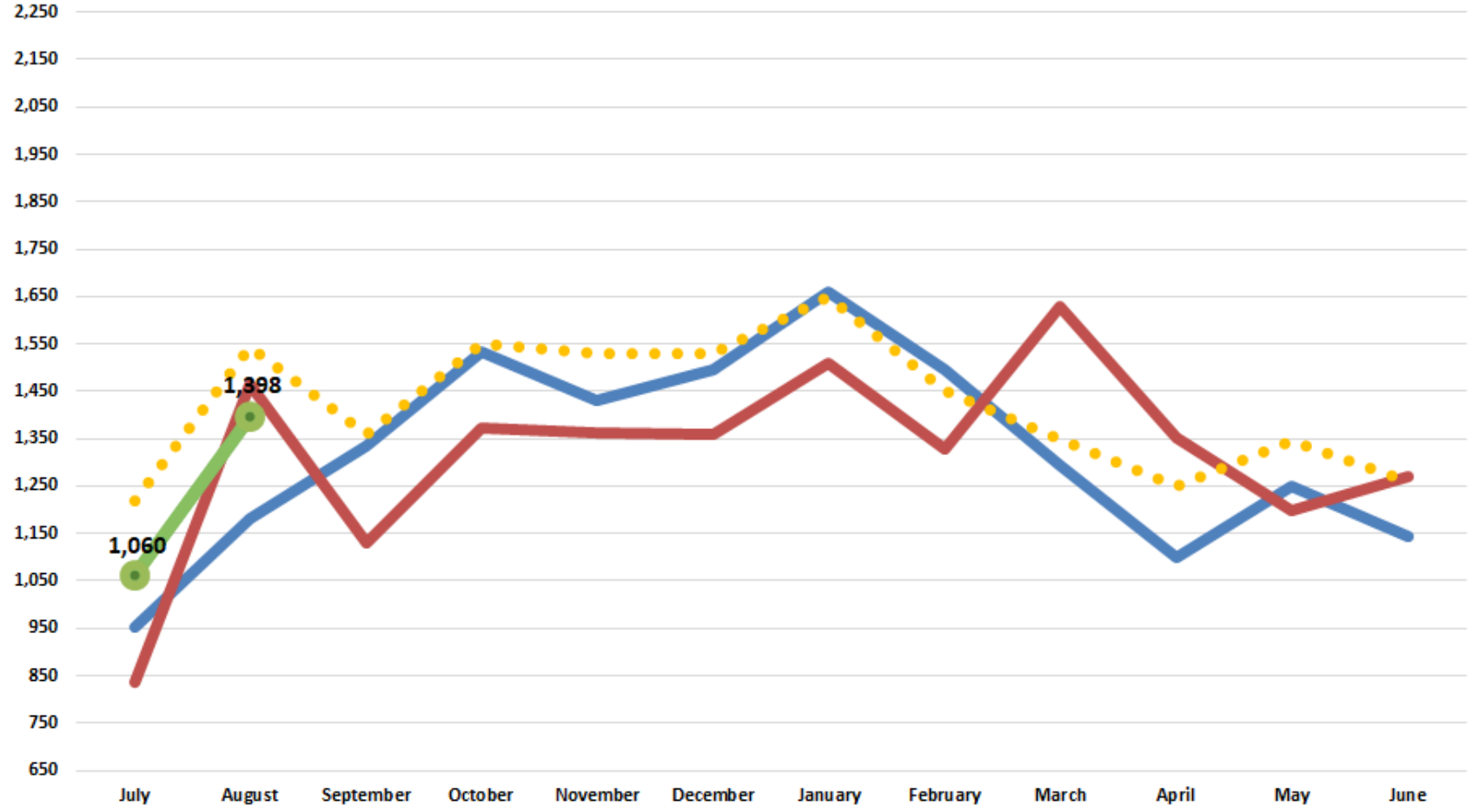


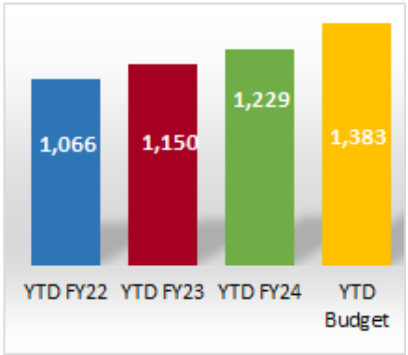


RHC Woodlake - Registrations

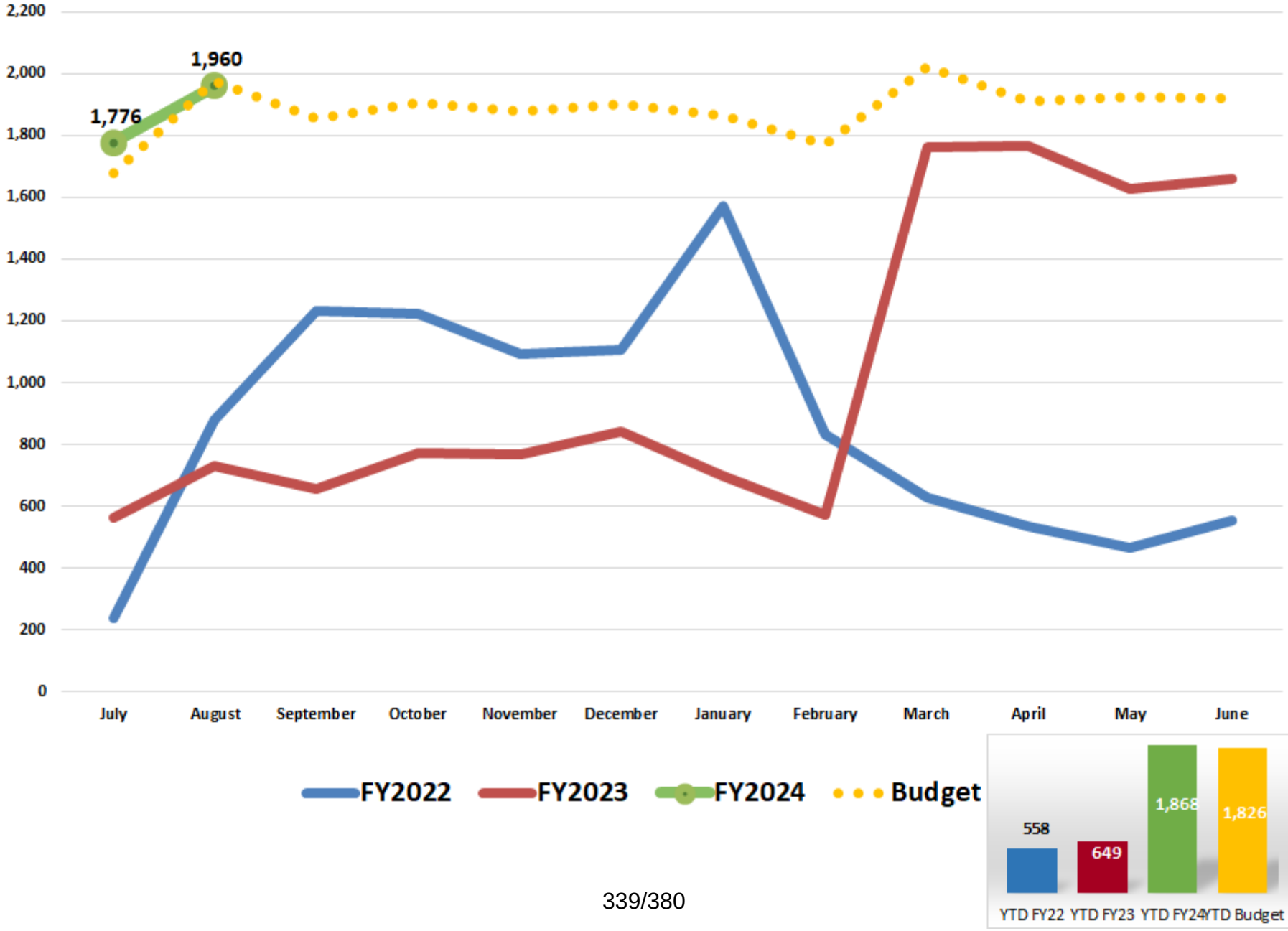


RHC Dinuba - Registrations

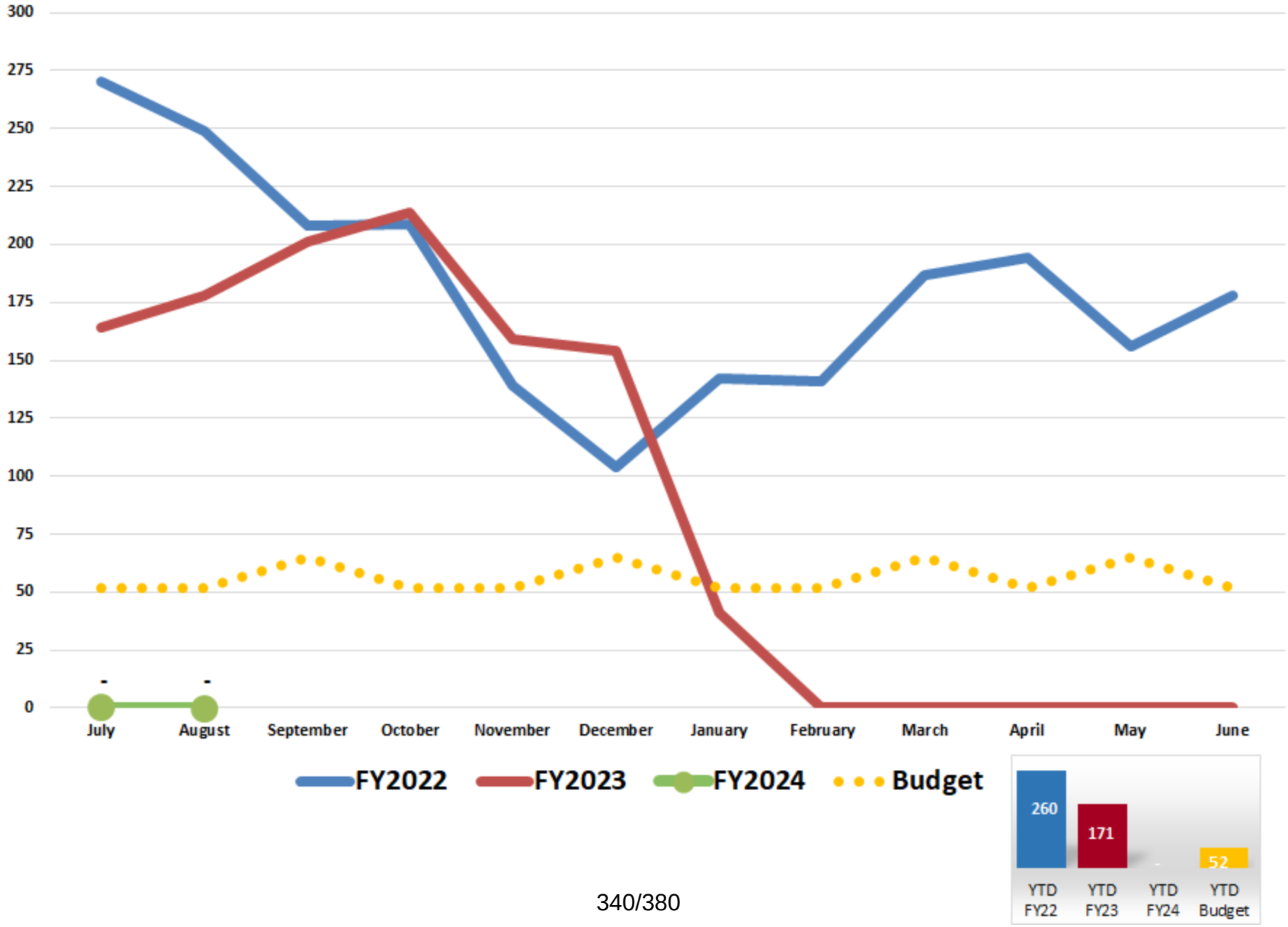




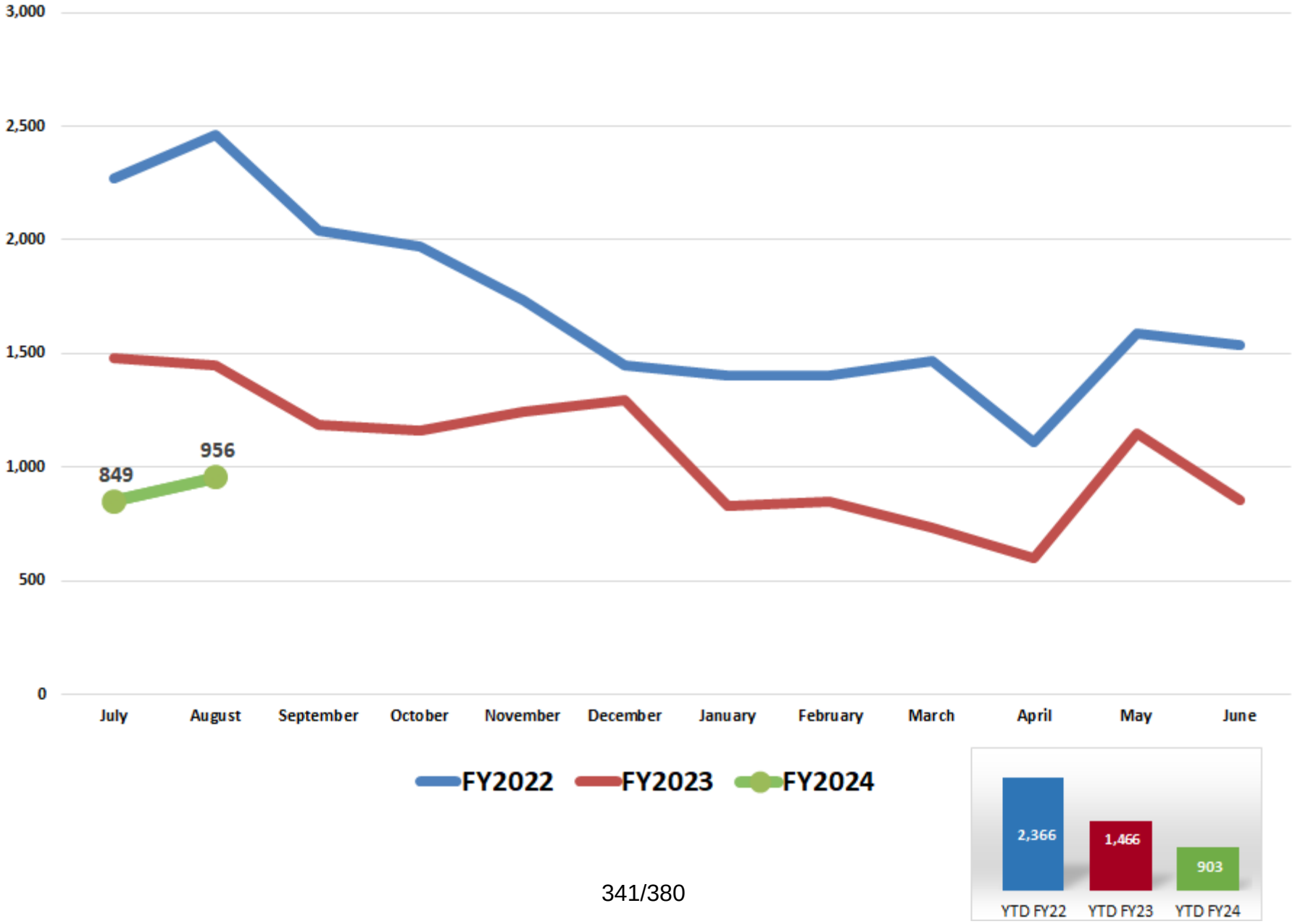
RHC Tulare - Registrations



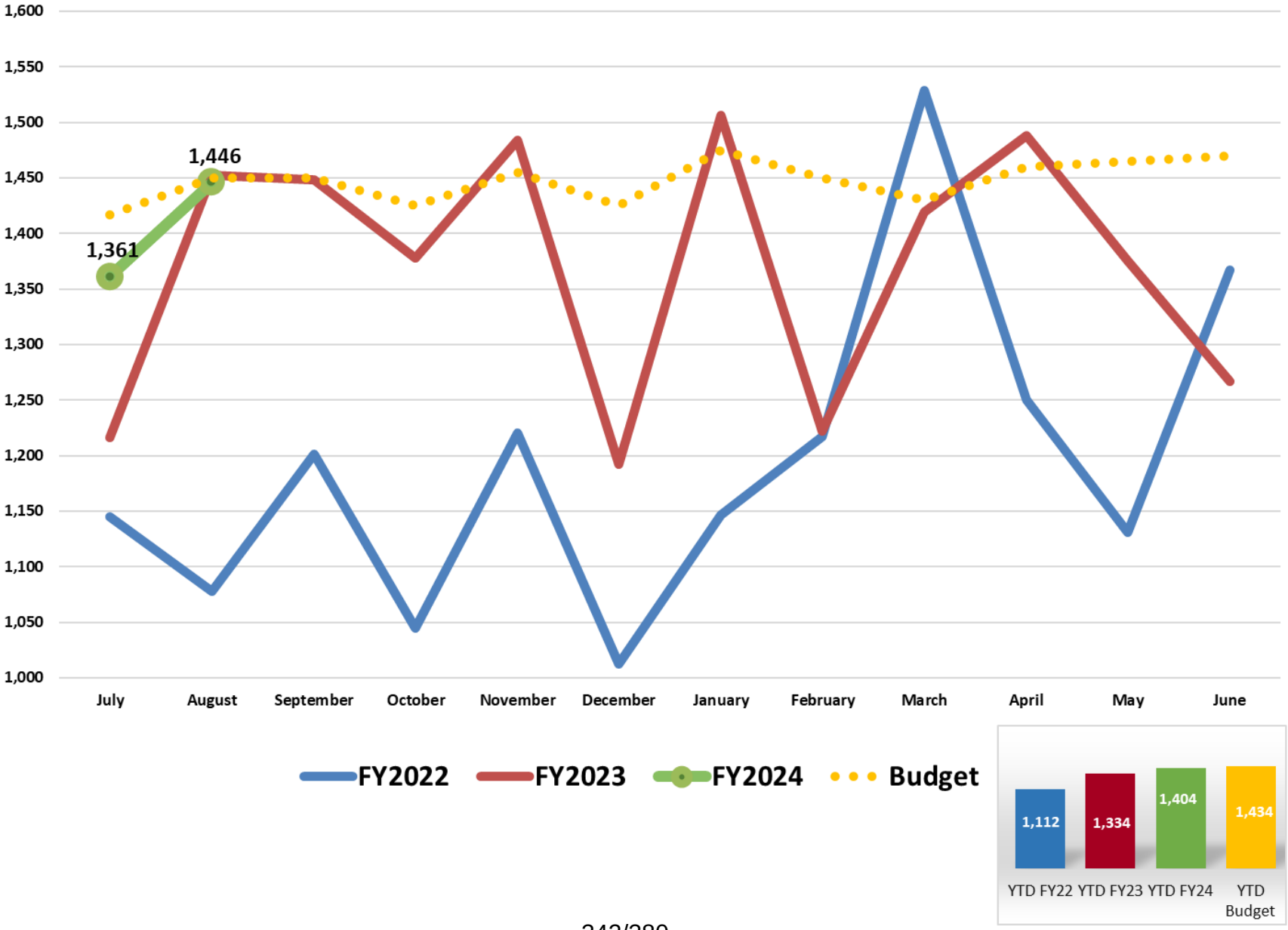
Neurosurgery Clinic Registrations



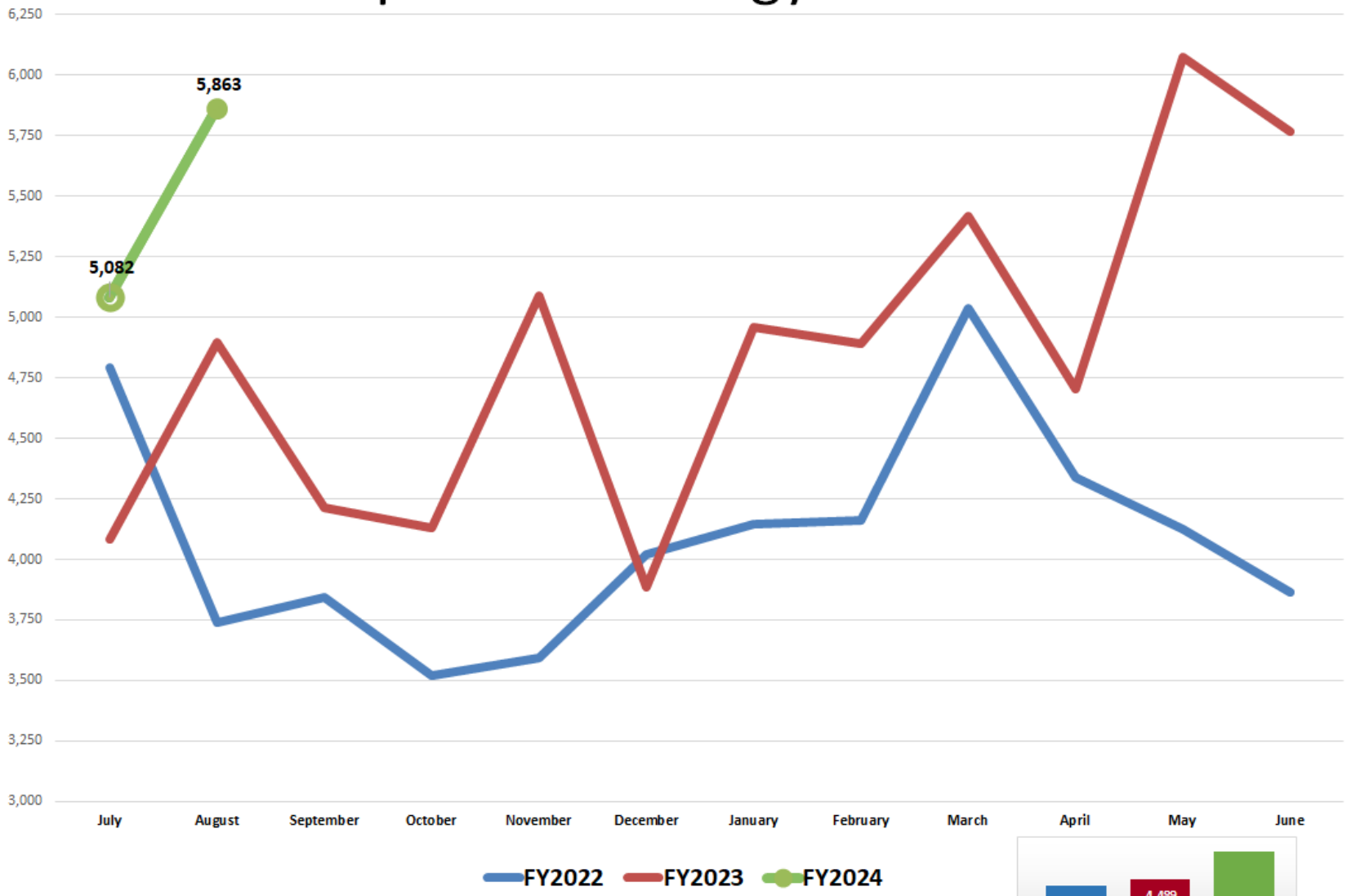
Neurosurgery Clinic - wRVU's

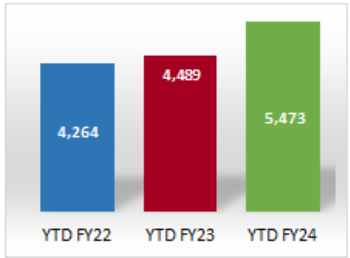


Sequoia Cardiology Registrations

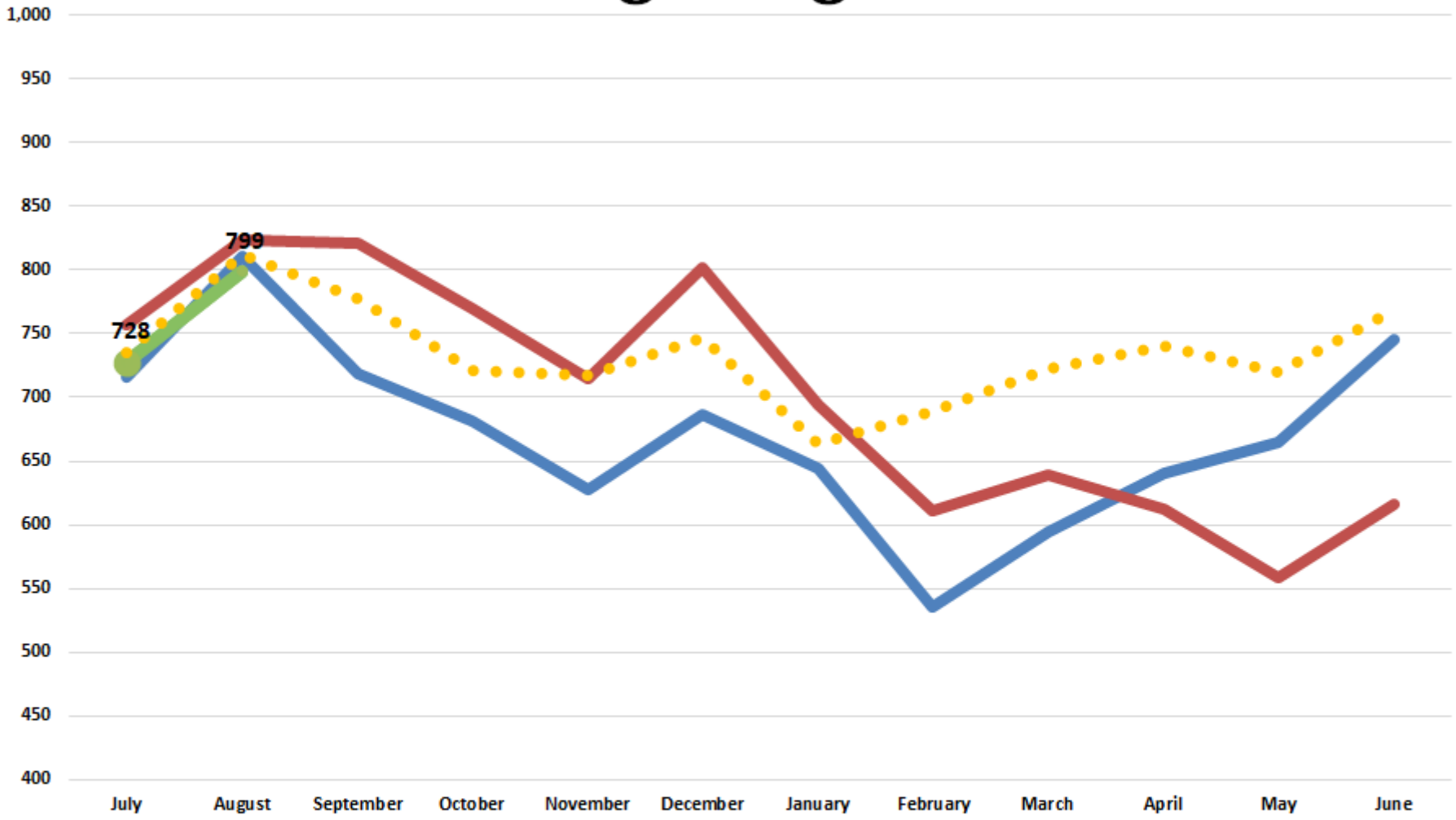


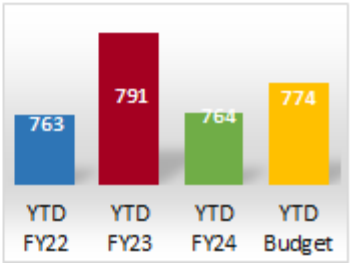
Sequoia Cardiology - wRVU's



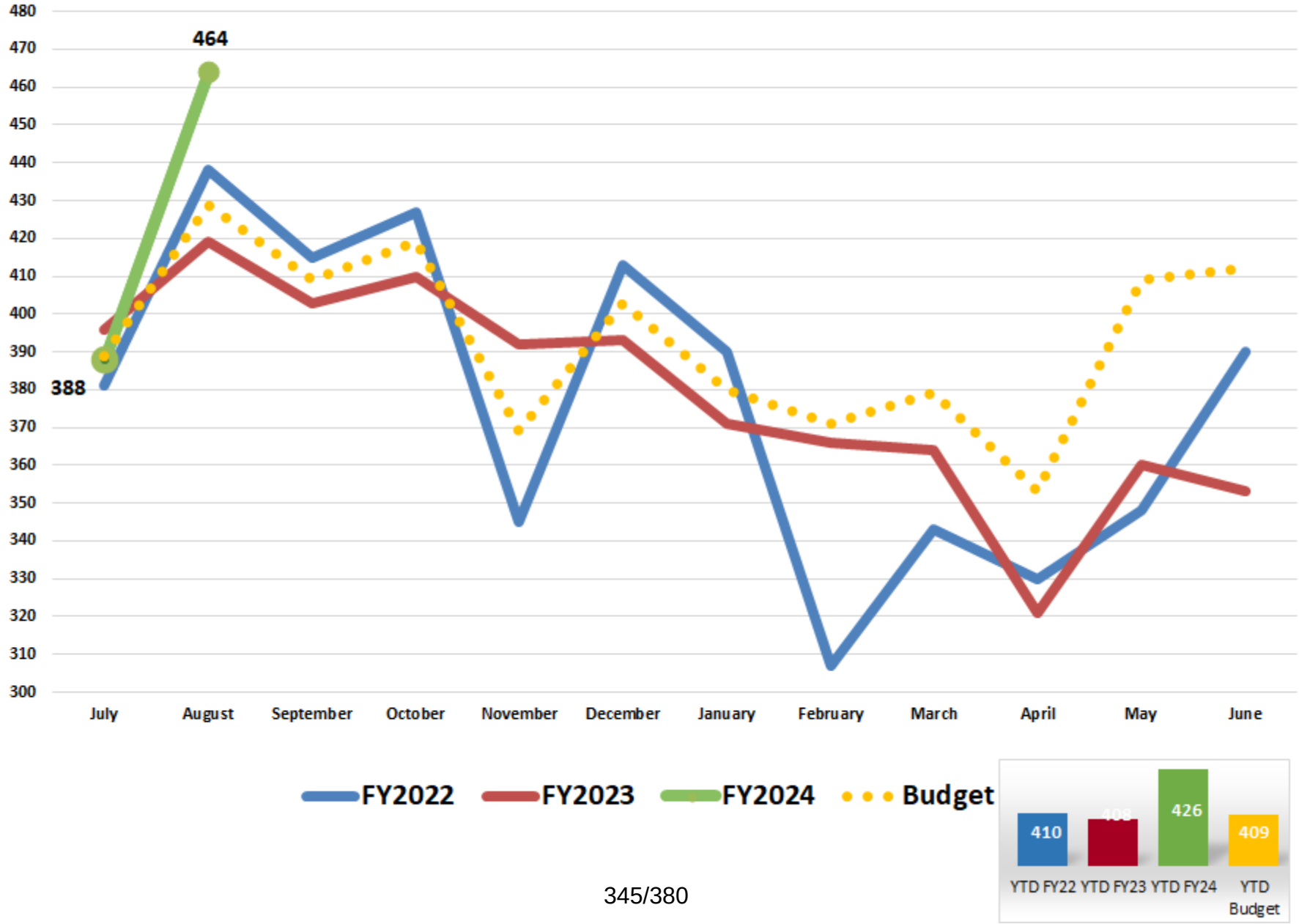


Labor Triage Registrations

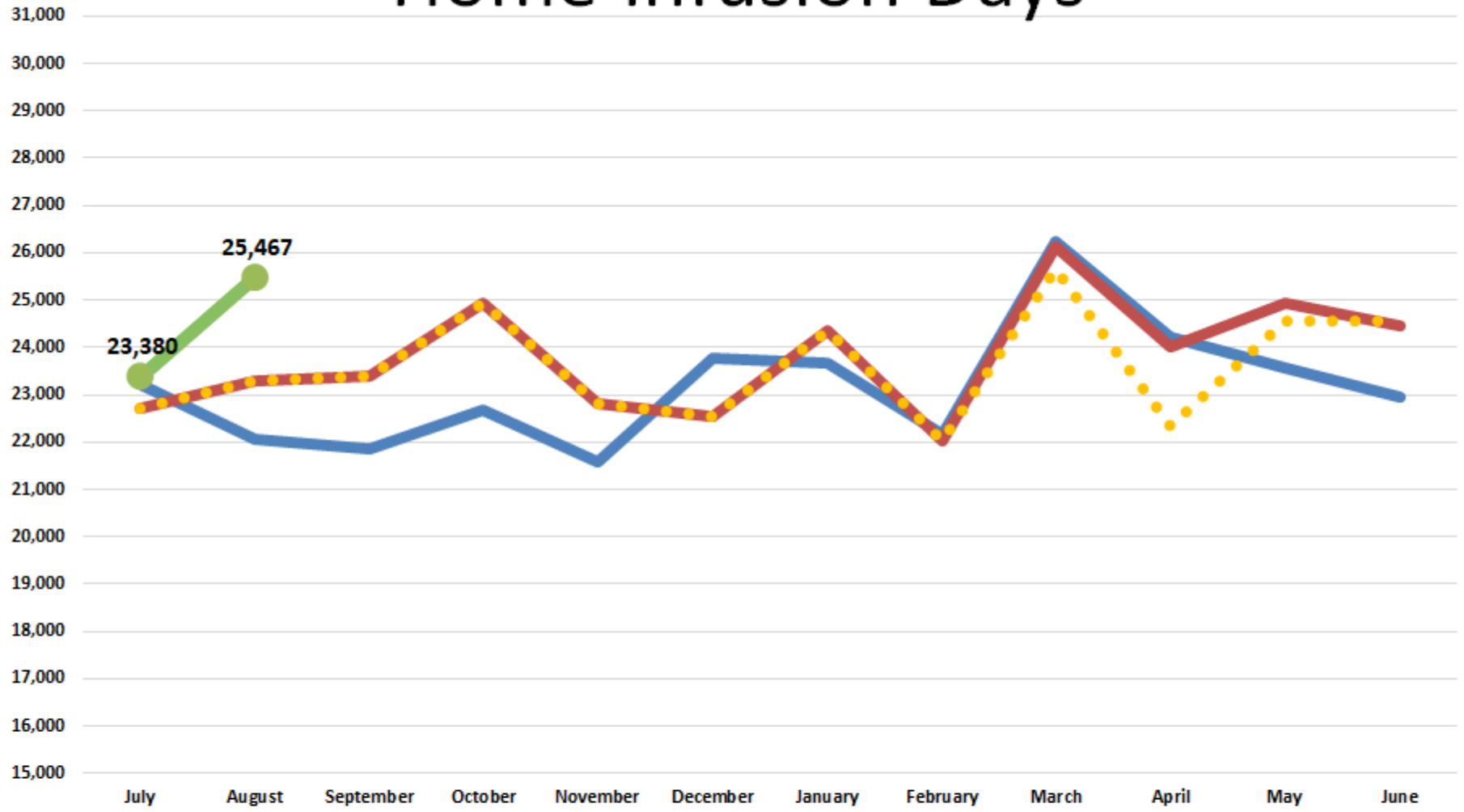


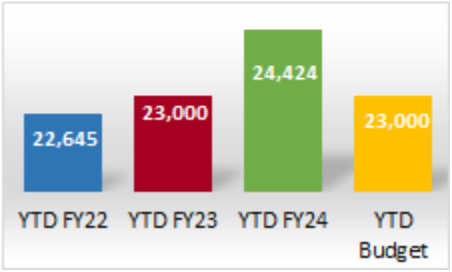


Deliveries

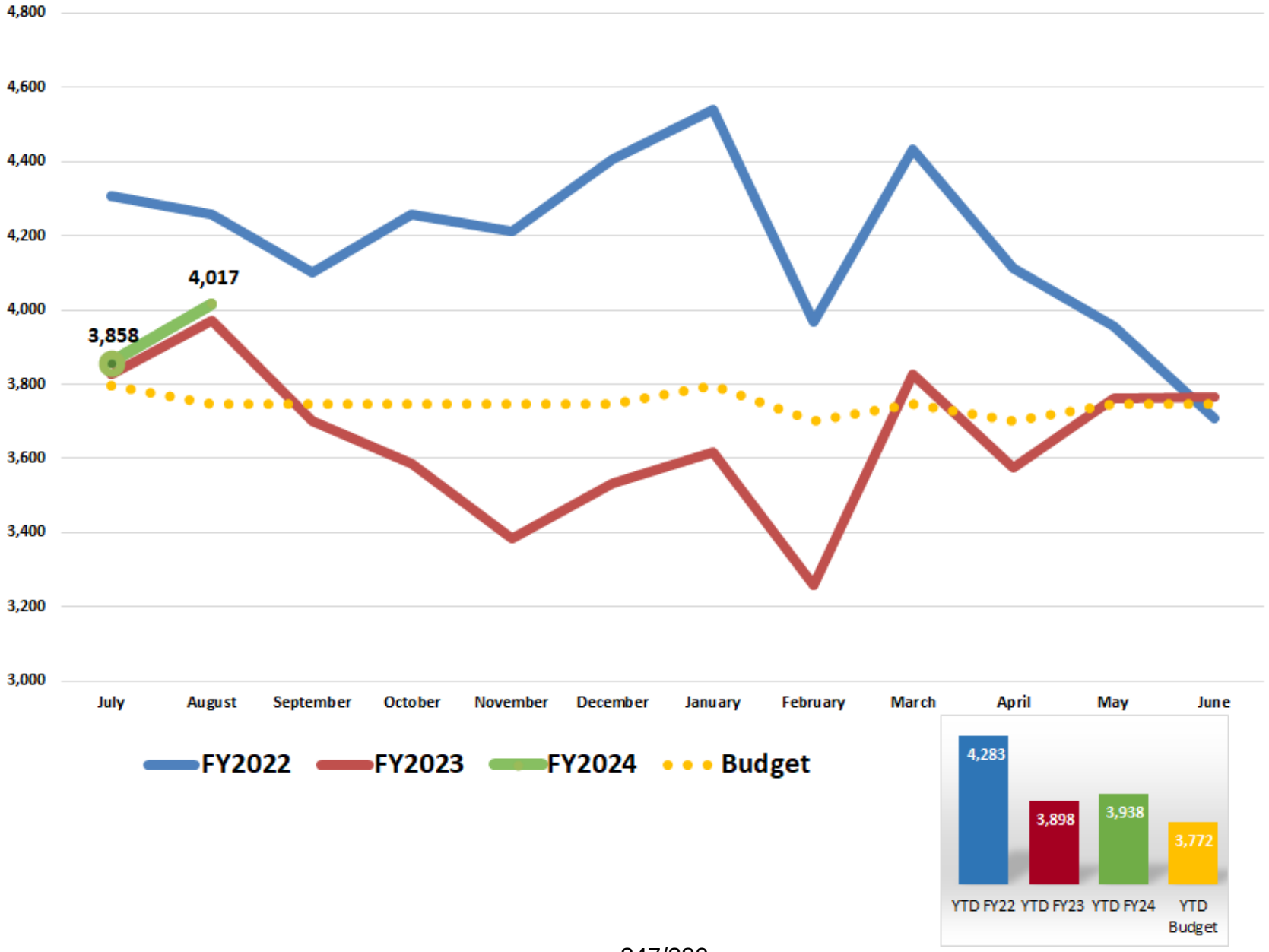

480
470
460
450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
464
388
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024
Budget
410
408
426
409
YTD FY22
YTD FY23
YTD FY24
YTD Budget

Home Infusion Days

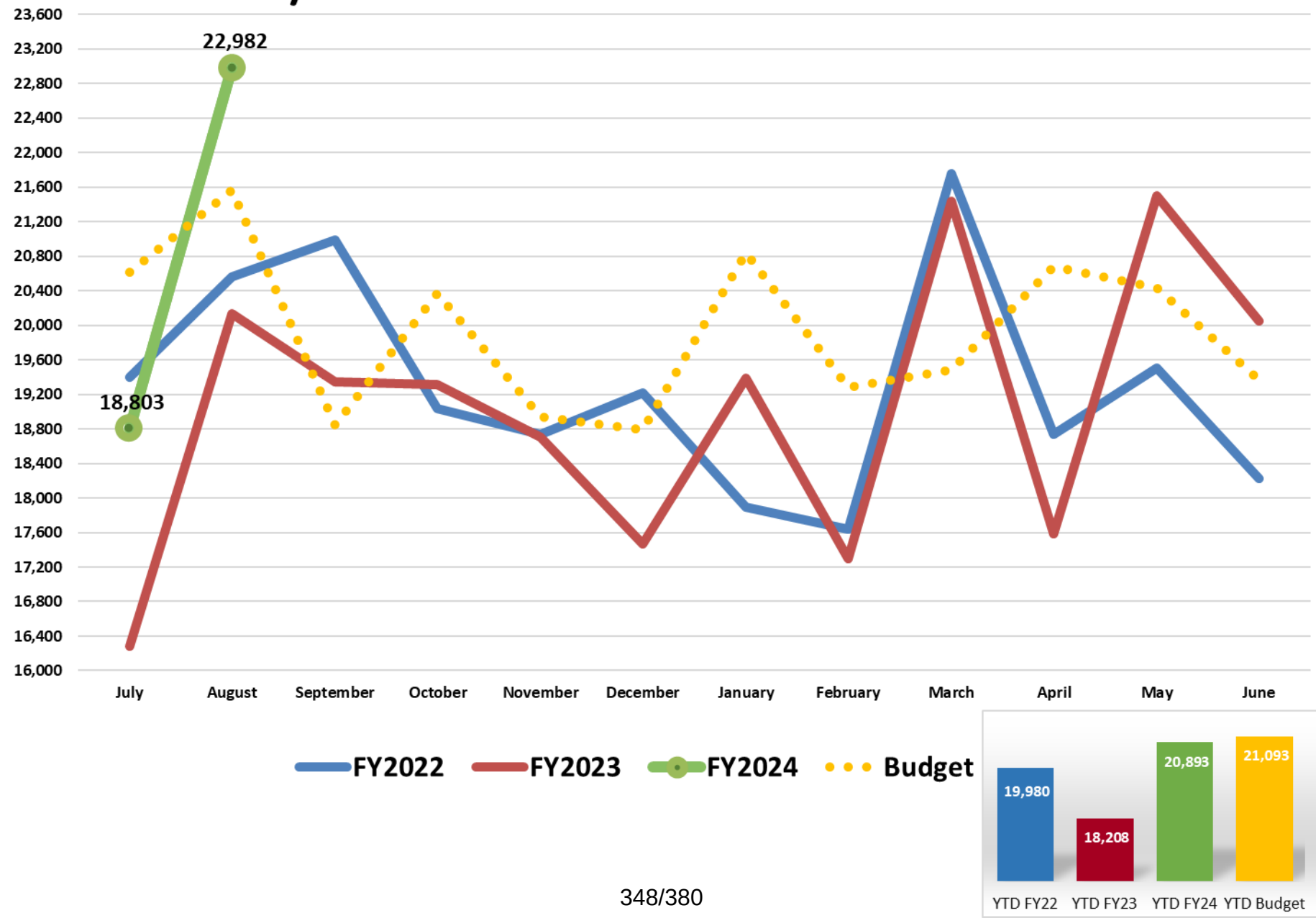




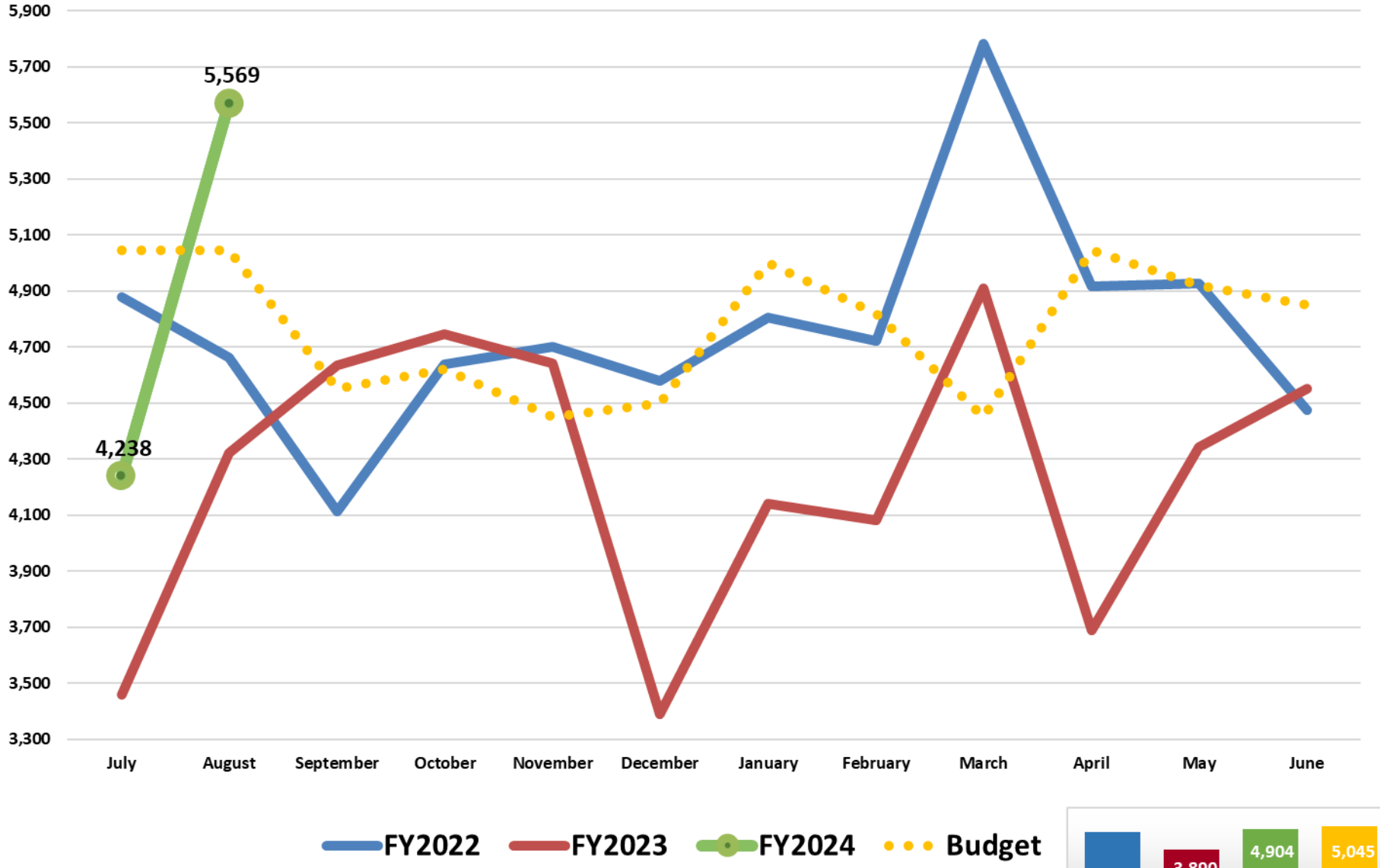
Hospice Days

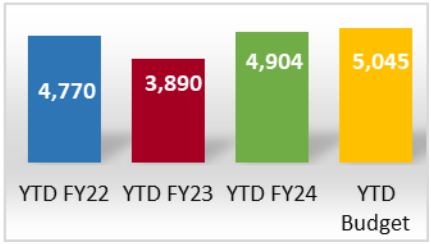


All O/P Rehab Svcs Across District

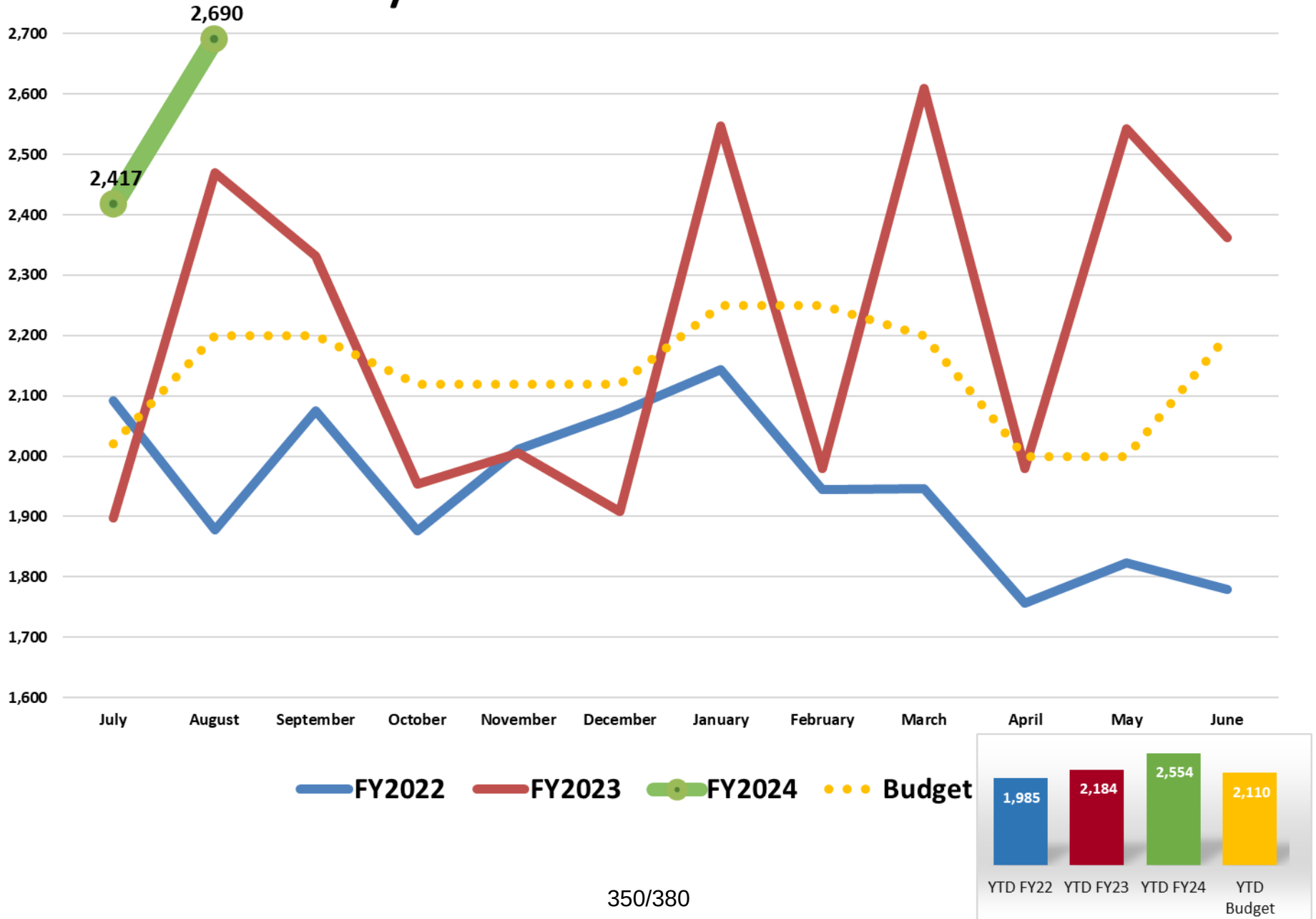


O/P Rehab Services

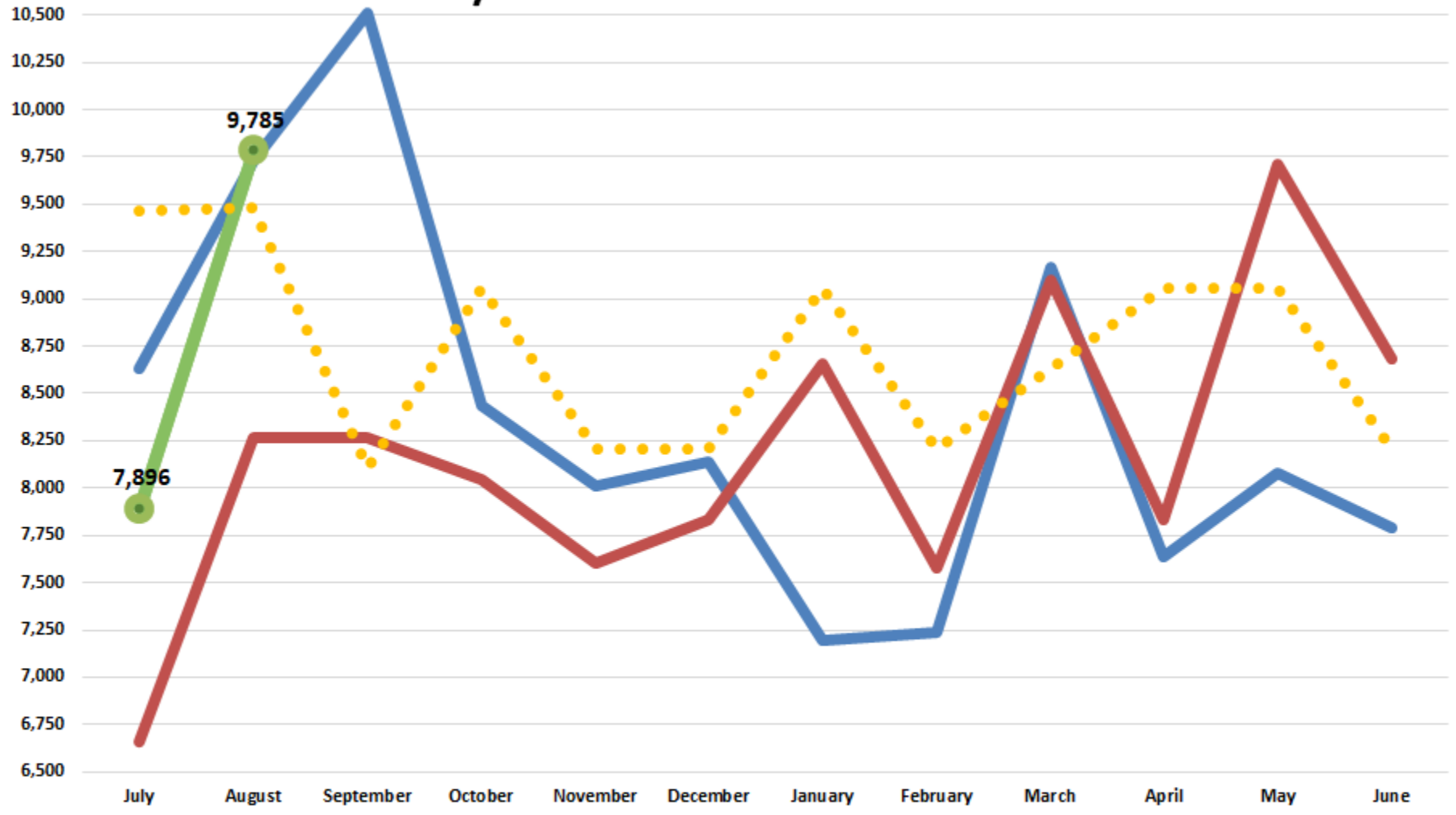


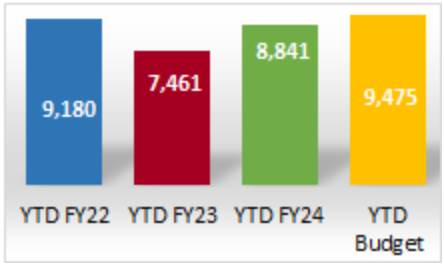


O/P Rehab - Exeter

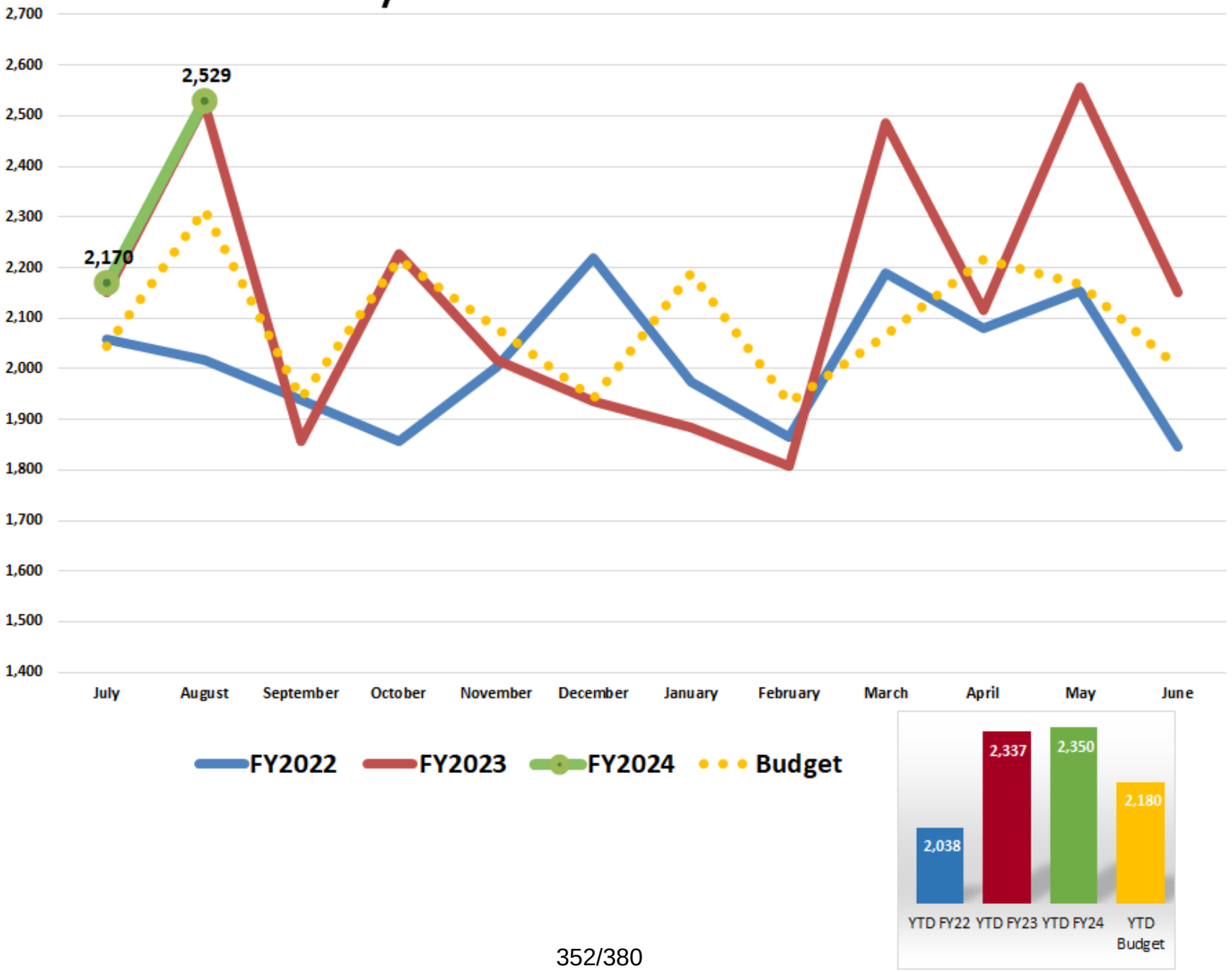


O/P Rehab - Akers

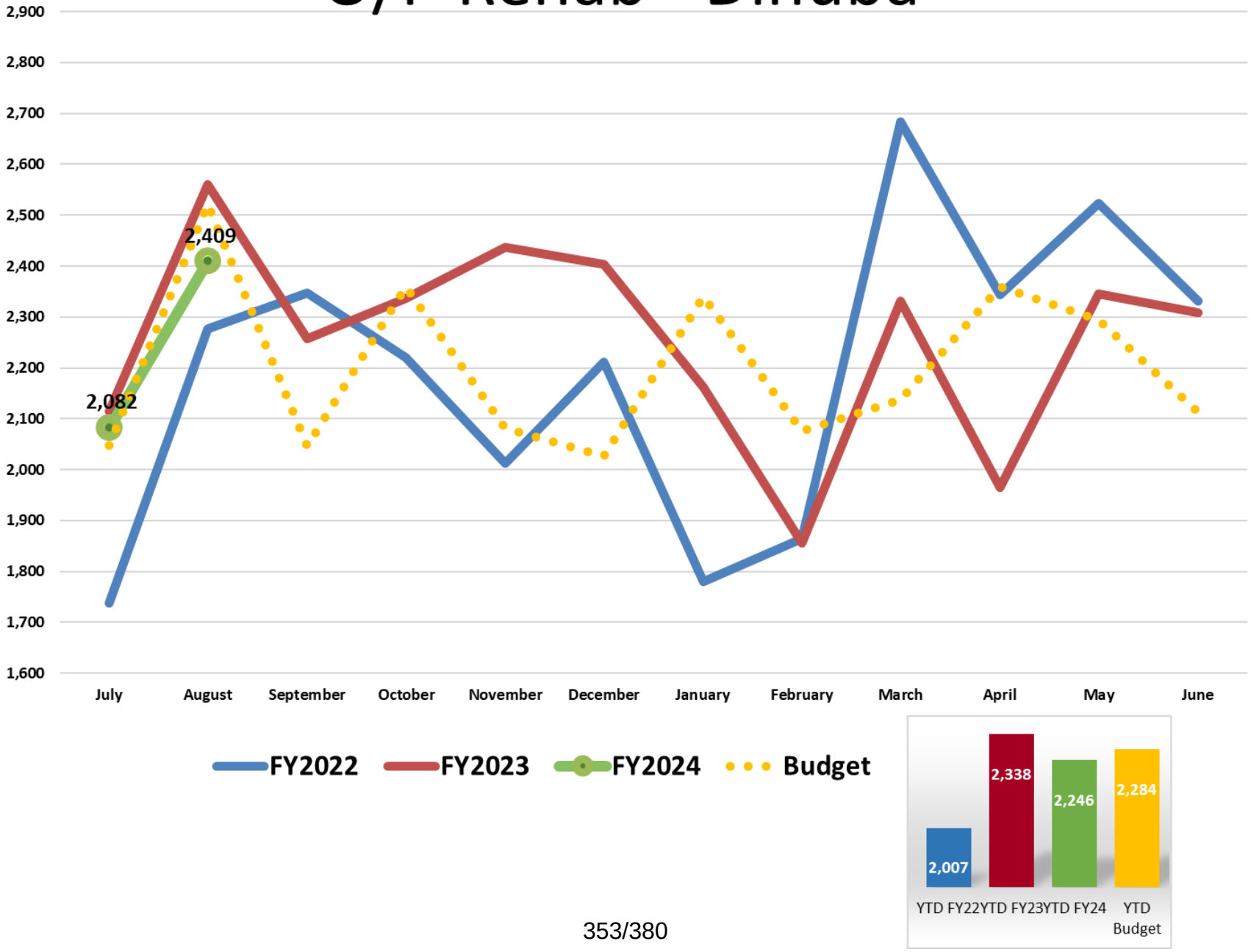




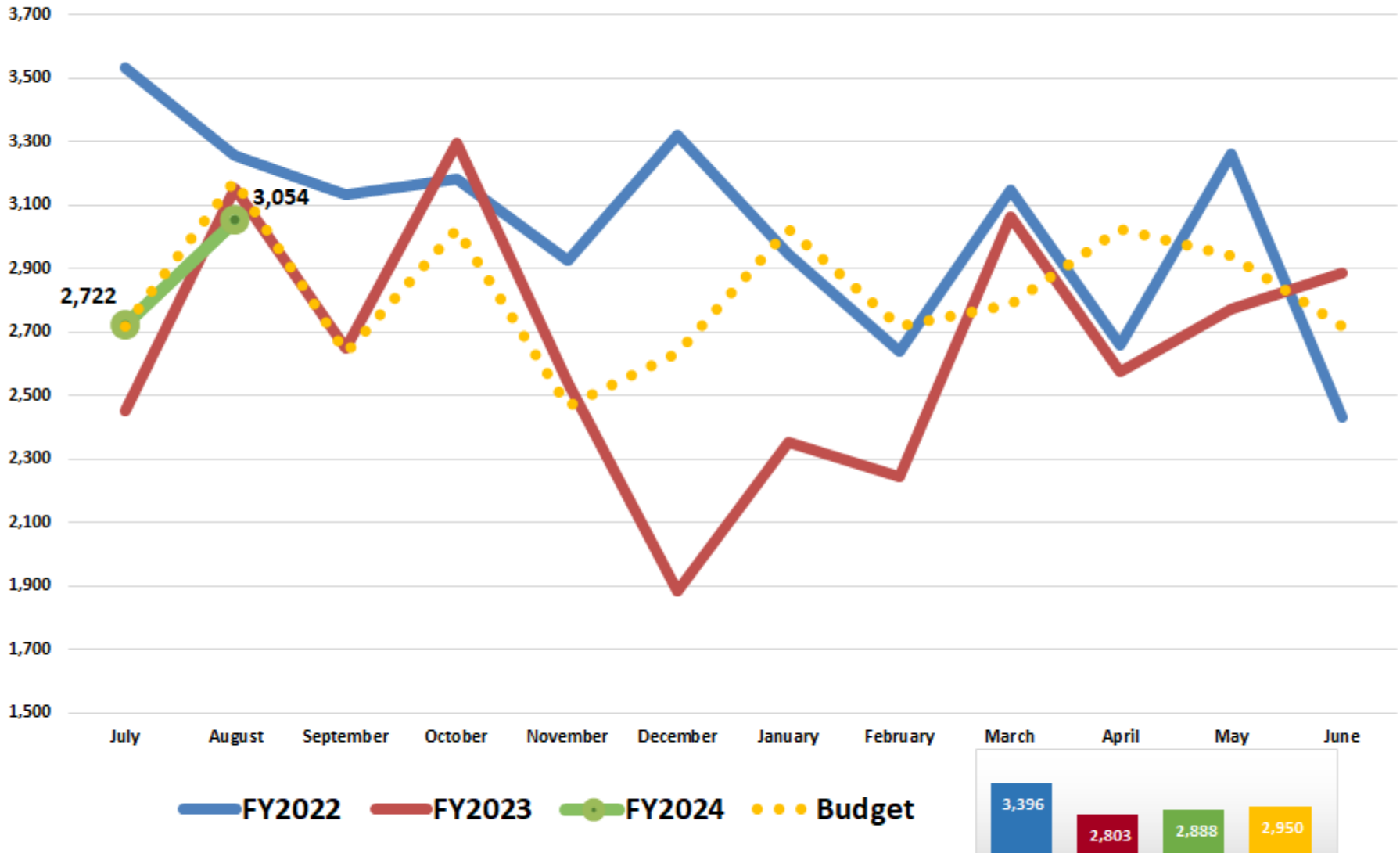
O/P Rehab - LLOPT

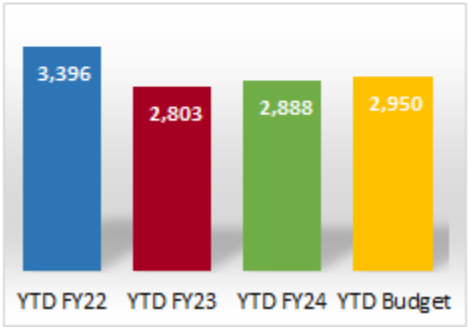


O/P Rehab - Dinuba

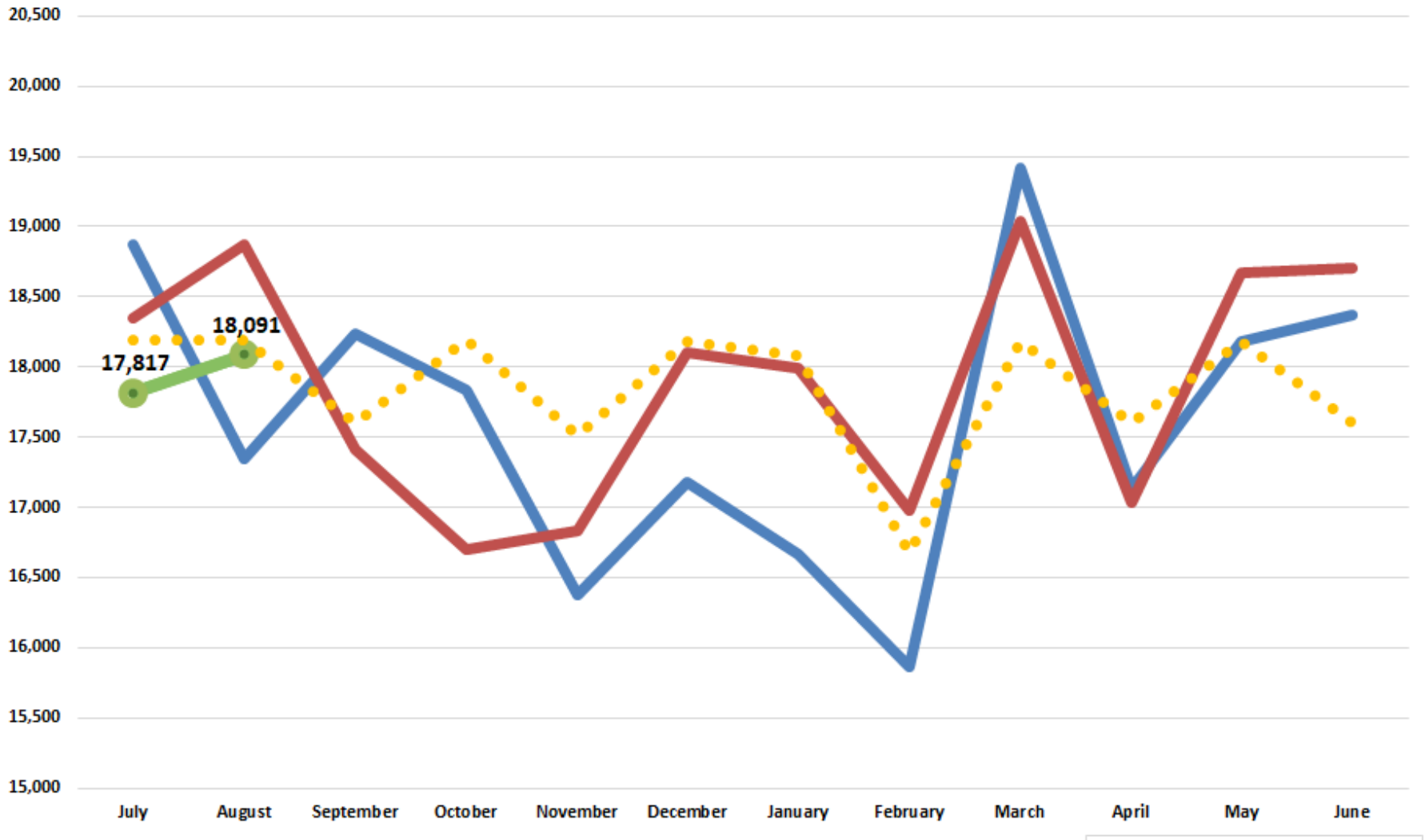


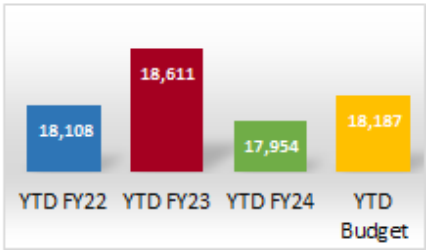
Therapy - Cypress Hand Center





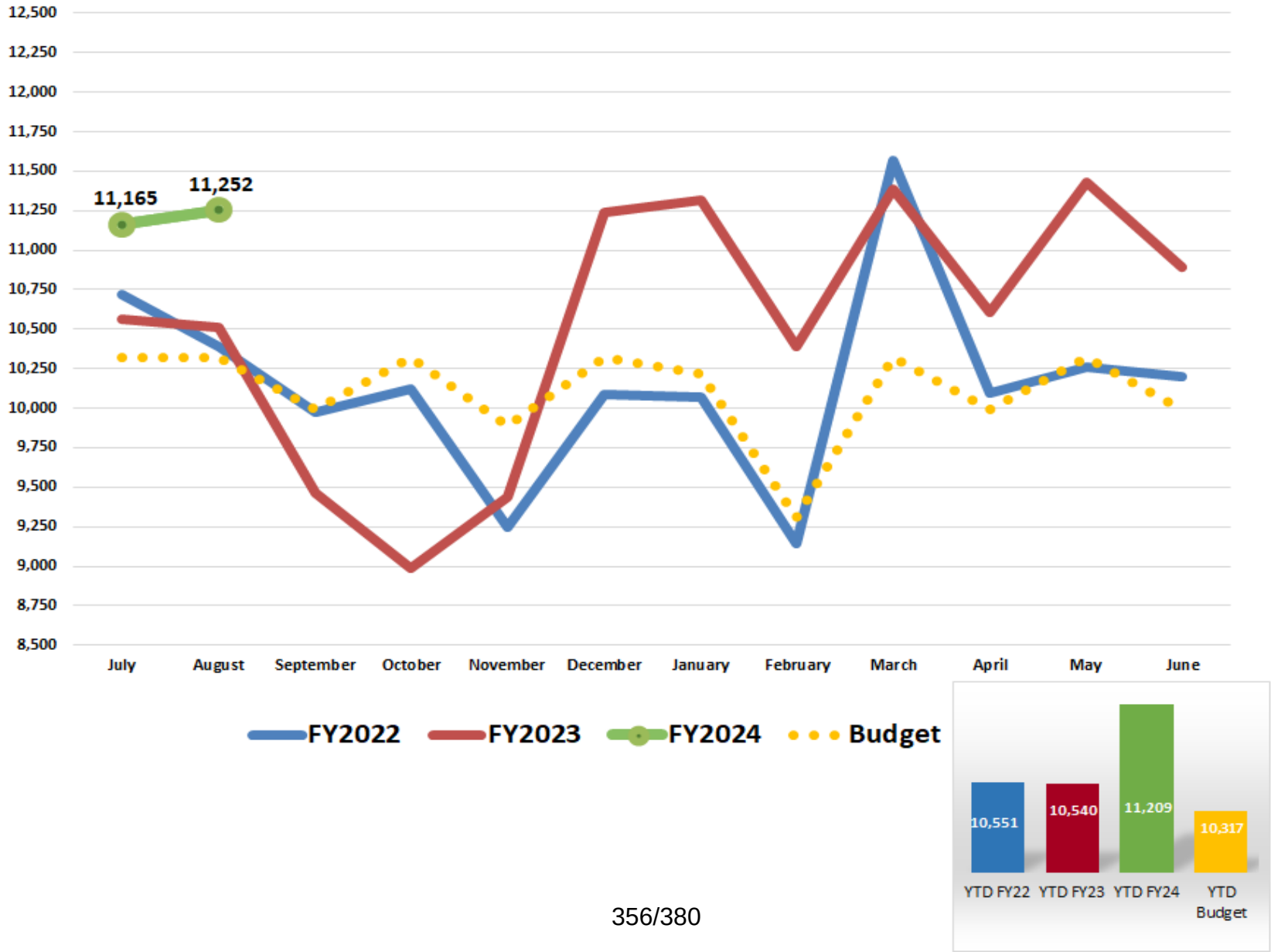
Physical & Other Therapy Units (I/P & O/P)



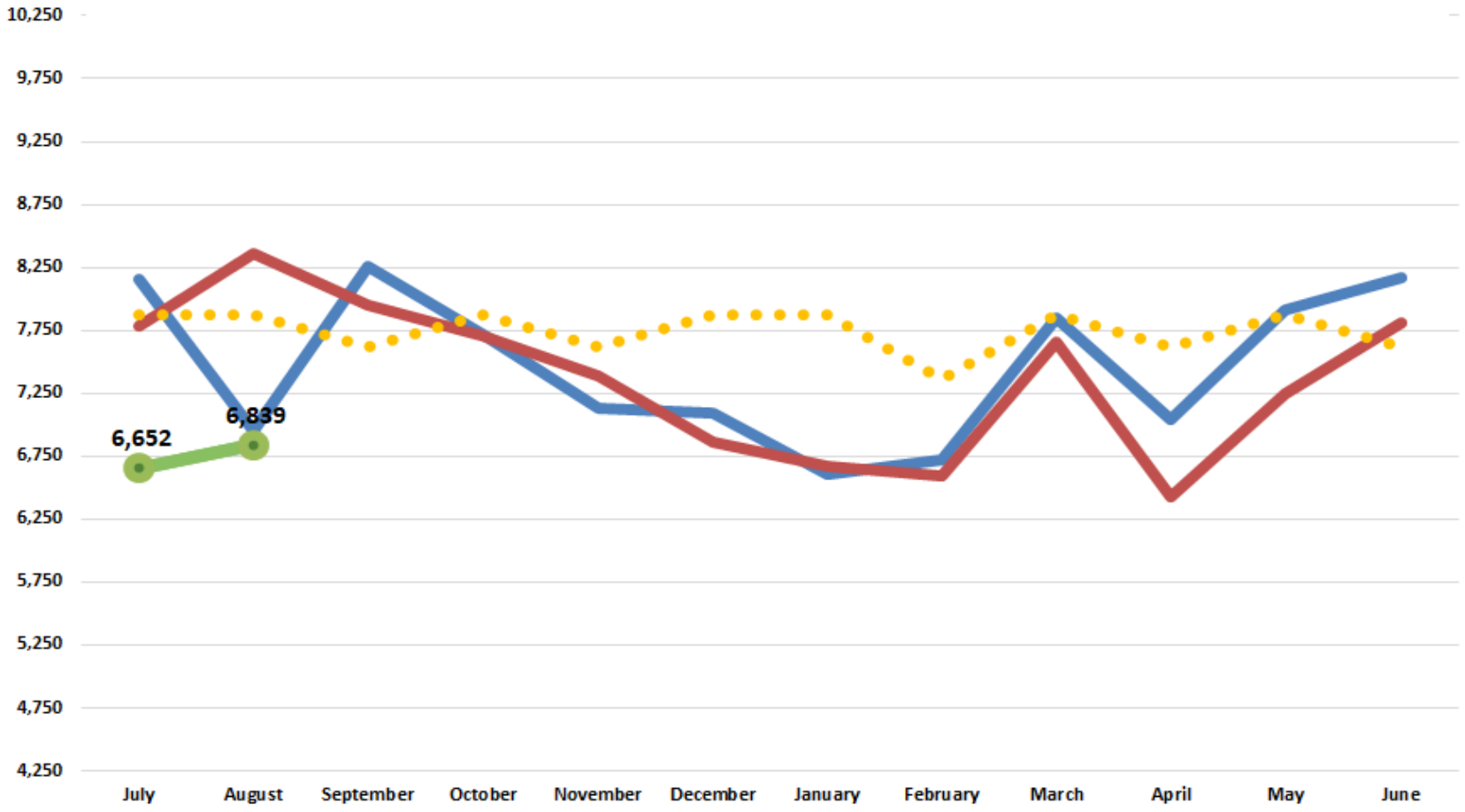


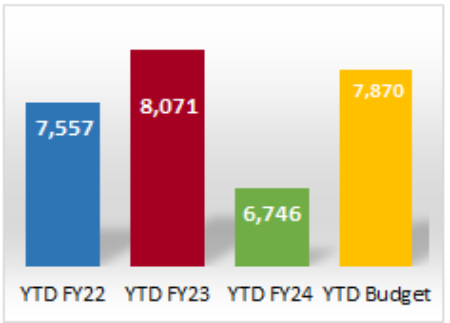
Physical & Other Therapy Units

(I/P & O/P)-Main Campus

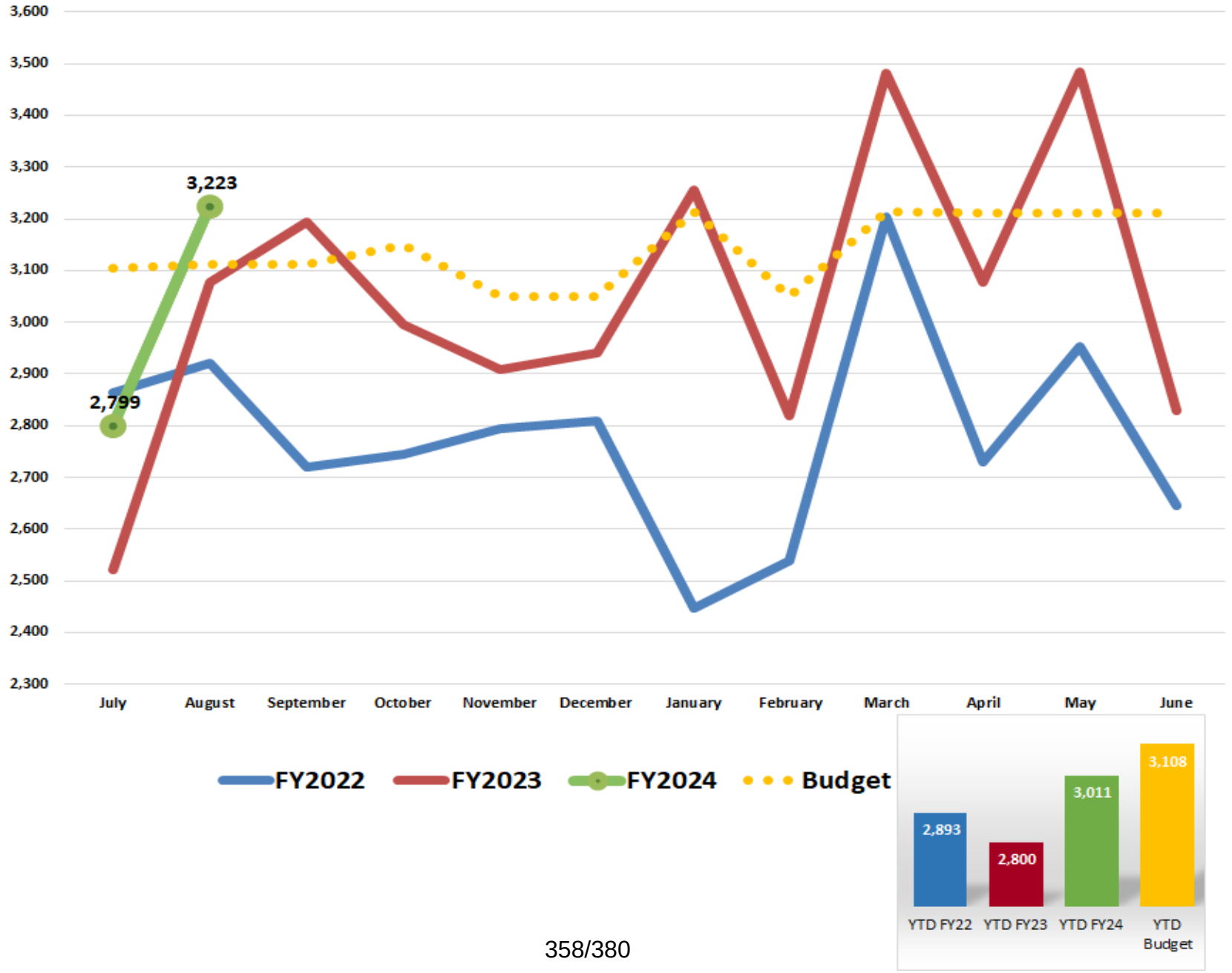


Physical & Other Therapy Units (I/P & O/P)- KDRH & South Campus

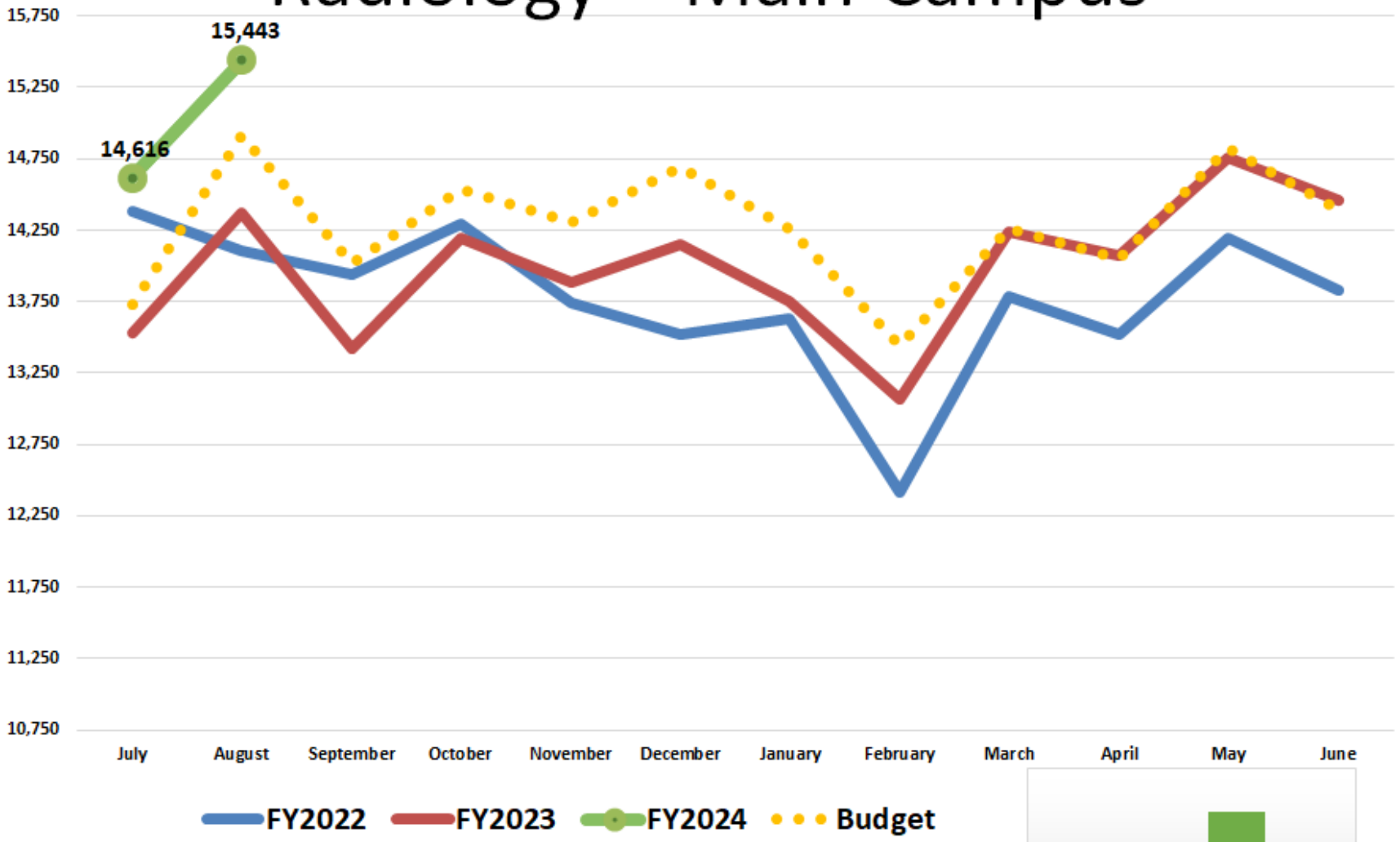


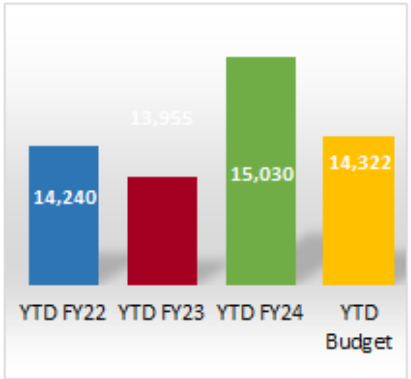


Home Health Visits

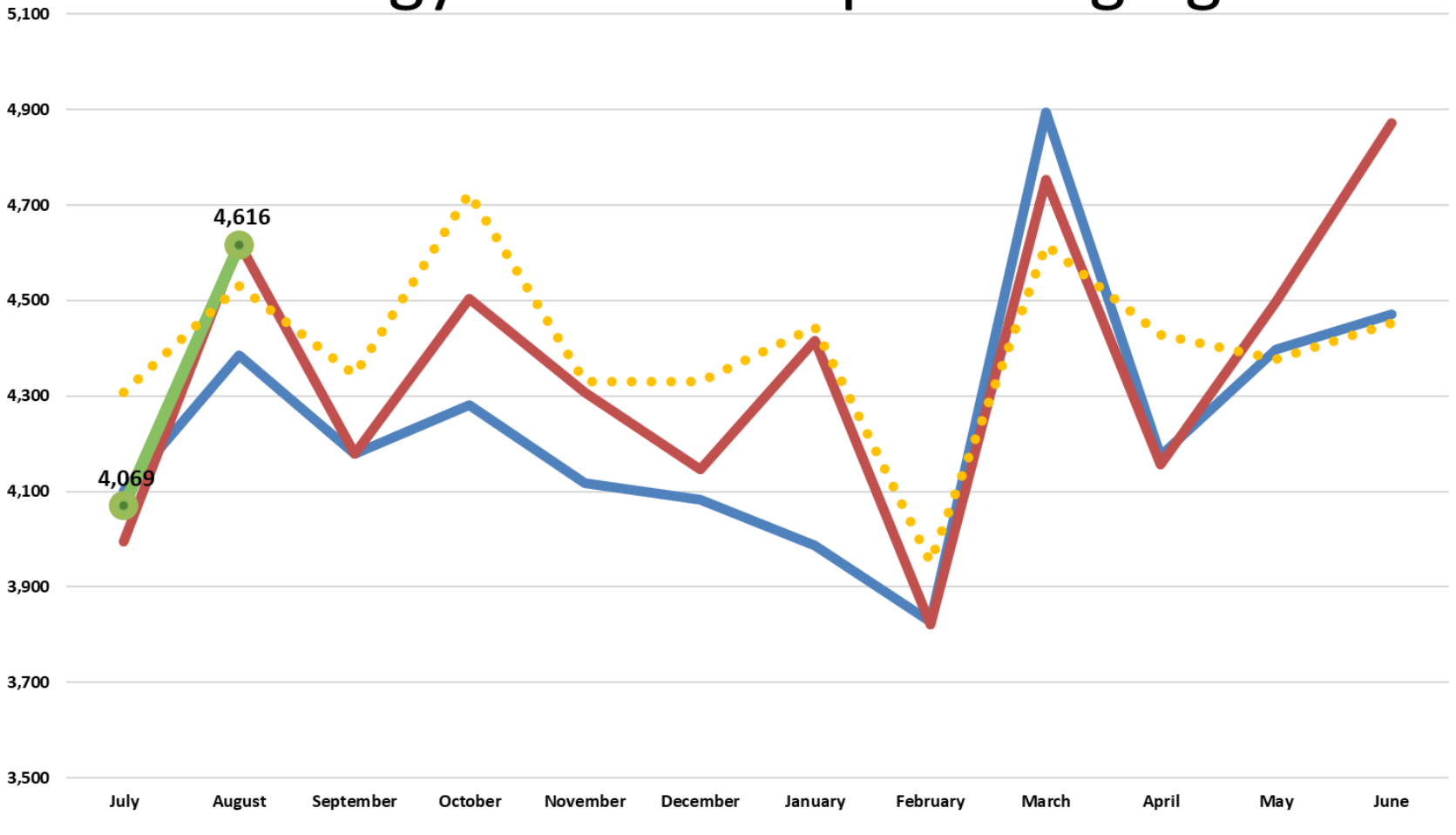


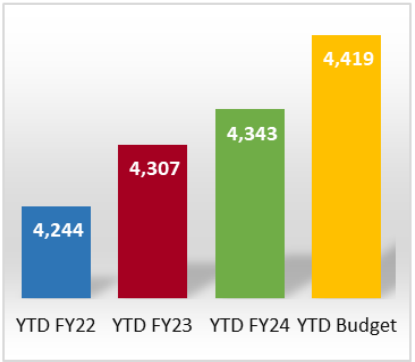
Radiology – Main Campus



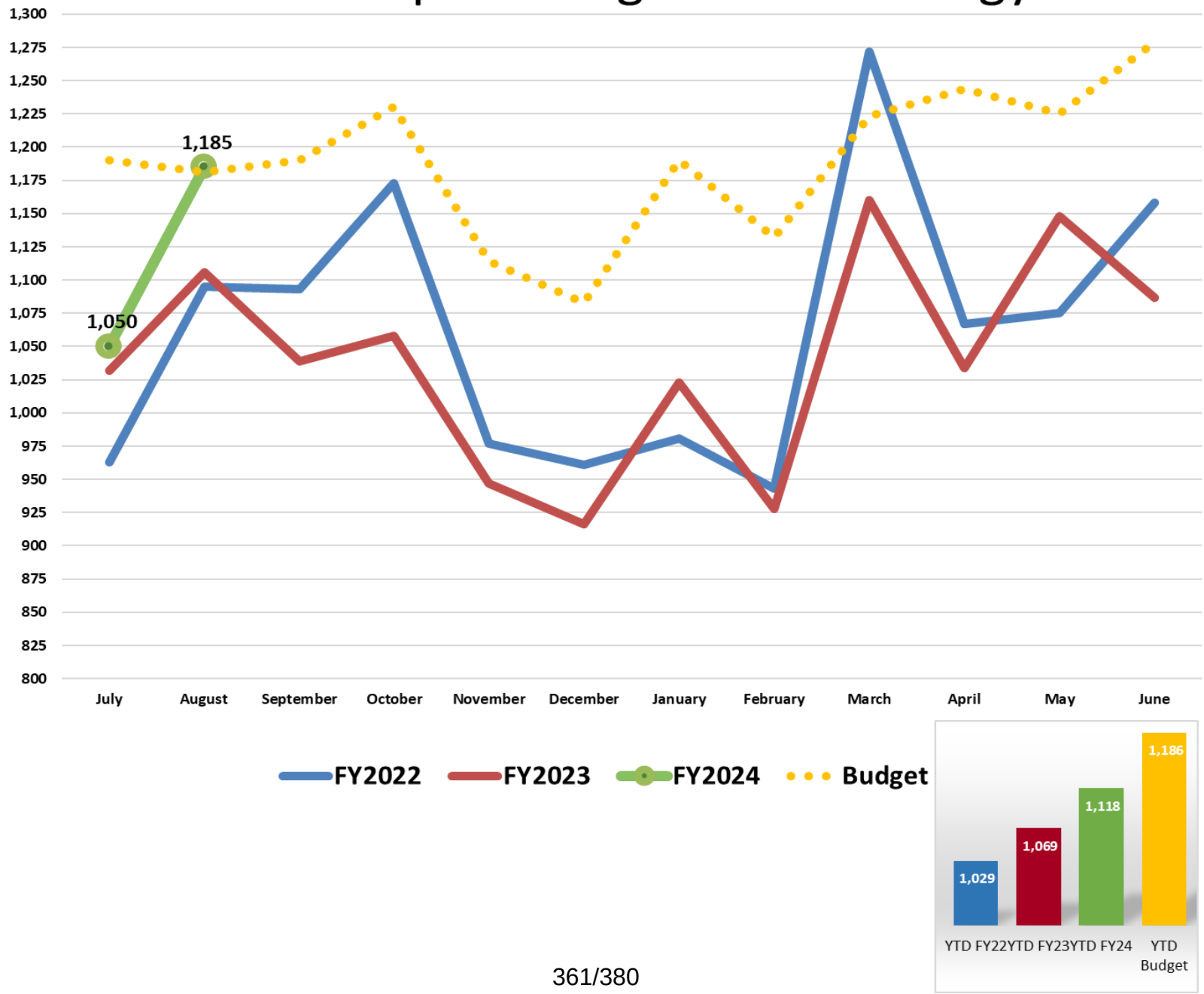


Radiology - West Campus Imaging

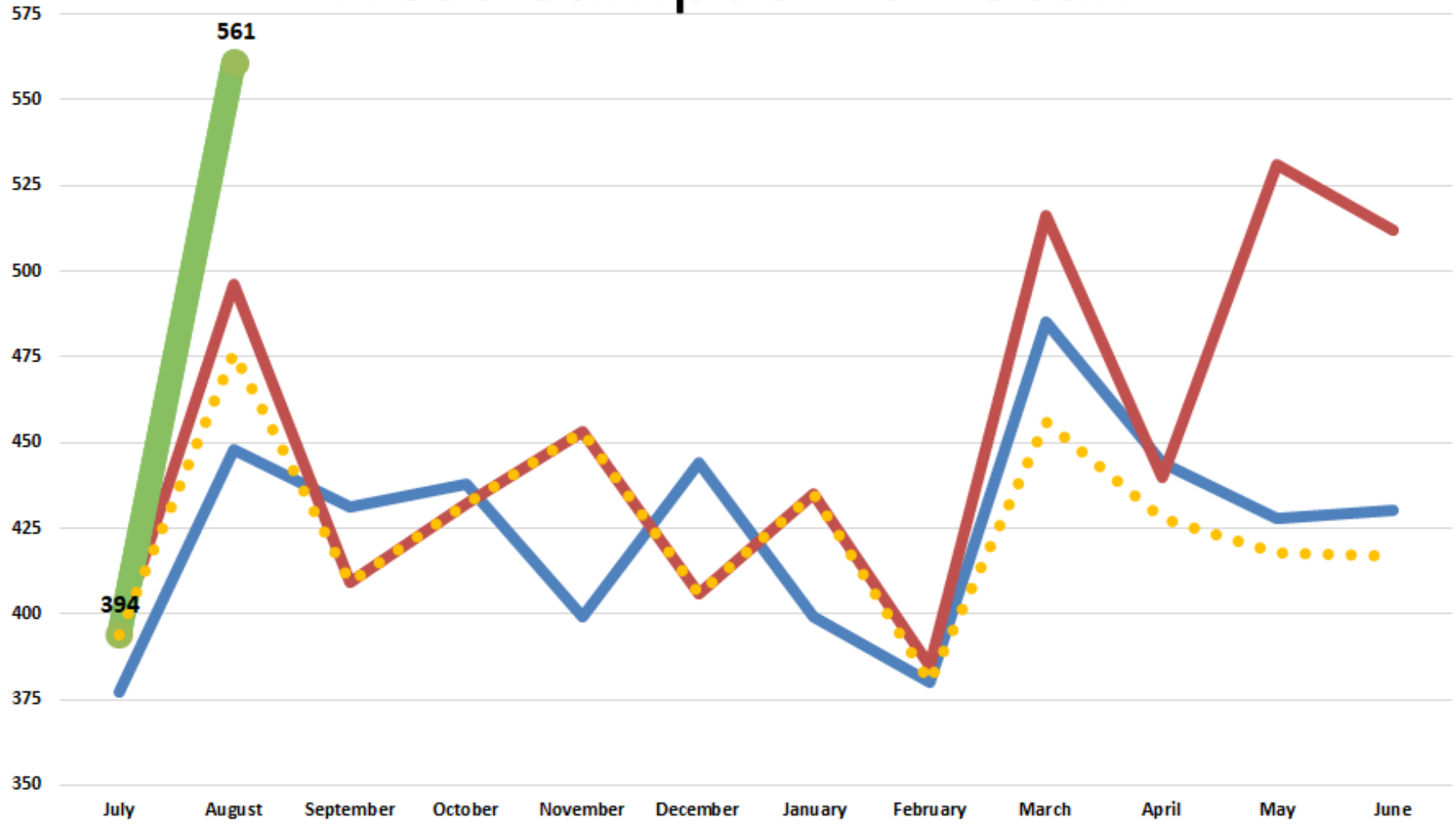


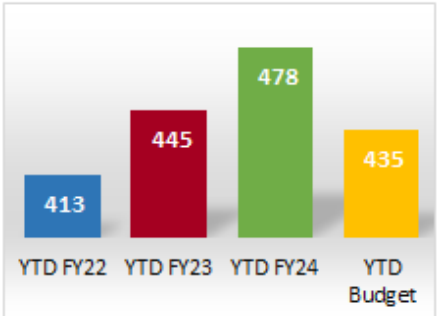


West Campus - Diagnostic Radiology

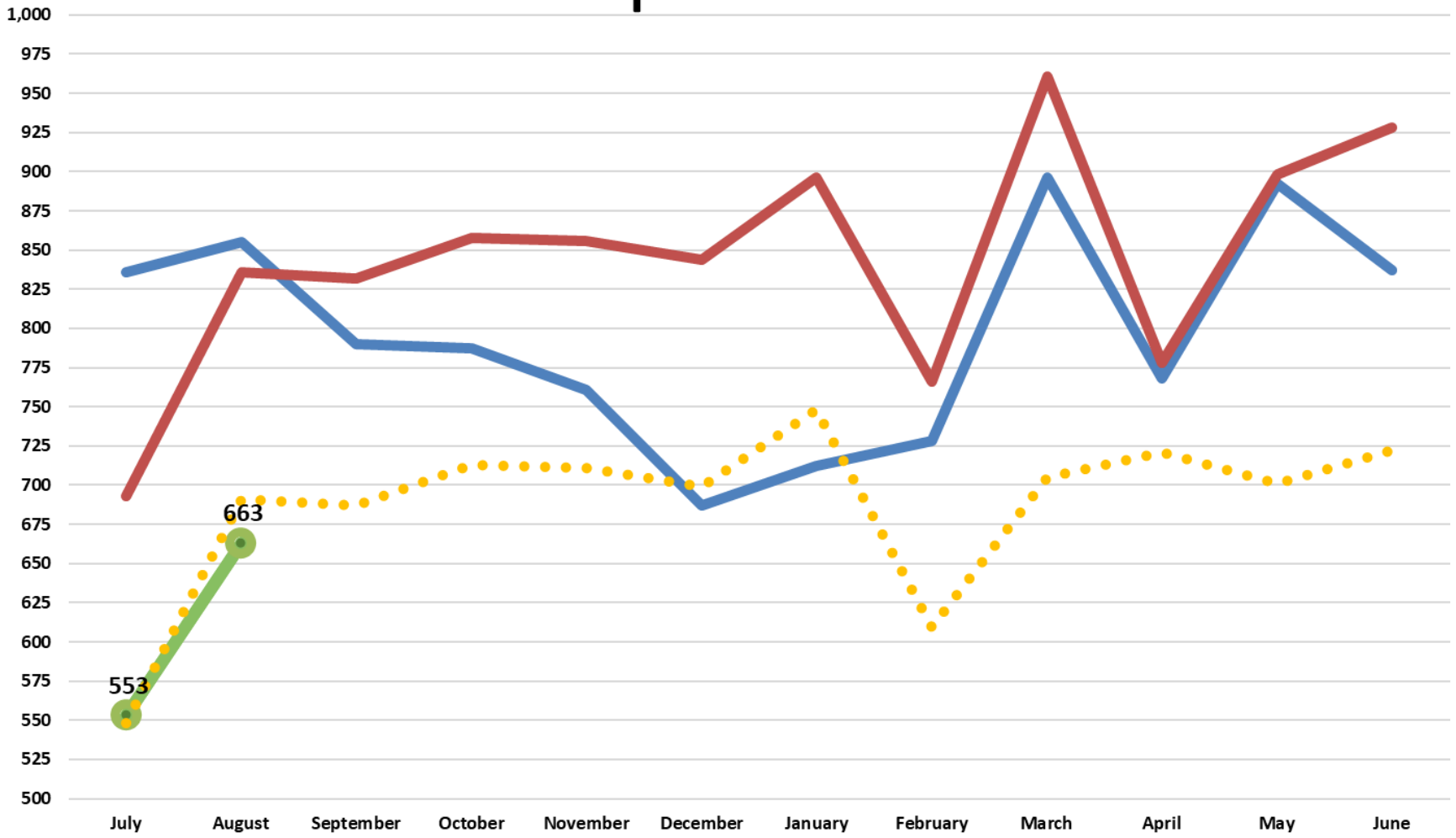


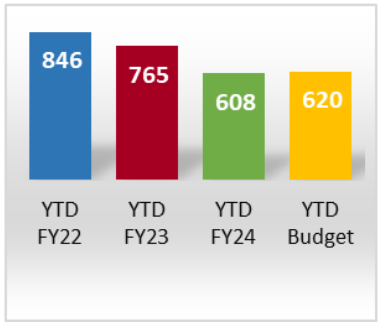
West Campus - CT Scan



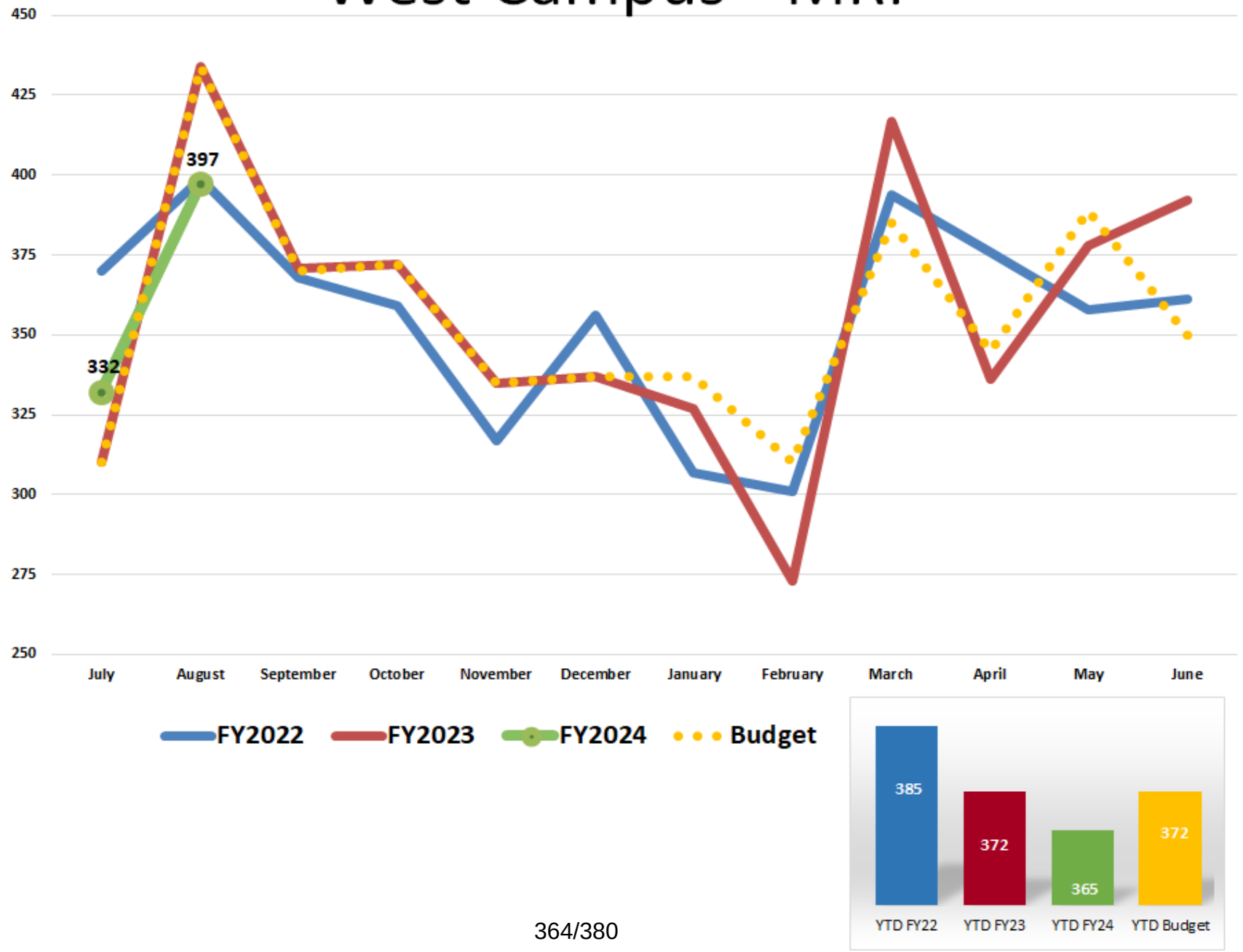


West Campus - Ultasound

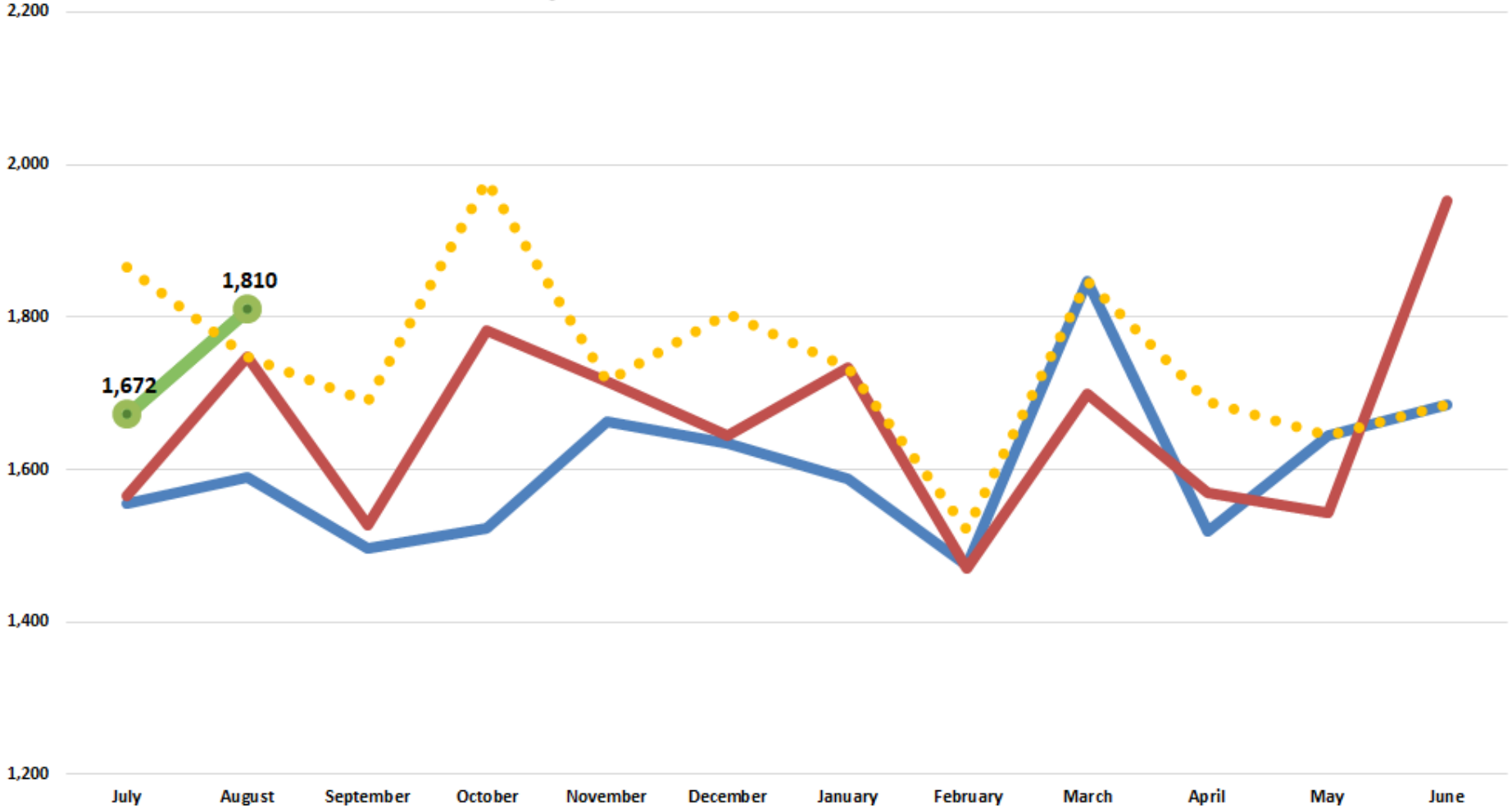


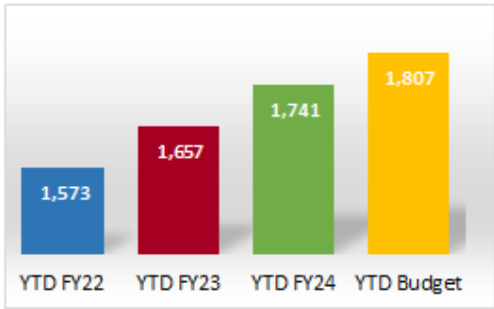


West Campus - MRI

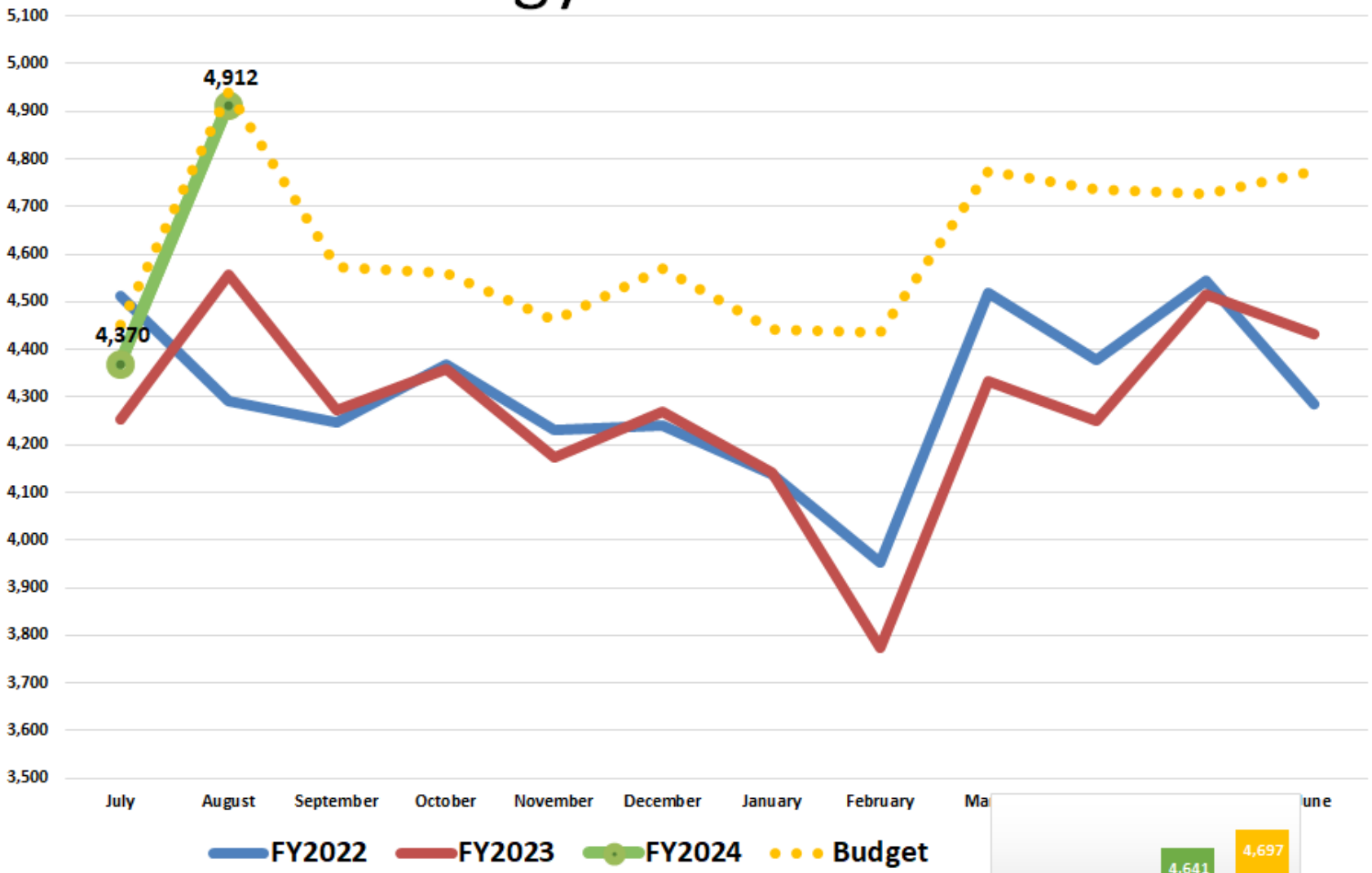


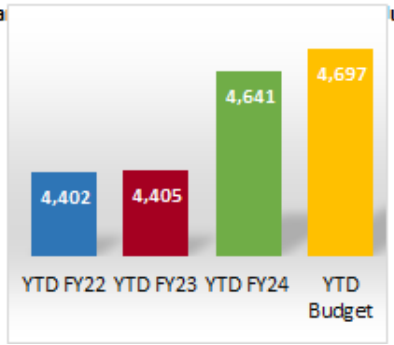
West Campus - Breast Center



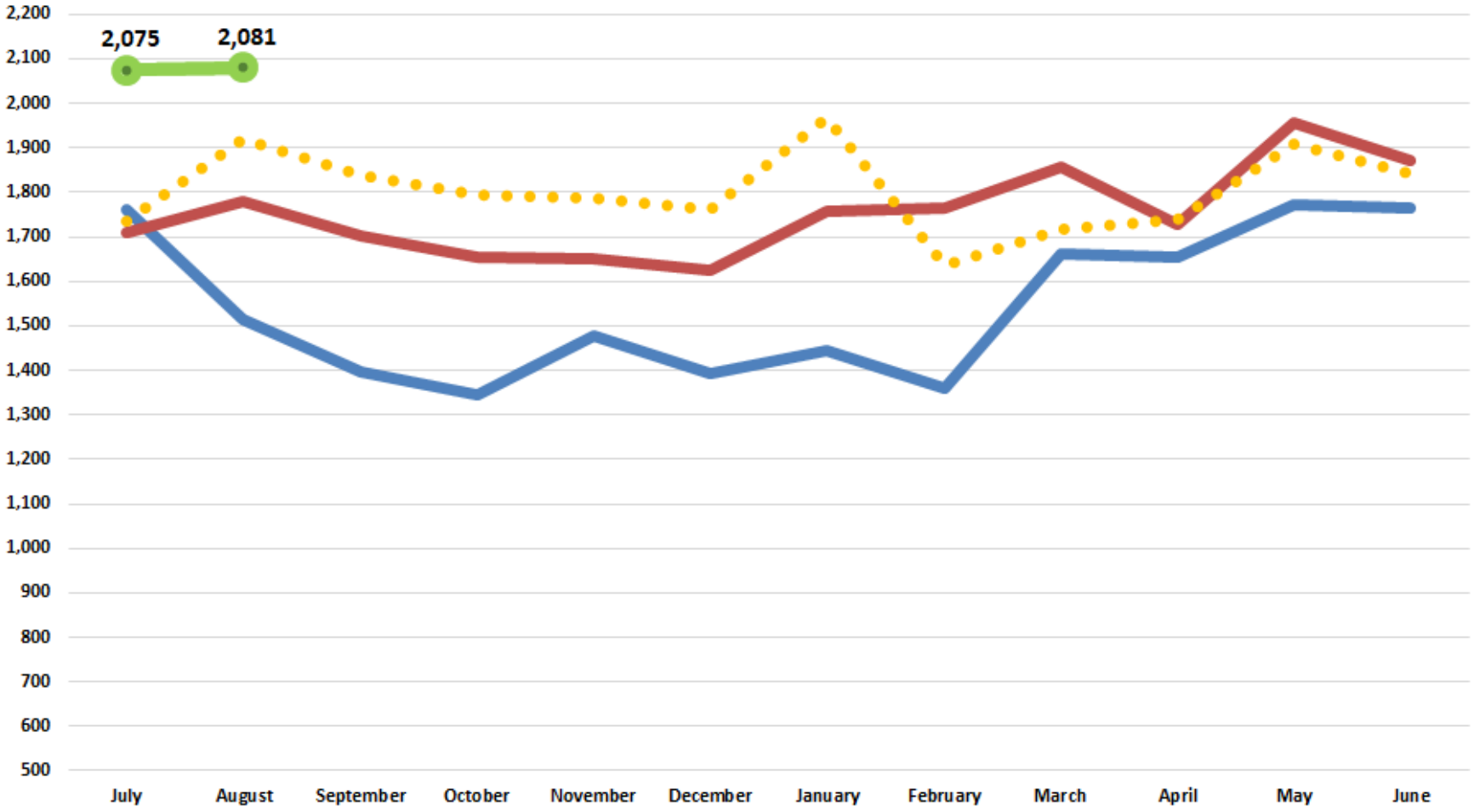


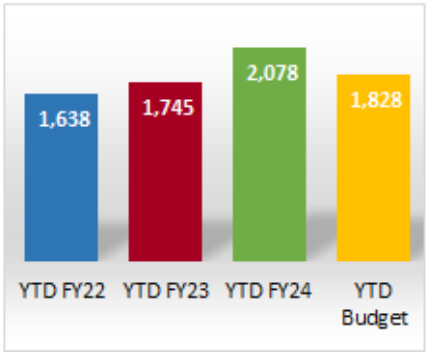
Radiology - CT - All Areas



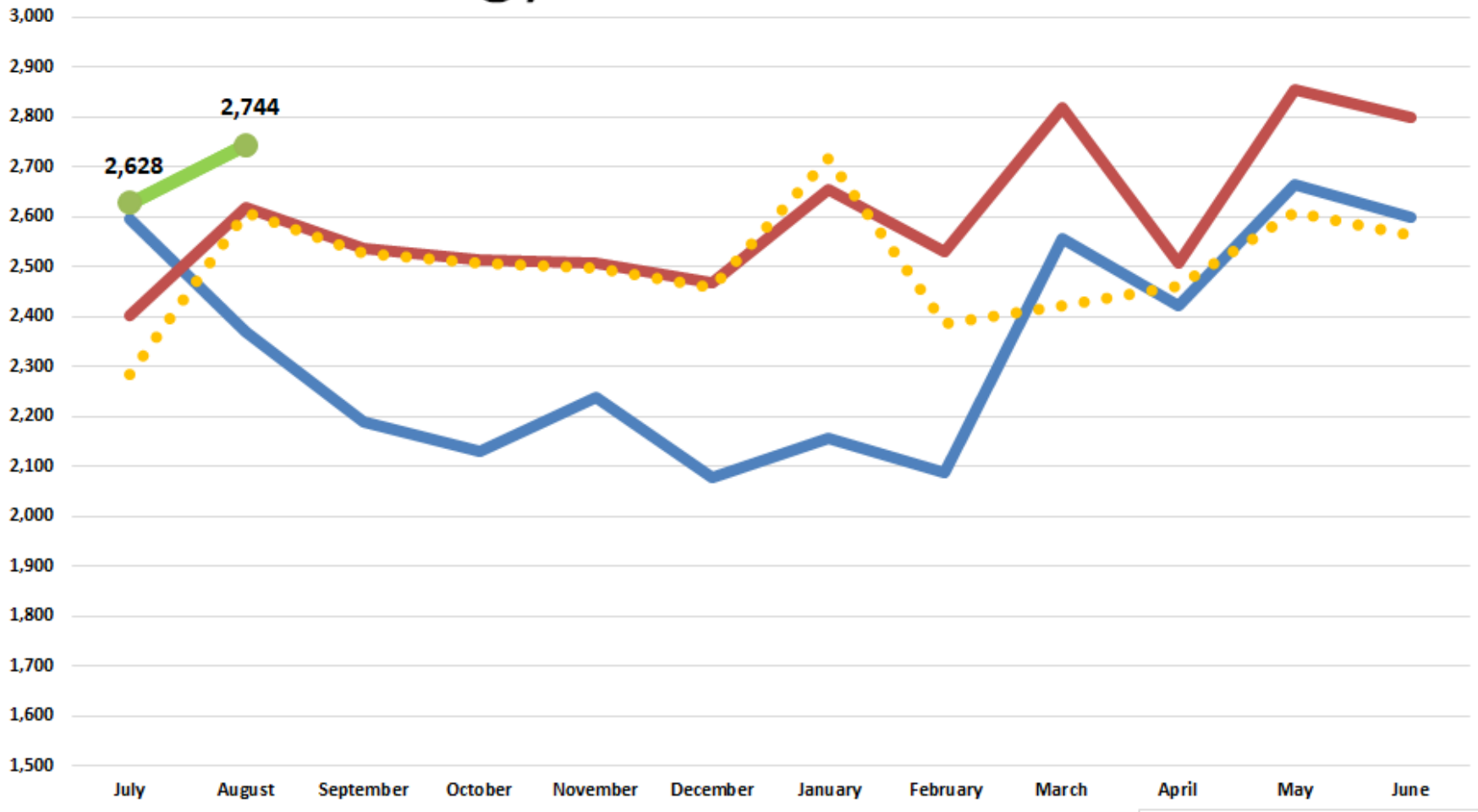


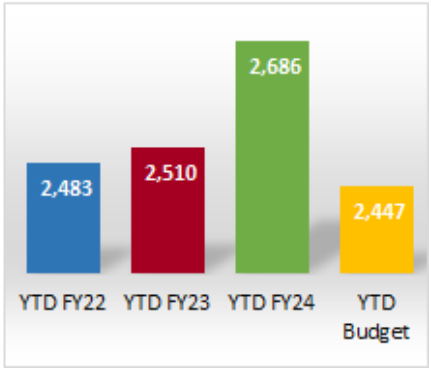
Radiology - Ultrasound - Main Campus



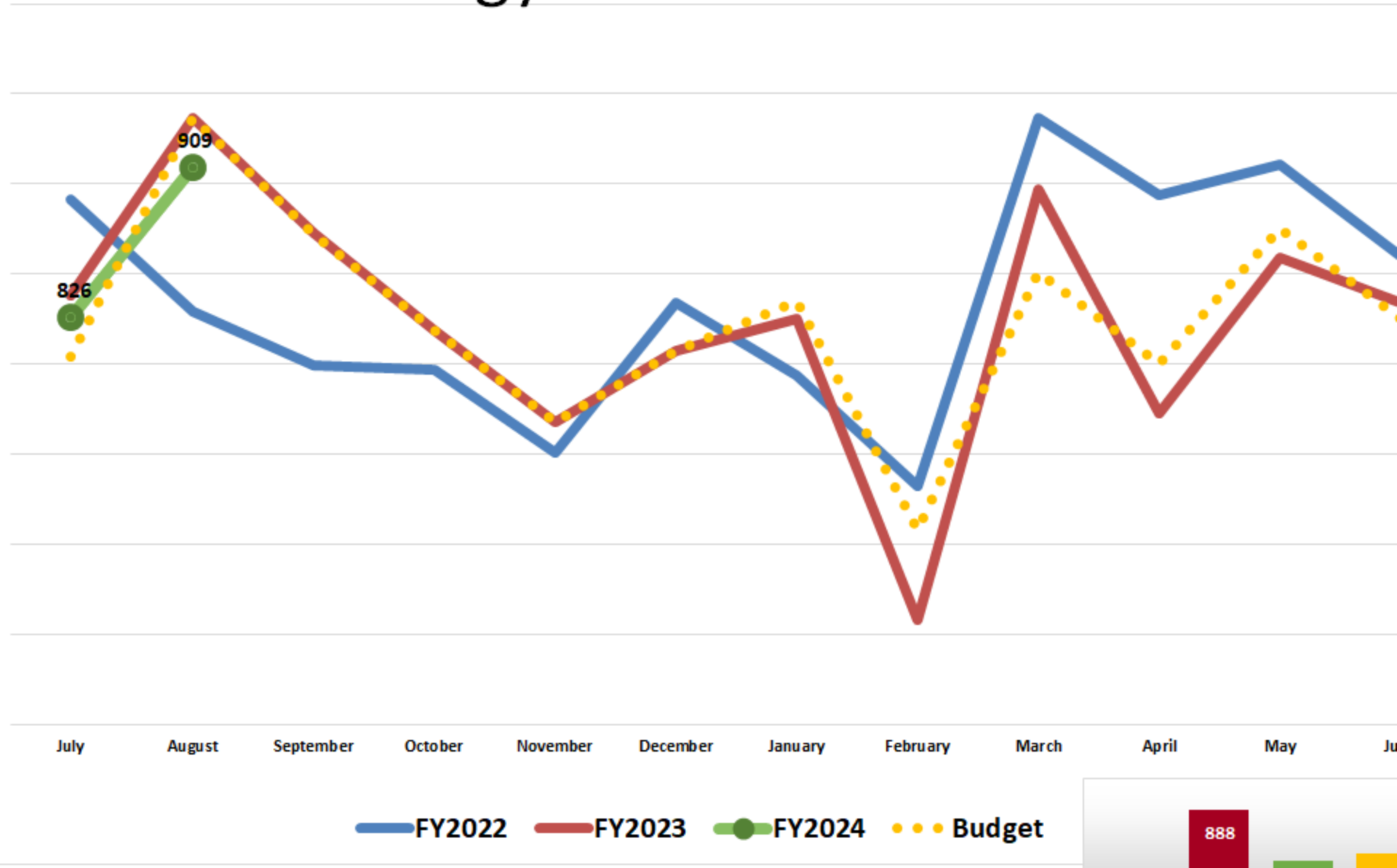


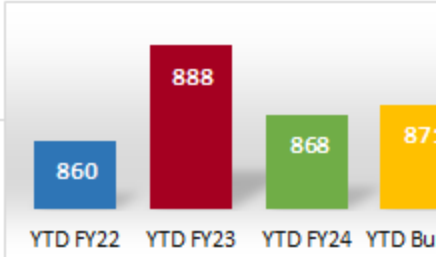
Radiology - Ultrasound - All Areas



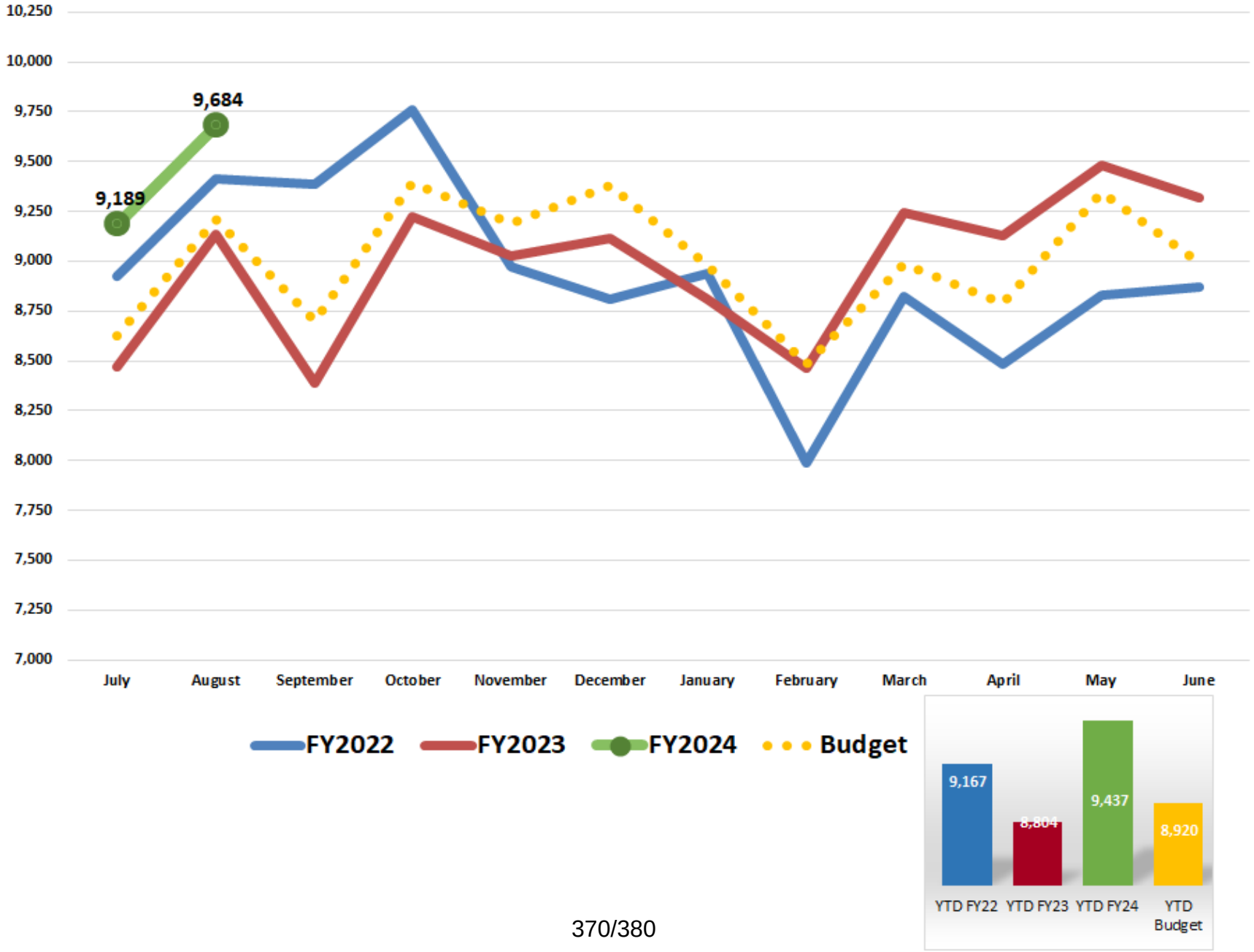


Radiology - MRI - All Areas

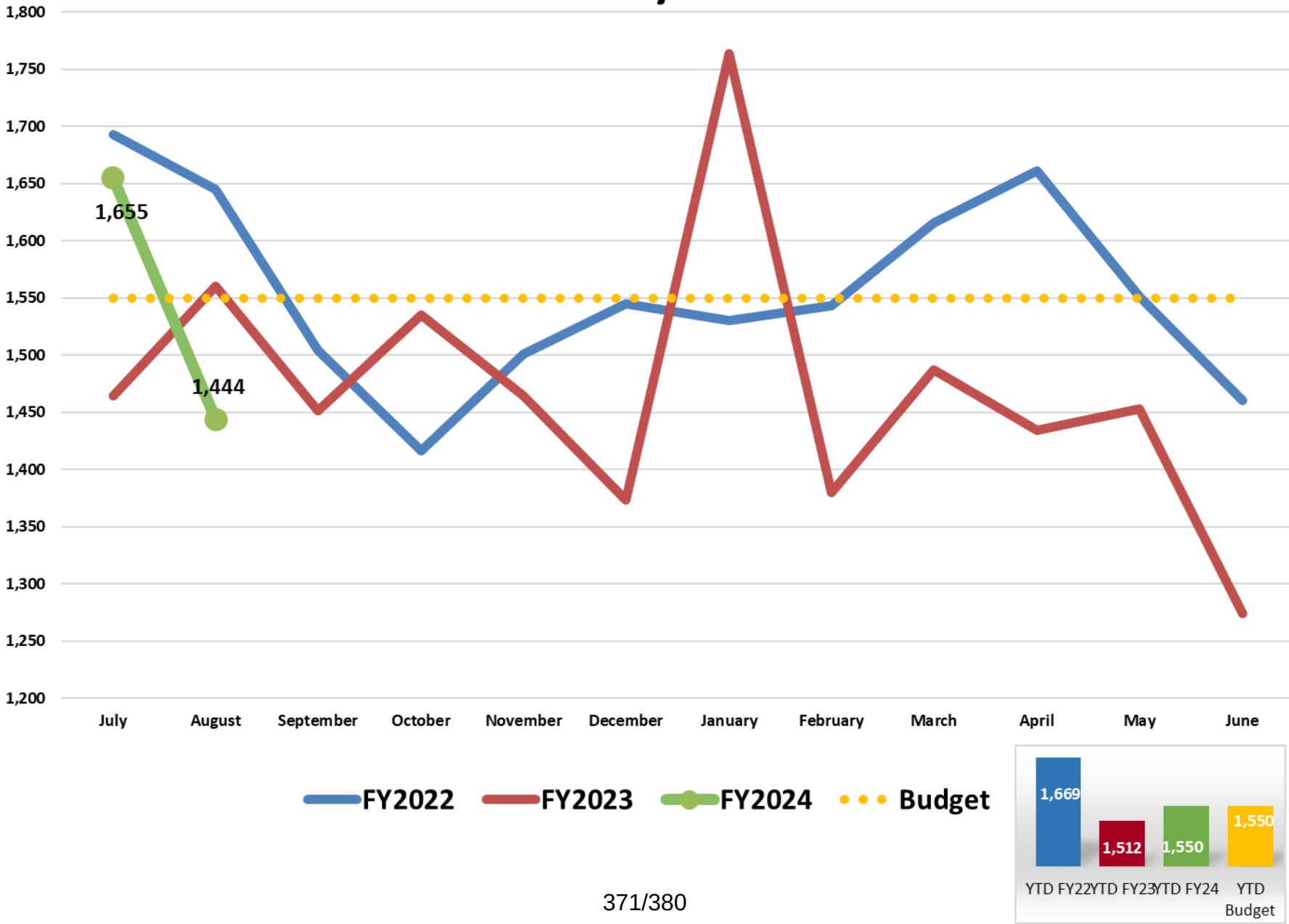




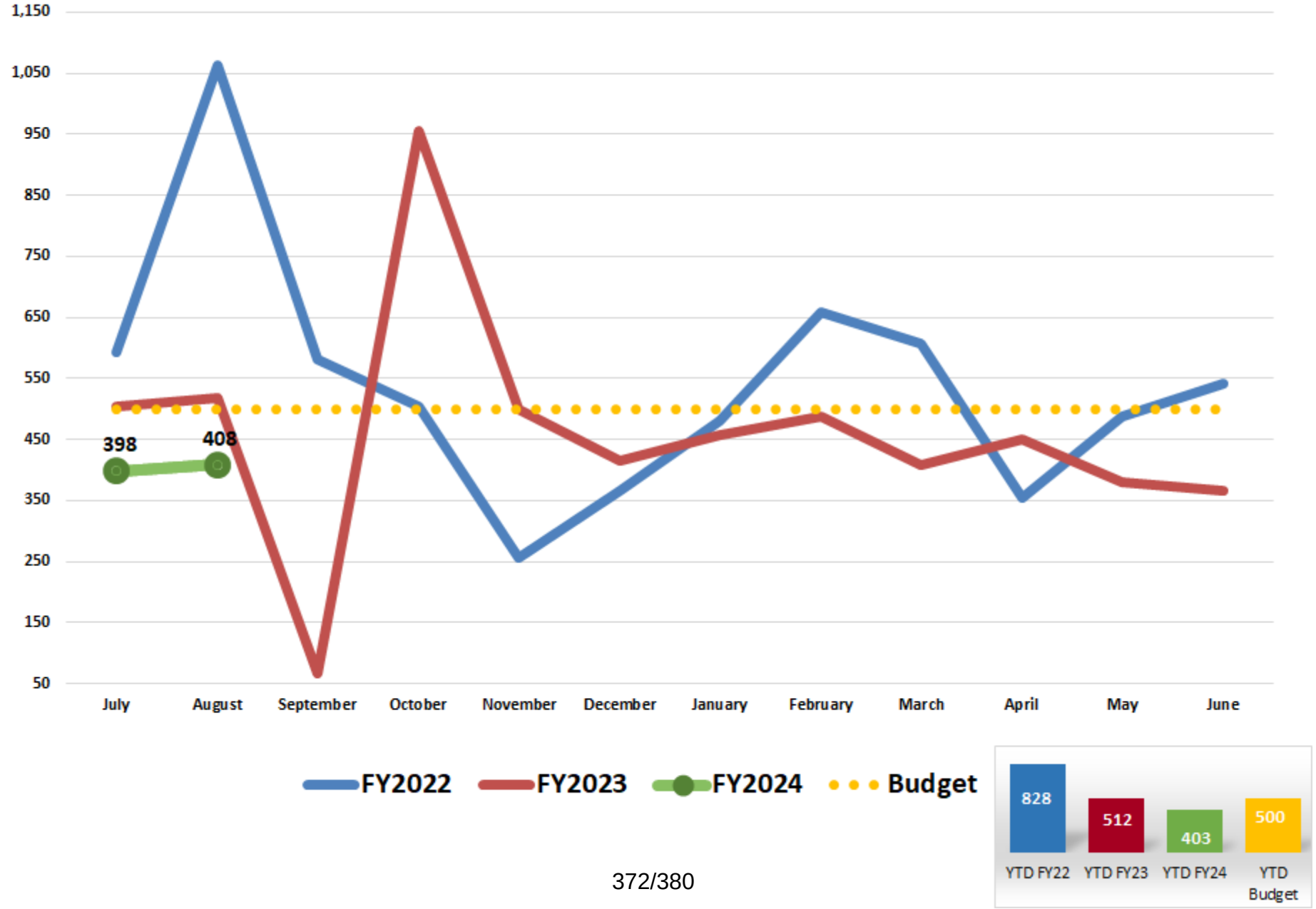
Radiology Modality - Diagnostic



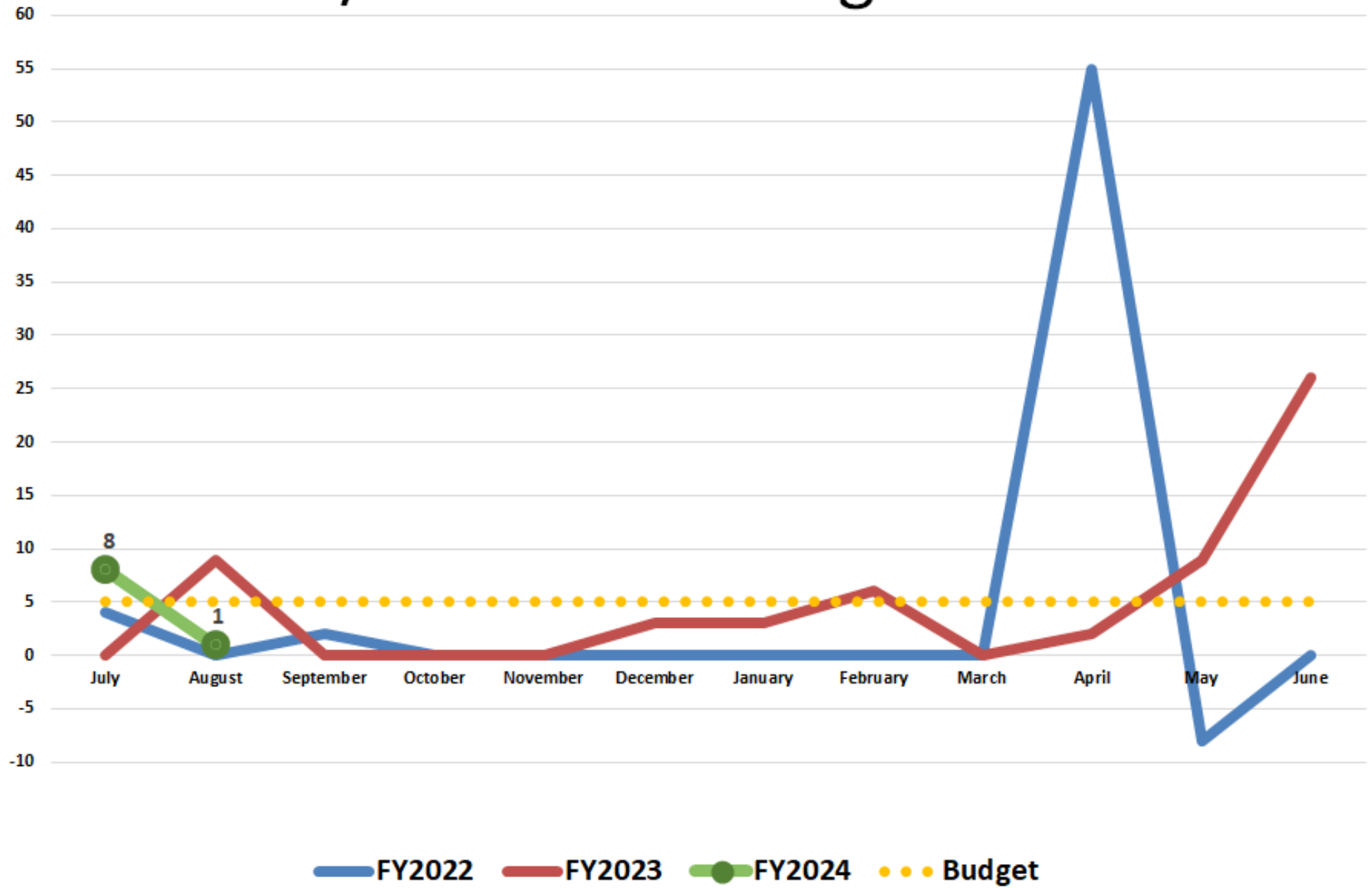
Chronic Dialysis - Visalia

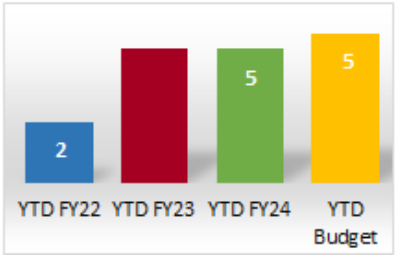


CAPD/CCPD - Maintenance Sessions

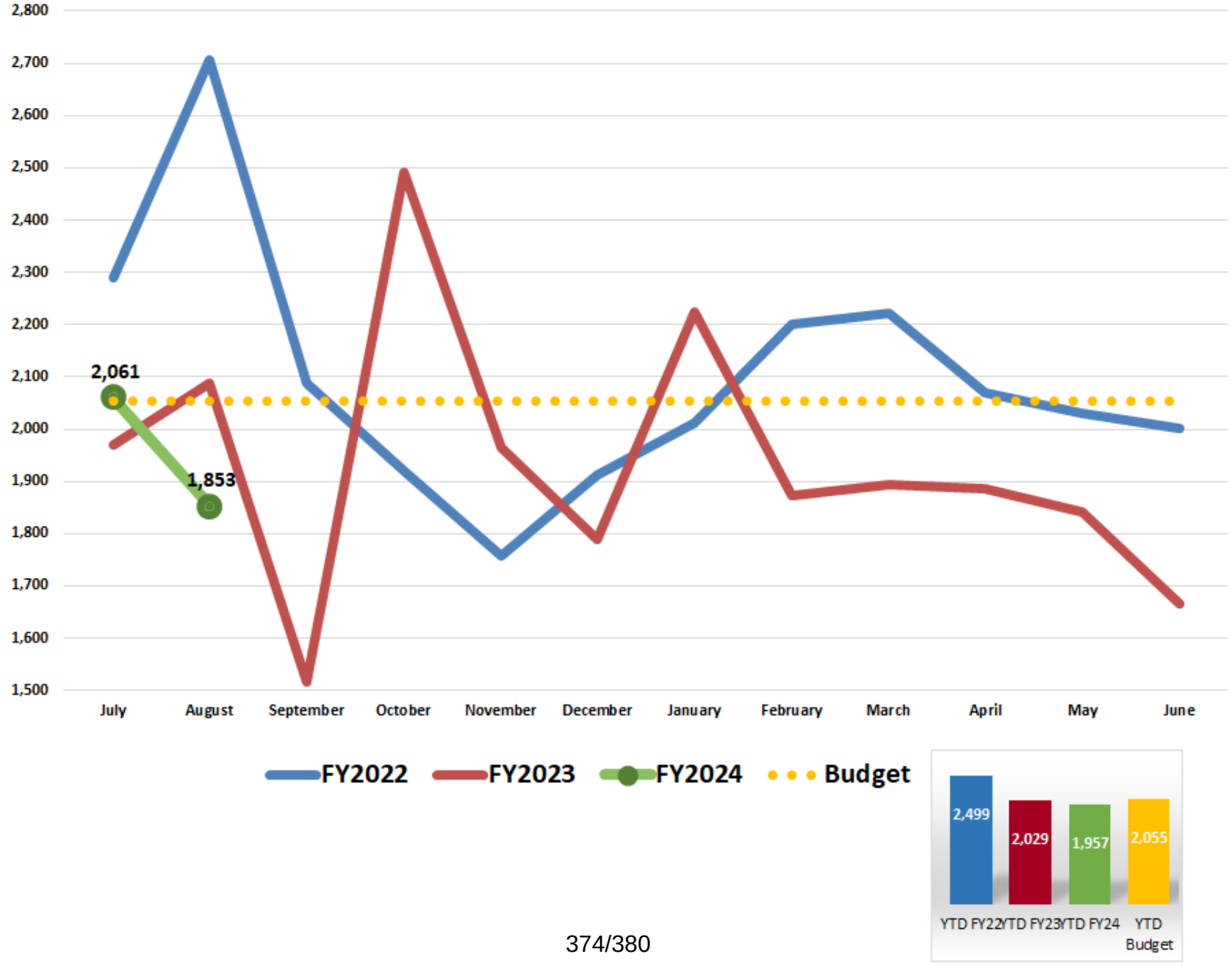


CAPD/CCPD - Training Sessions

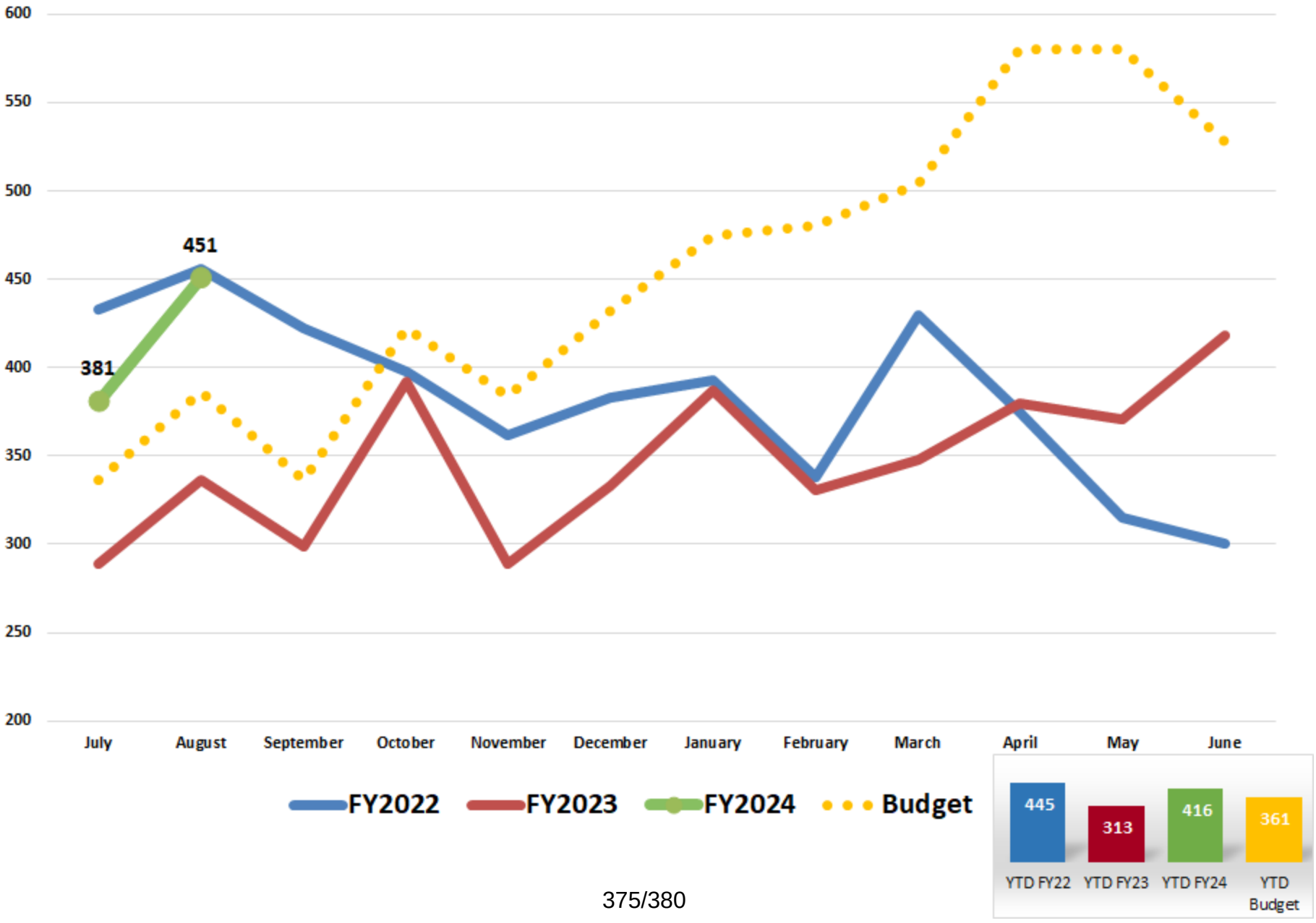




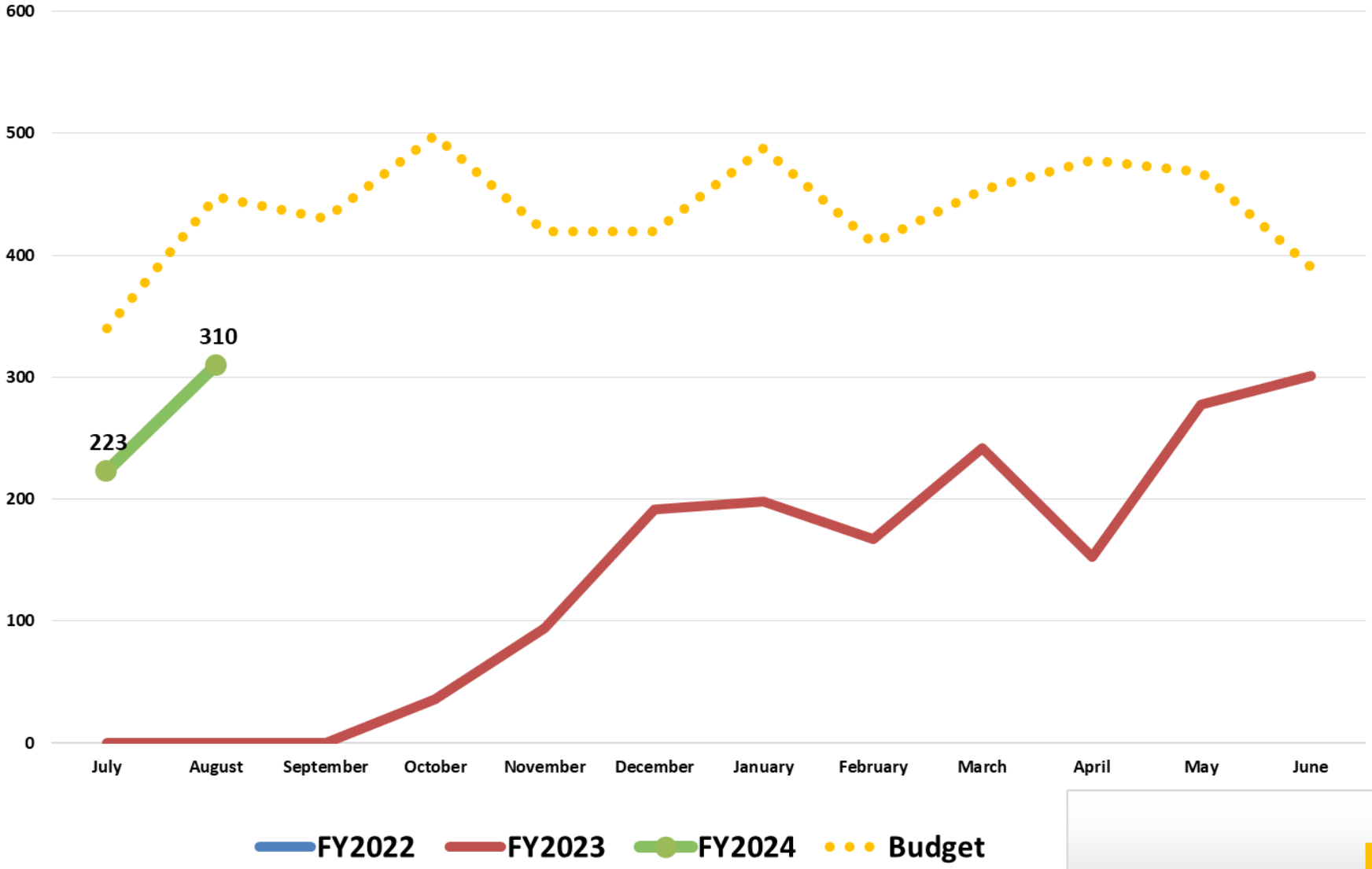
All CAPD & CCPD

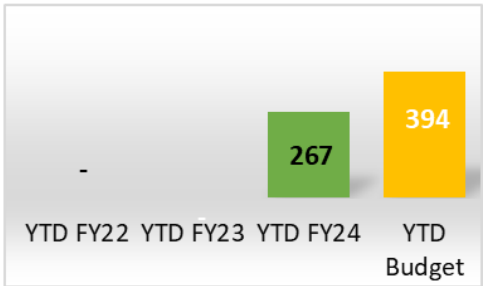


Infusion Center - Outpatient Visits

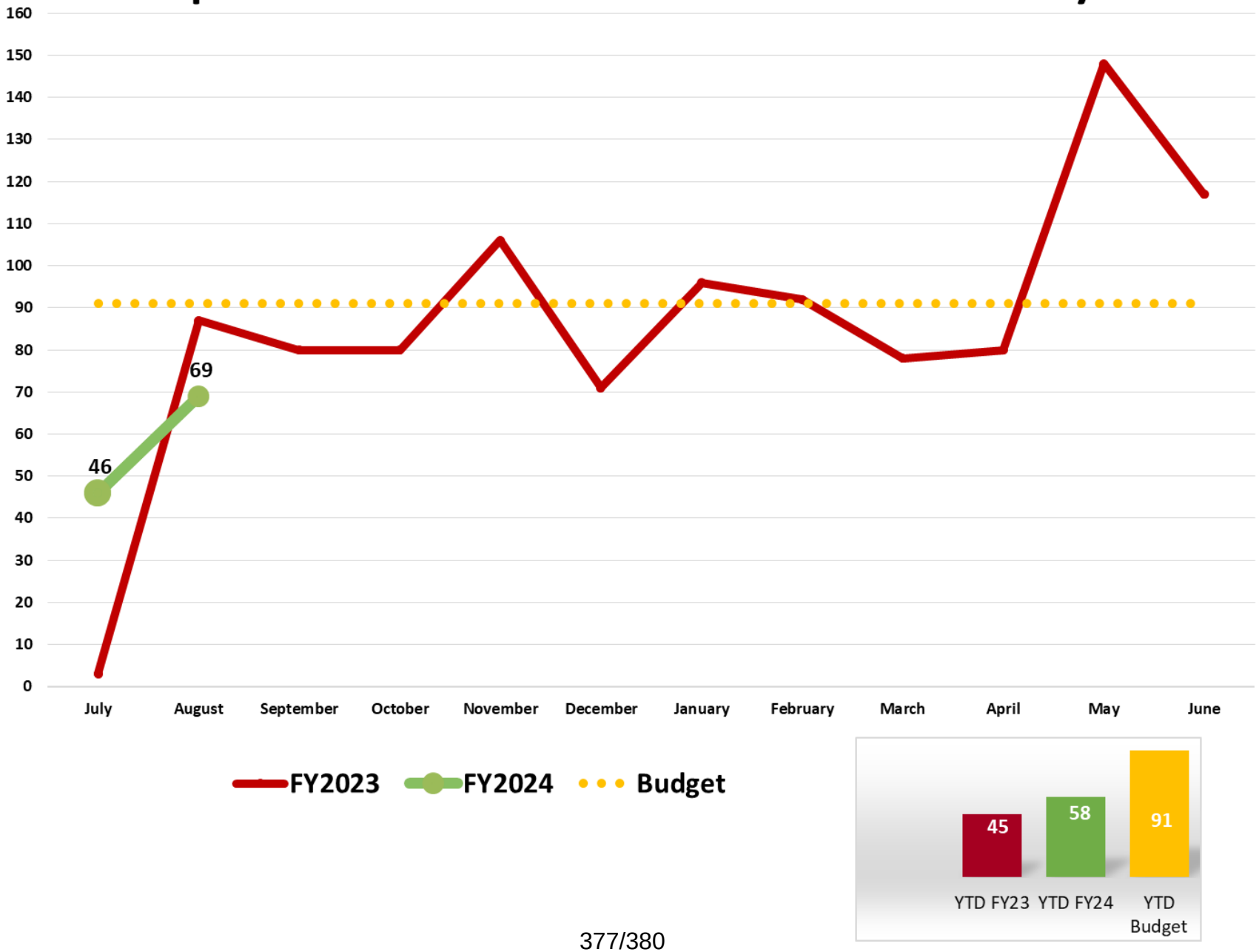


Urology Clinic Visits

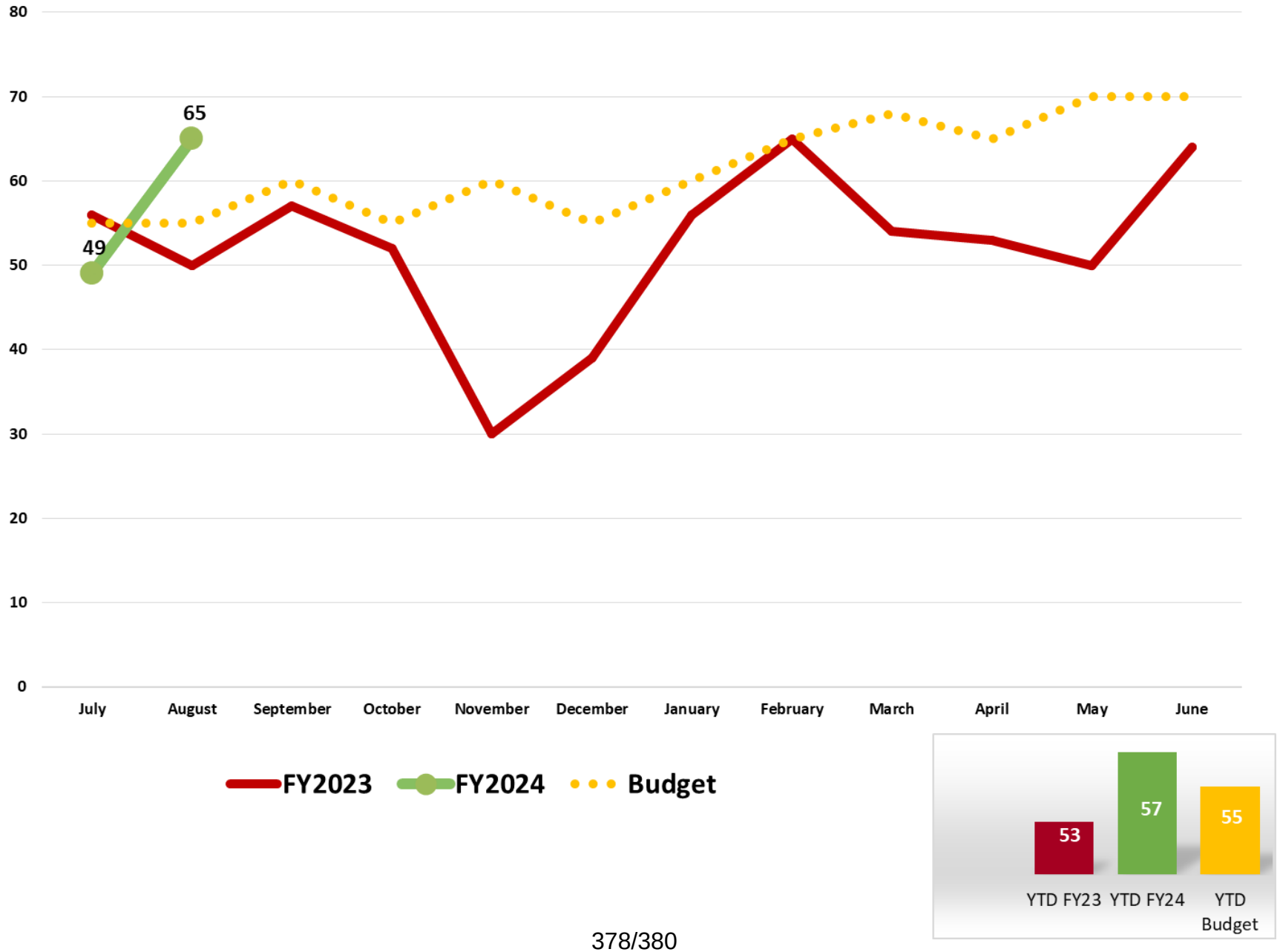




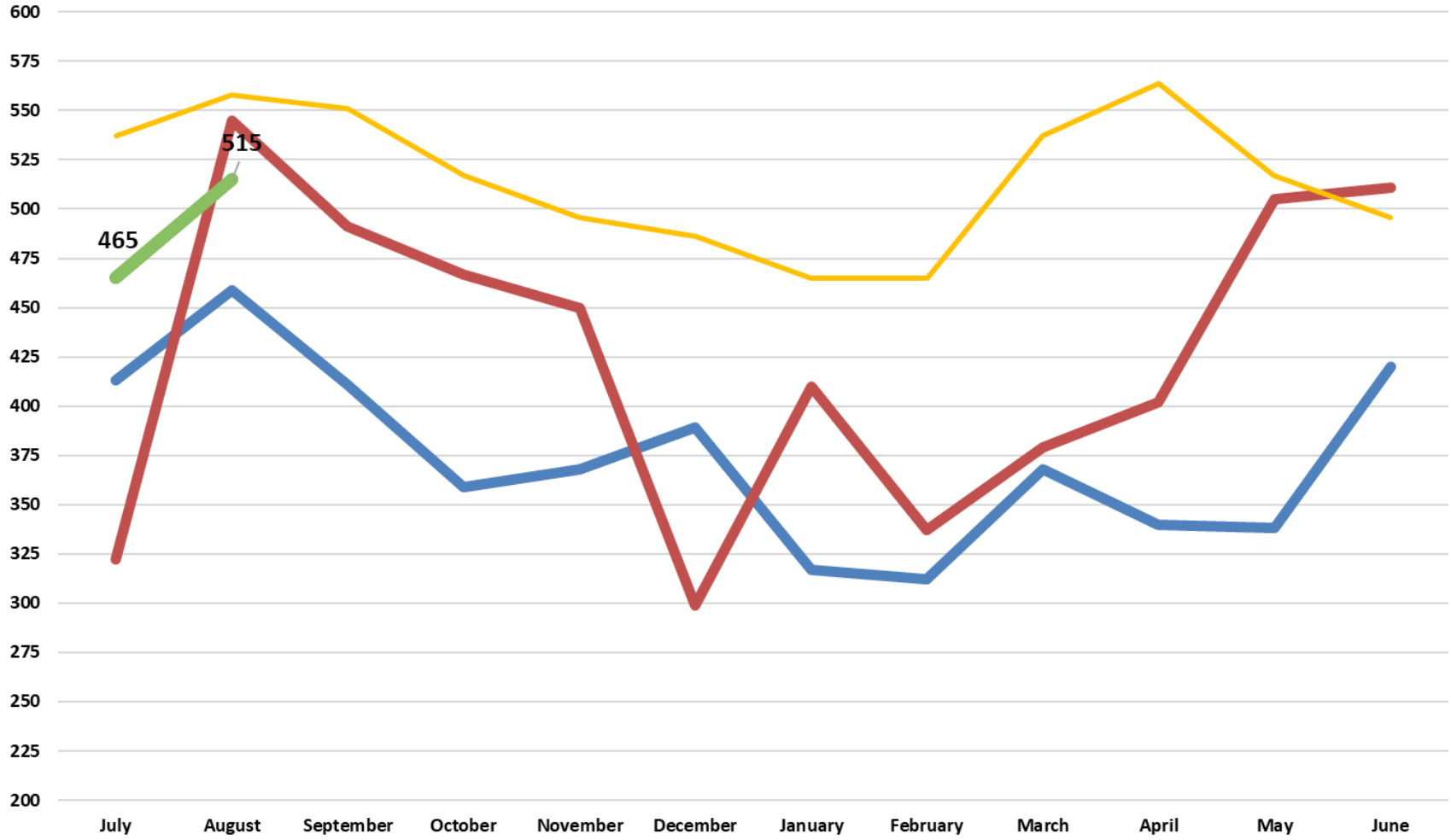
Open Arms House - Patient Days

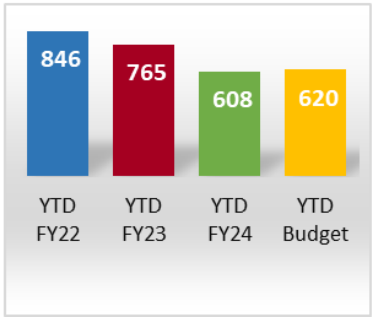


Cardiothoracic Surgery Clinic - Visits



Cardiac Rehabilitation





Therapy-Wound Care