August 18, 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 August 23, 2023: 4:00PM Open Meeting; 4:01PM Closed meeting pursuant to Government Code 54956.9(d)(2), Health and Safety Code 1461 and 32155; 4:30PM Open Meeting followed by a Closed meeting pursuant to Government Code 54957(b)(1).

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, CA

Wednesday August 23, 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. **Conference with Legal Counsel** – Existing Litigation {Shipman v. KDHCD Case #VCU287291 – Pursuant to Government Code 54956.9(d)(1) – *Richard Salinas, Legal Counsel*
    2. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 3 Cases **-** *Rachele Berglund, Legal Counsel and Evelyn McEntire, Director of Risk Management*
    3. **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*
    4. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Daniel Hightower, MD, Chief of Staff*
    5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Daniel Hightower, MD, Chief of Staff*
    6. **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.

Action Requested – Approval of the August 23, 2023 closed meeting agenda.

5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

CALL TO ORDER

1. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION** – Pursuant to Government Code 54956.9(d)(1) - Shipman v. KDHCD Case #VCU287291.

   Richard Salinas, Legal Counsel

2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 3 Cases.

   Evelyn McEntire, Director of Risk Management and Rachele Berglund

3. **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***.**

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

   Daniel Hightower, MD, Chief of Staff

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

   Daniel Hightower, MD, Chief of Staff

6. **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.

   Action Requested – Approval of the closed meeting minutes – July 26, 2023.

   ADJOURN

OPEN MEETING AGENDA {4:30PM}

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 July 26th 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 June 28th open board of directors meeting minutes.
6. **RECOGNITIONS** – *Director Francis*
   - **6.1.** Resolution 2201 for George Shroyer, Physical Therapy Assistant III, retiring with 33 years of service.
   - **6.2.** Resolution 2202 for Francisco Lizaola, Environmental Services Aide, retiring with 14 years of service.
   - **6.3.** AHA Silver Award – Kaweah Health Rapid Response Team
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
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 August 23rd Consent Calendar.

9.1. REPORTS

A. Strategic Plan
B. Compliance
C. Physician Recruitment

9.2. POLICIES – ADMINISTRATIVE

A. AP10 – Occurrence Reporting Process (Revised)
B. AP35 – Computer Software Usage (Revised)
C. AP86 – Disposals of Equipment (Revised)
D. AP107 - Patient Privacy Use and Disclosure of Patient Information (Revised)
E. AP110 – Reporting requirements for drug diversion illegal substance abuse or controlled substance abuse (Revised)
F. AP180 – Weapons Brought Into The District (Revised)
G. AP22 – Scheduling Meeting and/or Conference Rooms within District facilities (Reviewed)
H. AP53 – Patients' Rights and Responsibilities, and Non-Discriminiation (Revised)
I. AP116 – Public Information Request Policy (Reviewed)

9.3. POLICIES – BOARD OF DIRECTORS

A. BOD1 – Orientation of a New Board Member (Reviewed)
B. BOD2 – Chief Executive Officer (CEO) Transition (Revised)
C. BOD3 – CEO Criteria (Reviewed)
D. BOD4 – Executive Compensation (Revised)
E. BOD5 – Conflict of Interest (Revised)
F. BOD6 – Board Reimbursement for Travel and Service Clubs (Revised)
G. BOD7 - Presentation of Claims and Service Process (Revised)

9.4. POLICIES – ENVIRONMENT OF CARE

A. EOC 1001 Safety Management Plan / Revised
B. EOC 1002 Environment of Care Communication Flow Chart / Revised
C. EOC 1020 Indoor Air Quality / Revised
D. EOC 1031 Utility Failures and Repair / Revised
E. EOC 1035 Disruption of Service, Medical Gas / Revised
F. EOC 1040 Failure of High Pressure Boilers / Revised
G. EOC 1041 Disruption of Service, Elevator / Revised
H. EOC 1042 Failure of Fire Alarm System / Revised
I. EOC 1043 Failure or Absence of Nurse Call System While Caring for Patient / Revised
J. EOC 1045 Failure of Piped Vacuum Systems and Compressed Air / Revised
K. EOC 1085 District Electrical Safety / Revised
L. EOC 4404 Formaldehyde Spill / Revised
M. EOC 5000 Fire Prevention Management Plan / Revised

N. EOC 5003 Fire Watch / Revised
O. EOC 5010 Fire Prevention Code Compliance / Revised
P. EOC 5041 Department Decorations / Revised
Q. EOC 6007 Storage and Warming of Blankets in Warming Cabinets / Revised
R. EOC 6009 Safe Medical Device Act/Medical Device Tracking and Reporting / Revised
S. EOC 6012 Non Healthcare District Equipment Preventative Maintenance and Repair / Revised
T. EOC 7001 Utilities Management Plan / Revised
U. EOC 6002 Medical Equipment Defective Device Repair Policy / Reviewed
V. EOC 6018 Retirement/Deletion of Medical Equipment From MEM Program / Reviewed

9.5. POLICIES – EMERGENCEY MANAGEMENT

A. DM 2104 Emergency Impact Assessment / Revised
B. DM 2107 Media Plan / Revised
C. DM 2109 Program Management- Emergency Management Committee / Revised
D. DM 2111 Dependent Care Plan / Revised
E. DM 2112 Elevator Use During Emergency Situations / Revised
F. DM 2115 Person In Charge (Initial Response Coordinator) / Revised
G. DM 2116 Reporting For Duty/Building Access / Revised
H. DM 2117 Staff Support Plan / Revised
I. DM 2202 Code Blue/Code White Activation / Revised
J. DM 2203 Code Gray- Activation Plan / Revised
K. DM2204 Code Silver-Activation Plan / Revised
L. DM 2205 Code Pink- Infant Abduction / Revised
M. DM 2207 Code Red-Activation / Revised
N. DM 2208 Code Yellow – Bomb Threat / Revised
O. DM 2210 Code Orange- Hazardous Material Spill/Release / Revised
P. DM 2212 Earthquake Response / Revised
Q. DM 2215 Internal Flood- Activation Plan / Revised
R. DM 2218 Anhydrous Ammonia Safety Procedures / Revised
S. DM 2230 Radioactive Disaster Management / Revised
T. DM 2231 Radioactive Disaster Procedure / Revised
U. DM 2411 Volunteer Practitioners in the Event of a Disaster / Revised
V. DM 2216 Water Systems Failure/Disruption / Reviewed

9.6. POLICIES – EMPLOYEE HEALTH SERVICES

A. EHS. 05 Influenza Prevention {revised}
B. EHS. 06 Work Related Injury and Illness and Workers' Compensation {revised}
C. EHS. 11 Immunization Requirements {revised}

D. EHS. 14 Covid 19 Prevention Program {revised}
E. EHS. 17 Aerosol Transmissible Diseases Exposure Control Plan {revised}
F. EHS. 03 Ergonomics {delete}

9.7. POLICIES – HUMAN RESOURCES

A. HR. 04 Special Pay Practices {revised}
B. HR. 12 Equal Employment Opportunity {revised}
C. HR. 31 Transfers {revised}
D. HR. 28 Recruitment and Selection of Staff Members {revised}
E. HR. 36 New Hire Processing {revised}
F. HR. 49 Education Assistance {revised}
G. HR. 62 Exempt Employees Pay/Salary {revised}
H. HR. 63 Timekeeping of Payroll Hours {revised}
I. HR. 70 Meal Periods, Rest Breaks and Breastfeeding, and/or Lactation Accommodation {revised}
J. HR. 145 Family Medical Leave/CA Family Rights Act Leave of Absence {revised}
K. HR. 149 Bereavement Leave {revised}
L. HR. 184 Attendance and Punctuality {revised}
M. HR. 213 Performance Management and Competency Assessment {revised}
N. HR. 216 Progressive Discipline {revised}
O. HR. 234 PTO EIB and Healthy Workplace {revised}
P. HR. 239 Extended Illness Bank Donations {revised}
Q. HR. 241 Paid Time Off Cash Out {revised}

9.8. Approval of rejection of claim - Carolyn Zamudio vs. Kaweah Delta Health Care District.

9.9. Approval of returned claim – no action taken – Marty Potts

9.10. Approval of returned claim – no action taken – Deanna Potts

9.11. Recommendations from the August 2023 Medical Executive Committee:+-

A. Privilege Form – Neurology
B. Medical Staff Policy - MS.29 – Documenting current clinical competency (Co-management/Co-Admit).
C. Medical Staff Policy – MS.47 – Code of conduct for medical staff & Advanced Practice Providers.

10. **QUALITY – KAWEAH HEALTH CERTIFIED STROKE PROGRAM** – a review of key quality metrics and action plans associated with the care of the stroke population.

Sean Oldroyd, DO, Stroke Program Medical Director

11. **STRATEGIC PLAN - ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY** – Detailed review of Strategic Plan Initiative.

    Jag Batth, Chief Operating Officer & Rebekah Foster, Director Care Management / Speciality Care

12. **PATIENT THROUGHPUT PERFORMANCE** - Review of patient throughput performance improvement progress report.

    Jag Batth – Chief Operating Officer

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

    Malinda Tupper – Chief Financial Officer Chief Financial Officer

13. **REPORTS**
    - **13.1.** Chief Executive Officer Report - Report relative to current events and issues.
      Gary Herbst, Chief Executive Officer
    - **13.2.** Board President **-** Report relative to current events and issues.
      David Francis, Board President

14. **APPROVAL OF CLOSED AGENDA AS FOLLOWS:** Closed Meeting Agenda – Immediately following the 4:30PM open session
    - **14.1. CEO Evaluation** – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1) – *Gary Herbst, CEO, Rachele Berglund, Legal Counsel & Board of Directors*

15. **ADJOURN**

CLOSED MEETING AGENDA

1. **CALL TO ORDER**

2. **CEO EVALUATION** – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1).
   Gary Herbst, CEO. Rachele Berglund, Legal Counsel & Board of Directors

3. **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.

KAWEAH DELTA HEALTH CARE DISTRICT

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JULY 26, 2023 AT 3:30PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Havard Mirviss, Rodriguez & Olmos; D. Hightower, MD, 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, W. Brien, MD CMO/CQO; R. Berglund, Legal Counsel; and C. Moccio recording

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

Director Francis entertained a motion to approve the agenda.

MMSC (Havard Mirviss/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 – 3:31PM

- **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) – *Rachele Berglund, Legal Counsel and Evelyn McEntire, Director of Risk Management*
  - Rice vs Kaweah Delta Health Care District, Kaweah Delta District Hospital, Tu-Hi Hong, M.D.-Case # VCU295620
  - Newport vs Kaweah Delta Health Care District, Kaweah Delta District Hospital - Case # VCU295708
  - L.Vasquez vs Westgate Gardens Care Center, Inc, a California corporation, Kaweah Delta Care District, Kaweah Health Medical Center - Case # VCU294513
  - Benton vs Kaweah Delta Health Care District dba Kaweah Health Medical Center - Case # VCU295014
  - M.Vasquez vs Kaweah Health Medical Center; Eva Hirwe, M.D., Shamika Banks M.D. - Case # VCU297964
  - Williams vs Kaweah Health Medical Center; Jun Kim, D.O.- Case # VCU298276
  - Olivares vs Kaweah Delta Health Care, Inc., dba Kaweah Delta Healthcare District, and dba Kaweah Health Medical Center, Jessi Hill, M.D., Curt Lee Decker, C.R.T, Cynthia Rodriguez-Mendez, Alfredo Guerrero, D.O. - Case # VCU298480
  - Vanni vs Kaweah Health Medical Center; Kaweah Delta Health Care District; Cara Weese-Cooper, R.N.; Talaksoon Khademi, D.O.; G. Blaine Lake, M.D.- Case # VCU299235
- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 2 Cases **-** *Rachele Berglund, Legal Counsel and Evelyn McEntire, Director of Risk Management*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee —*Evelyn McEntire, Director of Risk Management*
- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **–** *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, Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Daniel Hightower, MD, Chief of Staff*
- **Approval of the closed meeting minutes** – June 28, 2023.

Director Francis requested the approval of the closed meeting agenda with the removal of closed agenda item 5 – Conference with Legal Counsel – Anticipated Litigation – 1 case.

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/Rodriguez) to approve the June 28, 2023 closed agenda with the removal of agenda item #5 – Conference with Legal Counsel – Anticipated Litigation – 1 case. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 3:31PM

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

ATTEST:

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 JULY 26, 2023 AT 4:00PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Havard Mirviss, Rodriguez & Olmos; D. Hightower, MD, 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, W. Brien, MD CMO/CQO; R. Berglund, Legal Counsel; E. McEntire, Director of Risk Management and C. Moccio recording

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

Director Francis asked for approval of the agenda.

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

PUBLIC PARTICIPATION – No comments.

CLOSED SESSION ACTION TAKEN: Approval the closed minutes from June 28, 2023.

OPEN MINUTES – Request approval of the open meeting minutes from June 28, 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/Rodriguez) to approve the open minutes from June 28, 2023. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, and Francis Abstained - Gipson

RECOGNITIONS

Presentation of Resolution 2199 to Martie Duyst, in recognition as the Kaweah Health World Class Employee of the month – July 2023.

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

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

Director Francis requested a motion for the approval of the credentials report.

MMSC (Havard Mirviss/Gipson) 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, Rodriguez, Gipson, and Francis

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

- No Report.

CONSENT CALENDAR – Director Francis entertained a motion to approve the July 26, 2023 consent calendar with the removal of item 9.3 {Approval of rejection of claim Carolyn Zamudio vs. Kaweah Delta Health Care District}.

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/Olmos) to approve the July 26, 2023 consent calendar with the removal of item 9.3 {Approval of rejection of claim Carolyn Zamudio vs. Kaweah Delta Health Care District}. This was supported unanimously by present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, Gipson, and Francis

QUALITY REPORT – **EMERGENCY MEDICINE** A review of key measures and action associated with emergency medicine (copy attached to the original of these minutes and considered a part thereof) - *Dr. Khoa Tu, Department Chair and Medical Director*

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 – *Jag Batth, COO*

- No Report.

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

- No Report.

ADJOURN - Meeting was adjourned at 4:36PM.

RESOLUTION 2201

WHEREAS, George Shroyer, is retiring from duty at Kaweah Delta Health Care District after 33 years of service; and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of his loyal service and devotion to duty;

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of his 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 appreciation to George Shroyer for 33 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 23rd day of August 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

RESOLUTION 2202

WHEREAS, Francisco Lizaola, is retiring from duty at Kaweah Delta Health Care District after 14 years of service; and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of his loyal service and devotion to duty;

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of his 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 appreciation to Francisco Lizaola for 14 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 23rd day of August 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

CONSENT DOCUMENTS

CONSENT CALENDAR

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

City of Visalia – City Council Chambers
707 W. Acequia, Visalia, CA

Wednesday August 23, 2023

August 18, 2023 – 3:00PM

Note to Board Packet:

The Consent Calendar item ***9.1A – Reports – Physician Recruitment*** has not been submitted. Once I receive it I will upload it for your review.

FY 2024 Strategic Plan

Monthly Performance Report

August 23, 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.

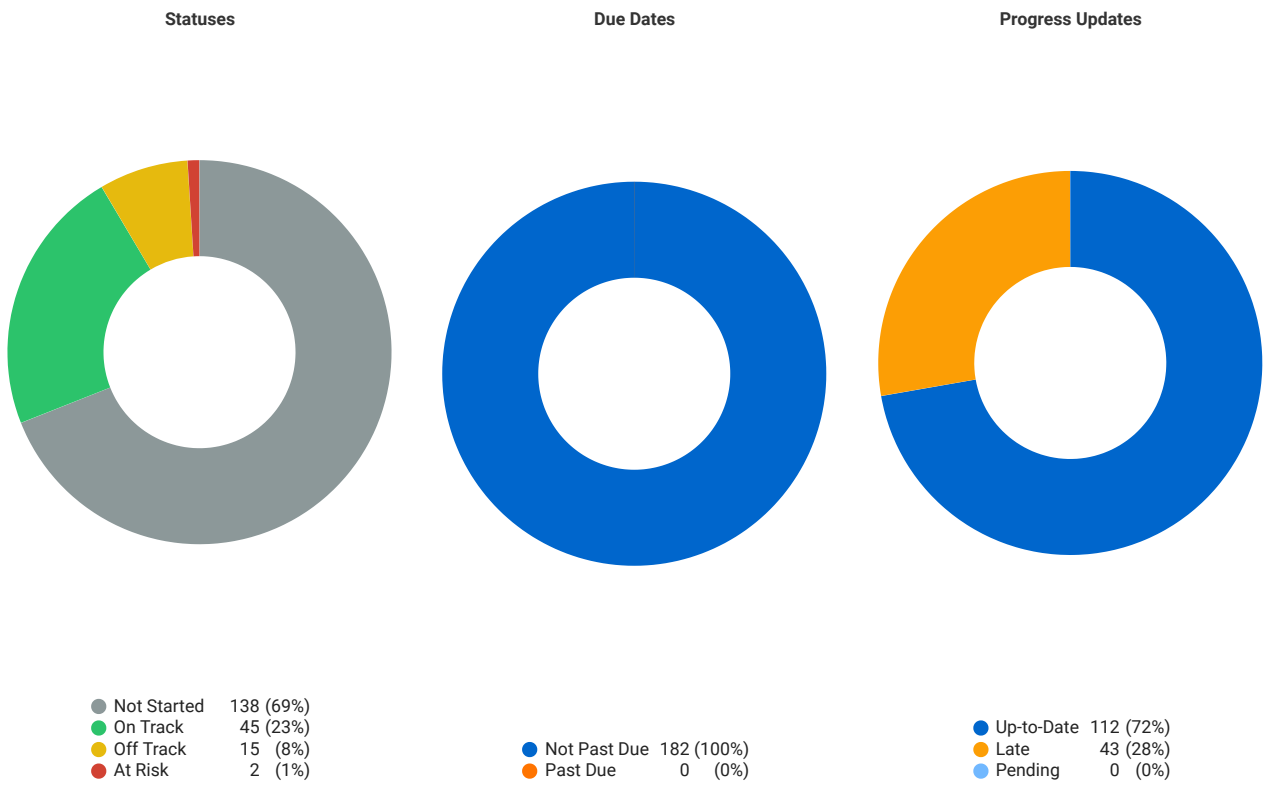
Our Pillars

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

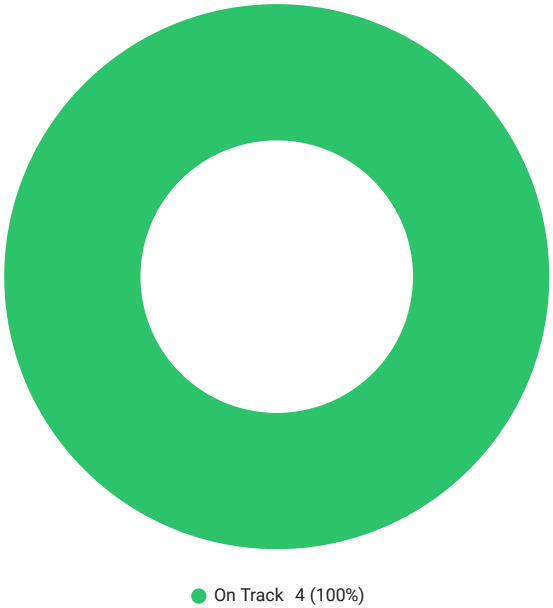
Champions: Dr. Lori Winston and Lacey Jensen

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

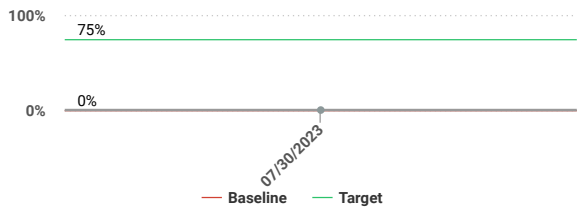
FY2024 Strategic Plan - Empower Through Education Strategies

#	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.

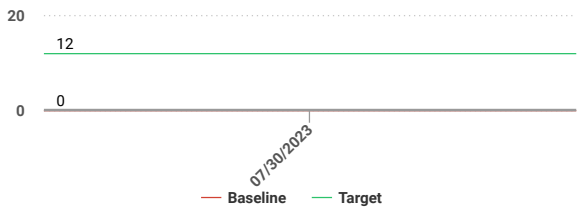
Objectives and Outcomes



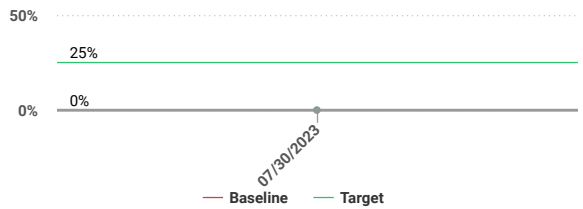
Automate the Week One Onboarding and Orientation Competencies for Patient Care Staff



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



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



Ideal Work Environment

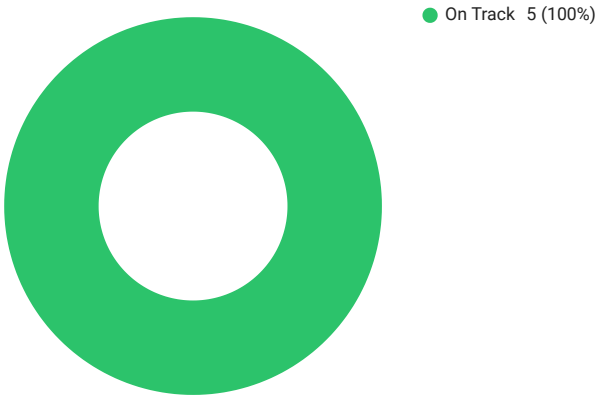
Champions: Dianne Cox and Raleen Larez

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

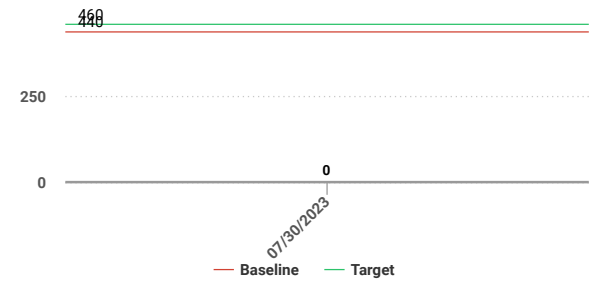
FY2024 Strategic Plan - Ideal Work Environment Strategies

#	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.

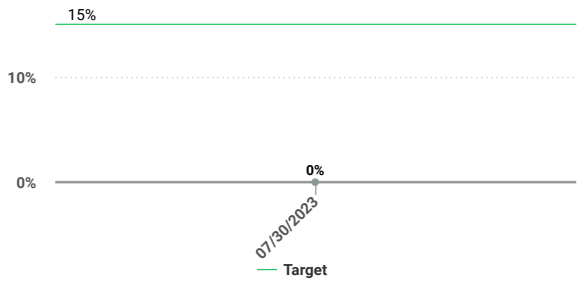
Objectives and Outcomes



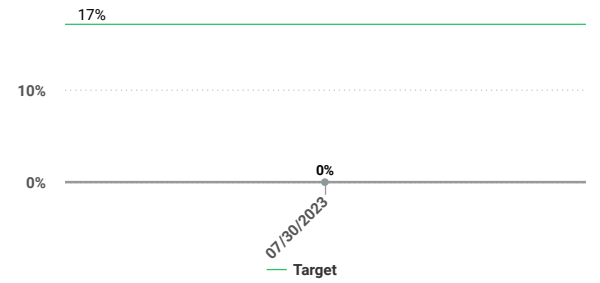
Increase to 460 Volunteers (by 6/30/24)



Decrease Overall KH Turnover Rate (< 15%)



Decrease Nursing Turnover Rate (< 17%)



Strategic Growth and Innovation

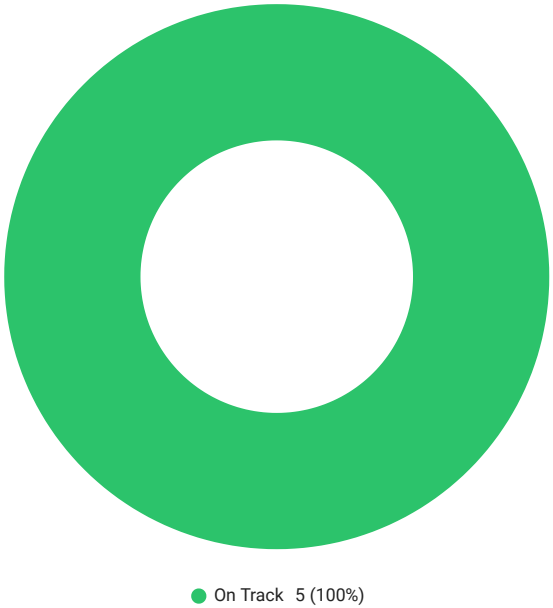
Champions: Ryan Gates and JC Palermo

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****.*

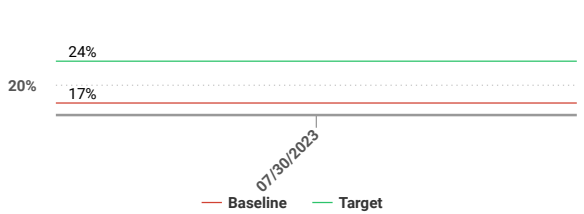
FY2024 Strategic Plan - Strategic Growth and Innovation Strategies

#	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.

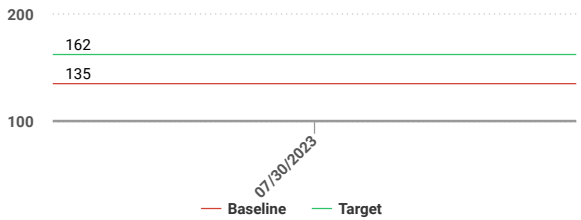
Objectives and Outcomes



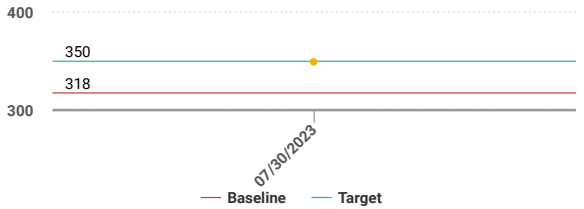
Increase the Percentage of Coronary Artery Bypass Graph Surgery Cases that are Elective



Increase Number of Urology Surgery Cases



Increase Monthly Endoscopy Case Volume



Organizational Efficiency and Effectiveness

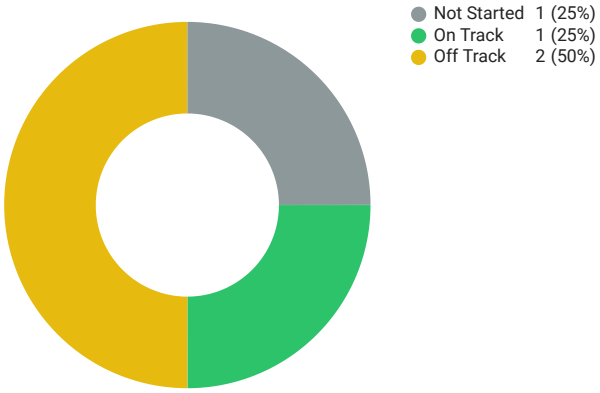
Champions: Jag Batth and Rebekah Foster

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

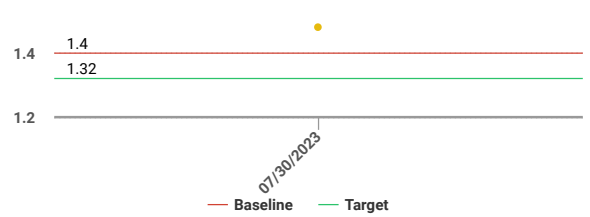
FY2024 Strategic Plan - Organization Efficiency and Effectiveness Strategies

#	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.

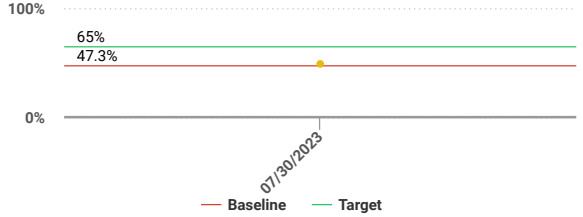
Objectives and Outcomes



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

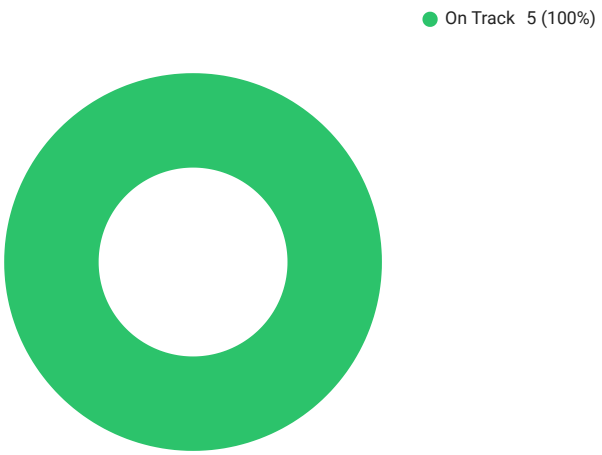
Champions: Dr. William Brien and Sonia Duran-Aguilar

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

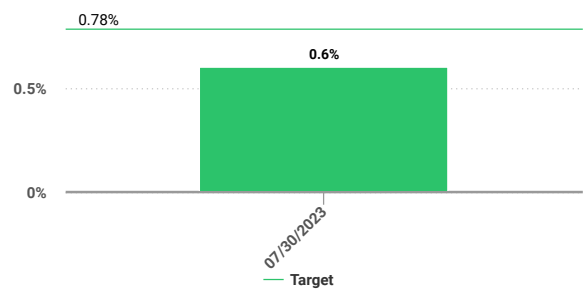
FY2024 Strategic Plan - Outstanding Health Outcomes Strategies

#	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	Proxy Performance (Cozeva) for CY 2023 currently under review. Will provide available performance/progress as next quarterly update.
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.

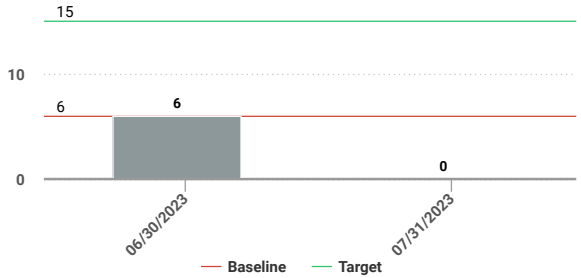
Objectives and Outcomes



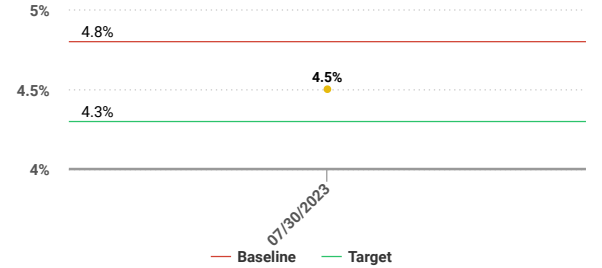
SEPSIS Mortality O/E



Meet QIP measure performance (15 of 17)



Hypoglycemia in Critical Care Patients (< 4.3%)



Patient and Community Experience

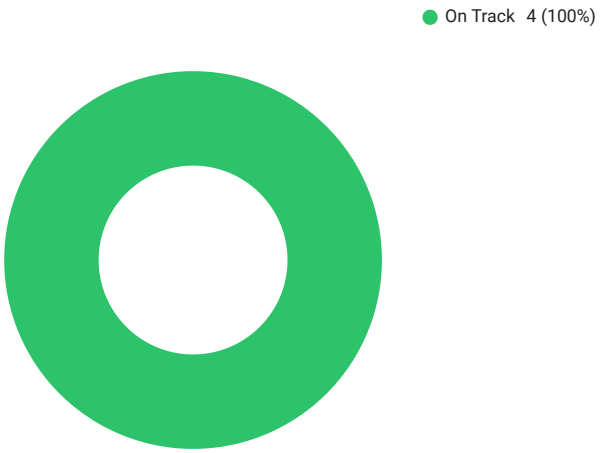
Champions: Keri Noeske and Deborah Volosin

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

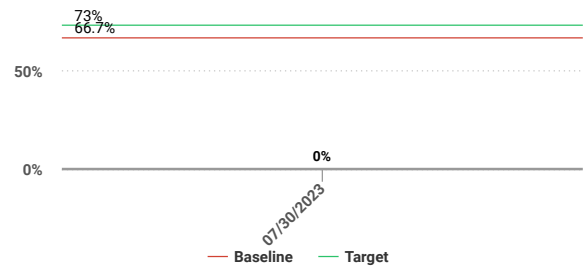
FY2024 Strategic Plan - Patient and Community Experience Strategies

#	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	Keri Noeske	

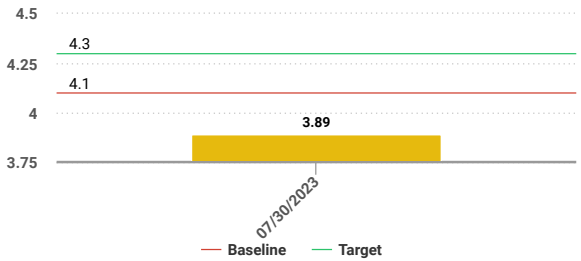
Objectives and Outcomes



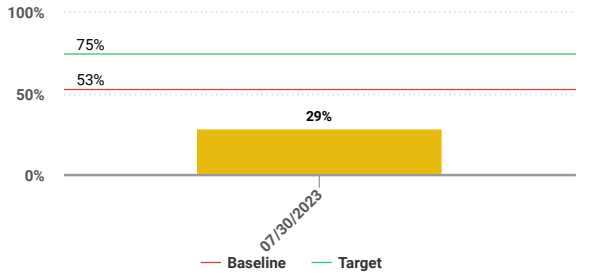
Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey



Achieve 4.3 Patient Feedback Score Goal on ED Survey



Reunite 75% of Lost Belongings with Owners



Compliance Program Activity Report – Open Session

May 2023 through July 2023

Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

- Compliance and Patient Privacy
  - Management Orientation
  - Health Information Management (HIM)
  - Case Management
  - Sequoia Surgery Center
  - Patient Accounting
  - GME New Resident Orientation

Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff

- Anti-Kickback and Stark
- You've Been Given A "FairWarning"

Prevention & Detection

- Californian Department of Public Health (CDPF) All Facility Letters (AFL) – Review and distribute AFLs to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk.

- Medicare and Medi-Cal Monthly Bulletins – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential/current risk.

- Office of Inspector General (OIG) Monthly Audit Plan Updates – Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk.

- California State Senate and Assembly Bill Updates – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk.

Prevention & Detection

- Patient Privacy Walkthrough – Observation of regulatory signage and privacy practices throughout Kaweah Health; issues identified communicated to area management for follow-up and education.

- User Access Privacy Audits – Fairwarning daily monitoring of user access to identify potential privacy violations.
  - Kaweah Health Employees
  - Non-employee users

- Office of Inspector General (OIG) Exclusion Attestations – Quarterly monitoring of department OIG exclusion list review and attestations.

- Medicare PEPPER Report Analysis – Quarterly review of Medicare Inpatient PEPPER statistical reports to identify outlier and/or areas of risk; evaluate with Kaweah Health leadership quarterly at PEPPER Review meeting; Distribution of Rehabilitation, Hospice, Home Health, and Mental Health PEPPER Reports to leadership for evaluation.

Oversight, Research & Consultation

New

Guidance for Physician Query No Longer with Kaweah – Research to determine whether a Clinical Documentation Improvement physician advisor or a department chair can respond to a query on behalf of a physician who is no longer practicing at Kaweah. It was determined that it would be acceptable for any member of the treating team to respond to the query. Findings were shared with appropriate leadership.

PECOS Denials Non-Attending Physicians - Research to determine why several denials for Medicare claims were received. It was determined that claims were submitted under providers in training who were not enrolled in the PECOS system. It was determined the claims were submitted listing the training provider as the attending physician rather than the supervising physician being indicated on the claim. Edits were put into place and findings were shared with appropriate leadership.

Oversight, Research & Consultation

New

Consult on a Hospital Acquired Condition (HAC) Patient Fall Billing Medicare or Write Off – Research to determine if Kaweah Health has an obligation to bill Medicare for a patient fall resulting in a fracture and requiring surgery during an inpatient stay. It was determined that Medicare no longer receives additional payment for cases in which an identified HAC occurred but was not present on admission but will be paid as though the HAC was not present. HACs should be coded as a secondary diagnosis at which point, CMS will determine if it is payable or should be manually written off. Findings were shared with appropriate leadership.

Obligation of Notification for Megan's Law – Research to determine if Kaweah Health has an obligation to notify the Skilled Nursing Facility that a patient is on the Megan's Law registry when seeking placement. It was determined that before a registered sex offender is released into a long-term facility, the official in charge of the current place of confinement shall notify the facility in writing. Findings were shared with appropriate leadership.

Oversight, Research & Consultation

Ongoing

Fair Market Value (FMV) Oversight – Ongoing oversight and administration of physician payment rate setting and contracting activities including Physician Recruitment, Medical Directors, Call Contracts, and Exclusive and Non-Exclusive Provider Contracts.

Licensing & Enrollment

New

Licensing Applications – Forms preparation and submission of licensing application to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications.

- *Additional CT Machine CDPH Site Survey*

Enrollment – Forms preparation and submission of licensing application to CDPH, as well as Medicare and Medi-Cal Facility Payor Enrollment; ongoing communication and follow-up regarding status of pending applications.

- *Kaweah Health Medical Clinic – Willow*
- *Kaweah Health Medical Clinic – Plaza*
- *Crisis Stabilization Unit (CSU)*

Auditing & Monitoring

New

Emergency Department (ED) with Diagnostic Testing Procedures

Situation: CMS is required by the Social Security Act to ensure payments for all radiology services provided in the ED are medically necessary, have documentation to support the claims, and are ordered by physicians. A post-payment review was conducted by Compliance based on evaluation of documentation of medical necessity and physician orders for radiology testing; the radiology testing was completed while the patient was in the ED, the Radiology Interpretation reports met American College of Radiology (ACR) communication of Diagnostic Imaging guidelines, the diagnosis met the requirements for the LCD and confirmation that the diagnostic test was billed appropriately on the UB-04 claim form and was paid.

Assessment: An internal review of thirty (30) randomly selected Medicare encounters for dates of service from October 2022 – December 2022 was conducted. The review noted a 94% compliance rate for appropriate documentation of medical necessity diagnosis as outlined by the LCD. The review noted a 100% compliance rate for Radiology testing, interpretations were completed during the ED visit, electronic reports were retained within the electronic medical record and met the American College of Radiology reporting standards and billed appropriately.

Recommendation: Based on the findings, no further assessment is required at this time.

Auditing & Monitoring

New

Infusion Center Drugs

Situation: CMS requires hospitals and other providers to care for and administer medications to patients in such a way that they are used most efficiently, in a clinically appropriate manner. Infusion Center drug administration has been the focus of Recovery Audit Contractor (RAC) reviews. A post-payment review was conducted by Compliance to determine whether Kaweah Health is submitting claims in compliance with Medicare documentation and billing guidelines for Infusion Center drug administration services for beneficiaries of Medicare, Medicare Advantage and Commercial plans.

Assessment: An internal review of fifty-seven (57) encounters, with dates of service from July 2022 – January 2023 was conducted. The review noted a 100% compliance rate for dose amount infused per the physician order as well as start and stop time documentation resulting in appropriate infusing duration. The review noted an 86% compliance rate for billing documentation. Seven (7) encounters where the drugs were donated were noted as non-compliant, as they did not contain the correct units of medication. One (1) encounter did not contain the IV administrative charge.

Recommendation: The Compliance Department will continue to reassess the risk associated with Infusion Center drugs and will conduct periodic audits in the future.

Auditing & Monitoring

New

Inpatient DRG without a Major Complication or Comorbidity (MCC)

Situation: Due to results from a recent PEPPER report indicating the possibility of under-coding claims, as well as internal audit results reflecting an increase in inpatient coder errors, a review of coding services was performed for Kaweah Health focusing on Inpatient Diagnosis Related Group (DRG) without Multiple Chronic Conditions and Complication or Comorbidity (MCC/CC). The purpose of the audit was to review documentation to determine if the diagnosis coding selected most accurately reflected the patient's condition resulting in assignment of the appropriate DRG.

Assessment: An external audit of fifty (50) randomly selected inpatient accounts with dates of service from January 20, 2022 – February 22, 2023 was completed. The audit noted a 96% compliance rate. The results of the review have been shared with leadership.

Recommendation: Based on the findings, no further assessment is required at this time.

Projects

Update

Business Associate Agreement Validation

Situation: Review, validation and collection of Business Associate Agreements (BAA) within the Compliance 360 Contract Database System. A BAA is defined as a legal document between a healthcare provider and a third party vendor who creates, receives, maintains, or transmits Protected Health Information (PHI) of our patients on our behalf. BAAs are crucial in protecting the privacy of our patients and protecting the organization against liability in the event of a breach of PHI committed by a Business Associate.

Assessment: Phase I will consist of a validation process to ensure accurate storage of BAAs within the system and removal of expired or invalid agreements. Phase II will consist of a thorough review, update and modernization of the BAA template language and provisions.

Outcome: Leadership has been re-educated to ensure BAAs are acquired, when appropriate, when executing new agreements. The result of the extensive review is intended to identify and execute (when necessary) agreements for all required vendors and ensure an organized process through the contracts management system for ease of access. Phase II is expected to begin in August 2023.

Projects

Update

Workday/FairWarning

Situation: On July 1, 2023, Kaweah Health launched the new Human Resources Information System (HRIS), Workday. Workday required the transition of current HR and IT system databases, which impacted the process of onboarding remote system access users (contingent workers). The transition to Workday also required a new integration with current EMR privacy monitoring tool, FairWarning.

Assessment: The Compliance Department initiated and oversaw the transition of over 1,600 contingent workers into the Workday platform. The transition included individual data entry, education assignment, system access request, and data validation for these users. In addition, the Compliance Department monitored the integration of Workday and FairWarning to ensure a successful transition.

Outcome: The Workday contingent worker transition and FairWarning integration were successful.

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Kaweah Delta Health Care District

Hospital Admin

Kaweah Health

Policy Number: AP10	**Date Created: 09/30/2007**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Occurrence Reporting Process	

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PURPOSE: ~~Describes~~ To describe the Occurrence Reporting process that supports ~~District~~ Kaweah Delta Health Care District ("Kaweah Health") ~~Performance Improvement,~~ Quality & Patient Safety, Risk Management and Compliance activities by collecting data on unusual events or process variances.

DEFINITIONS:

Occurrence - *An unusual or unexpected event, whether or not causing harm or potential harm to patients, visitors or staff that places ~~the District~~Kaweah Health at risk.*

Statement of Concern – *An event related to an unresolved interpersonal (behavioral) issue.*

Adverse Drug Event - *~~-~~A variance related to the use of omission of a drug as well as "close calls" or "safe catches." Adverse drug events (ADEs) are comprised of medication errors and medication incompatibilities. Adverse Drug Reaction - (ADR) An unusual or unintended noxious reaction that occurs at doses normally used for prophylaxis, diagnosis, therapy of disease and/or for the modification of physiological function.*

Significant ADE- *Any ADE that caused, or had the potential to cause, harm. Harm is defined as the impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.*

Medication Error – *A preventable medication-related event that adversely affects a patient and that is related to professional practice, health care products, procedures, systems, including but not limited to prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing,*

	distribution, administration, education, monitoring and use.
Medication Incompatibility	*A state in which two or more medications undesirably interact in a way that would interfere with their administration, safety or efficacy.*

POLICY:
Occurrences which may result in actual or potential harm to patients, staff members, ~~or District~~ Kaweah Health visitors, or otherwise expose ~~the District~~Kaweah Health or any of its employees or agents to liability are reported in an accurate and timely manner. In addition to its use as a Risk Management tool, the Occurrence Reporting process facilitates ~~District Performance Improvement,~~ Quality & Patient Safety, Risk Management and Compliance activities.

The Occurrence Reporting process also encompasses suspected child, elder and/or dependent adult abuse reporting, unresolved behavioral "Statement of Concern" reporting, complaint and grievance reporting, ~~and~~ ADE reporting, and reporting to other confidential matters. The paper and/or electronic forms are the data collection tools of the Occurrence Reporting process.

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The forms and/or their electronic equivalents are maintained within the Risk ~~Management Department~~Management Department as confidential documents, and as such are protected from discovery pursuant to California Evidence Code section 1157(b). The forms are NOT a part of the medical record. Occurrence Reporting policy and procedure is observed as follows:

I. Unusual events, significant ADEs, patient/family grievances or statements of concern are reported by completing an Occurrence Reporting form and submitting it to the Risk Management Department as soon as possible.

II. Staff should immediately contact the ~~telephone the~~ Risk Management Department via telephone of any unusual event, which results in patient injury ~~immediately~~. If ~~the R~~rRisk ~~M~~mManagement~~r~~ is unavailable, the House Supervisor is notified. Staff shall complete an Occurrence Reporting form immediately and submit to the Risk Management Department within **24 hours**. (See Sentinel Event Policy AP.87).

III. Staff should contact ~~telephone t~~the Clinical Engineering Department and the Risk Management Department via telephone for any unusual event~~,~~ which results in patient injury and is directly related to equipment malfunction within **24 hours** of the event or discovery of the event. Staff shall complete an Occurrence Reporting form and send it to the Risk Management Department within **24 hours**. The equipment in question ~~is~~ shall be removed intact from the patient care area, a red tag applied, and placed in the area designated by Clinical Engineering for retrieval.

IV. A multidisciplinary team including members from the organization and Medical Staff (METER Committee) review occurrence reports submitted within the

previous 24 hours each weekday to rank and triage events so immediate notification of high-risk or unusual events can be made to hospital and Medical Staff leadership. Occurrence reports received on weekends/holidays will be reviewed the following business day. High-risk or unusual events which occur during weekends/holidays will be immediately escalated to the House Supervisor and/or the Risk Manager on-call as described in Section II above.

~~V.~~ Significant ADEs ~~are~~ shall be reported immediately to the patient's attending or covering physician. Physician notification is documented in the patient's medical record. The Pharmacy Director or designee will be notified of ADEs and events which do not constitute an ADE, but pertain to medications (i.e.: medication loss, medication storage, potential drug diversion).

V.

VI. Any unusual event which is directly or potentially related to equipment malfunction, which DID NOT result in patient injury, ~~is~~ shall be reported by completing an Occurrence Report and sen~~ding it~~ to the Risk Management Department within **5 days**. The equipment and/or parts (i.e., stapler parts, drill bits, etc.) in question ~~are~~ shall be immediately removed intact from the patient care area, a red tag applied, and placed in the area designated by Clinical Engineering for retrieval. See Procedure section below, Item III.

VII. L~~Any l~~ost or damaged patient ~~property~~ items ~~issues~~ may be reported on the Kaweah Health website or an Occurrence Report may be completed. ~~They are~~Lost belongings shall be investigated by the Department Manager or designee. ~~, an Occurrence Report completed, and sent to the Risk Management Department.~~

~~VII.~~VIII. A case review of Coroner Referrals will be completed by the Medical Director of Quality &~~and~~ Patient Safety to evaluate and identify unusual occurrences or Adverse Events.

~~VIII.~~IX. The Risk Management Department will provide~~s~~ Department Directors or designee with monthly Occurrence Reporting aggregate data upon request. Data ~~are~~ is trended and used to improve ~~District~~ Kaweah Hel~~a~~lth processes. Data obtained from the Occurrence Reporting process ~~are~~ is also used in ~~m~~Medical ~~s~~Staff peer review for re-credentialing purposes, and by the Risk Management and Compliance Departments to report and trend data related to the Complaint and Grievance processes.

~~IX.~~X. All patient events are documented in the medical record. Documentation does **NOT** indicate that an Occurrence Report was generated.

PROCEDURE:

I. When an incident or unusual event occurs, the individual most familiar with the situation, or to whom a grievance was reported, ~~completes~~ shall complete the Occurrence Reporting form. The form is submitted to the Risk Management Department as soon as practically possible, but no later than~~within~~ **5 days** of the event, or at the time in which the event is discovered.

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II. Staff shall notify ~~telephone~~ the Risk Management Department via telephone of any unusual event, which results in patient injury **immediately**.

A. If the Risk Manager is unavailable, the House Supervisor is notified.
B. Staff complete an Occurrence Reporting form immediately and deliver to Risk Management Department within 24 hours. (See Sentinel Event Policy AP.87).

~~II.~~III. When the unusual event results in patient injury AND is directly related to equipment malfunction, the individual discovering the event is responsible to:

A. Notify the Director, House Supervisor, and Nurse Manager;
B. Notify the physician;
C. Telephone the Clinical Engineering Department and Risk Management within **24 hours** of event;
D. Complete and submit an Occurrence Reporting form to the Risk Management Department within **24 hours**;
E. Remove the intact defective equipment from the patient care area, including all attached peripheral devices (tubing, hoses, power cords, catheters, etc.);
~~E.~~ Attach a completed red tag, “Defective Equipment Tag”, to device (refer to Environment of Care policy 1106 – Electronic/Electromechanical Devices);
F.
~~F.~~G. Store equipment in designated area for pick-up by Clinical Engineering.

~~III.~~IV. If the unusual event is directly related to equipment malfunction, but did not cause patient injury, the individual that discovered the event incident is responsible to:

A. Complete and submit an Occurrence Reporting form to the Risk Management Department within 5 days.
B. Remove the intact defective equipment from the patient care area;
C. Complete and attach a red tag, “Defective Equipment Tag”, to device (refer to Environment of Care policy 1106 – Electronic/Electromechanical Devices);
D. Notify Clinical Engineering for pick-up of defective equipment;
E. Store equipment in designated area for pick-up by Clinical Engineering.

~~IV.~~V. Events related to ADE’s, patient falls, pressure injuries/skin breakdown, and equipment/medical device issues are reported electronically through the Occurrence Report process. Paper reports may be submitted during times of workstation or network outage.

~~V.~~VI. If any questions arise, staff may contact their Manager, the House Supervisor, or the Risk Management Department.

~~VI.~~VII. The individual completing the Occurrence Reporting form notifies and submits the completed report to their Nurse Manager or Department Director. All incomplete forms submitted to the Risk Management Department are returned to the Department Director or designee for completion.

~~VII.~~VIII. The Occurrence Reporting Form documentation includes:

A. Event description using only pertinent facts surrounding the event.
B. Description of any/all action(s) taken to eliminate the possibility of the event reoccurring;
C. List of individuals familiar with the circumstances of the event.
D. Physician notification of the event. Note: The patient's attending physician, covering physician, or clinical psychologist will be immediately notified of significant ADEs as defined in this policy.
E. Notification of Risk Management Department

~~VIII.~~IX. The Department Director, Nurse Manager or designee conducts the initial investigation and documents findings on the Occurrence Reporting form.

The Risk Management Department reviews each Occurrence Reporting form submitted. Graphical representation of data findings are reported at Patient Safety Committee meeting monthly.

References: California Code of Regulations, Title CCR, Division 17, §1711.

"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: AP35	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Computer Software Usage

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

POLICY: Kaweah Delta Health Care District's computer systems and/or other hardware shall not be utilized to manufacture or duplicate unauthorized copies of copyrighted software where such manufacture or duplication is restricted or prohibited by copyright law.

Computer software which has been illegally manufactured and/or duplicated in violation of copyright law may not be installed or in any way put to use on computer systems and/or other hardware owned or operated by Kaweah Delta Health Care District. All software installed on Kaweah Delta Health Care District's computers must be approved the Ddirector of ISS Technical Services.

"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: AP86	**Date Created: 07/01/1999**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Disposals of Equipment

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

POLICY: All disposals of ~~District~~ Kaweah Delta Health Care District dba Kaweah Health equipment with an original purchase price of $5~~2~~,000 or more shall be approved prior to disposition by the Chief Financial Officer (CFO) or designee. Negotiation of sales price or trade-in value shall take into account the remaining recorded value of the equipment in ~~the District~~Kaweah Health's fixed asset record and make every attempt to at least recover that value. All disposals of equipment must be communicated to the Finance Manager or designee for removal from ~~the District~~Kaweah Health~~'s~~ fixed asset records.

DEFINITION:

A disposal of equipment includes (i) equipment permanently retired from active operations, (ii) worn out or obsolete equipment being held in the warehouse (or other storage area) pending future disposal, (iii) the sale or trade-in of equipment, (iv) thief of equipment and (v) the donation of equipment for charitable purposes.

PROCEDURE:

1. BEFORE any action related to disposal is taken, department manager (or designee) must notify the Finance Accounting Manager or designee of impending disposal in order to determine current book value of equipment. Information provided by the requestor should include department cost center, equipment description, asset tag (if available), make, model, serial number and approximate date of acquisition.

2. Once book value is determined by Finance, all efforts should be made by the requestor to negotiate a sales price, trade-in credit, or continued use of the equipment to at least recover the remaining book value of the equipment.

3. **For Disposals to outside parties:** Prior to the finalization of the sale, trade-in or disposal arrangement, terms of the agreement shall be reviewed and approved by a Vice President ~~and by legal counsel~~, if

required for agreements under District Policy AP69, "Requirements for Contracting for Outside Service Providers".

a. While negotiating sales terms, every effort shall be made to secure payment in a single payment.
b. Terms must include that equipment is sold, "as is" and the contract must include the Equipment Release Form included in this policy.

4. **For Disposals to employees:** In addition to Items 1-3 above, the following additional steps must be taken for equipment with an estimated market value greater than $100 –
   a. Notification of the sale and the bidding process should be announced to employees using standard ~~District~~ Kaweah Health wide communications
   b. Bids should be submitted using the Sealed Bid Form included in this policy.

5. Subsequent to the review and approval of the disposition agreements, such agreements shall be forwarded to the CFO or designee for approval.

6. Information related to the donation of equipment or supplies shall be forwarded to the CFO or designee for approval prior to the actual donation.

7. Upon completion of the disposal process the (i) signed disposal/sale agreement, including the Equipment Release Form, (ii) sales proceeds and (iii) evidence of the disposing asset's calculated book value determined by Finance must be forwarded to the Finance Accounting Manager or designee. This will ensure that the sale proceeds are properly deposited and the disposal transaction is properly reflected in ~~the District~~Kaweah Health~~'s~~ accounting records.

8. All disposals of equipment with an original purchase price less than $52,000 shall be approved by the department Director currently using the equipment. If the department no longer has a use for the equipment, it must be offered to other ~~District~~ Kaweah Health departments before being permanently disposed of. ~~or sent to the District warehouse for storage or future disposal. For items that are transferred to the warehouse, the warehouse manager shall make the determination based upon the condition of the equipment, whether it should be stored for possible future District use, sold to an outside party or employee, or permanently disposed.~~

9. Sales or donations of equipment or supplies to physicians is not allowed due to regulatory and compliance prohibitions.

EQUIPMENT RELEASE FORM

Date:_____

I _____ understand that this piece of equipment of (list equipment, use separate sheet if needed)

is used and being sold “as is” and I the buyer – release the seller Kaweah Delta Health Care District dba Kaweah Health, its staff members, officers, directors agents and assigns from any and all liability for any damage, injury or harm which may be caused by, a result of, or in any way associated with the use of this equipment. I take personal responsibility for any and all occurrences after taking possession of the equipment.

Buyer:

_____
Signature Date

_____
Print Name

_____
Title

Seller:

_____
Signature Date

_____
Print Name

_____
Title

_____
_____
_____

Kaweah Delta Health Care District
400 West Mineral King Avenue
Visalia, California 93291-6263

SEALED BID FORM

Name:_____
Employee #:_____
Department #:_____

BIDS

ITEM #1: **Minimum Bid Amount**

_____

Bid Submitted

_____

Description:_____
_____
_____
_____
_____
_____
_____

ITEM #2: **Minimum Bid Amount** _____
Bid Submitted _____

Description:_____
_____
_____
_____
_____
_____
_____

ADDITIONAL COST & INFORMATION

- Viewing equipment by appointment only scheduled through _____, Ext #____
- Fees that will be the responsibility of the employee include:_____
- Employee must include the Kaweah ~~Delta~~ Health Equipment Release Form along with submission of Bid
- Equipment will not be transferred to the employee until payment has cleared employee bank. The employee will be charged $25.00 for any returned checks due to insufficient funds or for any reason.

Signature:_____ Date_____
Bids must be received by _____P.M. on _____, 201_. Submit your bid form to _____, Finance, extension #____.

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Policy Number: AP107	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 Use and Disclosure of Patient Information

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PURPOSE: This policy outlines how Kaweah DeltaDelta Health Care District (Kaweah DeltaHealth) complies with the patient privacy requirements forand the use and disclosure of Protected Health Information (PHI) in accordance with the Federal Health Insurance Portability and Accountability Act and the requirements of State of California privacy-related laws and regulations.

POLICY: Kaweah DeltaHealth complies with all Federal and State of California laws and regulations with regards to protecting patient privacy and using or disclosing patient information. When PHI is used, disclosed, or requested, Kaweah DeltaHealth will take reasonable efforts to limit the PHI that is used, disclosed, or requested to the minimum amount necessary to accomplish the purpose of the use, disclosure, or request.

DEFINITIONS:

"Limited Data Set" is protected health information that excludes the following direct identifiers of patients, including: (a) names; (b) postal address information, other than town or city, sState, and zip code; (5 number zip code), (c) telephone numbers; (d) fax numbers; (e) electronic mail addresses; (f) Ssocial sSecurity numbers; (g) medical record numbers; (h) health plan beneficiary numbers; (i) account numbers; (j) certificate/license numbers; (k) vehicle identifiers and serial numbers, including license plate numbers; (l) device identifiers and serial numbers; (m) web universal resource locators (URLs); (n) Internet Protocol (IP) address numbers; (o) biometric identifiers, including finger and voice prints; and (p) full face photographic images and any comparable images; and (q) any other unique identifying number, characteristic or code.

"Organized Health Care Arrangement" meanis a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. This includes a hospital, in which patients receive services both from the hospital and from independent members of the medical staff. or an organized system of health care where more than one covered entity participates and where the participating covered entities and the providers hold themselves out to the public as participating in a joint

arrangement. For Kaweah DeltaHealth, the District, including all of its facilities and services, credentialed medical staff, and allied health professionals, is in an organized health care arrangement.

"**Protected Health Information (PHI)"** means any information in any form or medium that is created or received by Kaweah DeltaHealth that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Individually-identifiable health information that is transmitted or maintained in electronic media or any other form or media. (See AP.53 Patients' Rights and Responsibilities for a more comprehensive definition)

PROCESS:

I. Uses of PHI:—

A. Kaweah DeltaHealth may use or disclose PHI for Ttreatment of patients, request payment for services, and for health care operations activities. Kaweah DeltaHealth discloses PHI to other health care providers and/or business associates for these same activities to ensure continuity of care.

II. Disclosures of PHI –

A. For disclosures of PHI except as permitted or required by this policy, Kaweah DeltaHealth shall obtain a valid authorization from the patient or their personal representative. (See policy AP.04 Access and Release of Protected Health Information)

1. The authorization shall become a part of the patient's medical record. A copy of the signed authorization must be provided to the individual.

2. An individual may revoke an authorization in writing.

a) The revocation does not apply to actions Kaweah DeltaHealth has taken in reliance on the authorization.

b) The written revocation shall become a part of the individual's medical record.

B. Kaweah DeltaHealth may use or disclose an individual's PHI for uses or disclosures not authorized in the Notice of Privacy Practices, provided that the individual is informed in advance of the use or disclosure and the individual has the opportunity to agree, prohibit, or restrict the use or disclosure. Kaweah DeltaHealth may verbally inform the individual of and obtain the individual's verbal agreement or objection to a use or disclosure PHI permitted by this section.

1. Kaweah ~~Delta~~Health may use the following PHI to maintain a directory of individuals in its facility: (a) the individual's name, (b) the individual's location in Kaweah ~~Delta~~Health's facility, (c) the individual's condition described in general terms that does not communicate specific medical information about the individual, and (d) the individual's religious affiliation.

2. Disclosures for involvement in the patient's care and notification purposes:

   a) Kaweah ~~Delta~~Health may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the PHI directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.

   b) Kaweah ~~Delta~~Health may use or disclose PHI or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition~~-~~, or death.

   ~~b)~~c) At times deemed necessary by Kaweah ~~Delta~~Health, a 4-digit passcode may be issued to up to two individuals (typically the patient's emergency contact, family member/s, or close personal friend~~/~~(s)) designated as the spokesperson(s)~~/s~~ in order to receive PHI directly related to the patient's general condition. The spokesperson(s)~~/s~~ must provide the 4-digit passcode over the phone in order to receive patient information.

   ~~c)~~d) If the individual is present for, or otherwise available prior to, a use or disclosure permitted as described in a) or b) above, and has the capacity to make health care decisions, Kaweah ~~Delta~~Health may use or disclose the PHI if Kaweah ~~Delta~~Health obtains the individual's agreement, provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or reasonably infers from the circumstances that the individual does not object to the disclosure.

   ~~d)~~e) If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an

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emergency circumstance, Kaweah ~~Delta~~Health may determine whether the disclosure is in the best interests of the individual and, if so, disclose only the PHI that is directly relevant to the person's involvement with the individual's heath care.

~~e)~~f) Kaweah ~~Delta~~Health may disclose PHI to a public or private entity available to assist in disaster relief efforts.

C. In certain situations, Kaweah ~~Delta~~Health shall disclose PHI without an authorization or verbal agreement from the individual.

1. Kaweah ~~Delta~~Health shall disclose PHI to public health authorities or law enforcement agencies to the extent the disclosure is required by law. The disclosure shall be limited to the relevant requirements of such law and will be made in accordance with AP.04 Access and Release of Protected Health Information (PHI); AP.66 Suspected Child and/or Dependent Adult Abuse Reporting; ED.1004 Deadly Weapons or Criminal Act Injuries Report; ED.1006 Examination/Testing for the Collection of Evidence; IP 1.7 Reporting Infection/Communicable Disease, ED.4013 Overdose or Poisoning: Management and Referral; and ED.3002 Patients Who Present to ED with Complaint of Suspected Sexual Assault.

2. Kaweah ~~Delta~~Health shall disclose PHI as necessary, and as allowable under state and federal laws, to avert a threat to health or safety.

3. Kaweah ~~Delta~~Health shall disclose PHI for specialized government functions including:

a) Disclosure to military command authorities regarding armed forces personnel.

b) Disclosures to authorized federal officials for intelligence and national security activities.

4. Kaweah ~~Delta~~Health shall disclose PHI regarding an inmate to a correctional institution or a law enforcement official.

5. Kaweah ~~Delta~~Health shall disclose PHI to the extent necessary to comply with laws regarding workers' compensation or other similar programs.

III. Other requirements regarding the use and disclosure of PHI include:

A. Kaweah ~~Delta~~Health may use or disclose health information which has been **de-identified** by removing the following identifiers:

- Names
- Geographic subdivisions smaller than State, i.e. address, city, county, precinct, zip code
- All elements of dates except year for birth dates & all elements, including year, for all ages over 89
- Telephone number
- Fax number
- E-mail address
- Social security number
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle ID & serial numbers; license plate numbers
- Device identifiers and serial numbers
- URLs or Internet Protocol address numbers
- Biometric identifiers including finger & voice prints
- Full face photographic images or comparable images
- Any other unique identifying number, characteristic or code

B. Kaweah ~~Delta~~Health shall limit the PHI used and/or disclosed on a routine basis to the **minimum amount necessary**.

1. Use of PHI shall be limited to only the information needed for an employee or volunteer to do their job.

2. Disclosure of PHI shall be limited to only the information necessary to accomplish the purpose for which the disclosure is made.

3. Unless the circumstances are unreasonable, Kaweah ~~Delta~~Health staff may rely on a request from one of the requestors listed below as establishing the minimum necessary PHI that may be disclosed to:

   a) Public officials that are requesting PHI in accordance with the requirements of 45 CFR § 164.512 for the performance of public health functions, health oversight functions, law enforcement functions, and specialized government functions, if the public official demonstrates that the information requested is the minimum amount necessary to perform the function.

      i. Staff will verify the identity of public officials by:

a. Looking at the agency identification badge, official credentials or other proof of government status for requests made in person.

b. Noting that the request is on appropriate government letterhead for requests made in writing.

ii. Staff will verify the authority of public officials by:

a. Receiving a written statement of legal authority or documenting an oral statement of such authority.

b. Accepting a civil, judicial or administrative warrant, subpoena, order or other legal process.

b) Another healthcare provider

c) A business associate (as established by way of written agreement or contract)

d) A professional that is a member Kaweah ~~Delta~~Health staff, or a business associate of Kaweah ~~Delta~~Health that is requesting the information to provide professional services to Kaweah ~~Delta~~Health, provided that the professional demonstrates that the information requested is the minimum necessary required for the purpose requested.

e) A researcher that is requesting PHI for research purposes and that provides an authorization from an individual, a waiver of authorization from an instructional review board (IRB), a data use agreement, assurance regarding use preparatory to research, or an assurance regarding the use of decedents' PHI.

C. Kaweah ~~Delta~~Health will sometimes disclose information to a contracted business associate in a limited data set for the purposes of research, public health or health care operations. In these cases, the business associate contract shall be amended to include a data use agreement. The Privacy Officer shall ensure that data use agreements comply with the content requirements of the HIPAA Privacy regulation.

D. Kaweah ~~Delta~~Health may share demographic information and dates of health care provided to a patient with the Kaweah ~~Delta~~Health Foundation. Any fundraising materials sent out shall include a

description of how the individual may opt out of receiving any further fundraising communications.

E. **Prior** to disclosing patient information, Kaweah ~~Delta~~Health staff shall verify the identity of the person requesting the information **and** the authority of that person to access the information.

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Policy Number: AP110	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Reporting requirements for drug diversion illegal substance abuse or controlled substance abuse

POLICY: Kaweah Delta Health Care District dba Kaweah Health is committed to maintaining a safe environment for patients, staff and visitors. Confirmed incidents of drug diversion will be reported to the appropriate agencies.

DEFINITION: Drug diversion – To obtain, possess, prescribe, or use any controlled substance or drug in violation of state or federal law.

PROCEDURE:

1. When suspicious patterns of activity are identified or other reasonable cause to suspect drug diversion is present an investigation will be initiated.
2. The ~~Vice President~~Chief, or their designee, of the involved department will collaborate with Human Resources, Pharmacy, and Risk Management in investigating the suspected drug diversion.
3. Confirmed cases of drug diversion will be reported to:
   a. Drug Enforcement Agency - by Pharmacy;
   b. California Board of Pharmacy - by Pharmacy;
   c. Professional licensing or certifying board of the person confirmed to have diverted drugs – by Human Resources
   d. Visalia Police Department and/or other law enforcement agency - by Pharmacy
   e. California Department of Public Health - by Risk Management
4. Drug diversion will be considered confirmed if after investigation there is:
   a. An admission of guilt by the person suspected;
   b. Refusal to consent to drug testing or to authorize a release of the test results per Human Resources Policy HR.200 Drugs and Alcohol by the person suspected;
   c. Sufficient evidence of drug diversion to terminate the person suspected and all appeals to that termination have been exhausted per Human Resources Policy HR.218 **NOTIFICATION REQUIREMENTS, PRE-DETERMINATION PROCESS AND APPEAL PROCESS FOR INVOLUNTARY TERMINATION, SUSPENSION WITHOUT PAY FOR MORE THAN FIVE DAYS AND DEMOTION**;
   d. Evidence of patient harm or an adverse event directly related to the drug diversion.

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Kaweah Health

Administrative Manual

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

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

PURPOSE:

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

DEFINITION:

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

Examples of weapons include, but are not limited to:

- Firearms
- Edged weapons (Swords, Knives)
- ~~Generally pocket knives and multi-tools are not considered weapons; however, extreme caution should be taken in their presence.~~ Any edged weapon with a blade length of over 3 inches will be considered a weapon and will be stored in the safe. (Generally pocket knives and multi-tools are not considered weapons (except in Zone 4 of the ED and in the Mental Health Hospital); however, extreme caution should be taken in their presence.)
- Striking implements (Batons, Clubs)
- Missile throwing objects (slingshots, bow/arrows)
- Explosives
- Incendiary devices
- Any other object deemed to be inherently dangerous to ~~Sentara~~ patients, staff, visitors, contractors, or vendors.

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POLICY:

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

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

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LAW ENFORCEMENT/ OFF-DUTY PEACE OFFICER EXCEPTION:

It is not uncommon for the Medical Center, Urgent Care Centers, or off-site clinics to receive visits from uniformed peace officers as well as off-duty (plain clothes) officers. These members of our community are sworn peace officers with the State of California and their respective agencies, and are authorized to carry their department issued or off-duty firearm.

PEACE OFFICERS SEEKING TREATMENT AT UCC/ OFF-SITE CLINICS:

On-duty law-enforcement officers

If, during the course of treating an o~~O~~n~~N~~-duty law enforcement officer, they are unable to maintain control or security of their weapon (i.e. treatment/exam would require the weapon to be out of their immediate control, administration of medications that may impair judgement, etc.) the law enforcement departmenagencyt is to be contacted, and they will provide another officer to take control of the weapon.

Off-duty law-enforcement officers

If, during the course of treating an ~~OFF~~off-duty law enforcement officer, they are unable to maintain control or security of their weapon... (i.e. treatment/exam would require the weapon to be out of their immediate control, administration of medications that may impair judgement, etc.):

1) Have the patient secure their weapon in their home or vehicle
2) Have the patient return for service when they are unarmed
3) Send the patient to the emergency department where hospital security can help with gun storage needs

OFF-DUTY PEACE OFFICER FIREARMS RESTRICTIONS – SUICIDE RISK PATIENTS

Armed ~~OFF~~off-duty peace officers (plain clothes) visiting suicide risk patients in the Emergency Department, including visiting patients who are being seen in an area of the ED or the Mental Health Hospital, where suicide risk patients are being cared for, are not permitted to carry a firearm.

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EMPLOYEE EXCEPTION:

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Understanding that our employee workforce is our greatest resource and that we have a shared value to keep our employees safe, Kaweah Health will permit

employees to carry mace/pepper spray and stun gun/taser electroshock self-defense devices tools when coming to and leaving work.

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

STORAGE:
Employees are responsible for ensuring that self-defense tools are stored properly where patients and the public cannot access the property.

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

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

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

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FY 24 Attendance Appreciation Program

Name:	Total quantity of gift cards:	Initials:
Theresa Croushore	4	
Rebekah Foster	16	
Christine Aleman	12	
Mara Lawson	4	
Shannon Cauthen	20	
Michelle Peterson	4	
Emma Mozier	12	
Emma Camarena	4	
Kari Knudsen	16	
Amy Baker	16	
Frank Martin	4	
Tracy Salsa	12	
Melissa Filiponi	16	
Melissa Quinonez	8	
Maribel Aguilar	4	
Molly Niederreiter	12	

One certificate for quarterly drawing.
36X4=156
$20.00 each (Downtown certificates)
=$2,880 from JWD funds

Policy Number: AP53	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Patients' Rights and Responsibilities, and Non-Discrimination	

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

PURPOSE: To support the expression of patients' values and beliefs within the limits of the organization's mission and philosophy, to allow patients to exercise cultural and spiritual beliefs and sexual orientation and gender identity that do not interfere with the well-being of others or the planned course of medical therapy for the patient and to ensure appropriate use and disclosure of patient information. To outline patient rights to access, amend, use, and request restrictions on the use and disclosure of Protected Health Information (PHI) and provide the framework for patient complaints regarding the access, use and disclosure of PHI so as to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and more specifically the Privacy Rule. To comply with applicable State and Federal civil rights laws regarding non-discrimination on the basis of race, color, national origin, age, disability or sex.

DEFINITIONS:

"**Closed Medical Records**" describes a completed record after discharge or after services have been provided.

"**Open Medical Records**" indicates the patient is not yet discharged from the facility.

"Designated Record Set" refers to a group of records that include protected health information ("PHI") that is maintained, collected, used or disseminated by, or for, Kaweah ~~Delta~~ Health for each individual that receives care from Kaweah ~~Delta~~ Health or another entity that Kaweah ~~Delta~~ Health's clinicians include in the individual's records.

The designated record set includes the following:

- Medical records and billing records about individuals maintained by or for a covered health care provider or one of its business associates.
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan.

- Information used, in part or in whole, to make decisions about individuals. (Information from third parties should not be included)

Any research activities that create PHI should be maintained as a part of the designated record set and are accessible to research participants unless a HIPAA Privacy Rule exception exists.

"**Protected Health Information (PHI)"** Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. May also be referred to as electronic protected health information (ePHI).

-or-

Any information in any form or medium that is created or received by Kaweah ~~Delta~~ Health that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

-or-

Information (i) that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse about a patient and (ii) including demographic information that may identify a patient that relates to the patient's past, present, or future physical or mental health or condition, related health care services, or payment for health care services.

POLICY:

In accordance with requirements of Section 70707 of the California Code of Regulations, Title 22, Medicare Conditions of Participation, Section 1557 of the Patient Protection and Affordable Care Act (42 USC 18116), Section 504 of the Rehabilitation Act of 1973, the Health Insurance Portability and Accountability Act (HIPAA) and The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission), Kaweah Health ~~Delta~~ has adopted the patients' rights and responsibilities detailed below.

I. Patient Rights

A. A patient shall have the right to exercise these rights without regard to sex, age, disability, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity or marital status or the source of payment of care:

1. Considerate and respectful care and to be made comfortable. The patient has the right to receive respect for their cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. Have a family member (or other representative of their choosing) and their own physician notified promptly of their admission to the hospital.

3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating their care and the names and professional relationships of other physicians and non-physicians involved in their care.

4. Receive information about their health status, diagnosis, prognosis, course of treatment, prospect for recovery and outcomes of care (including unanticipated outcomes) in terms the patient can understand. The patient has the right to effective communication and to participate in the development and implementation of their plan of care. The patient has the right to participate in ethical questions that arise in the course of their care, including issues of conflict resolution, withholding resuscitative services, and foregoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as they may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, the patient does not have the right to demand inappropriate or medically unnecessary treatment or services. The patient has the right to leave the hospital against the advice of physicians, to the extent permitted by law.

7. Be advised if the hospital/licensed health care practitioner proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of their pain, information about pain, pain relief measures and to participate in pain management decisions. The patient may request or reject the use of any or all modalities to relieve pain, including opiate medication, if they suffer from severe chronic intractable pain. The physician may refuse to prescribe the opiate medication, but if so, the physician must inform the patient that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if the patient becomes incapable of understanding a proposed treatment or become unable to communicate their wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on the patient's behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be told the reason for the presence of any individual. The patient has the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to their care and stay in the hospital. The patient will receive a separate "Notice of Privacy Practices" that explains their privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. The patient has the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.

15. Reasonable continuity of care and to know in advance, the time and location of appointments as well as the identity of the person providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. The patient has the right to be involved in the development and implementation of your discharge plan. Upon their request, a friend, domestic partner or family member may be provided this information also.

17. Know which hospital rules and policies apply to patient conduct while a patient.

18. Designate visitors of their choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, or registered domestic partner status, unless:

- No visitors are allowed.
- The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
- The patient has told the health facility staff that they no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform the patient (or the support person, where appropriate) of the visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. To have their wishes considered, if they lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status, or the source of payment for care.

22. File an internal grievance. The patient or their representative may do so by writing or calling:

~~Patient Relations Department~~Risk Management Department
Kaweah ~~Delta~~ Health
400 West Mineral King Avenue
Visalia, CA 93291
PHONE (559) 624-6665
FAX (559) 635-4064

The ~~Patient Relations~~Risk Management Department will review each grievance and provide the patient with a written response. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Medicare Utilization and Quality Control Peer Review Organization (PRO).

23. File an external complaint with California Department of Public Health and/or The Joint Commission regardless of whether they use the hospital's internal grievance process.

California Department of Public Health
1200 Discovery Plaza, Suite 120
Bakersfield, CA 93309
PHONE (661) 336-0543
FAX (661) 336-0529

The Joint Commission
Division of Accreditation Operations
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
PHONE (800) 994-6610
FAX (630) 792-5636
www.complaint@jcaho.org

B. Patient Rights shall be posted at appropriate places throughout Kaweah Health~~Delta~~. Patients of Kaweah ~~Delta~~Health, upon admission or shortly thereafter, will be given a copy of Patient Rights and will have this policy explained by Patient Access staff.

II. Patient Privacy Rights/Notice of Privacy Practices (NOPP)

Patients, and other interested persons, will be provided with a defined opportunity to receive adequate notice of (1) the uses and disclosures of protected health information (PHI) that may be made by Kaweah ~~Delta~~Health, (2) patient rights concerning PHI, and (3) Kaweah ~~Delta's~~ Health's legal duties pertaining to PHI.

A. Reasonable effort shall be made to provide patients or their legally authorized representative the current NOPP on the date of the first service deliver, except where the first service delivery involves emergency medical treatment; in such cases, the NOPP shall be provided as soon as it is reasonably practicable to do so.

B. Except in emergencies, reasonable effort shall be made to obtain a signed acknowledgement of receipt of the current NOPP from the patient or the legally authorized representative.

C. Document reasonable attempts to provide the current NOPP by filing the signed acknowledgement of receipt in the medical record. Refusals to sign the acknowledgement, or refusals to accept the NOPP, shall also be documented.

D. A current NOPP will be posted in a prominent location where it is reasonable to expect that patients will see and have an opportunity to read it. In addition, the current NOPP must be prominently posted and made electronically available on Kaweah ~~Delta's~~ Health's website. At any time, a patient or the patient's legally authorized representative may request and receive a copy of the current NOPP.

E. The NOPP shall provide a description of actual privacy practices, policies and procedures; a description of all uses and disclosures of PHI that Kaweah ~~Delta~~ Health may make without written authorization; a description of the types of uses and disclosures that require written authorization; and a statement that uses and disclosures not described in the NOPP also require written authorization.

F. The NOPP shall be revised and distributed promptly to reflect material changes to the uses or disclosures of PHI, patients' rights, Kaweah ~~Delta's~~ Health's legal duties, or the privacy practices stated in the notice. Subsequent to any revision, a copy of the 'old' NOPP shall be retained for 6 years from the date it was last effective.

G. Any person, not only a patient, who has questions about the NOPP or privacy/confidentiality practices shall be directed to the Compliance and Privacy Official for further information, if necessary.

H. Any member of the general public (who is not a patient or a patient's legally authorized representative) requesting the NOPP shall be provided the current NOPP as promptly as circumstances permit. The documentation requirements do not apply.

III. Patient responsibilities.

A. All patients have a responsibility to:

1. Provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his/her health.

2. Report unexpected changes in his/her condition to the responsible practitioner.

3. Report whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

4. Follow the treatment plan recommended by the practitioner primarily responsible for his/her care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implement the responsible practitioner's orders, and enforce the applicable Kaweah ~~Delta~~ Health rules and responsibilities.

5. Keep appointments and, when unable to do so for any reason, notify the responsible practitioner or hospital.

6. Assure that the financial obligations associated with his/her health care are fulfilled as promptly as possible.

7. Follow the hospital rules and regulations affecting patient care and conduct.

8. Be considerate of the rights of other patients and Kaweah Health ~~Delta~~ staff members and for assisting in the control of noise, smoking, and the number of visitors.

9. Be respectful of the property of other persons and of Kaweah ~~Delta~~Health.

10. Be accountable for his/her actions if treatment is refused or if he/she does not follow the practitioner's instructions.

IV. Non-Discrimination

Kaweah ~~Delt~~Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaweah ~~Delta~~ Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kaweah ~~Delta~~Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats);
- Provides free language services to people whose primary language is not English, such as: q~~Q~~ualified interpreters;

- Information written in other languages.

If a person needs any of these services, contact the Interpreter Services Department at (559) 624-5902.

If a person believes that Kaweah HealthDelta has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, one can file a grievance in accordance with the procedure outlined above. (See I.A(22) and I.A(23) above and AP.08 Patient Complaint & Grievance Management)

A person can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Complaints regarding privacy concerns may be filed with the Chief Compliance and Risk Privacy Officer, 400 W. Mineral King, Visalia CA 93291, 559-624-21545006, Fax 559-635-4064., email www.kdhcd.orgwww.kaweahhealth.org. If assistance is needed, the Compliance and Privacy Officer, or their designee, is available.

"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."

Attachment A

(Forms available online at:
https://www.kaweahdelta.org/Patients-Visitors/For-Patients/Request-Medical-Records.aspx)

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2218 - Fax: 559.741.4888

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (___) _____ Alternate Phone: (___) _____

DOB: _____ SSN: _____

I hereby authorize _____ (Name of physician, hospital or health care provider) to disclose to:

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (___) _____ Fax: (___) _____

Purpose of requested disclosure:

[ ] Medical Care [ ] Personal [ ] Other: _____

Date of Service: _____

This authorization applies to the following information:

[ ] History and Physical [ ] Dialysis Records [ ] Operative Report
[ ] Discharge Summary [ ] Labs/X-Rays/HIV Results
[ ] Mental Health Treatment Info [ ] Alcohol/Drug Treatment

Method of Release:

[ ] Pick up by Patient
[ ] Mail to: _____
[ ] Fax to: _____
[ ] Pick up by other than patient:
Name: _____

EXPIRATION

This authorization expires (insert date): _____

Kaweah Health
400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____)_____ Alternate Phone (____)_____

DOB _____ Last 4 Digits of SSN _____

I hereby authorize _____(Name of physician, hospital or health care provider) to disclose to:

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____)_____ Fax:(____)_____

Purpose of requested disclosure:

❑Medical Care ❑Personal ❑Other: _____

Date of Service: _____

This authorization applies to the following information:

❑History and Physical
❑Discharge Summary
❑Mental Health Treatment Info
❑Operative Report
❑Office/Clinic Note
❑Immunization Record
❑Wellness Check (Physical)
❑Dialysis Records
❑Labs/X–Rays
❑HIV Treatment
❑Alcohol/Drug Treatment
❑Emergency Department Report
❑Genetic Information
❑Other: _____

Method of Release:

❑CD ❑Flashdrive ❑Paper ❑Mailed ❑Email

If emailed to patient, email address: _____

❑Pick up by patient

❑Pick up by other than patient:
Name: _____

EXPIRATION

This authorization expires (one year from today's date): _____

Kaweah Health
400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this authorization. I have the right to receive a copy of this authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

Kaweah Health
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re–disclosed by the recipient and might no longer be protected by federal confidentiality law(HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or
unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.

If this box ❑ is checked, the requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Patient: _____ Signature: _____ Date/Time: _____

☐ Signed by other due to patient's condition at time of service

Other's Signature: _____ Date/Time: _____ Relationship: _____

Attending must authorize release of Psychiatric and Chemical Dependency records:

Please check one: ❑ Authorize Release ❑ Deny Release

Physician	Signature	Physician #	Date/Time
			am / pm

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2218 - Fax: 559.741-4888

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

Kaweah Delta Health Care District
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including *psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.*

If this box [ ] is checked, the requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(Patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Attending must authorize release of Psychiatric and Chemical Dependency records:
Please check one: [ ] Authorize Release [ ] Deny Release

Signature: _____ Date: _____
(Attending Practitioner Signature)

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2000

AUTORIZACIÓN PARA EL USO O LA DIVULGACIÓN DE INFORMACIÓN MÉDICA

Completar este documento autoriza la divulgación y / o uso de información médica personal que podría identificarlo, según se explica a seguir, de conformidad con la ley Federal y de California pertinente a la privacidad de dicha información.
No proporcionar toda la información solicitada puede invalidar esta autorización.

USO O DIVULGACIÓN DE INFORMACIÓN MÉDICA

Nombre del paciente: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ Teléfono alternativo: (___) _____

Fecha de nacimiento: _____ Número de seguro social: _____

Por medio del presente Yo autorizo a _____
(Nombre del médico, hospital or proveedor de cuidado de salud,
para que intercambie información con:

Nombre del Solicitante: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ FAX: (___) _____

Propósito de la divulgación solicitada: [ ] Atención médica [ ] Personal
[ ] Otro: _____

Fecha del servicio: _____

Esta autorización aplica a la siguiente información:

[ ] Historial Médico y Examen Físico
[ ] Resumen al dársele de alta
[ ] Informe Operativo
[ ] Info. de Tratamiento de Salud Mental
[ ] Registro de Diálisis
[ ] Laboratorio / Rayos X / Resultados VIH
[ ] Info. de Tratamiento por Abuso de Alcohol / Drogas

Método de divulgación: [ ] Enviado por Fax a: _____
[ ] Recogido por el paciente [ ] Enviado por correo a: _____
[ ] Recogido por otra persona que no es el paciente
Nombre: _____

Kaweah Health

400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTORIZACIÓN PARA EL USO Y DIVULGACION DE DATOS MEDICOS

Al completar este documento usted autoriza la divulgación y/o uso de datos médicos individuales que lo identifican, como se describe a continuación, de acuerdo a la ley Federal y de California sobre la privacidad de tal información. **El no suministrar toda la información solicitada pudiera causar que ésta autorización no sea válida.**

USO O DIVULGACIÓN DE DATOS MÉDICOS

Nombre del paciente: _____

Domicilio: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ Teléfono alternativo: (___) _____

Fecha de nacimiento: _____ Últimos 4 números de su seguro social: _____

De esta manera autorizo a _____

(Nombre del médico, hospital o profesional de atención médica)

para divulgar a:

Nombre del Solicitante: _____

Domicilio: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ Fax: (___) _____

Motivo por el cual se solicita la divulgación:

❑Atención médica ❑Personal ❑Otro: _____

Fecha en que se dieron los servicios: _____

Esta autorización aplica a lo siguiente:

❑Historial Médico y Examen Físico
❑Resumen al dársele de alta
❑Informe Operativo
❑Información de Tratamiento de Salud Mental
❑Nota de oficina/clinica
❑Registro de vacunas
❑Examen fisico (wellness)
❑Registro de Diálisis
❑Laboratorio / Radiografías
❑Tratamiento de VIH
❑Tratamiento por Abuso de Alcohol / Drogas
❑Informe de Sala de Emergencias
❑Información genética
❑Otro: _____

Método de divulgación

❑Recogido por el paciente: ❑Papel ❑CD ❑Unidad flash ❑Correo ❑Correo electronico
Si se manda por correo electrónico al paciente, indique el correo electrónico: _____

❑Recogido por otra persona que no es el paciente
Nombre: _____

VENCIMIENTO

Esta Autorización se vencerá (un año a partir de la fecha de hoy): _____

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2000

AUTORIZACION PARA EL USO O LA DIVULGACION DE INFORMACION MÉDICA

VENCIMIENTO

Esta Autorización vence: Fecha: _____

NOTIFICACIÓN DE DERECHOS Y OTRA INFORMACIÓN

Yo puedo negarme a firmar esta autorización. Tengo derecho a recibir a una copia de esta autorización. Puedo revocar esta autorización en cualquier momento. Mi revocación debe ser realizada por escrito, firmada personalmente por mí o por una persona que firme en mi nombre, y debe ser enviada a la siguiente dirección:

Kaweah Delta Health Care District, Health Information Management
400 W. Mineral King Avenue Visalia, CA 93291

Mi revocación entrará en efecto desde el momento en que sea recibida, pero no tendrá efecto referente a los actos que el Solicitante u otras personas hayan realizado basándose en esta autorización.

Mi decisión de dar o de negarme a dar esta autorización no condicionará el tratamiento, pago o mi elegibilidad para beneficios.

La información divulgada de conformidad con esta autorización podría a su vez ser divulgada por el receptor y podría dejar de estar protegida por la ley federal de confidencialidad (HIPAA, por su siglas en inglés). Sin embargo, las leyes de California prohíben a la persona que recibe mi información médica divulgarla a los otras personas, a menos que se obtenga otra autorización para esta divulgación de mi parte o que tal divulgación sea específicamente requerida o permitida por ley.

~~Puedo examinar u obtener una copia de la información médica que me están pidiendo~~ autorizar para usar o divulgar.Yo entiendo que lo anterior puede incluir TODOS los registros médicos, u otra información relacionada con mi tratamiento, hospitalización, y/o atención médica como paciente externo para mi condición, incluyendo *impedimento psicológico o psiquiátrico, abuso de drogas y/o alcoholismo y resultados de exámenes para detectar el VIH.*

Si este casillero está marcado [ ], el Solicitante recibirá compensación por el uso o divulgación de mi información.

FIRMA

Fecha: _____ Hora: _____am/pm

Firma: _____
(Paciente/representante/esposo/esposa/persona económicamente responsable)

Si firma otra persona que no sea el paciente, indique la relación legal a el paciente:

_____

El profesional que atiende debe autorizar la divulgación de los registros Psiquiátricos y de Dependencia Química:

Por favor, marque una: [ ] Autorizo la divulgación [ ] No autorizo la divulgación

Firma: _____ _____
(Firma del Profesional que atiende al paciente) *(Fecha)*

Kaweah Health
400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTORIZACIÓN PARA EL USO Y DIVULGACIÓN DE DATOS MÉDICOS

NOTIFICACIÓN DE DERECHOS Y OTRA INFORMACIÓN

Yo puedo negarme a firmar esta autorización. Tengo derecho a recibir una copia de esta autorización. Puedo revocar esta autorización en cualquier momento. Mi revocación debe ser realizada por escrito, firmada personalmente por mí o por una persona que firme en mi nombre, y debe ser enviada a la siguiente dirección:

Kaweah Health
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

Mi revocación entrará en efecto desde el momento en que sea recibida, pero no tendrá efecto referente a los actos que el Solicitante u otras personas hayan realizado basándose en esta autorización.

Mi decisión de dar o de negarme a dar esta autorización no condicionará el tratamiento, pago o mi elegibilidad para beneficios.

La información divulgada de conformidad con esta autorización podría a su vez ser divulgada por el receptor y podría dejar de estar protegida por la ley federal de confidencialidad (HIPAA, por sus siglas en inglés). Sin embargo, las leyes de California prohíben a la persona que recibe mi información médica divulgarla a los a otras personas, a menos que se obtenga otra autorización para esta divulgación de mi parte o que tal divulgación sea específicamente requerida o permitida por ley.

Puedo examinar u obtener una copia de la información médica que me están pidiendo autorizar para usar o divulgar. Yo entiendo que lo anterior puede incluir TODOS los registros médicos, u otra información relacionada con mi tratamiento, hospitalización, y/o atención médica como paciente externo para mi condición, incluyendo *impedimento psicológico o psiquiátrico, abuso de drogas y/o alcoholismo y resultados de exámenes para detectar el VIH.*

Si este casillero está marcado ❑, el Solicitante recibirá compensación por el uso o divulgación de mi información.

FIRMA

Paciente _____ Firma _____ Fecha/Hora _____

☐ Firmado por otra persona debido a la condición del paciente al momento de los servicios

Firma de la otra persona _____ Fecha/Hora _____ Relación: _____

El profesional que atiende debe autorizar la divulgación de los registros Psiquiátricos y de Dependencia Química:

Por favor, marque una: ❑Autorizo la divulgación ❑No autorizo la divulgación

			am / pm
Physician	Signature	Physician #	Date/Time

Policy Number: BOD1	Date Created: 09/08/2004
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Orientation of a New Board Member

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

PURPOSE: To acquaint newly-elected or appointed directors with Board policies and procedures and the fundamental organizational, physical, and operational aspects of the District.

POLICY: The Board of Directors, the Chief Executive Officer, and Kaweah Delta Health Care District dba Kaweah Health staff shall assist each new member-electee or appointee to understand the Board's functions, policies, and procedures upon taking office.

PROCEDURE:

I. The Board member shall be given and will review the following materials with the Board President related to carrying out the duties of a Kaweah Delta Health Care District Board of Directors member including the following:

A. Board of Directors Bylaws

B. Board of Directors Policies

C. Board of Directors member listing including terms of office

D. Board Committee Structure

E. Board minutes for the past year

F. District Conflict of Interest Policy including Statement of Economic Interest (Form 700) to be completed upon taking office.

G. Brown Act Guidelines

II. The Chief Executive Officer shall assist each new Board member in the review of the following materials relevant to District orientation.

A. Vision, Mission, and Pillars

B. District Goals

C. Strategic Plan and Initiatives

D. Projects and Priorities

E. District's Organization Chart

F. Budget for current fiscal year, immediate prior fiscal year and current financial statement. This will be reviewed with the Board member in an education session on the Districts financial statements.

G. Continuum of Care

H. Kaweah Health Medical Staff Executive Committee member listing

III. The Chief Executive Office will coordinate a personal introduction of the new Board member to the Kaweah Health Medical Executive Committee members.

IV. The Chief Executive Officer will coordinate a tour of all of the District facilities for the new Board member and meetings with the District's Vice Presidents.

V. Incoming Board members shall be invited to attend Board meetings prior to taking office to become familiar with Board discussions and meeting protocol.

VI. New Board members will be invited to attend a Governance Institute (GI) Conferences where they will receive materials relative to Board member duties in conjunction with their training at these sessions.

VII. After elected, a new Board member will be assigned another Board member to serve as a mentor.

"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: BOD2	Date Created: 09/01/2004
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Chief Executive Officer (CEO) Transition

PURPOSE: It is the belief of the Board of Directors of Kaweah Delta Health Care District dba Kaweah Health that the continued proper functioning of the District, the maintenance of the highest quality of patient care and the preservation of the District's financial integrity require that the District have a pre-established and orderly process for replacement of the CEO, in the event of the CEO's death, disability or termination of his/her employment relationship with the District.

Accordingly the Board adopts the following policy.

POLICY:

I. **Temporary Succession of CEO when unable to perform duties.** In the event the CEO becomes unable to perform his/her duties as the result of death or the sudden onset of disability, or in the event the Board decides to immediately terminate the District's employment relationship with the CEO, the Chief Nursing Officer shall immediately assume those responsibilities pending further action of the Board Of Directors. In the event the Chief Nursing Officer is unable to immediately assume those responsibilities because of death, disability or vacancy in the position of Chief Nursing Officer, then the Chief Financial Officer shall immediately assume those responsibilities pending further action of the Board of Directors.

II. **Death of the CEO** - In the event of the CEO's death, the Board shall immediately commence the process for hiring a new CEO.

III. **Temporary Disability of the CEO** - If the disability of the CEO is temporary, as determined by Board in the reasonable exercise of its discretion, after reviewing appropriate medical information, the CEO shall again assume the duties of CEO as soon as he/she is able.

IV. **Permanent Disability of the CEO** - If the disability of the CEO is permanent (i.e. will extend for 6 months or more) and prevents the CEO from performing his/her duties, as determined by the Board in the reasonable exercise of its discretion, after reviewing appropriate medical information, the Board may terminate the CEO's contract, in accordance with the contract provisions, and commence the process for hiring a new CEO.

V. **Voluntary termination of the CEO's employment contract** - If the CEO advises the Board of his/her intention to voluntarily end his/her employment relationship with the District, or if

the Board makes a decision to terminate the CEO's contract or a decision not to renew the CEO's contract at the expiration of its term, the Board shall commence the process for hiring a new CEO expeditiously so as to minimize, or avoid if possible, the time during which there would be no CEO under contract with the District.

VI. **Involuntary Termination of the CEO**

A. Basis. During the term of his/her contract, the CEO's employment may be terminated by the Board if the CEO fails to properly carry out the responsibilities of the CEO, if the CEO engages in conduct which reflects poorly on the District, if the CEO engages in conduct which is criminal or which involves moral turpitude, or if, for any other reason, the Board loses confidence in the CEO's ability to properly discharge the duties of CEO.

B. Interim Suspension. In the event the Board makes a preliminary determination to terminate the employment of the CEO, the Board shall have the right, in the exercise of its discretion, to immediately suspend all or any part of the responsibilities of the CEO, pending the outcome of the hearing described in Subparagraph 3 below.

C. Confirmatory Hearing. If the Board makes a decision to terminate the employment of the CEO, the CEO shall have the right, within five (5) days of being advised of the Board's decision, to request, in writing, a hearing on the Board's decision. The written request shall be delivered to the Board President. Failure to request a hearing within that time, and in the manner described, shall be deemed a waiver of the hearing.

If properly requested, the hearing shall be held within ten (10) days of the CEO's request and shall be conducted before one of the personnel hearing officers appointed by the Board to conduct personnel hearings of District employees. The purpose of the hearing will be to allow the hearing officer to review the evidence relevant to the Board's decision to terminate the employment of the CEO, and to have the hearing officer render an opinion indicating his/her agreement or disagreement with the Board's decision. Each side may be represented by counsel and may offer oral and/or documentary evidence and may cross examine the witnesses who testify. The strict rules of evidence will not apply. The hearing officer will have the discretion to admit or deny whatever evidence he/she deems appropriate and to give whatever weight he/she deems warranted to the evidence admitted. The hearing officer will render a written opinion within two (2) days of the hearing.

The decision of the hearing officer is advisory only. Nothing in this policy or in the conduct of the hearing shall be interpreted or deemed to reflect a right in the CEO to continued employment beyond the specific terms of this policy and the CEO's contract.

VII. **Hiring of a new CEO**

A. Recruitment and Search. When it becomes necessary for the Board to replace the CEO, the District will look internally as well as advertising the position widely and/or engage a consultant to assist in the search, in a manner which the Board determines at that time will be effective for attracting qualified candidates. If, however, in the Board's opinion, a qualified candidate (or candidates) are already employed by the District, the Board, at

its discretion, may waive the foregoing requirements. The Board may consult with the District's ~~Vice President for~~Chief Human Resources Officer to acquire information on processes available for advertising the position or for engaging a consultant to assist in the search for a new CEO. At the time of the search, the Board will establish criteria for selecting its new CEO.

B. Interviews of Prospective CEO Candidates. Interviews of prospective CEO candidates will be done by the entire Board. The Board will determine in the exercise of its discretion if individuals other than elected Board members will participate in the actual CEO candidate interviews. In the course of evaluating potential candidates, the Board will consult with the President of the District's Medical Staff and ask him/her to make recommendations to the Board on the candidates under consideration.

C. CEO Contract. The CEO shall be employed for a definite period of time pursuant to a written contract which sets forth the specific terms of the CEO's employment, including the compensation and other consideration to be paid, the term of the agreement, a detailed description of the duties of the CEO, the specific criteria to be used by the Board to evaluate the CEO's performance, and the bases upon which the contract can be terminated by either the Board or the CEO. The contract shall require the CEO to provide at least six (6) months' notice of the CEO's voluntary termination of the contract.

It is the policy of the District to compensate the CEO in a manner that is appropriately competitive in the marketplace, taking into consideration, among other things, the compensation paid to CEOs of similar sized California hospitals. Accordingly, the Board will review surveys of salaries paid to CEOs of California hospitals as part of the process of setting the CEO's compensation. The Board may consult with the District's ~~Vice President for~~Chief Human Resources Officer to acquire information on available survey information.

"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: BOD3	Date Created: 11/02/1999
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Chief Executive Officer (CEO) Criteria

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

The Board has determined that the criteria to be used in the selection of the Chief Executive Officer will be as follows:

I. Education

A. A graduate degree in healthcare management is required. Such degree could be from a variety of graduate schools such as a business school, a school of public health, school of public administration or a school with an interdisciplinary program. An equivalency to a graduate degree in health administration will be considered if the candidate has bachelor's degree with professional certification and a minimum of five years' experience in an executive leadership position in a hospital or healthcare system.

B. The prospective candidate should be a Fellow in the American College of Healthcare Executives or a member committed to advancement in this professional organization.

C. The candidate should possess business ability and financial acumen that has been demonstrated in past executive management or leadership positions. The candidate in this regard should be familiar with business proformas, budgets, financial statements, and decision-making tools.

D. The candidate should demonstrate a social conscience in terms of specific activities, which relates to development or implementation of services related to the improvement of health or the quality of life in the population being served.

II. Spirit of Service

A. The candidate should have values that are patient centered and compatible with the values of the District.

B. The candidate should demonstrate skills and competency in the requirements of leadership and organizational development.

C. The candidate should possess imagination and creativity and should show results which demonstrate this characteristic.

D. The candidate should have initiative and be able to work independently and without supervision to carry out the policies of the Board and the strategic plan of the District.

E. The candidate must possess executive ability, which involves maintaining a sound organization that has both human and fiscal resources necessary to carry out the Mission of the District.

F. The candidate should have a track record of diplomacy and effectiveness in dealing with a wide variety of constituents and a record of being successful in handling difficult and complex situations.

"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: BOD4	Date Created: 06/01/2008
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Executive Compensation

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

PURPOSE: This Executive Compensation Policy of Kaweah Delta Health Care District ~~("Kaweah Delta")~~dba Kaweah Health is intended to set forth the rationale and the processes to be utilized by the Board of Directors ("Board") with respect to the compensation of the Chief Executive Officer ("CEO"), and to set forth the rationale and the processes to be utilized by the CEO with respect to the compensation of the other members of the Executive Team.

Currently, competition for quality executives in the healthcare industry is very high while the years of continuous employment of healthcare executives at a specific institution is surprisingly low. Unnecessary turnover in executives, especially the CEO, can cause major disruptions at healthcare institutions, potentially adversely impacting employee relations, Medical Staff relations, strategic planning, organizational development, implementation of programs and services, physician and patient satisfaction and ultimately the quality of care.

It is the position of the Board, in order to maintain appropriate continuity in the Executive Team, while at the same time continuing as good stewards of Kaweah ~~Delta's~~ Health's funds, that the CEO and the members of the Executive Team should receive total compensation that is at or near the median for executives in functionally comparable positions at comparable institutions. Comparable institutions will be included, consistent with industry standards, on the basis of number of licensed beds, nonprofit status, number of full-time employees, and geographic location, among other factors.

It is also the position of the Board, after years of working with an independent consulting firm with expertise in healthcare executive compensation, that incentive compensation for healthcare executives is a common, expected and valuable part of a total compensation package. Accordingly, it will continue to be the policy of Kaweah ~~Delta~~ Health to provide for appropriate incentive compensation for members of the Executive Team as part of their total compensation.

POLICY:

I. **Chief Executive Officer**

A. **CEO Contract**. Employment of the CEO at Kaweah ~~Delta~~ Health is pursuant to written contract between Kaweah ~~Delta~~ Health and the CEO. California law permits each contract with the CEO to be up to four (4) years in duration. When negotiating a new or renewed contract with the CEO, the Board President shall be the chief negotiator for the Board and shall work closely with legal counsel for Kaweah ~~Delta~~ Health with respect to the negotiation and completion of the written agreement. The Board President may utilize the assistance of the Board Secretary/Treasurer in conducting and evaluating CEO negotiations. The Board President will regularly report to the full Board on the status of CEO contract negotiations. All terms of an agreement with the CEO are subject to final approval by the entire Board.

B. **CEO Base Salary**. The appropriateness of the CEO's Base Salary will be confirmed on an annual basis through the use of an outside and independent consulting firm with nationwide expertise in healthcare executive compensation. Automatic annual adjustment of the CEO's base salary, consistent with adjustments in the base salaries of CEO's in comparable institutions, may be provided for in the written agreement with the CEO. Confirmation of any compensation adjustment pursuant to a written contract provision will be made by the full Board.

C. **Potential CEO Incentive Compensation**. Part of the CEO's annual compensation will be on an incentive basis, i.e., based on the successful completion of specific, objectively definable and measurable goals for that contract year. The goals, the potential incentive compensation amount, and the percentage of the total incentive compensation amount attributable to the successful completion of each goal must be set in advance, must be in writing, and must be agreed to by the CEO and the Board. The successful completion of each of the goals must be capable of determination on an objective basis. Potential incentive compensation amounts for the CEO for each contract year shall be within the range set forth in the last data received from the healthcare executive compensation consultant, and shall be consistent with the Board's general approach to maintaining the combination of base CEO salary and potential incentive compensation amounts at or near the median for comparable institutions. The Board President and the CEO will confer at the end of the contract year with respect to the CEO's successful completion of the incentive goals, and together they will report their determinations to the full Board. Any incentive compensation amount to be paid to the CEO as the result of successful completion of goals must be approved in advance by the full Board.

D. **Overall Consideration**. As an employee of Kaweah ~~Delta~~Health, the CEO will be entitled to health and retirement benefits as offered to other employees of Kaweah ~~Delta~~Health. In evaluating and setting base salaries, incentive

compensation, and overall consideration, the Board shall take into consideration and may make adjustments for the overall consideration (which may include health, life and disability benefits, deferred compensation or other retirement benefits, and other perquisites common in the industry) provided to CEO's in comparable institutions, with a view toward having the total overall consideration provided to Kaweah ~~Delta's~~ Health's CEO be at or near the median of the total overall consideration provided to CEO's at comparable institutions.

II. **Executive Team Compensation Other Than the CEO.**

A. **Base Salaries**. The appropriateness of the base salaries of Executive Team members other than the CEO will be confirmed on at least a biennial basis through use of an outside and independent consulting firm with expertise in healthcare executive compensation. The CEO and the Board President will confer on an annual basis with respect to the most recent information received from the consultant and the consistency of existing executive compensation ranges with that information. The CEO retains authority to set base salary amounts consistent with the information received from the consultant and consistent with the Board's general approach to maintaining executive base salaries at or near the median for comparable institutions.

B. **Potential Incentive Compensation**. On an annual basis, Kaweah ~~Delta~~ Health will include in its budget a specific amount for potential incentive compensation for members of the Executive Team. The CEO and the Board President will work together, with counsel for Kaweah ~~Delta~~ Health if necessary, to establish specific, objectively definable goals for each of the members of the Executive Team for that fiscal year. The goals, the potential incentive compensation amounts, and the percentage of the total incentive compensation amount for that executive attributable to the successful completion of each goal must be set in advance, must be in writing, and must be agreed to by the Executive Team member in question in advance as indicated by his/her signature on the written goals. The successful completion of each of the goals must be capable of determination on an objective basis. Potential incentive compensation amounts for each of the members of the Executive Team shall be within the ranges set forth in the last data received from the healthcare executive compensation consultant for that position, and shall be consistent with the Board's general approach to maintaining the combination of base executive salaries and potential incentive compensation amounts at or near the median for comparable institutions.

C. **Overall Consideration.** As employees of Kaweah ~~Delta~~Health, the other members of the Executive Team will be entitled to health and retirement benefits as offered to other employees of Kaweah Delta. In evaluating base salaries and incentive compensation, the CEO may take into consideration the overall consideration (which may include health, life and disability benefits, deferred compensation or other retirement benefits, and other perquisites common in the industry) provided to executives in functionally comparable positions at comparable institutions, with a view toward having the total consideration provided to members of Kaweah ~~Delta's~~ Health's Executive Team

be at or near the median of the total consideration provided to executives in functionally comparable positions at comparable institutions. If the CEO believes that any member of the Executive Team should, on the basis of such information, have his/her salary or incentive compensation re-set above the median for executives in functionally comparable positions at comparable institutions, the CEO shall obtain the prior approval of the Board.

"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: BOD5	**Date Created: 11/01/2011**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Conflict of Interest

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POLICY:

Government Code Section 87300 requires each state and local government agency to adopt and promulgate a Conflict of Interest Code. The Fair Political Practices Commission has adopted Section 18730 of Title 2 of the California Code of Regulations, which contains the terms of a model conflict of interest code (hereinafter "Standard Code") which may be adopted by reference by any state or local agency which desires to do so. For the purpose of providing a conflict of interest code for Kaweah Delta Health Care District dba Kaweah Health {Kaweah Health}, its Board of Directors, and its employees, the terms of the Standard Code and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference and made a part hereof as if set forth herein at length, and, along with Exhibits A and B attached hereto, in which officials and employees are designated and disclosure categories are set forth, such Standard Code shall constitute the Conflict of Interest Code for Kaweah Delta Health Care District Kaweah Health, its Board of Directors, and its employees. The Chief Executive Officer shall ensure that a current copy of the Standard Code is kept on file in the ~~District's~~ Kaweah Health administrative office with this Conflict of Interest Code. A copy of the current version of the Standard Code is attached hereto as "Exhibit C" for information purposes only.

Pursuant to Section 4 of the Standard Code, designated employees shall file statements of economic interests with the Chief Executive Officer of Kaweah ~~Delta Health Care District~~Health . Upon receipt of the statements filed by the designated employees of the department, the Chief Executive Officer shall make and retain ~~a copy~~the original and forward ~~the original~~a copy of these statements to the code reviewing body, which in this case is the Tulare County Board of Supervisors.

Adopted by the Board of Directors of Kaweah Delta Health Care District effective ~~April 27, 2020~~June 29, 2022.

PROCEDURE:

I. Members, Board of Directors and Chief Executive Officer

All members of the Kaweah ~~Delta Health Care District~~ Health Board of Directors and the individual occupying the position of Chief Executive Officer must complete and file Statements of Economic Interest with the Office of the Chief Executive Officer. Disclosure must include items listed in Exhibit "B"

II. Other Affected Positions

Individuals occupying positions as noted in Exhibit "A" are also required to complete and file, with the office of the Chief Executive Officer of Kaweah ~~Delta Health Care District~~Health, Statements of Economic Interest. The types of interest to be disclosed are identified on "Exhibit B" per position held with ~~the District~~Kaweah Health.

III. Filing Deadlines

Individuals required to complete and file Statements of Economic Interest must do so with the appropriate office:

A. within thirty (30) days after the effective date of the adoption of the Conflict of Interest Code;
B. within thirty (30) days after assuming a position requiring filing such Statement;
C. within thirty (30) days after leaving a position requiring filing of such Statement; and,
D. annually, during the month of January, no later than April 1, for each year in which the individual occupies a position requiring a Statement.

EXHIBIT "A"

KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Disclosure Categories

Designated Positions	Category of Interests Required to be Disclosed
Members of the Board of Directors	1
Employees	
Chief Executive Officer	1
Chief Financial Officer	1
Chief Operating Officer	1
Chief Quality Officer	1
Chief Medical Officer	1
Chief Nursing Officer	1
Chief Information & Cybersecurity Officer	1
Chief Human Resources Officer	1
Chief Strategy Officer	1
Chief of Population Health	1
Chief of Medical Education	1
Chief Compliance and Risk Officer	1
Director of Audit and Consulting	1
Director of Procurement and Logistics Material Management	1
Kaweah Health Medical Group Chief Executive Officer	1
Kaweah Health Medical Group Chief Financial Officer	1
Director of Risk Management	1
Director of Facilities	1
Director of Facilities Planning Services	1
All Directors of Kaweah Delta Health Care District dba Kaweah Health	4B
Consultants	
Legal Counsel to the Board of Directors	1

["Consultants may be designated employees who must disclose financial interests as determined on a case-by-case basis. The District must make a written determination whether a consultant must disclose financial interests. The determination shall include a description of the consultant's duties and a statement of the extent of the disclosure requirements, if any, based upon that description. All such determinations are public records and shall be retained for public inspection with this conflict of interest code.

["Consultants can be deemed to participate in making a governmental decision when the consultant, acting within the authority of his or her position:

(1) Negotiates, without significant substantive review, with a governmental entity or private person regarding certain governmental decisions; or

(2) Advises or makes recommendations to the decision-maker either directly or without significant intervening substantive review, by:

a. Conducting research or making an investigation, which requires the exercise of judgment on the part of the person and the purpose of which is to influence a governmental decision; or

b. Preparing or presenting a report, analysis, or opinion, orally or in writing, which requires the exercise of judgment on the part of the person and the purpose of which is to influence the decision."

(From the Tulare County Counsel)

{A consultant is also subject to the disclosure requirements if he/she acts in a staff capacity (i.e., performs the same or substantially all the same duties that would otherwise be performed by an individual holding a position specified in the Code).]

EXHIBIT "B"

KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Disclosure Categories

1. **Full Disclosure:**

Designated persons in this category must report:

All interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interest or option to acquire such interest in real property.

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

2. **Full Disclosure (excluding interests in real property):**

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

3. **Interests in Real Property (only):**

All interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interest or option to acquire such interest in real property.

4. **General Contracting (two options):**

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the District.

[Intended for employees whose duties and decisions involve contracting and purchasing for the entire District.]

B. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the employee's department or division.

[Intended for employees whose duties and decisions involve contracting and purchasing for a specific department or division of the District.]

5. **Regulatory, Permit or Licensing Duties:**

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that are subject to the regulatory, permit or licensing authority of, or have an application for a license or permit pending before, the employee's department or division, or the District.

6. **Grant/Service Providers/Departments that Oversee Programs:**

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the source is of the type to receive grants or other monies from or through a specific department or division of the District.

[Intended for employees whose duties and decision involve awards of monies or grants to organizations or individuals.]

EXHIBIT "C"

KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Standard Code

§ 18730. Provisions of Conflict of Interest Codes.

(a) Incorporation by reference of the terms of this regulation along with the designation of employees and the formulation of disclosure categories in the Appendix referred to below constitute the adoption and promulgation of a conflict of interest code within the meaning of Government Code section 87300 or the amendment of a conflict of interest code within the meaning of Government Code section 87306 if the terms of this regulation are substituted for terms of a conflict of interest code already in effect. A code so amended or adopted and promulgated requires the reporting of reportable items in a manner substantially equivalent to the requirements of article 2 of chapter 7 of the Political Reform Act, Government Code sections 81000, *et seq*. The requirements of a conflict of interest code are in addition to other requirements of the Political Reform Act, such as the general prohibition against conflicts of interest contained in Government Code section 87100, and to other state or local laws pertaining to conflicts of interest.

(b) The terms of a conflict of interest code amended or adopted and promulgated pursuant to this regulation are as follows:

(1) Section 1. Definitions.

The definitions contained in the Political Reform Act of 1974, regulations of the Fair Political Practices Commission (2 Cal. Code of Regs. sections 18100, *et seq*.), and any amendments to the Act or regulations, are incorporated by reference into this conflict of interest code.

(2) Section 2. Designated Employees.

The persons holding positions listed in the Appendix are designated employees. It has been determined that these persons make or participate in the making of decisions which may foreseeably have a material effect on economic interests.

(3) Section 3. Disclosure Categories.

This code does not establish any disclosure obligation for those designated employees who are also specified in Government Code section 87200 if they are designated in this code in that same capacity or if the geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction in which those persons must report their economic interests pursuant to article 2 of chapter 7 of the Political Reform Act, Government Code sections 87200, et seq.

In addition, this code does not establish any disclosure obligation for any designated employees who are designated in a conflict of interest code for another agency, if all of the following apply:

(A) The geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction of the other agency;

(B) The disclosure assigned in the code of the other agency is the same as that required under article 2 of chapter 7 of the Political Reform Act, Government Code section 87200; and

(C) The filing officer is the same for both agencies. [1]

Such persons are covered by this code for disqualification purposes only. With respect to all other designated employees, the disclosure categories set forth in the Appendix specify which kinds of economic interests are reportable. Such a designated employee shall disclose in his or her statement of economic interests those economic interests he or she has which are of the kind described in the disclosure categories to which he or she is assigned in the Appendix. It has been determined that the economic interests set forth in a designated employee's disclosure categories are the kinds of economic interests which he or she foreseeably can affect materially through the conduct of his or her office.

(4) Section 4. Statements of Economic Interests: Place of Filing.

The code reviewing body shall instruct all designated employees within its code to file statements of economic interests with the agency or with the code reviewing body, as provided by the code reviewing body in the agency's conflict of interest code. (5) Section 5. Statements of Economic Interests: Time of Filing.

(A) Initial Statements. All designated employees employed by the agency on the effective date of this code, as originally adopted, promulgated and approved by the code reviewing body, shall file statements within 30 days after the effective date of this code. Thereafter, each person already in a position when it is designated by an amendment to this code shall file an initial statement within 30 days after the effective date of the amendment.

(B) Assuming Office Statements. All persons assuming designated positions after the effective date of this code shall file statements within 30 days after assuming the designated positions, or if subject to State Senate confirmation, 30 days after being nominated or appointed.

(C) Annual Statements. All designated employees shall file statements no later than April 1.

(D) Leaving Office Statements. All persons who leave designated positions shall file statements within 30 days after leaving office.

(5.5) Section 5.5. Statements for Persons Who Resign Prior to Assuming Office.

Any person who resigns within 12 months of initial appointment, or within 30 days of the date of notice provided by the filing officer to file an assuming office statement, is not deemed to have assumed office or left office, provided he or she did not make or participate in the making of, or use his or her position to influence any decision and did not receive or become entitled to receive any form of payment as a result of his or her appointment. Such persons shall not file either an assuming or leaving office statement.

(A) Any person who resigns a position within 30 days of the date of a notice from the filing officer shall do both of the following:

(1) File a written resignation with the appointing power; and

(2) File a written statement with the filing officer declaring under penalty of perjury that during the period between appointment and resignation he or she did not make, participate in the making, or use the position to influence any decision of the agency or receive, or become entitled to receive, any form of payment by virtue of being appointed to the position.

(6) Section 6. Contents of and Period Covered by Statements of Economic Interests.

(A) Contents of Initial Statements.

Initial statements shall disclose any reportable investments, interests in real property and business positions held on the effective date of the code and income received during the 12 months prior to the effective date of the code.

(B) Contents of Assuming Office Statements.

Assuming office statements shall disclose any reportable investments, interests in real property and business

positions held on the date of assuming office or, if subject to State Senate confirmation or appointment, on the date of nomination, and income received during the 12 months prior to the date of assuming office or the date of being appointed or nominated, respectively.

(C) Contents of Annual Statements. Annual statements shall disclose any reportable investments, interests in real property, income and business positions held or received during the previous calendar year provided, however, that the period covered by an employee's first annual statement shall begin on the effective date of the code or the date of assuming office whichever is later, or for a board or commission member subject to Government Code section 87302.6, the day after the closing date of the most recent statement filed by the member pursuant to 2 Cal. Code Regs. section 18754.

(D) Contents of Leaving Office Statements.

Leaving office statements shall disclose reportable investments, interests in real property, income and business positions held or received during the period between the closing date of the last statement filed and the date of leaving office.

(7) Section 7. Manner of Reporting.

Statements of economic interests shall be made on forms prescribed by the Fair Political Practices Commission and supplied by the agency, and shall contain the following information:

(A) Investments and Real Property Disclosure.

When an investment or an interest in real property[3] is required to be reported,[4] the statement shall contain the following:

1. A statement of the nature of the investment or interest;

2. The name of the business entity in which each investment is held, and a general description of the business activity in which the business entity is engaged;

3. The address or other precise location of the real property;

4. A statement whether the fair market value of the investment or interest in real property equals or exceeds two thousand dollars ($2,000), exceeds ten thousand dollars ($10,000), exceeds one hundred thousand dollars ($100,000), or exceeds one million dollars ($1,000,000).

(B) Personal Income Disclosure. When personal income is required to be reported,[5] the statement shall contain:

1. The name and address of each source of income aggregating five hundred dollars ($500) or more in value, or fifty dollars ($50) or more in value if the income was a gift, and a general description of the business activity, if any, of each source;

2. A statement whether the aggregate value of income from each source, or in the case of a loan, the highest amount owed to each source, was one thousand dollars ($1,000) or less, greater than one thousand dollars ($1,000), greater than ten thousand dollars ($10,000), or greater than one hundred thousand dollars ($100,000);

3. A description of the consideration, if any, for which the income was received;

4. In the case of a gift, the name, address and business activity of the donor and any intermediary through which the gift was made; a description of the gift; the amount or value of the gift; and the date on which the gift was received;

5. In the case of a loan, the annual interest rate and the security, if any, given for the loan and the term of the

loan.

(C) Business Entity Income Disclosure. When income of a business entity, including income of a sole proprietorship, is required to be reported,[6] the statement shall contain:

1. The name, address, and a general description of the business activity of the business entity;

2. The name of every person from whom the business entity received payments if the filer's pro rata share of gross receipts from such person was equal to or greater than ten thousand dollars ($10,000).

(D) Business Position Disclosure. When business positions are required to be reported, a designated employee shall list the name and address of each business entity in which he or she is a director, officer, partner, trustee, employee, or in which he or she holds any position of management, a description of the business activity in which the business entity is engaged, and the designated employee's position with the business entity.

(E) Acquisition or Disposal During Reporting Period. In the case of an annual or leaving office statement, if an investment or an interest in real property was partially or wholly acquired or disposed of during the period covered by the statement, the statement shall contain the date of acquisition or disposal.

(8) Section 8. Prohibition on Receipt of Honoraria.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept any honorarium from any source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests. This section shall not apply to any part time member of the governing board of any public institution of higher education, unless the member is also an elected official.

Subdivisions (a), (b), and (c) of Government Code section 89501 shall apply to the prohibitions in this section.

This section shall not limit or prohibit payments, advances, or reimbursements for travel and related lodging and subsistence authorized by Government Code section 89506.

(8.1) Section 8.1 Prohibition on Receipt of Gifts in Excess of $390.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept gifts with a total value of more than $390 in a calendar year from any single source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests. This section shall not apply to any part time member of the governing board of any public institution of higher education, unless the member is also an elected official.

Subdivisions (e), (f), and (g) of Government Code section 89503 shall apply to the prohibitions in this section.

(8.2) Section 8.2. Loans to Public Officials.

(A) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the elected officer holds office or over which the elected officer's agency has direction and control.

(B) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the public official holds office or over which the public official's agency has direction and control. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(C) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that

elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status.

(D) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(E) This section shall not apply to the following:

1. Loans made to the campaign committee of an elected officer or candidate for elective office.

2. Loans made by a public official's spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such persons, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.

3. Loans from a person which, in the aggregate, do not exceed five hundred dollars ($500) at any given time.

4. Loans made, or offered in writing, before January 1, 1998.

(8.3) Section 8.3. Loan Terms.

(A) Except as set forth in subdivision (B), no elected officer of a state or local government agency shall, from the date of his or her election to office through the date he or she vacates office, receive a personal loan of five hundred dollars ($500) or more, except when the loan is in writing and clearly states the terms of the loan, including the parties to the loan agreement, date of the loan, amount of the loan, term of the loan, date or dates when payments shall be due on the loan and the amount of the payments, and the rate of interest paid on the loan.

(B) This section shall not apply to the following types of loans:

1. Loans made to the campaign committee of the elected officer.

2. Loans made to the elected officer by his or her spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.

3. Loans made, or offered in writing, before January 1, 1998.

(C) Nothing in this section shall exempt any person from any other provision of Title 9 of the Government Code.

(8.4) Section 8.4. Personal Loans.

(A) Except as set forth in subdivision (B), a personal loan received by any designated employee shall become a gift to the designated employee for the purposes of this section in the following circumstances:

1. If the loan has a defined date or dates for repayment, when the statute of limitations for filing an action for default has expired.

2. If the loan has no defined date or dates for repayment, when one year has elapsed from the later of the following:

a. The date the loan was made.

b. The date the last payment of one hundred dollars ($100) or more was made on the loan.

c. The date upon which the debtor has made payments on the loan aggregating to less than two hundred fifty dollars ($250) during the previous 12 months.

(B) This section shall not apply to the following types of loans:

1. A loan made to the campaign committee of an elected officer or a candidate for elective office.

2. A loan that would otherwise not be a gift as defined in this title.

3. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor has taken reasonable action to collect the balance due.

4. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor, based on reasonable business considerations, has not undertaken collection action. Except in a criminal action, a creditor who claims that a loan is not a gift on the basis of this paragraph has the burden of proving that the decision for not taking collection action was based on reasonable business considerations.

5. A loan made to a debtor who has filed for bankruptcy and the loan is ultimately discharged in bankruptcy.

(C) Nothing in this section shall exempt any person from any other provisions of Title 9 of the Government Code.

(9) Section 9. Disqualification.

No designated employee shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any governmental decision which he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the official or a member of his or her immediate family or on:

(A) Any business entity in which the designated employee has a direct or indirect investment worth two thousand dollars ($2,000) or more;

(B) Any real property in which the designated employee has a direct or indirect interest worth two thousand dollars ($2,000) or more;

(C) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating five hundred dollars ($500) or more in value provided to, received by or promised to the designated employee within 12 months prior to the time when the decision is made;

(D) Any business entity in which the designated employee is a director, officer, partner, trustee, employee, or holds any position of management; or

(E) Any donor of, or any intermediary or agent for a donor of, a gift or gifts aggregating $390 or more provided to, received by, or promised to the designated employee within 12 months prior to the time when the decision is made.

(9.3) Section 9.3. Legally Required Participation.

No designated employee shall be prevented from making or participating in the making of any decision to the extent his or her participation is legally required for the decision to be made. The fact that the vote of a designated employee who is on a voting body is needed to break a tie does not make his or her participation

legally required for purposes of this section.

(9.5) Section 9.5. Disqualification of State Officers and Employees.

In addition to the general disqualification provisions of section 9, no state administrative official shall make, participate in making, or use his or her official position to influence any governmental decision directly relating to any contract where the state administrative official knows or has reason to know that any party to the contract is a person with whom the state administrative official, or any member of his or her immediate family has, within 12 months prior to the time when the official action is to be taken:

(A) Engaged in a business transaction or transactions on terms not available to members of the public, regarding any investment or interest in real property; or

(B) Engaged in a business transaction or transactions on terms not available to members of the public regarding the rendering of goods or services totaling in value one thousand dollars ($1,000) or more.

(10) Section 10. Disclosure of Disqualifying Interest.

When a designated employee determines that he or she should not make a governmental decision because he or she has a disqualifying interest in it, the determination not to act may be accompanied by disclosure of the disqualifying interest.

(11) Section 11. Assistance of the Commission and Counsel.

Any designated employee who is unsure of his or her duties under this code may request assistance from the Fair Political Practices Commission pursuant to Government Code section 83114 and 2 Cal. Code Regs. sections 18329 and 18329.5 or from the attorney for his or her agency, provided that nothing in this section requires the attorney for the agency to issue any formal or informal opinion.

(12) Section 12. Violations.

This code has the force and effect of law. Designated employees violating any provision of this code are subject to the administrative, criminal and civil sanctions provided in the Political Reform Act, Government Code sections 81000 – 91014. In addition, a decision in relation to which a violation of the disqualification provisions of this code or of Government Code section 87100 or 87450 has occurred may be set aside as void pursuant to Government Code section 91003.

NOTE: Authority cited: Section 83112, Government Code.
Reference: Sections 87103(e), 87300-87302, 89501, 89502 and 89503, Government Code.

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[1] Designated employees who are required to file statements of economic interests under any other agency's conflict of interest code, or under article 2 for a different jurisdiction, may expand their statement of economic interests to cover reportable interests in both jurisdictions, and file copies of this expanded statement with both entities in lieu of filing separate and distinct statements, provided that each copy of such expanded statement filed in place of an original is signed and verified by the designated employee as if it were an original. See Government Code section 81004.

[2]See Government Code section 81010 and 2 Cal. Code of Regs. section 18115 for the duties of filing officers and persons in agencies who make and retain copies of statements and forward the originals to the filing officer.

[3]For the purpose of disclosure only (not disqualification), an interest in real property does not include the principal residence of the filer.

[4]Investments and interests in real property which have a fair market value of less than $2,000 are not investments and interests in real property within the meaning of the Political Reform Act. However, investments or interests in real property of an individual include those held by the individual's spouse and

dependent children as well as a pro rata share of any investment or interest in real property of any business entity or trust in which the individual, spouse and dependent children own, in the aggregate, a direct, indirect or beneficial interest of 10 percent or greater.

[5]A designated employee's income includes his or her community property interest in the income of his or her spouse but does not include salary or reimbursement for expenses received from a state, local or federal government agency.

[6]Income of a business entity is reportable if the direct, indirect or beneficial interest of the filer and the filer's spouse in the business entity aggregates a 10 percent or greater interest. In addition, the disclosure of persons who are clients or customers of a business entity is required only if the clients or customers are within one of the disclosure categories of the filer.

Policy Number: BOD7	Date Created: 10/30/2013
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Presentation of Claims and Service Process

POLICY: Suits for money or damages filed against a public entity such as Kaweah Delta Health Care District dba Kaweah Health are regulated by statutes contained in division 3.6 of the California Government Code, commonly referred to as the Government Claims Act. Government Code § 905 requires the presentation of all claims for money or damages against local public entities such as Kaweah Health, subject to certain exceptions. Claims for personal injury and property damages must be presented within six (6) months after accrual; all other claims must be presented within one (1) year.

Presentation of a claim is generally governed by Government Code § 915 which provides that a claim, any amendment thereto, or an application for leave to present a late claim shall be presented to Kaweah Health by either delivering it to the clerk, secretary or auditor thereof, or by mailing it to the clerk, secretary, auditor, or to the governing body at its principal office.

Service of process on a public entity such as Kaweah Health is generally governed by Code of Civil Procedure § 416.50 which provides that a summons may be served by delivering a copy of the summons and complaint to the clerk, secretary, president, presiding officer or other head of its governing body.

This policy is intended to precisely identify those individuals who may receive claims on behalf of Kaweah Health and those individuals who may receive a summons and complaint on behalf of Kaweah Health.

PROCEDURE:

I. **Presentation of a Government Claim**

A. Personal Delivery. Only the Board Clerk, the Board Secretary, or the Auditor are authorized to receive delivery of a Government Claim on behalf of Kaweah Health. In the absence of the Board Clerk, the Board Secretary, and the Auditor, the ~~Vice President,~~ Chief Compliance and Risk Officer. In the absence of the Board Clerk the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer is authorized to receive personal delivery of a government claim on behalf of Kaweah Health. No other individual is authorized to receive delivery of a Government Claim on behalf of Kaweah Health.

B. Mailing. Only the Board Clerk, the Board Secretary, or the Auditor are authorized to receive mailing of a Government Claim on behalf of Kaweah Health. No other individual is authorized to receive mailing of a Government Claim on behalf of Kaweah Health, unless the claim is addressed to the Board of Directors and mailed to the Board of Directors of Kaweah Health at 400 West Mineral King Avenue, Visalia, CA, 93291, the principal office of the Board of Directors.

C. Processing a Presented Claim. If a claim is (1) delivered to the Board Clerk, the Board Secretary, or the Auditor. In the absence of the Board Clerk, the Board Secretary, and the District's Auditor, the ~~Vice President,~~ Chief Compliance and Risk Officer, the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer is authorized to receive personal delivery of a government claim on behalf of the District; or (2) received in the mail addressed to the Board Clerk, the Board Secretary, or the Auditor; or (3) received in the mail addressed to the Board of Directors of Kaweah Health at 400 West Mineral King Avenue, Visalia, CA, 93291, the claim shall be immediately provided to the Board Clerk, in the Board Clerks absence the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer- shall ~~so the~~ date, time and manner of delivery/mailing can be recorded ~~by the Board Clerk~~ in a log to be maintained in the Board Clerk's office. The Board Clerk shall then make prompt arrangements to have a copy of the claim, as well as the log information for the claim, provided to the Kaweah Health Risk Management Department and to the legal counsel for Kaweah Health who will be representing Kaweah Health with respect to the claim. In the event that a claim is accepted by the Auditor or the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer, in the absence of the Board Clerk, the claim shall be marked with the date/time and manner of delivery/mailing recorded. The claim shall be immediately forwarded to the Risk Management Department to be processed as noted above.

If delivery of a claim is attempted on any individual other than the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer), the Board Secretary, or the Auditor, then the person attempting delivery shall be advised by the individual on whom delivery of a claim is being attempted that he/she is not authorized to receive delivery of a claim on behalf of Kaweah Health and he/she shall decline to accept delivery. If a claim is delivered to any individual other than the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing

Officer)~~Board Clerk~~, the Board Secretary, or the Auditor, then the claim shall be promptly forwarded directly to Kaweah Health's general counsel for possible return to the sender. The ~~-~~general counsel shall advise the District's Risk Management Department of the handling of the improperly presented claim.

If a claim is received in the mail that is not addressed to the Board Clerk, the Board Secretary, or the Auditor and is not addressed to the Board of Directors of the District at 400 West Mineral King Avenue, Visalia, CA, 93291, then the claim shall be promptly forwarded directly to Kaweah Delta's general counsel for possible return to the sender. Kaweah Delta's general counsel shall advise the Risk Management Department of the handling of the improperly presented claim.

II. Service of Summons and Complaint.

A. Personal Delivery. Only the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer)~~Board Clerk~~, the Board Secretary or the Board President is authorized to accept delivery of a summons and complaint on behalf of Kaweah Delta. In the absence of the Board Clerk, the Board Secretary, or the Board President, the Chief Compliance and Risk Management Officer and the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer)is authorized to receive personal delivery of a Summon and Complaint on behalf of Kaweah Delta. In the absence of the Board Clerk, Board Secretary, Board President ~~and~~ the Chief Compliance and Risk Management Officer, the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer the Administration Department staff will contact Kaweah Delta's general counsel who will advise how to proceed with the service of the summons and complaint. No other individual, and no other manner of service, is authorized in the absence of a court order or a specific authorization from the Board President, who is granted limited authority as described in this policy.

B. Processing a Delivered Summons and Complaint. If a summons and complaint are delivered to the Board Clerk, the Board Secretary or the Board President, they shall be immediately provided to the Board Clerk so the date, time and manner of delivery can be recorded by the Board Clerk in a log to be maintained in the Board Clerk's office. In the absence of the Board Clerk, the Board Secretary, or the Board President, the Vice President, Chief Compliance & Risk Management Officer or the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer) is authorized to receive personal delivery of a Summon and Complaint on behalf of the District. The Board Clerk shall then make prompt arrangements to have a copy of the summons and complaint, as well as the log information for the summons and complaint, provided to the ~~-~~Risk Management Department and to the legal counsel for Kaweah Health who will be representing Kaweah Health with respect to the litigation.

If service of a summons and complaint is attempted on any individual other than the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing

Officer)~~Board Clerk~~, the Board Secretary or the Board President, then the person attempting delivery shall be advised by the individual on whom delivery is being attempted that he/she is not authorized to accept service of a summons and complaint on behalf of Kaweah Health and he/she shall decline to accept service.

An exception to the forgoing may be made only in circumstances where legal counsel for Kaweah Health receives prior authorization from the Board President to accept service of a summons and complaint on behalf of Kaweah Health.

If a summons and complaint is received under circumstances other than by delivery to the Board Clerk, the Board Secretary or the Board President, or through receipt by legal counsel with prior authorization from the Board President to accept service on behalf of Kaweah Health, then the summons and complaint shall be promptly forwarded directly to Kaweah Health's general counsel for possible return to the party who attempted service. Kaweah Health's general counsel shall advise the Risk Management Department of the handling of the improperly served summons and complaint.

"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 1001	**Date Created: 06/01/2009**
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)	

Safety 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 Safety at Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) is to provide a built-environment wherein patient care can be optimized~~,~~ and to create an environment that minimizes physical harm and hazards for the patient-care population, staff, volunteers, physicians, contracted workers and visitors. It is an accreditation/standards-based and regulatory driven program, which is assessed for effectiveness during the annual evaluation process.

II. SCOPE

The scope of this management plan applies to KH and any off site area as per KH license. Off-site areas are monitored for compliance with this plan during routine surveillance by Environment of Care (EOC) committee members. Each off site area is required to have a unit-specific safety plan that addresses the unique considerations of the building environment. Off-site areas are monitored for compliance with this plan during routine environmental surveillance by EOC Committee members. It is the responsibility of the Safety Officer to assess and document compliance with the Safety Management Plan. Safety-related issues may be brought to the attention of the EOC Committee. The scope of the plan and program includes, but is not limited to the following safety-related activities: surveillance activities, applicable safety policies and procedures, educational and performance improvement activities.

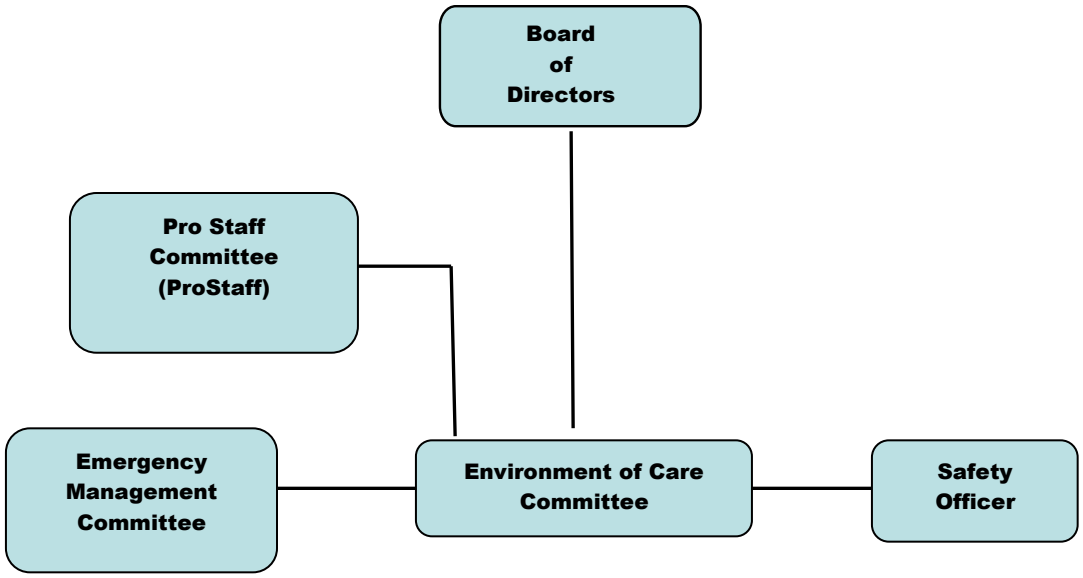
III. AUTHORITY

The authority for the Management Plan for Safety is EC. 01.01.01 and EC. 04.01.01. The authority for overseeing and monitoring the safety management plan and program lies in the EOC Committee, for the purpose of ensuring that safety management activities are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary. Whenever possible, regulatory requirements are integrated with accreditation standards to avoid duplication of efforts and to assist in meeting or exceeding the requirements or the accreditation standards. The Chief Executive Officer and Board of Trustees have given the Safety Officer the authority to intervene whenever a hazard exists that poses a threat to life or property at a KH facility.

IV. ORGANIZATION

The following represents the organization of safety management at KH:

Organization - Safety Management



V. RESPONSIBILITIES

Leadership within KH has varying levels of responsibility and work together in the management of risk and in the coordination of risk reduction activities in the physical environment as follows:

Board of Directors: The Board of Directors supports the Safety Management Plan by:

- Review and feedback if applicable of the quarterly and annual *Environment of Care* reports
- Endorsing budget support as applicable, which is needed to implement a safe and healthy environment, identified through the activities of the Safety Management Program.

ProStaff: Reviews annual *Environment of Care* 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 Safety Management Program

Environment of Care Committee: EOC Committee members review and approve the quarterly *Environment of Care* reports, which contain a Safety Management component. Members also monitor and evaluate the Safety Management program **(EC .04.01.01-1)** and afford a multidisciplinary process for resolving EOC issues. Committee members represent clinical, administrative and support services when applicable. The committee addresses *EOC* issues in a timely manner, and makes recommendations as appropriate for approval. *EOC* issues are communicated to the KH's leaders through quarterly and annual evaluation reports. At least annually, one Process Improvement activity may be selected by EOC Committee members, based upon risk to the organization. EOC issues are communicated to those responsible for managing the patient safety program as applicable.

Directors and Department Managers: These individuals support the Safety Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process.
- Communicating recommendations from the EOC Committee to affected staff in a timely manner.
- Developing education programs within each department that insure compliance with the policies of the Safety Management Program including, but not limited to department-specific safety training for new hires, students, volunteers, contracted workers, annual safety reorientation and unit-specific hazard training applicable to their areas.

- Supporting all required employee safety education and training by monitoring employee participation and setting clear expectations for employee participation to include a disciplinary policy for employees who fail to meet the expectations.
- Serving as a resource for staff on matters of health and safety.
- Ensuring employees are knowledgeable on how to access EOC Policies on Policy Tech.
- Ensuring that the procedure for work-related injuries is followed, and that accident investigation is completed immediately post injury or exposure, and documented on the appropriate form.

Employees. Employees of KH are required to participate in the Safety Management program by:

- Completing required safety education.
- Using the appropriate personal protective equipment when applicable. Practicing safe work habits and reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification.

Medical Staff: Medical Staff will support the Safety Management Program by practicing safe work practices while performing procedures at KH, and assisting in the care of employees who receive a work-related injury.

SAFETY OFFICER AUTHORITY

Safety Officer. A qualified individual, is appointed by executive leadership to assume the safety officer role, and oversees the development, implementation and monitoring of safety management at KH. The Safety Officer is responsible for responding to system or process failures that may have an impact on employee, patient or building safety.

MANAGEMENT OF SAFETY RISKS

(KH) identifies safety risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root-cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. If a risk is identified, a risk/benefit analysis process is used to determine if actions and monitoring activities are required. This information is documented and presented to the EOC committee.

Risk Assessment: The management of risks within KH is multi-focal, and consists of the following processes:

1. **Policy/Plan/Program Development**. Inherent in risk assessment are the development of safety policies (e.g., Safety Manual or unit-specific), management plans, and program development for safety through the structure of the EOC Committee. Regulations, accreditation or industry standards (e.g., TJC, Title 8 – Employee Illness and Injury Prevention Program, Title 22-licensing requirements for acute care facilities, Title 17-Radiation Safety, OSHA 29 CFR 1910-Chemical Hygiene Officer and Plan) provide the basis and authority for policy/plan and program development.
2. **Environmental Surveillance, Results of Root-Cause Analyses, Pro-active Risk Assessment of high-risk processes.** Included in risk assessment are findings during environmental surveillance that reflect risk identification, and findings from root-cause analyses that require follow-up and improvement actions. During the annual evaluation process, risk identification may occur from a retrospective analysis of performance monitoring of high-risk processes, which will require a plan for improvement to minimize unfavorable outcomes from the possibility of consequential risks. Accountability for assessment and improvement activities are with the EOC committee.
3. **External Sources:** *Sentinel Event Alerts*, Regulatory and Insurer inspections, Audits, and Consultants. Risk assessment may occur as a result of findings or recommendations generated from external sources, such as *Sentinel Event Alerts,* Regulatory and/or Insurer surveys, or audits conducted by recruited consultants. Accountability for assessment and improvement activities is with the EOC committee.

4. **Education:** Education is implemented to provide information~~,~~ and thereby mitigate risk and includes, but is not limited to:
    - New hire
    - Annual Reorientation
    - Department Specific Education
    - Education for patients, staff, physicians, volunteers, students
    - Education based upon a needs assessment for any specific population.
    - Education based upon risk assessment or the results of surveys, inspections or Audits
5. **Drills – Planned Exercises:** Conducting drills such as fire, disaster, and infant security constitute activities designed to inform, educate and thereby mitigate risk when areas of risk are identified during the debriefing and or evaluation process.
6. **Interim Life Safety Risk Assessment.** The *Interim Life Safety Risk Assessment* process is used to identify potential risks associated with construction, with the intent to develop interim life safety measures to mitigate the risks associated with construction projects. Concurrent building safety guidelines/processes are used to mitigate the risks associated with new construction (e.g., permits, Life Safety Code compliance, current *Statement of Conditions, Guidelines for Design and Construction of Hospitals and Health Care Facilities).*
7. **Reporting and Investigation of Incidents:** Complementary to risk assessment is proper reporting and investigation of incidents. There are multiple processes within KH wherein reporting and investigating elements contribute to risk assessment. Internal processes and activities that support risk assessment include reporting and investigation mechanisms which may identify the opportunity to mitigate risk, such as:
    - Security investigation of property damage, thefts, vandalism, burglary, assault, battery and any workplace violence incidents.
    - Risk Management investigations of patient and visitor incidents, including incidents on the grounds and premises.
    - Employee Health investigations that addresses employee incidents and injuries within Kaweah Health and on the grounds and premises.
    - Infection Control investigations and or surveillance that pro-actively identify practices that provide the opportunity to mitigate risks
    - Material Distribution recalls for products that may pose risk and the opportunity to proactively mitigate the potential for adverse outcomes
    - Pharmaceutical recalls, medication errors or near-misses that may provide the opportunity to proactively mitigate risk

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SAFETY RISKS

KH **takes action to minimize or eliminate identified safety risks.**

When risks are identified from the above processes, the EOC Committee uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to KH. Moreover, the identified risks may serve as the basis for the selection of performance standards, with the criteria identified as follows:

- The performance standard represents a high-volume activity, thereby representing risk by virtue of ongoing occurrences.
- The performance standard could represent a sentinel event activity (e.g., infant abduction). These types of activities, though rare in occurrence, represent risk due to their seriousness.
- The performance standard represents an activity or finding that needs improvement due to the possibility of adverse outcomes

Risk Reduction Strategies-Proactive

The following strategies are in place at KH to proactively minimize or eliminate safety risks:

1. **Worker Safety Program with Safety Officer Role**. The *Environment of Care* Committee outlines the broad objectives of the safety program for (KH), and implements various activities to ensure the program is viable, as well as defines, through the Safety Management Plan, how the overall plan and program will be evaluated for effectiveness. The Safety Officer has the authority to intervene whenever a hazard exists that poses a risk to the safety of the patients and or building. Alternate individuals are identified in the

absence of the Safety Officer. A Chemical Hygiene Officer role is in place within the Laboratory that oversees policies and procedures relating to lab safety for employees. An Infection Control Nurse oversees surveillance and infection control programs to minimize exposure risks.

2. **Committees.** The EOC Committee is the structure through which safety-related problems and issues can be identified and resolved. It should be noted that the EOC Committee is closely integrated with patient safety functions. The purpose of the EOC Committee with respect to the Patient Safety standards is to remain aware of sentinel event alert information from the Joint Commission and to assess organizational practices against current information relating to patient safety. Additionally, when recommendations are made for hospitals, each recommendation is critically reviewed, with a plan of action established. If sentinel events occur within the District setting that reflect *environment of care* issues, the EOC Committee will participate in improving outcomes relating to patient safety.

   The Radiation Safety Committee impacts worker safety as it oversees the radiation safety program and issues relating to the safety of the worker and radiation exposures. The Emergency Management Subcommittee convenes for the purpose of minimizing risks associated with unforeseen emergent situations that have the potential for consequential or adverse events.

3 **Reporting and Investigation Mechanisms:** Multiple sources of reporting and investigating mechanisms are in place (as identified above) that have the potential to identify risk and thereby implement action as needed to mitigate or minimize the identified risks.

4 **Policies/Procedures.** Safety policies and procedures are in place to assist the employee in the performance of safe-related activities related to the nature of their job tasks or their work areas. Policies and procedures are reviewed at least every three years.

5. **Education** – for Newly-hired Staff and Ongoing

   New hire education. Education relating to general safety processes is given during new hire orientation, and covers such topics as introductory information, an employee ‘s role with respect to general safety processes, types of safety materials and resources available for the employee on his/her unit, preliminary introduction to the concepts of “RACE” and compartmentalization”, emergency management, and introductory information relating to “Employee Right to Know”. This education is documented. Licensed Independent practitioners (LIP’s) receive *Environment of Care* education through the re-credentialing process, which identifies how LIP’s can eliminate or minimize physical risks in the environment of care, actions to take in the event of an incident, and how to report risks.

   a) **Area Specific Safety**. Area specific safety is covered for new employees and contracted workers on each department within (KH) and is the responsibility of the department manager and is documented. Information may include, but not be limited to location of the department’s fire alarms, fire extinguishers, exits, evacuation plans; and location of unit- specific policies and procedures.
   b) **Specific Job-Related Hazards**. Education relating to specific job-related hazards may be part of the new employee’s competencies, and part of the competency reorientation process. Examples of this may include job-related hazards related to the use of chemotherapy for nurses, “lock-out-tag out” for engineering staff, or use of certain cutting materials in the kitchen. Education for specific job-related hazards is the responsibility of the department manager and is documented.

Educational sources

Various types of experience at (KH) provide sources from which educational material is developed. These include, but will not necessarily be limited~~,~~ to, the following:

   a) **Environmental surveillance trends**. Through trending of surveillance results, it may be determined that staff need additional education. The survey process itself may be an educational tool for staff. For example, when staff are asked specific questions relating to fire or disaster roles, or location of SDS, or relating to their responsibilities with respect to defective equipment.

b) **Fire and Disaster drills**. When staff performance is evaluated during fire and disaster drills, educational topics may be developed if a knowledge deficit exists or if staff performance was not at the expected level.
c) **Changes in Operational Practices**. Whenever changes occur within (KDHCD) that requires additional safety education, the education will be determined by the EOC committee.
d) **Needs Assessment**. Another source of education is determined from periodic needs assessment tools. These can be gathered from educational evaluations wherein the staff may be asked, "What other types of educational topics would you like to see?" Or it may be done at the unit level, for example, with the use of medical equipment when user errors occur.
e) **Illness and Injury Trends**. When illness and injury trends demonstrate an increase, the increase may be the catalyst for further education. Increasing back or needle stick injuries, or falls are examples of using injury trends to substantiate the need for additional education.
f) **Consequential Events or Risk of Consequential Events**. An incident may occur that results in an adverse patient, visitor or employee injury. This will warrant investigation, and the possibility of additional education.
g) ***Environment of Care*** **Committee**. The EOC Committee may impose education upon staff due to various regulatory and/or accreditation agencies that require updating.
h) **Risk Assessment Activities**. When risks have been identified, the risks will serve as a source of education for staff, based upon the severity and type of risk assessed.

Risk Reduction Strategies – When Risks Have Been Identified
When proactive risks have been assessed, risk reduction strategies will be the responsibility of the EOC Committee, unless the risk poses the potential for serious consequential events (i.e., death, serious injury or building threat). In this instance, the individual who has assessed the risk will notify the Safety Officer and Risk Management leadership who will then assume responsibility for reduction of the risk threat. Risk reduction strategies for the possibility of non-serious or non-imminent consequential events may be addressed through the *Sentinel Event Review* or EOC Committee, based upon the severity and type of risk identified. Risk reduction strategies include, but are not limited to the following:

1. Policies and Procedures. Policies and procedures may require development or revision, with applicable training completed for affected staff.
2. Education. New or reinforced education may be implemented to minimize the potential for future risk.
3. Equipment. The purchase of new equipment or the use of current equipment may require evaluation.
4. Administrative Controls. Administrative controls such as changes in staffing, or changes in staffing patterns may require evaluation and implementation.
5. Equipment Training. Training on equipment may be implemented or re-enforced.
6. Repairs/ Upgrades on Equipment. Repairs and or upgrades on medical, utility, or building equipment may be required.
7. Elimination of the Risk. Elimination of the risk through removal of a hazard may occur.
8. Product or Equipment Change-out or Recall. Faulty or defective products or equipment may be recalled and replaced.

MAINTENANCE OF GROUNDS AND EQUIPMENT
(KH) manages risks associated with the grounds and equipment in order to minimize consequential events or adverse outcomes related to accidents.
Environmental surveys are done routinely by EOC Committee personnel. Additionally, routine and varied security patrols are conducted wherein any safety hazards are brought to the attention of the EOC Committee. Routine building/grounds surveys with a contractor's representative are conducted when construction activities are occurring. Special investigations by the Safety Officer and other designated staff, when requested, are conducted. Additionally, Risk Management reviews data from reported incidents that may identify patterns, trends and opportunities for improvements. The data involves all patient and visitor incidents related to accidents or other unusual events which are not

consistent with routine patient care and treatment. Incidents that involve patients or visitors, wherein some aspect of the building/grounds plays a consequential role, the Safety Officer will be notified so the hazard may be investigated and corrected as necessary. All of these activities contribute to an overall monitoring plan for the grounds and safety-related equipment.

Equipment - Imaging Risk Reduction:
The hospital provides MRI services, and manages safety risks associated with MRI for the following circumstances:

- Patients who may experience claustrophobia, anxiety or emotional distress: Medication may be provided by the physician to help the patient relax or to decrease his/her anxiety or emotional distress. The RN or MRI technologist may provide psycho-social support as necessary. .
- Patients who may require urgent or emergency medical care: for these patients, a crash cart is available if needed, with transfer to the Emergency Room or Critical Care an option when necessary.
- Patients with medical implants, devices or imbedded foreign objects (such as shrapnel): All patients receive a pre-screening questionnaire to determine if he/she has any imbedded implants, devices or foreign object that will require a clinical judgment to proceed or terminate the MRI. Implants are reviewed by MRI technologist to check for MRI conditional status and review parameters necessary, prior to MRI.
- Ferromagnetic objects entering the MRI environment: MRI staff have been trained to decrease/eliminate any ferromagnetic objects from entering the MRI environment.
- Acoustic noise: The noise made by the MRI can be bothersome to some patients. Patients are informed of this possibility, and that the MRI may be stopped if the noise becomes unbearable. Headphones, where available, and/or earplugs are provided to reduce MRI noise.
- Restricting access to everyone not trained in MRI safety or screened by MRI-trained staff from the scanner room and the area that immediately precedes the entrance to the MRI scanner room: Signage is in place that prohibits unauthorized personnel from entering the MRI area. Door is secure with key pad which effectively restricts entrance to only those who have been safety trained in MRI safety and individually screened using MRI screening questions.
- Making sure that these restricted areas are controlled by and under the direct supervisor of MRI-trained staff: Controlled areas to the MRI are under the direct supervision of MRI-trained staff.
- Posting signage at the entrance to the MRI scanner room that conveys the potentially dangerous magnetic fields that are present in the room. Signage should also indicate that the magnet is always on. Signage is posted at the entrance to the MRI stating that the MRI scanner room has potentially dangerous magnetic fields present, and no one is allowed except authorized personnel. All personnel review annual MRI safety during annual training via MyNetlearning.

Performance evaluation of Imaging Equipment.
To reduce the potential of risks relating to the operation and function relating to imaging equipment, the following activities and processes are in place:
For Diagnostic Radiology Equipment:

- A least annually a diagnostic medical physicist conducts a performance evaluation of all Diagnostic Imaging equipment that produce ionizing radiation. The evaluation, along with any recommendations and corrections, are documented. The evaluation utilizes phantoms to measure accuracy of dosages; alignment of beam, light, and collimators; and any functional process involved in acquiring images. Image quality of Computerized Radiography Reading units, Digital Detector Plates, workstations and monitors throughout the Imaging are also evaluated annually for image quality and accuracy, to include high and low contrast resolution, and artifact evaluation

For MRI Equipment:

- A least annually a diagnostic medical physicist or MRI scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation, along with any recommendations, are documented. The evaluation includes the use of phantoms to assess the following: image uniformity for all radiofrequency coils used clinically, slice

position accuracy, alignment light accuracy, high and low contrast resolution, geometric or distance accuracy, magnetic field homogeneity, and artifact evaluation.

FOR CT Equipment:

- Quality control and maintenance is in effect to maintain the clarity/quality of diagnostic images produced. Biomedical leadership identifies the frequency of maintenance activities for Imaging from a risk-based standpoint, and or manufacturer's recommendations.
- Annually, a medical physicist completes the following: measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol] for the adult brain, adult abdomen, pediatric brain and pediatric abdomen.
- Verifies that the radiation dose in the form of the CTDIvol that is displayed by the CT imaging system for each tested protocol is within 20% of the CTDIvol displayed on the CT console. The dates, results and verifications of these measurements are documented (Note: this is only applicable for systems capable of calculating and displaying radiation doses in the form of CTDIvol.
- Annually a medical physicist conducts a performance evaluation of all CT Imaging equipment, with the evaluation, along with recommendations for correcting any problems, documented. The evaluation includes the use of phantoms to assess the following: image uniformity, slice thickness accuracy, slice position accuracy (when prescribed from a scout image), alignment light accuracy, table travel accuracy, radiation beam width, high contrast resolution, low contrast resolution, geometric or distance accuracy, CT number accuracy and uniformity, artifact evaluation.
- All CT protocols on CT units are password protected and reviewed by CT technologist, radiologist and radiation safety officer (RSO).

FOR Nuclear Medicine Equipment:

- At least annually, a diagnostic medical physicist conducts a performance evaluation of all Nuclear Medicine imaging equipment. The evaluation, along with recommendations for correcting any problems identified, are documented.
- The evaluations are conducted for all the image types produced clinically by each type of Nuclear Medicine scanner (e.g., 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), sensitivity, energy resolution, count rate performance and artifact evaluation.

FOR PET Imaging:

- At least annually, a diagnostic medical physicist conducts a performance evaluation of all PET Imaging equipment. The evaluation results, along with recommendations for corrections, 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), and artifact evaluation. Note: the following tests are recommended, though not required for PET: sensitivity, energy resolution and count-rate performance; this is at the discretion of the Imaging leadership.

FOR Diagnostic X-Ray, MRI, CT, NM, PET Equipment: the annual performance evaluation conducted by the medical physicist includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution and spatial accuracy.

Product Notices and Recalls

Product Notices and Recalls. Product safety recall reports are presented to the EOC Committee with follow-up and outcome(s) on a quarterly basis. Noted are whether or not there were any adverse actions for the patient, the type of the product and the disposition of the product. Affected managers are notified when the product is identified within our inventory.

Pharmacy Safety: In support of safe and sterile conditions within the Pharmacy during compounding or admixing, sterility of packaging is present with "event shelf life" or dated products. Infection Control

surveillance observes for sterility of packaging, and Pharmacy implements quality control by observing for sterility prior to the use of a product. The only exception is in an urgent situation in which a delay could harm the patient or when the product's stability is short. (KH) is constructed to allow for clean, uncluttered and functionally separate areas for product preparation, and pharmacy staff is trained to use clean or sterile techniques. During preparation of pharmaceutical drugs and solutions, pharmacy staff is trained to visually inspect the medications for particulates, discoloration or other loss of integrity, and to remove the product from usage, and report the information to the vendor. To support pharmaceutical safety, (KH) has a laminar airflow hood for the preparation of intravenous admixtures or any other sterile product. The laminar airflow receives preventive maintenance in accordance with the manufacturer's recommendations.

Prohibition of Smoking

A nonsmoking policy is in place at (KH) and is enforced and monitored throughout all buildings by management, employees and Security staff. The purpose of the policy is to restrict smoking at KH and to reduce risks to patients who have a history of smoking, including possible adverse effects on treatment, and to reduce the risks to others of passive smoking and fire. The smoking policy prohibits smoking anywhere on District property. The smoking policy is addressed with all new employees upon hire and new patients upon admission. Security personnel are the primary monitoring personnel for enforcement. If breaches of policy are noted, the EOC Committee will develop strategies in conjunction with Security as enforcement, to eliminate the incidence of policy violations.

Information Collection System to monitor conditions in the Environment

1. (KH) establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
    - Injuries to patients or others within the District's facilities
    - Occupational illnesses and injuries to staff
    - Incidents of damage to its property or the property of others
    - Security incidents involving patients, staff or others within its facilities, including those related to workplace violence
    - Hazardous materials and waste spills and exposures
    - Fire safety management problems, deficiencies and failures
    - Medical or laboratory equipment management problems, failures and use errors
    - Utility systems management problems, failures or use errors

Through the EOC Committee structure, each of the above elements are reported and investigated on a routine basis by managerial or administrative staff, with oversight by the committee. Minutes and agendas are kept for each *Environment of Care* meeting.

Environmental Tours

(KH) conducts environmental tours to identify deficiencies, hazards and unsafe practices**.**

Department environmental tours are conducted throughout the District, including offsite locations by EOC Committee members for both the patient care and non-patient care areas. Environmental tours are conducted in the patient care areas, and in the non-patient care areas, with deficiencies, hazards and unsafe practices identified and corrected, or with a plan implemented.

Annual Evaluation of the Safety Management

On an annual basis EOC Committee members evaluate the Management Plan for Safety, 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 Safety Management plan will be evaluated to determine continued relevance for Kaweah Delta Health Care District (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 safety management plan: the targeted population for the management plan will be

evaluated (e.g., did the scope of the plan reach employee populations in the off-site areas, and throughout KH?)

- Performance Standards. Specific performance standards for the Safety 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.

(KH) analyzes identified Environment of Care Issues
Environment of care issues 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 Governing Board.

Priority Improvement Project
At least annually, one or more priority Improvement activities may be selected by Environment of Care Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment.

KH improves its Environment of Care
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of safety management. Performance standards are also identified for Security, Hazardous Materials, Emergency Management, Fire Prevention, Medical Equipment management and Utilities 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 *Environment of Care* issue that has impact on the safety of our patients. This may be determined from *Sentinel Event* surveillance, environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue emerges it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

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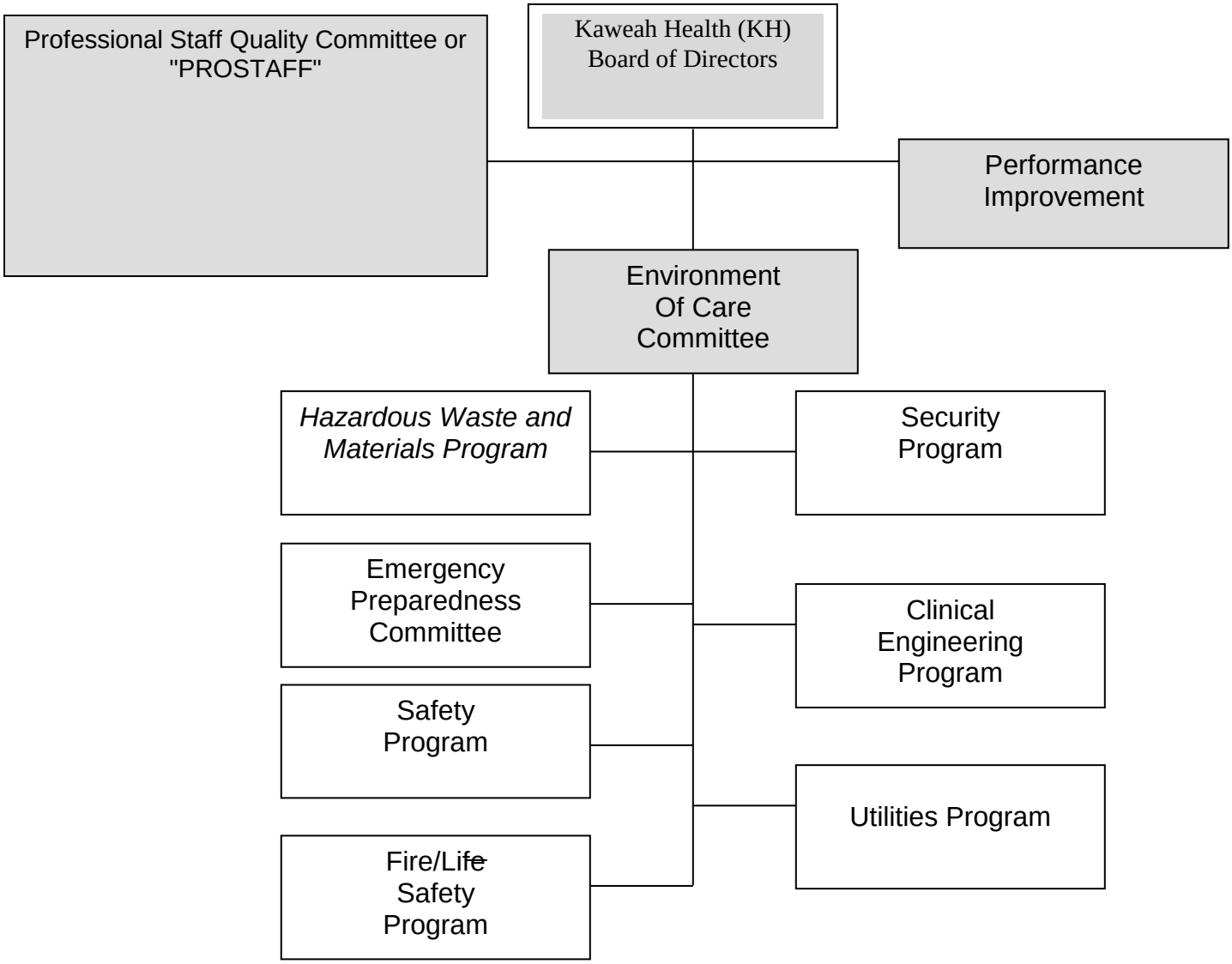
Subcategories of Department Manuals not selected.

Policy Number: EOC 1002	**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)	

Environment of Care Communication Flow Chart

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



Note: This flow chart is intended to illustrate the usual flow of safety-related information. Generally, data is obtained from incident reports, security incidents, hazard surveillance reports and other sources of information.

Notice this data is forwarded to appropriate committee is communicated to the Environment of Care Committee and can ultimately be provided to the KH Board of Directors.

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Policy Number: EOC 1020	Date Created: 06/06/2011
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)	

Indoor Air Quality

Policy: Kaweah Health (KH) will immediately assess all suspected cases of unsafe Indoor Air Quality in Kaweah Health facilities and provide timely intervention.

Procedure:

1) Indoor Air Quality concerns may be identified by any individual stating a concern. This includes visual identification, odors, and/or a complaint filed with Employee Health Services (EHS) of non-seasonal respiratory symptoms occurring only in the work environment.

2) The Director of Facilities (DOF) is responsible for completing all Indoor Air Quality investigations and remediation. An oversight group called the Indoor Air Quality (IAQ) Team shall be notified by the DOF of all suspected or confirmed complaints of Indoor Air Quality. The IAQ Team shall consist of representatives from the District Infection Prevention Team, Safety Officer, and Risk Management. Employee Health Services may be included as needed.

3) The Director of the affected department shall be notified by the DOF that a Indoor Air Quality concern has been reported in their department. An internal assessment shall be initiated as soon as possible.

    i) An IAQ Occurrence Report shall be initiated by the DOF as the required processes/notifications are completed. (Attachment A)

4) If the Indoor Air Quality concern of the affected area is validated, the area will be sealed with plastic barrier and remain sealed until consultation and testing with the outside contractor is complete. Interim Life Safety Measures (ILSM) will be initiated.

5) The contractor shall , at a minimum, conduct the following investigations:
    i) Air spore sample
    ii) Visual inspection
    iii) Moisture meter survey

6) Remediation for any positive results shall be conducted timely by the outside contractor upon approval of the DOF.

7) The IAQ Team and Department Director shall be kept informed of the current status and of all test results.

8) The IAQ Team evaluates each case to determine if additional communication or follow up is indicated. The IAQ Team does not need to approve each project before work begins.

9) Prior to occupancy, the outside consultant shall conduct air quality samples to ensure a safe environment.

10) Completed IAQ Occurrence Reports shall be reported to the Environment of Care and Infection Prevention Committees at least quarterly and as needed.

KH Indoor Air Quality Occurrence Report

EOC 1020 Indoor Air Quality (Indoor Air Quality Remediation) Policy – Attachment A

Instructions: **Must be completed by the District Safety Officer (or designee) for EACH suspected or confirmed occurrence of Indoor Air Quality within any District facility.**

Date of Report: _____/_____/_____ Time: _____ Location: _____

Date/Time	Initial	ACTION
		Complaint received by Facilities office
		IAQ Team notified
		Infection Prevention, IAQ Chair (State name)
		Safety officer (State name)
☐ N/A		Risk Management (State name)
☐ N/A		Employee Health Service (State name)
		Department Director of Indoor Air Quality location notified
		Initial internal assessment by Facilities completed
		Barrier applied to affected area YES ☐ NO ☐
		ILSM initiated
		Outside contractor notified Name: _____ Phone: _____
		Contractor testing start
		Contractor testing end
		Written recommendation for room closure YES ☐ NO ☐
		Written test results & report received by Safety, IP and Facilities
		Remediation Priority Assigned Circle one: 1 2 3 4
		IAQ Team meeting with Remediation Contractor & Department Director
		ICRA & permit issued for remediation
		Remediation start
		Remediation end
		Contractor final clearance test report received
		Clearance report to IAQ Team, Department Director
		Construction ICRA & permit issued for construction
		Committee report:
		Environment of Care
		Infection Prevention
		Other (describe as needed)

INITIAL	NAME (Print)	SIGNATURE

ORIGINAL REPORT WILL BE FILED WITH THE KH SAFETY OFFICER

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Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 1031	**Date Created: 08/01/2013**
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)	

Utility Failures and Repair

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

PURPOSE:
To provide guidelines for planned and emergency utility disruptions at Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH), ensuring that impact to patient care and business operations is minimized.

PROCEDURE:

Emergency Repairs

1. Emergency repairs shall be made when a system is failing and negatively impacting patient care or the safety of building occupants, or when failure to begin repairs immediately shall negatively impact patient care or the safety of building occupants.
2. Kaweah Health Facilities staff shall begin emergency repairs only after ensuring that the Nursing Supervisor, Facilities Manager and/or Maintenance on-call personnel have been informed of the issue and the scope of the required repairs.
   The Nursing Supervisor shall then inform the Director of Facilities Operations/Designee, Safety, Infection Control and Risk Management.
   If outside repair staff are assisting on the repairs, they shall be supervised at all times (when feasible) by Kaweah Health Facilities staff.
3. The Nursing Supervisor shall decide whether to inform the Administrator/Director On Call.
4. Facilities staff shall ensure that they communicate the involved utilities, the areas/departments impacted, the impact on the safety of building occupants and the length of time of the anticipated repairs.
5. 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 surgical/medical cases need to be cancelled/rescheduled. The Nursing Supervisor shall utilize Security, Facilities, Construction and other support staff as necessary to maintain patient and building occupant safety.
6. The Director of Facility Operations, Safety, and Risk Management shall ensure that appropriate documentation is completed, and that regulatory bodies are informed of such incidents as appropriate.

Non-Emergency Repairs

1. Non-emergency repairs are those that can be postponed for a reasonable period of time to allow for planning with involved departments.

2. Facilities staff shall begin non-emergency repairs only after ensuring that the Nursing Supervisor, Director of Facilities Operations/Designee, Safety, Infection Prevention, Risk Management., and all other impacted departments are informed of the repairs. Typically, a meeting will allow for the formulation of a plan that will serve as the communication tool to be shared with impacted departments. This plan shall be shared with involved contract repair staff to ensure that they understand the scope, flow, and chain of command for the project.

3. A pre- construction risk assessment shall be completed as a part of the planning process, and may lead to an Infection Control Risk Assessment, and/or Interim Life Safety Measures.

4. Kaweah Health Facilities staff shall utilize available blueprints, as built documents, and other resources to assist in planning repairs. All involved valves, circuits, dampers, etc., shall be tested to ensure that they are turned on or off as appropriate for each project, and that the intended effect has occurred (water turned off for example) prior to work starting on the repairs.

Policy Number: EOC 1035	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, Medical Gas

PURPOSE:

To define the steps which will be taken in the event of a failure of the medical gas system.

POLICY:

A current set of plans are maintained in the Engineering Department office which outline the areas served by each medical gas distribution system and the location of shutoff valves for each system. Emergency shutoff controls are clearly labeled. If Engineering staff is unable to resolve the problem immediately, the person currently responsible for each of the affected areas will be notified and kept informed of progress to restore the system to full operational condition, including estimated down time. Clinical staff are authorized to shut off medical gas in an emergency situation.

OXYGEN:

In an emergency.

1. Shut off supply to the affected zone using the appropriate zone valve.
2. Notify the affected area first and receive permission from medical personnel before shutting off the Oxygen.
3. Check to ensure that the reserve supply is on-line. If both oxygen supply and reserve are not working and the problem cannot be corrected immediately, notify the affected areas and ask Respiratory to deliver portable cylinders. An immediate critical assessment of oxygen needs will be completed by the Respiratory Care Practitioner prior to shutting off oxygen to any patient care unit. Mobilization of oxygen E-cylinders to support prescribed oxygen therapy will be provided. Simultaneously, emergent contact with Airgas will be made to mobilize an emergent shipment of replacement E-cylinders to assure we maintain vital oxygen therapy to our patients at all times
4. If the integrity of the piping system has been breached and is reparable call Certified Medical Testing for recertification of system.

MEDICAL GAS OUTAGE:
At PBX, an alarm will sound when the following occurs:

1. Low Pressure Oxygen
2. Low Pressure Nitrous Oxide
3. Low Pressure Nitrogen
4. Low Pressure Medical Air
5. Low Pressure Medical Vacuum

Upon receiving an alarm, PBX will notify Maintenance and the Respiratory Department of the alarm and the designated area of location for the alarm.

In the event that the bulk oxygen supply should be compromised for any conceivable reason, the reserve system will automatically activate. In the event that the oxygen supply from the primary and secondary systems fail, the Respiratory Care Department would then supply the necessary oxygen via "H" and "E" cylinders to meet patient care requirements. The respiratory care practitioners will immediately notify the Director or designee. Each room in ICU has a back-up oxygen system that consists of a wall mount for "E" cylinders and regulators.

"E" cylinders will be used for the following reasons:

- If there is a power failure and ventilators stop working, "E" cylinders will be used to supply oxygen to hand resuscitators for ventilation of these patients.
- If there is a decrease in the oxygen line pressure or a complete drop in line pressure, these cylinders shall be used with hand resuscitators to ventilate patients or to administer supplemental oxygen to patients as prescribed.

A limited number of oxygen "H" cylinders are maintained at KDDH and will be used with ventilators as needed.

Maintenance of the "H" and "E" cylinders within the hospital will be the responsibility of Respiratory Care Department. Maintenance of the bulk oxygen tank, the oxygen reserve system and the nitrous oxide system will be the responsibility of the Maintenance Department with support from our local supplier, Airgas Healthcare located in Fresno California.

NITROUS SYSTEM FAILURE:

The nitrous gas is supplied in two tanks of cylinders. The alarms for the nitrous system are as follows and sound in the PBX and the Co-generation building.

- Nitrous Reserve in use
- Nitrous low line pressure primary bank
- Nitrous low line pressure secondary bank

If both banks of nitrous gas are exhausted, anesthesiologists must revert to the back-up cylinders of nitrous on their anesthesia equipment.

Should failure occur in any part of the system, Maintenance is to be notified immediately, via the PBX.

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Policy Number: EOC 1040	**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 High Pressure Boilers

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

PURPOSE:

In the event that boilers are beyond repair for the on-call maintenance engineer the Director for Facility Operations or designee will be called to determine whether the Engineering Department staff can repair the problem or if an outside company shall be called.

In the event of a disruption or failure of the high pressure boiler system, Maintenance shall call the Nursing Supervisor, Sterile Processing and all Surgery areas to inform them of the situation and possible time it will take to complete.

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

All affected departments shall be notified upon restoration of service.

Policy Number: EOC 1041	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, Elevator

POLICY:

Engineering Department staff is responsible for responding to any call concerning elevator malfunction. Engineering staff will place a malfunctioning elevator out of service on the ground floor and identify the elevator as being out of service with a sign.

PROCEDURE:

Engineering Staff will attempt to place inoperative elevators back in service. In the event the elevator cannot be re-set by the Engineering staff, the appropriate service contractor will be called to service the elevator and return it to service.

- If the elevator fails with a passenger(s) inside, Maintenance staff will be immediately notified and will call the elevator company for “Emergency Service.”

Policy Number: EOC 1042	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 Fire Alarm System

Procedure

In the event that the Fire Alarm System fails, follow the procedure listed.

PBX will immediately notify maintenance.

Maintenance will initiate troubleshooting to determine cause. If beyond the capabilities of staff call vendor for immediate repair.

Notify all departments affected

California Department of Public Health will be notified if the failure exceeds 4 hours by Risk Management Department.

Security will be responsible to conduct a fire-watch if the failure exceeds 4 hours. All areas will be monitored each hour. Security will maintain documentation of the firewatch.

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 all affected departments upon service restoration.

Policy Number: EOC 1043	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 or Absence of Nurse Call System While Caring for Patient

POLICY: A call system will be maintained in operating order on all nursing units. Call systems will be maintained to provide visible and audible signal communication between nursing personnel and patients**.**

PROCEDURE:

I. Maintenance staff will take the necessary steps to correct any failures of essential equipment or notify the proper service or persons when repair is beyond the capabilities of the Maintenance staff.

II. After determining that repairs cannot be made in a timely manner or beyond the scope of in-house capabilities:
Facilities will call the appropriate vendor for repairs.

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

IV. DEPARTMENT RESPONSIBILITIES:

A. PBX:
Notify affected departments. Inform of expected downtime.

Notify affected departments upon completion of repairs.

B. NURSING RESPONSIBILITIES:
All affected patients will be immediately informed of call system outage.

Nursing units will assign runners to circulate halls listening for patients who can vocalize and/or may assign individual bells for patients to ring to notify caregivers. Patients who are unable to vocalize will be provided with a bell to notify caregivers. Patients unable to use bells will be closely observed in accordance with their clinical needs.

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Policy Number: EOC 1045	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 Piped Vacuum Systems and Compressed Air

PROCEDURE:

Maintenance staff will respond to failures in the piped vacuum and compressed air systems. If there is a failure of a vacuum pump or air compressor, shut off faulty pump or compressor allowing back-up unit to carry any load.

If the problem is a pipeline leak or outlet leak, engineering staff will repair said leak. The Director of Facilities or designee will determine any immediate needs and appropriateness of Engineering expertise as well as capability of in-house repair.

Maintenance will notify affected departments, Nursing Supervisor and Administrator on Call 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.

Units will use portable suction units where appropriate and KH may need to call for rental units.

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Policy Number: EOC 1085	**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)	

District Electrical Safety Policy

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

POLICY:

Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH), will comply with all rules and regulations of the NFPA 70, National Electrical Code, CDPH, and other regulatory agencies as required.
Any staff member who knowingly, willfully, or negligently fails to comply with this policy will be subject to disciplinary action, up to and including termination.

All personnel will be responsible for assessing the condition of electrical equipment they use.

A. The Clinical Engineering department will be responsible for the electrical safety inspection of all patient-care-related electrical equipment.

B. AC powered (Class 1 Devices) devices used at Kaweah Health, shall have a three-pronged plug attached to the power cord of the device. The power cord of these devices will be no less than three conductors, with an integral ground wire of the appropriate size to accommodate the current load of the device. The device will be Nationally Recognized Testing Laboratories (NRTLs).

Exception:

Double Insulated (Class 2 Devices) AC powered devices that are so labeled shall not be subject to the above requirement. However, they must have a NRTL certification on the 2 wire power cord with a two-pronged plug in good condition.

C. Personal electrical items that are brought into the District by a patient or family member of a patient, shall be governed by the rules and procedures contained in EOC Policy: EOC 6015.

D. Personal electrical items that are brought into the District by an employee or staff member of Kaweah Health, shall fall under the same rules and regulations and must be approved by department management following EOC 015.

EXTENSION CORD USE:

1. The use of extension cords, shall be permitted for **TEMPORARY USE ONLY**.
   - **a. For a period not to exceed 24 hours**.
   - **b**. Extension cords shall not be covered by carpeting, clothing, furniture, or other objects that could prevent adequate air circulation and cooling of the cord.
   - **c.** Extension cords shall not be used in bathrooms.
   - **d.** Extension cords used in wet or damp areas shall be connected to a ground fault interrupter device (GFCI) circuit.

2. The Maintenance / Facilities Engineering department shall be responsible for the control and issuance of all Extension Cords with the following guidelines:

CONSTRUCTION OF ELECTRICAL EXTENSION CORDS:

- Will have three (3) conductors of copper.
- Will be type SO, ST, or STO. Type SH is not acceptable.
- Will be 16 gauge or larger, depending on the electrical load and length.
- Will have UL tested hospital grade, male and female caps, rated at 20 amps.

PROCEDURE:

The Facilities Engineering Department will be responsible for the storage and issuing of electrical extension cords as needed to the departments, excluding the Environmental Services.

Each department will contact the Maintenance / Facilities Engineering Department in the event of a requirement for an electrical extension cord. The department will provide the following information:

1. **Location where extension cord is required.**
2. **What equipment the extension cord will be used with.**

RELOCATABLE POWER TAPS (RPTs) AND POWER STRIP USE:

1. In new health care facilities or existing facilities that undergo renovation or a change in occupancy, patient care rooms and patient bed locations shall be provided with receptacles as required in Section 6.3.2.2.6 of NFPA 99-2012.

2. Power strips that are deemed unsafe by the Engineering Services, Safety, or Biomedical Engineering departments or hospital administrators will be taken out of service.

3. In the patient care vicinity, power strips may not be used to power non-patient care-related electrical equipment (e.g., personal electronics).

4. Outside the patient care vicinity, some types of power strips may be used for both patient care-related electrical equipment and non-patient-care-related electrical equipment.

5. In patient care rooms:

- Patients and visitors are prohibited from using a personally owned EXTENSION CORD, POWER STRIP OR POWER TAP.

6. In all non-patient care rooms, power strips or relocatable power taps that are UL listed 1363A or UL60601-1 and meet NEC, NFPA, and OSHA requirements may be used.

Summary of Appropriate Use of Power Strips in Designated Areas

Power Strip Type	Patient Care Vicinity	Patient Care Room	Non-Patient Care Area
UL 60101-1 SPRPT	A	A	A
UL 1363A RPT	A	A	A
RPT	N	N	A
Power Strip	N	N	A

A = Allowed N = Not Allowed

Notes:

1. Power strips providing power to patient care-related electrical equipment in use with patients must be SPRPTs listed as UL 1363A or UL 60601-1 compliant.
2. Power strips providing power to non-patient care-related electrical equipment in patient care rooms must be RPTs listed as UL 1363A compliant.

7. Resident rooms in long-term care or other residential care facilities using line-operated patient-care-related electrical equipment in the patient care vicinity must comply with NFPA 99-2012 power strip requirements and this policy.

Definitions:

NFPA – National Fire Protection Agency (National Electrical Codes)

UL Listed – (Instead of UL Approved), certifies that the ENTIRE DEVICE meets or exceeds ALL Underwriter's Laboratories Testing Standards for Electrical Device Safety and Manufacturing Guidelines. UL "Approved" applies SPECIFICALLY to an INDIVIDUAL component of the device itself, and does NOT meet the Electrical Safety Policy of the District.

GFCI – Ground Fault Circuit Interrupt. Describes a device or circuit that is designed to Interrupt Current should the device that is plugged into it, lose its electrical ground path due to short circuit, or similar failure. Most GFCI circuits are utilized in Wet or Surgical Areas where the possibility of electrical shock may be increased.

Daisy-Chained – Plugging TWO, or Multiple Extension Cords, or Multi-Outlet Power Strips, or Surge Protectors into each other, to form a continuous line of outlets. This creates an overload condition on the circuit that the FIRST cable is plugged into, and creates a Fire Hazard.

Ampacity is defined in Section 3.3.7 of NFPA 99-2012: *Health Care Facilities Code* as "the current, in amperes, that a conductor can carry continuously under the conditions of use without exceeding its temperature rating."

Patient bed location is defined in Section 3.3.136 of NFPA 99-2012 as "the location of a patient sleeping bed, or the bed or procedure table of a critical care area."

Patient care area. See *Patient care room*.

Patient-care-related electrical equipment is defined in Section 3.3.137 of NFPA 99-2012 as "electrical equipment . . .that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity."

Patient care room is defined in Section 3.3.138 of NFPA 99-2012 as "any room of a health care facility wherein patients are intended to be examined or treated." Note that this term replaces the term "patient care area" used in the 1999 edition of NFPA 99.

Patient care vicinity is defined in Section 3.3.139 of NFPA 99-2012 as “a space, within a location intended for the examination and treatment of patients [i.e., patient care room], extending 1.8 m (6 ft.) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extends vertically to 2.3 m (7 ft. 6 in.) above the floor.”

Power strip is a block of electrical sockets that attaches to the end of a flexible cable (typically with a grounded plug on the other end), allowing multiple electrical devices to be powered from a single electrical receptacle.

Receptacle is defined in Section 3.3.154 of NFPA 99-2012 as “a contact device installed at the outlet for the connection of an attachment plug. A single receptacle is a single contact device with no other contact device on the same yoke. A multiple receptacle is two or more contact devices on the same yoke.”

Relocatable power tap (RPT) is a power strip of the polarized or grounded type equipped with overcurrent protection and listed as in compliance with UL 1363.

Special purpose relocatable power tap (SPRPT) is a power strip of a polarized or grounded type equipped with overcurrent protection and listed as in compliance with UL 1363A or UL 60601-1 for use with medical equipment. SPRPTs come in two types: Type 1 – permanently attached to equipment assembly and Type 2 – non-mounted type.

Reference:

NFPA 93-1999 Standard for Health Care Facilities
CCR Title 22 70837 (e) Department of Health Services
National Electrical Code NFPA 99-2005, NFPA 70-2011
Life Safety 101
CMS Categorical Waiver Ref: S&C: 14-46-LSC
NFPA 70: *National Electrical Code*®
NFPA 99: *Health Care Facilities Code*
Underwriter’s Laboratories standard 1363, 1363A and 60601-1

Policy Number: EOC 4404	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)	

Formaldehyde Spill

Purpose: To ensure that employees are prepared to properly respond to a spill of formaldehyde.

Definitions:

Minor Formaldehyde spill (<200 ml of 5% or less formaldehyde, <30 ml of greater concentrations) Employees who have been trained in the formaldehyde spill emergency action plan shall respond to the spill.

Major Formaldehyde spill (>200 ml of 5% or less formaldehyde, >30 ml of greater concentrations) No attempt should be made to clean up the spill. The 911 HAZMAT team shall be called to respond to the spill.

Procedure:

Minor Formaldehyde spill

Equipment

Protective equipment including:

- Eye protective goggles or face shield
- Gloves: Latex or Vinyl
- Ansul SPILL-X-FP dry media or any formaldehyde treatment agent.

Warning: If any eye or upper respiratory irritation is experienced while cleaning up the spill, stop immediately and Dial 44 and announce Code Orange and location for assistance.

I. Ventilate the area of spill to keep the vapors from spreading.

II. The staff member responding to the spill will wear personal protective equipment. (Goggles, gloves)

III. Sprinkle a sufficient quantity of Spill-X-FP dry media (neutralizing agent) or other formaldehyde neutralizing agent on the spill to completely cover all surface areas of the spill. The neutralizing agent is added to the spill in a ratio of 1:1. Leave the area.

IV. Reaction is complete in approximately 15-18 minutes.

V. Clean treated residue by sweeping with broom into a dustpan. If unable to easily sweep with broom, scrape residue with dustpan and then sweep.

VI. The spill cleanup materials must be double-bagged in a yellow bag, tightly closed, and labeled "hazardous waste".

VII. Notify EVS at 624-2244 for proper disposal of hazardous waste.

Major Formaldehyde Spill

I. No attempt should be made to clean up the spill.

II. Close off area of spill if possible.

III. Call Extension 44 notify operation there is a Code Orange for the HAZMAT team to provide emergency cleanup of the spill.

IV. Alert the House Supervisor and Charge Nurse who will determine the need to evacuate the rest of the employees and patients.

V. Re-enter the area only after the HAZMAT team has performed air sampling and determined that it is safe to re-enter the area.

Subcategories of Department Manuals not selected.

Policy Number: EOC 5000	Date Created: 06/01/2009
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)	
Fire Prevention 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 Fire Prevention Life Safety at Kaweah Delta Health Care District (KDHCD) herein after referred to as Kaweah Health (KH) are to provide an environment wherein patient care can be safely administered~~,~~ to provide a fire safe *environment of care* to protect patients, personnel, visitors and property from fire and the products of combustion, and to provide for the safe construction and use of building and grounds in accordance with applicable codes and regulations for the State of California.

II. SCOPE

The scope of this management plan applies to **all buildings within Kaweah Health**

Each off site area is required to have a unit-specific fire plan that addresses the unique considerations of the environment, including, but not limited to, building evacuation requirements. Off-site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care (EOC) committee members.

It is the responsibility of the Safety Officer to assess and document compliance with the Fire Prevention Plan for the off-site areas, using an environmental surveillance checklist.

III. AUTHORITY

The authority for overseeing and monitoring the fire prevention management plan and program lies with the *Environment of Care* Committee, whose members will ensure that fire prevention activities are identified, monitored and evaluated, and will also ensure that regulatory activities are monitored and enforced, as necessary.

IV. RESPONSIBILITIES

KH Leadership have varying levels of responsibility and work together in the management of fire risks as identified below:

Board of Directors: The Board of Directors supports the Fire Prevention Management Plan through review and feedback, if applicable, of the quarterly and annual *Environment of Care* reports and endorsing budget support.

Professional Staff Quality Committee/PROSTAFF: Reviews the annual *Environment of Care* report from the *Environment of Care* Committee, providing feedback, if necessary.

Quality Council: Reviews annual *Environment of Care* report from the *Environment of Care* Committee and provides broad direction in the establishment of performance monitoring standards relating to fire prevention and fire risks.

Administrative Staff: Administrative staff provides active representation during the *Environment of Care* Committee meetings and sets an expectation of accountability for compliance with the Fire Prevention Program.

Environment of Care Committee: Environment of Care Committee members review and approve the quarterly *Environment of Care* reports, which contain a Fire Prevention component and oversee any issues relating to the overall fire prevention program.

Directors and Department Managers: Support the Fire Prevention Management Program by:

1. Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to fire risks
2. Communicating recommendations from the Environment of Care Committee to affected staff in a timely manner.
3. Developing education programs within each department that ensure compliance with the policies of the Fire Prevention Management Program.
4. Supporting all required employee fire prevention education and training to include a disciplinary policy for employees who fail to meet the expectations.
5. Serving as a resource for staff on matters of fire prevention.

Employees: Employees of KH are required to participate in the Fire Prevention Life Safety Management program by:

1. Completing required fire prevention education.
2. Participating in fire drills
3. Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a fire risk.

Medical Staff: Medical Staff will support the Fire Prevention Management Program by abiding by the District's policies and procedures relating to fire prevention and Life Safety.

V. MANAGEMENT OF FIRE RISKS

KH has multiple processes in place that minimize the potential for harm from fire, smoke and other products of combustion, they include, but are not limited to:

1. This written plan serves to identify the overall components of the *Management Plan for Fire Prevention and Life Safety*.
2. Life Safety policies and procedures, which include an overall fire response plan for all staff
3. Fire Drills: Fire drills are performed per code to test staff response relating to the overall fire plan and to keep staff trained through rehearsal.
4. Procedures for testing, inspection and maintenance: Procedures are in place to ensure fire equipment testing and suppression equipment are properly tested, inspected and maintained.

5. Risk Assessment: Risk assessment for life safety includes ongoing hazard surveillance, *the Interim Life Safety Assessment* process, loss audits, regulatory, insurer and accreditation surveys.
6. Performance Standards: Performance standards are in place, based upon risk to the medical center, and monitored quarterly.
7. Education: Education and training of staff, physicians, temporary workers, students and volunteers is in place.
8. Testing, Inspection and maintenance: Testing, inspection and maintenance of fire extinguishing and suppression equipment, and fire alarm systems is in place.
9. *Statement of Conditions*: A Statement of Conditions is in place and is current. The deemed responsibility for the Statement of Conditions lies, jointly, with the Safety Office and the Facilities Director.

Reviewing Proposed Acquisitions:

To minimize the risks associated with flammable products brought into KH, a process is in place for the review of proposed acquisitions of bedding, window draperies, furnishings, decorations, wastebaskets and other equipment and materials. KH has all "requests for purchases" submitted to Facilities for review. The materials are acquired or approved through Facilities and Purchasing, and ensures:

1. Product(s) meets smoke and flame-resistant standards
2. Waste baskets are of noncombustible materials, or other approved material
3. Flame resistant coating and covering are maintained to retain their effectiveness
4. Attention is given to heat-generating combustible material and placement of equipment close to heat sources.

Staff will acquire samples and/or specification to assure that they have Class A rating (flame spread 0-25 and smoke development of 0-450) or rating such as Plenum, Fire rated per material. Staff will proceed with acquisition only when approved specifications are met, and are responsible for maintaining the specifications on file for each acquisition. Furniture purchased for the hospital meets state technical bulletin requirements, which requires a rating tag be attached to each article of furniture.

All materials within the hospital shall meet federal, state and local requirements for system construction, and treating and testing by approved testing agencies. Records of all materials shall be maintained on the hospital premises in the form of independent test laboratory reports, i.e., tags, or construction documentation.

These items include, but are not limited to:

Item	Verification
Finish materials	Independent Test Report
Low Voltage Wire	UL Smoke Rating/Independent Test
Construction Materials	Approved As-Builts
Furniture (State bulletins)	Test Report/Tags
Bedding/Curtains	Test report/Tags/Treat
Decorations	Test report/Tags/Treat
Holiday Trees	Office of State Fire Marshal Tag/Treat
Waste Baskets (similar items)	Location/Material/Approved

Contractors:

All contractors, before starting work at KH, are responsible for adhering to the following criteria.

1. All equipment installed in the facility (high and low voltage) will be listed and approved by an independent testing lab (approved by the State of California).
2. All components will be hospital grade.
3. Modifications to existing equipment cannot be made without written approval of the KH (re-certification may be required).
4. All finish material will be approved and meet code requirements.
5. All furniture will meet state bulletin requirements for sprinkled and non-sprinkled areas.
6. All construction will meet federal/state and local requirements.
7. Contractors will become familiar with KH's Fire Procedures.
8. Contractors are to act in a professional manner, and to maintain proper identification and demonstrate respect for patient privacy and confidentiality.

Before initiation of a construction project, interim life safety measures (ILSM) will be assessed by the safety department, and an Infection Control permit will be issued. Ongoing ILSM's are the responsibility of the Safety Officer. A policy is in place that identifies in detail the ILSM process, including individuals who are responsible for implementation.

Newly constructed and existing environments of care are designed and maintained to comply with the *Life Safety Code.*

To minimize the potential for harm from fire, when newly constructed and existing environment of care are designed, only licensed architects are used, who oversee the process of subcontractors, who are independently licensed and bonded. Local, state and federal regulations are followed.

Exceptions to this are made on an case by case basis, by the Facilities Department, in conjunction with authorized personnel ensuring that all applicable regulations, codes and standards are followed.

Other Methods in Place to minimize the potential for harm from Fire, Smoke and other Products of Combustion include the following:

1. Fire/Smoke Doors: All doors are held open only by approved devices, i.e. electromagnetic or electromechanical. At NO TIME may doors be propped open with doorstops or other devices not connected to the fire alarm system.

2. General Environment: All areas of KH are kept clean and orderly. Trash is removed regularly from designated holding areas.

3. Portable Electric Equipment: All plugs must be grounded. Extension cords must comply with the extension cord policy. Equipment must be in good operating condition.

4. Smoking: "No Smoking" regulations are strictly enforced, policy HR.193.

5. Ventilation Hoods: Ventilation hoods are cleaned on a regular basis, to code, to prevent buildup. The automatic fire extinguishing systems are properly charged and inspected and all nozzles securely fastened.

6. Storage Areas: Every attempt is made to arrange stock in an orderly fashion, with a minimum of eighteen (18) inches below the sprinkler heads and a minimum of twenty four (24) inches below the ceiling in non-sprinkled areas.

7. Aisles: Aisles between storage shelves are at least three feet apart. No storage is permitted within thirty-six (36) inches in front of electrical panels. Combustible materials shall not be stored in electrical rooms.

8. Space Heaters: Portable space heating devices shall be prohibited in all District areas, with the following exception: Approved portable space heating devices may be allowed in **non-patient care areas** as long as they conform to the following:
   - Heating elements of such devices do not exceed 212 degrees Fahrenheit (NFPA 101©, 2000 Edition, §19.7.8)
   - Required for medical or extreme necessity
   - Approval of the Director of Facilities, Clinical Engineering and Chief Operating Officer
   - The heating device must be equipped with a tip over shut off
   - The heater shall not be plugged into a surge protector or extension cord

9. Flammable Liquids: (Such as acetone, alcohol, benzene, and ether) limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

10. Electrical Hazards: Report promptly any frayed, broken or overheated extension cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

11. Acids: All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

Minimization of risk to patients who smoke:

See policy HR.193 “Tobacco Free Campus.”

Maintaining free and unobstructed access to all exits:

Surveillance activities allow *Environment of Care* Committee members to monitor compliance with *Life Safety Code* requirements, including maintaining free and unobstructed access to all exits. Should an exit need to be obstructed for some reason (i.e. construction, renovation, etc.) an ILSM assessment will be made before the exit path is impeded and Interim Life Safety Measures will be put into place.

The District has a written fire response plan:

See policy EOC.5002 “Fire Response Plan.”

Specific roles and responsibilities of Staff, Licensed Independent Practitioners (LIPs) and Volunteers in preparing for building evacuation:

Specific roles and responsibilities of staff, LIPs and volunteers in preparing for building evacuation are integrated into new-hire orientation and annual safety training, the information is also discussed during fire drills.

The District conducts fire drills:

1. Fire drills are conducted quarterly on all shifts in each building defined by the *Life Safety Code* as the following:
   - Ambulatory Health Care Occupancy
   - Health Care Occupancy

2. Fire drills are conducted annually in all free standing buildings classified as a business occupancy as defined by the *Life Safety Code*.

3. At least 50% of fire drills are unannounced at KH facilities.

4. Staff and who work in buildings where patients are housed or treated participate in fire drills

   Note: Staff participate in fire drills in all areas of the hospital, with the exception of those who cannot leave patient care during the time of a drill.

5. KH critiques fire drills to evaluate fire safety equipment, fire safety-building features, and staff response to fire.
   - The evaluation is documented and reported to the *Environment of Care* on a quarterly basis.
   - Fire drills are critiqued post drill to identify deficiencies and opportunities for improvement.

The District maintains fire safety equipment and fire safety building features:
The following types of equipment or features exist within the District, with the following maintenance, testing and inspection requirements in place. All tests and/or inspections are documented and maintained in the Facilities Department.

1. At least quarterly, KH tests supervisory signal devices (except valve tamper switches).
   a. Note: Supervisor signals include the following: control valves; pressure supervisor; pressure tank, pressure supervisory for a dry pipe, steam pressure; water level supervisor signal initiating device; water temperature supervisory; and room temperature supervisory.

2. Every six months, KH tests valve tamper switches and water flow devices.

3. Every 12 months, KH tests duct detectors, , heat detectors, manual fire alarm boxes and smoke detectors.

4. Every 12 months, KH tests visual and audible fire alarms, including speakers and door releasing devices on the inventory.

5. Every quarter, KH tests fire alarm equipment for notifying off-site fire responders.

6. Every week, KH tests diesel fire pumps under no-flow conditions.

7. Every week, KH inspects electric motor driven fire pumps under no-flow conditions.

8. Every month, KH tests electric motor driven fire pumps under no-flow conditions.

9. Every 12 months KH tests main drains at system low point or at all system risers.

10. Every quarter, KH inspects all fire department water supply connections.

11. Every 12 months, KH tests fire pumps under flow conditions.

12. Every 5 years, KH conducts water-flow tests for standpipe systems.

13. Every 6 months, KH inspects any automatic fire-extinguishing systems in a kitchen.

14. Every 12 months, KH tests carbon dioxide and other gaseous automatic fire-extinguishing systems.

15. At least monthly, KH inspects portable fire extinguishers.

16. Every 12 months, KH performs maintenance on portable fire extinguishers.

17. KH operates fire and smoke dampers one year after installation and then at least every 6 years to verify that they fully close.

18. Every 12 months, KH tests automatic smoke-detection shutdown devices for air-handling equipment.

19. Every 12 months, KH tests sliding and rolling fire doors for proper operation and full closure.

20. Every 12 months, KH tests and inspects door assemblies.

21. Every month, KH tests elevators with fire fighters' emergency operations.

22. Every month, KDHCD inspects fire sprinkler gauges and valve tamper switches.

Monitoring Conditions in the Environment:

Kaweah Health establishes a process for continually monitoring, internally reporting, and investigating fire safety management problems, deficiencies and failures.

Through the *Environment of Care* Committee structure, the above elements are reported and investigated on a routine basis by managerial or administrative staff, with oversight by the committee. Minutes and agendas are kept for each *Environment of Care* meeting and filed in Performance Improvement.

Patient Safety: Periodically there may be an *Environment of Care* issue that has impact on the safety of our patients relating to life safety and or fire prevention. This may be determined from *Sentinel Event* surveillance, environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue relating to life safety or fire prevention emerges, it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

Annual Evaluation of the Fire Prevention Management Plan:

On an annual basis *Environment of Care* Committee members evaluate the Fire Prevention Life Safety Management Plan, as part of a risk assessment process. Validation of the plan occurs to ensure contents of each plan support ongoing activities within the District.

Based upon findings, goals and objectives will be determined for the subsequent year.

A report will be written and forwarded to the Board of Directors.

The annual evaluation will include a review of the following:

1. Objectives: The objective of the Fire Prevention Management plan will be evaluated to determine continued relevance for the District (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?)

2. The scope: The following indicator will be used to evaluate the effectiveness of the scope of the Fire Prevention Life Safety Management Plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in throughout the entire District?)

3. Performance Standards: Specific performance standards for the Fire Prevention Life Safety Management Plan will be evaluated, with plans for improvement identified as needed.

   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.

4. 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.

The District analyzes identified Environment Of Care issues:

Environment of care issues relating to Life Safety and/or fire prevention are identified and analyzed through the *Environment of Care* Committee with recommendations made for resolution.

It is the responsibility of the *Environment of Care* 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, PROSTAFF and the Board of Directors.

Priority Improvement Project:

At least annually, a performance improvement project is selected by the Environment *of Care* Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. Based upon risk assessment, a priority improvement project may be related to Life Safety or Fire Prevention issues.

Improvement of the Environment of Care:

Performance standards are identified monitored and evaluated that measure effective outcomes in the area of fire prevention management.

Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Medical Equipment management and Utilities management.

The standards are approved and monitored by the *Environment of Care* 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.

"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 5003	**Date Created: 05/29/2023**
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); Aguilar, Maribel; Moccio, Cindy	

Fire Watch

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

PURPOSE:

To provide emergency measures for monitoring any fire alarm and/or fire sprinkled building in the Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) in the event of an impaired fire alarm or fire sprinkler system.

DEFINITIONS:

Fire Watch: A temporary measure that provides surveillance rounding to the area(s) of the building where the fire alarm and/or fire sprinkler are not currently in full functioning capacity. Fire Watch allows buildings to be temporarily occupied when the fire suppression systems or the fire alarms are out of service.

Fire Watcher: A dedicated, trained person(s), whose sole responsibility is to, either, look for fires within an appointed area or watch the fire alarm panel for the duration of the unsafe condition. The fire watcher is required to patrol the affected area(s), initiate Code Red, prevent a fire from occurring and extinguish small fires, if safe to do so.

System Bypass: When the fire alarm and/or fire sprinkler reporting system has been bypassed so that it will not remotely report a fire or trouble alarm to the off-site monitoring company. These systems will still alarm to the fire alarm panel itself.

System Down: When the fire alarm has been completely taken off line and will not ring at the panel, if needed, or report out to the off-site monitoring company. Fire Watch rounds are to be implemented immediately when this occurs.

System down also applies when the fire sprinklers have to be drained for repair work to be completed. Fire Watch rounds will also be implemented immediately when this occurs.

POLICY:

Fire Watch is required to be implemented when any of the following takes place:

1. The fire alarm and/or sprinkler system is temporarily shut down or taken off-line for more than four (4) hours in a twenty-four (24) hour period (does not need to be consecutive). Fire Watch will begin, immediately, at the end of the four (4) hour window.

2. A system failure of the fire alarm control panel or monitoring capabilities occurs. In this instance, Fire Watch will start immediately.

3. The fire watch log (Attachment A) must be completed by facilities lead/manage/on-call or construction manager/designee.

Conducting Fire Watch Rounds:

1. Only Fire Watch trained personnel, who are familiar with the building(s) and evacuation plan(s), shall conduct Fire Watch rounds.

2. Fire Watchers shall have knowledge of: preventing, identifying and controlling fire hazards.

3. In the event that Security or Maintenance is not available for Fire Watch, staff will be trained by condensed orientation and literature review.

   Documentation of completed training, See "*Attachment B*," shall be kept by the Safety Department or designee; a copy will also be kept in the employee file.

4. Fire Watchers will be familiar with fire extinguisher locations.

5. When on Fire Watch, Fire Watcher will be solely dedicated to this task. They will not be pulled off for other duties (without being replaced) or asked to do any other tasks while on Fire Watch rounds.

Discontinuing Fire Watch Rounds:

1. Fire Watch shall not be discontinued without approval from the Maintenance Department.

PROCEDURE:

1. <u>Routine maintenance, testing and inspection:</u>

   A. When routine maintenance is performed and the fire alarm and/or fire sprinkler system is put into bypass, a timer shall be started or resumed from original timing (if previous Fire Watch was started during the previous twenty-four (24) hours). Attachment "A" shall be filled out during business hours with 24 hour notice.

B. When the timer reaches a combined total of four (4) hours, the Fire Watcher will immediately notify Maintenance and PBX that a Fire Watch is now being implemented.

C. Rounds will commence immediately and be conducted within every 60 minutes.

D. Rounds will be tracked on the Fire Watch Log *"Attachment A,"* see attached.

E. During the 60 minute rounds of the Fire Watcher, rooms that will be checked include: storage areas, hazardous areas, restrooms, break rooms, offices, exit corridors, and exit stairwells.

F. After the system(s) have been repaired and tested, Maintenance will notify Security and PBX that Fire Watch is no longer necessary.

G. Security will then send the Fire Watch Log(s) to Maintenance via EFAX and give the originals to the Security Department Manager.

2. Emergency Deactivation of System(s):

A. When an emergency occurs and the fire alarm and/or fire sprinkler system is inoperable, the facility shall immediately be put into Fire Watch and rounds will be conducted accordingly.

B. Rounds will be tracked on the Fire Watch Log *"Attachment A,"* see attached.

C. During the 60 minute rounds of the Fire Watcher, rooms that will be checked include: storage areas, hazardous areas, restrooms, break rooms, offices, exit corridors, and exit stairwells.

D. After the system(s) have been repaired and tested, Maintenance will notify Security and PBX that Fire Watch is no longer necessary.

E. Security will then send the Fire Watch Log(s) to Maintenance via EFAX and give the originals to the Security Department Manager.

RESPONSIBILITIES:

1. Maintenance/Construction:

A. When putting the system in bypass (non-emergency):

I. Notify: Maintenance Lead, Maintenance Manager, or the On-Call Maintenance individual (Swing/Night Shift) of the need for Fire Watch. Document the need and time for Fire Watch in the pass

down log, fire watch log (attachment A) and the fire watch control log (attachment C).

II. Call the Fire Alarm monitoring company and let them know how long the system will be in bypass.

III. Call the Visalia Fire Department Dispatch Center at: 559-734-8117 and let them know how long we will be in bypass and at which building/campus.

IV. Call the Security Department Lead on duty and notify them of the condition of the system. If you cannot reach the Lead directly, call PBX and have them contact the Lead to call you back. It is very important to speak with Security directly.

V. When repairs, tests, inspections or emergencies have been completed and the system is back in normal condition, call each of the above places to notify them that we are no longer on Fire Watch. Document the need and time for Fire Watch in the pass down log.

B. When putting the system in bypass (emergency):

I. Notify: Maintenance Lead, Maintenance Manager, Facilities Director, House Supervisor and the On-Call Maintenance individual (Swing/Night Shift) of the need for Fire Watch. Document the need and time for Fire Watch in the pass down log, on the fire watch log and the fire watch control log.

II. Call the Fire Alarm monitoring company and let them know how long the system will be in bypass.

III. Call the Visalia Fire Department Dispatch Center at: 559-734-8117 and let them know how long we will be in bypass and at which building/campus.

IV. Call the Security Department Lead on duty and notify them of the condition of the system. If you cannot reach the Lead directly, call PBX and have them contact the Lead to call you back. It is very important to speak with Security directly.

V. When repairs, tests, inspections or emergencies have been completed and the system is back in normal condition, call each of the above places to notify them that we are no longer on Fire Watch. Document the need and time for Fire Watch in the pass down log.

2. Security:

A. System(s) in bypass:

I. Upon receiving notification from Maintenance that the fire alarm and/or fire sprinkler systems are in bypass for testing, inspection or repair, Security will check the Fire Watch clipboard, located in PBX, to notate the Fire Watch Control Log (Attachment "C") and check the last time that a bypass was requested.

II. Check the guidelines below and start the timer:

a. If the system was last in bypass during the last 24 hours, the timer will **CONTINUE** from the last point it stopped.

b. If the system was last in bypass more than 24 hours ago, the timer will **RESTART** for the 4 hour countdown.

III. If/when the timer runs out and the system has been on bypass for 4 hours (total) in a 24 hour period, Fire Watch will begin immediately. Contact Maintenance to inform them that Fire Watch rounds have begun.

B. System(s) down:

I. Upon receiving notification from Maintenance that the fire alarm and/or fire sprinkler system(s) are completely down, due to repair or an emergency, Security will begin Fire Watch rounds immediately.

3. Safety, Facilities Director and/or Designee:

Upon notification that the facility is in Fire Watch, the designated person will complete the following:

A. Contact the District's Director of Risk Management or Designee to inform them that a building (specify) is on Fire Watch.

B. Contact the Fire Marshal (Authority Having Jurisdiction) to notify which building (give the address and location) is in Fire Watch. Be as specific as possible with dates and times.

C. When fire watch rounds are complete and the system is back on line:

I. Call Risk Management to notify that rounds are complete and that the system is back on line.

II. Call the Fire Marshal to notify that rounds are complete and that the system is back on line.

4. Risk Management:

A. After the initial 4 hour grace period, notify the California Department of Public Health (CDPH) by fax at: 661.336.0529 to notify them that we are

on fire watch and the estimated time when we will be back to normal function.

B. When fire watch rounds are complete and the system is back on line, fax the completed fire watch rounding sheets to CDPH along with a memo stating that the rounds have been completed. If there was a repair to be made, note that the repair was made and attach the service record from the vendor.

5. Unable to perform Fire Watch:

A. If Security is unable to perform Fire Watch duties, the task will be performed by the Maintenance and/or Construction Department.

B. If Maintenance is unable to perform Fire Watch duties, they will call their immediate Supervisor.

TRAINING:

Upon new hire, training shall be held for Security and Maintenance personnel to teach best practices in order to conduct Fire Watch.

REGULATIONS AND STANDARDS:

2016 California Fire Code, Title 24, Part 9, Chapter 9, Section 901.7

NFPA 101:2012 Life Safety Code, §9.6.1.8

The Joint Commission, Life Safety Code, LS.01.02.01, EP 1

Attachment "A"
FIRE WATCH LOG

ASSIGNED BUILDING/AREA: _____ DATE: _____
TIME NOTIFIED: _____ TIME FIRE WATCH TO START: _____

WHY IS THE FIRE WATCH IN EFFECT? _____

1. ** To be filled out by facilities manager/lead/designee or construction manager/designee. Copy to be kept in PBX during fire watch.
2. A. Who is completing form: _____
   B. Who is performing work: _____
   C. Contact name: _____
   D. Contact phone number: _____

Circle One

	A. System Working	**1**
	A. System bypassed for scheduled repairs or maintenance and testing *while being monitored by vendor at annunciator and can verbally communicate alarms to PBX operator*.	**1**
	A. System bypassed for scheduled repairs or maintenance and testing *while* ***NOT*** *being monitored by vendor at annunciator* **and** **B.** Has the system been disabled for 4 or more hours in the last 24 hours?	**3**
	A. System bypassed for scheduled repairs or maintenance and testing *while* ***NOT*** *being monitored by vendor at annunciator* **and** **B.** Has the system been disabled between 0 to 4 hours in the last 24 hrs?	**2**
	A. Has the system broke down or malfunctioned	**3**
1=No fire watch, **2***=Start fire watch after a total of 4 hours in the last 24 hours, **3***=Start fire watch NOW * Only the area(s) effected by the Malfunctioned/Repair/Testing need to be under Fire Watch		

FIRE-WATCHER: _____ INITIALS:____
FIRE-WATCHER: _____ INITIALS:____
FIRE-WATCHER: _____ INITIALS:____
(May add additional names and initials on the back of this form)

Fire watch personnel must perform continuous, un-interrupted tours such that rooms in their assigned area are **checked at no less than 60 minute intervals**. Times must be recorded using the 24-hour clock and initialed. Any problems found during the fire watch must be documented (along with the time found and initialed) and reported immediately, at the time of discovery, to the maintenance lead, manager and/or designee for immediate correction.

I certify (by my initials below) that I completed a tour of my entire assigned area at the following times:									
Time Tour Completed	Initials		Time Tour Completed	Initials		Time Tour Completed	Initials		Time Tour Completed	Initials
00__			06__			12__			18__	
01__			07__			13__			19__	
02__			08__			14__			20__	
03__			09__			15__			21__	

04__			10__			16__			22__	
05__			11__			17__			23__	

Problems noted during fire watch (also note who you reported the problems to): By signing this form you agree that you have verified the accuracy of this Fire Watch Log: Security Lead Signature: _____ Date: _____

Attachment "A" continued

KAWEAH HEALTH

FIRE WATCH IMPLEMENTATION CHECKLIST

Your primary role, as the Fire Watcher, is to serve as a "human smoke/heat/fire detector" and to notify the Switchboard at x44 at the first sign of smoke, excessive heat or fire.

Conduct a continuous patrol of the entire area(s), including but not limited to: storage areas, hazardous areas, restrooms, break rooms, offices, exit corridors, and exit stairwells. Remain alert to signs of smoke, excessive heat and fire.

To be a human smoke/heat/fire detector:

- ✓ Remain attentive. Patrol your designated area, at least, every 60 minutes
- ✓ Listen for in-room smoke detectors sounding
- ✓ Look for observable signs of smoke and/or fire
- ✓ Enter all stairwells – open doors and look into each stairwell

At the first sign of smoke and/or fire:

- ✓ Call PBX at x44 and initiate a *Code Red* (off-site facilities also dial 9-911)
- ✓ If possible and safe, use a nearby fire extinguisher to extinguish the flames (P.A.S.S.)
- ✓ If the fire is too big to extinguish or too dangerous, initiate R.A.C.E.

Attachment "B"

KAWEAH HEALTH
FIRE WATCH ACKNOWLEDGEMENT OF TRAINING

I understand that, during Fire Watch, I will be responsible for all of the items listed below:

1. Rounds must be conducted, at a minimum, of every 60 minutes for the area where I am assigned.

2. Be aware of your surroundings. Use your nose, eyes and ears to detect fire and/or smoke. In addition, listen to your intuition, if something does not seem right find out why.

3. During the 60 minute rounds rooms that will be checked include: storage areas, hazardous areas, restrooms, break rooms, patient rooms, offices, exit corridors, and exit stairwells.

4. Corridors and Exits must be kept free and clear of all obstructions.

5. Check to ensure that exit and fire doors are not blocked by anything that could keep them from closing.

By signing below, I agree that I have been made aware of the expectations placed upon me during a Fire Watch at Kaweah Health .

I agree to conduct Fire Watch Rounds within 60 minutes for my designated area.

I agree that I have been informed that Fire Watch Rounds are to be completed by me and that I am not to conduct any other business during this time period. I will be solely dedicated to the task of Fire Watch Rounds.

If, at any time, I feel that I cannot conduct these Fire Watch Rounds (for various reasons), I agree to contact my Supervisor immediately.

Print Name: _____Date: _____

Signature: _____

Attachment "C"

KAWEAH HEALTH

FIRE WATCH CONTROL LOG (To be kept updated in PBX)

Building	Date	Time notified by Maintenance to Start	Time notified by Maintenance to Stop	Time Fire Watch Rounds will Start (within 24 hours)	Total Time that the System was off (within 24 hours)

Policy Number: EOC 5010	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)	

Fire Prevention Code Compliance

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

POLICY:
All buildings within Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) that are under the ownership or control of the Governing Board, will maintain compliance with the appropriate provisions of the current edition of the Life Safety Code 101 of NFPA. Where this is not possible, equivalent protection will be provided and documented.

Documentation of all Life Safety Requirements will be maintained on an ongoing, visible basis. When conditions change due to construction, program, function additions or deletions, the policies and procedures will be revised. Reports or changes in condition(s) shall be submitted regularly to the Safety Committee and will be monitored by the committee.

Periodically the Visalia Fire Department will make an inspection to orient their staff to Kaweah Health facilities.

A Statement of Conditions (SOC) that describes the current condition of the building's structural features of fire protection shall be completed for every building housing patients overnight or where patients receive treatment. The SOC shall be maintained in a current status, a printed version will be kept in the office of the Facilities Director.

All circuits of all fire alarm and fire detection systems are tested on a quarterly basis and all components have annual preventative maintenance.

All automatic fire-extinguishing systems are inspected and tested annually.

The control of all designated fans and/or dampers in air handling and smoke-management systems and the transmission of fire alarm signals to the local fire department shall be reliable and functional at all times.

All portable fire extinguishers are clearly identified, inspected monthly, and maintained annually.

A comprehensive plan to correct any Life Safety deficiencies, which occur or are identified by any source, will be developed immediately in writing per Part Four, Statement of Conditions.

"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 5041	**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)	

Department Decorations

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

POLICY:

To promote the highest standard of Fire Prevention as well as to comply with all State and Local Fire Regulations, please observe the following departmental decorating guidelines:

1. Holiday decorations, including quilts, blankets and tapestries may never be placed in any Kaweah Health(KH) EXIT corridor. Decorations may only be used in KH facilities provided they have been treated with a California State Fire Marshal rated flame resistant product. **Proof of fire resistance must remain with the decorations or in the department.**

2. Do not hang anything from the ceiling sprinkler heads. Any decorations hung from the ceiling must hang at least 18" below ceiling height to prevent interference with the sprinkler system. Please ensure that hanging decorations do not impede walk-through traffic

3. Christmas lights and/or candles, of any variety or type, are prohibited in patient care areas.

4. UL Listed/Approved lights may be utilized in non-patient care areas.

5. Decorations must not block corridors or exits, or interfere with patient care.

6. Please use masking tape when necessary. Do not use scotch tape or thumb tacks on the walls.

7. Candles are prohibited. The Flameless Candles will generally be allowed in ALL Patient Treatment areas with the exception of Electrically Sensitive Patient Areas, such as ICU, CVICU, CVOR, CVC, 5T and specific areas of 3 West where patient monitoring is on-going. These items MUST have the UL Listed or CSA Stamp of approval affixed to them

8. Live Christmas Trees may only be used in KH facilities provided that they have been treated with an approved California State Fire Marshal rated flame resistant product. Live trees may never be placed in/or immediately adjacent to an EXIT corridor. Live Christmas trees may not be used in patient care

areas. Live Christmas tree usage and placement within the District must have prior approval from the District Safety Officer.

A non-lighted, artificial tree may be used within KH facilities provided that it has been treated by a California State Fire Marshal rated flame resistant product.

Proof of fire resistance must remain with the decorations or in the department.

NOTE: Anything that impedes the complete closure of the fire doors must be removed.

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Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 6007	Date Created: 08/01/2013
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)	

Storage and Warming of Blankets in Warming Cabinets

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

Policy: Warming cabinets will be used according to manufacturer's recommendations in order to provide safe and appropriate warming and storage of blankets for patient use.

Procedure:

I. Blankets will be layered in the cabinets to allow for adequate air flow around the blankets to allow for appropriate warming of the blankets.

II. Warming cabinets are not to be set to operate above 170 degrees Fahrenheit.

III. IV fluids or irrigation fluids are not to be mixed in the same compartment with blankets. If the warming cabinet is used to warm fluids they must be in a separate compartment with a separate temperature regulator. The temperature for this compartment is not to exceed 104 degrees Fahrenheit.

IV. Ongoing temperature monitoring of blanket warmers is not required.

V. Preventative maintenance will be performed in accordance with manufacturer's recommendations.

Reference:

HEALTH DEVICES JULY 2009 □ www.ecri.org, **Page 230,** ECRI Institute Revises Its Recommendation for
Temperature Limits on Blanket Warmers

J Perianesth Nurs. 2012 Jun;27(3):181-92. doi: 10.1016/j.jopan.2012.01.011.
Health Devices. 2005 May;34(5):168-71.
OR Manager. 2005 Oct;21(10):32, 34.
Health Devices. 2009 Jul;38(7):230-1.

"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 6009	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)	

Safe Medical Device Act/Medical Device Tracking and Reporting Policy

Policy:
In accordance with the Guidelines set forth in the Safe Medical Device Act of 1990, and the Medical Device Tracking Regulations of August 1993, any device incident that results in an injury or death, to a patient, visitor, or staff member shall be reported to the Food and Drug Administration (FDA) and to the Device Manufacturer.

Risk Management shall have the ORIGINAL OCCURRENCE REPORT forwarded **NO LATER THAN 24 HOURS** from the time the District first becomes aware of an incident
Any and all Medical Devices, whether implantable or not, that are contained in the listing promulgated by the Food and Drug Administration as Trackable Devices shall be reported to the manufacturer of the device in question.

DEFINITIONS:

A **"Medical Device"** shall be defined as follows:

Any device, instrument, or machine that is primarily used for the treatment, diagnosis, or prevention of disease, or injury. This shall include but not be limited to Gauze pads, Diagnostic Monitoring equipment, infusion devices, implants, catheters, in-vitro diagnostic test kits, accessories, and related software. This shall also include devices listed as "Trackable" by the Food and Drug Administration.

For the purposes of Safe Medical Device Act reporting, **"Serious Injury and Serious Illness"** shall be defined as follows:

1. ***An Injury or Illness which is life threatening.***

2. Results in permanent impairment of a bodily function or permanent damage to a body structure.

3. Necessitates medical or surgical intervention to preclude permanent impairment or damage.

For the purposes of Medical Device Tracking, a **"Trackable Device"** shall be defined as follows:

A device that is "Life-supporting or Life-sustaining" and that is used outside a device user-facility (i.e. Kaweah Delta Healthcare District) and a "Permanently implantable" device that is contained

on the listing promulgated by the Food and Drug Administration as a "Trackable Device." This listing contains specific devices determined by the Food and Drug Administration to require tracking through the distribution chain from the manufacturer to the patient.

PRESCRIBED ACTION:

Device Tracking:

When Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) first takes possession of a Trackable Device purchased after August 29, 1993, the following guidelines shall be followed:

1. The required information shall be provided to the device manufacturer using the form provided for such notification after verification that the device is contained on the Food and Drug Administration List of Trackable Devices. (See Attached Enclosures).

2. This form shall be completely filled out by the individual(s) receiving the device and submitted to the Hospital Medical Device Tracking representative for review and submission to the device manufacturer.

3. This information **MUST** be provided to the device manufacturer **within five (5) working days** from the date that Kaweah Health first takes possession of the device(s). The information must also be provided to the manufacturer in the following incidences:

    - When the device is first provided to a patient or patients for use; or to the device manufacturer; permanently retired from service; returned to hospital inventory; upon implantation or distribution, (Sale/Rent/Loan); upon explanation; or permanently disposed of.

    - If a device is provided to a patient through a Home Health Agency or Home Infusion Facility of Kaweah Health. In this instance, Kaweah Health then becomes a "Multi-Distributor" of a device and must retain this information as well as notify the manufacturer of the distribution.

4. The Safe Medical Device Act / Medical Device Tracking Representative for Kaweah Health shall be the Risk Manager or other personnel as designated by the Risk Manager, EOC Committee Chairperson, Safety Officer, and / or Chief Nursing Executive.

PRESCRIBED ACTION:
In the event that a medical device is suspected of causing, either directly or indirectly, a device related incident, the following guidelines **shall** be followed:

1. The individual **DIRECTLY INVOLVED** shall fill out the Occurrence Report form immediately in accordance with prescribed guidelines set forth in the Nursing Policy Manual under "Occurrence Reporting." Included in this report shall be **ALL** pertinent device information including but not limited to model number, serial number, manufacturer, lot number, category code, biomedical I.D. #, etc., and any setting or setup information used on the suspect device at the time of the incident.

2. The device in question including any and all attached peripheral devices (tubing, hoses, power cords, catheters, etc.,) shall be red-bagged, and held until picked up by Clinical Engineering. Removal of the device from the patient shall only proceed after it has been determined that further injury will not occur due to removal.

3. The Nursing Supervisor shall immediately be notified of the device related incident.

4. The manager of Clinical Engineering shall immediately be notified by contacting the Clinical Engineering Department at Ext. 2403 or cellular phone at (559) 302-8049.

5. The Risk Manager shall also be notified immediately by telephone at Ext. 2340. The **ORIGINAL COPY** of the Occurrence Report shall be forwarded to the Risk Manager **NO LATER THAN 24 HOURS** from the time of the original event occurrence.

6. Upon receipt and review of a device related Occurrence Report, the Risk Manager of Kaweah Health shall:

   - Determine if the suspect device may have caused a death, serious injury, or serious illness and immediately notify the following individuals:

     EOC Committee Chairperson
     Chief Nursing Executive
     Director of the area in which event occurred
     Director of Materials Management
     Manager of Clinical Engineering or designee
     Hospital Legal Consultant or Attorney

   - Contact the Clinical Engineering Department at Ext 2296 to determine whether an evaluation of the device in question is necessary to determine the cause of failure or malfunction or to document the device condition. This evaluation may be conducted by the Hospital Clinical Engineering Department or by an independent, outside Third-party company at the discretion of the Risk Manager.

   - Determine if the suspect device is contained in the Food and Drug Administration Listing for Trackable Devices. If the device in question should be listed, the Risk Manager shall ensure that all required guidelines of the Hospital Medical Device Tracking System Reporting Policy have been met.

7. Upon notification from the Risk Manager of Kaweah Health of a device related incident, the Clinical Engineering Department shall:

   - Collect and secure the suspect device including any and all peripheral devices from the unit reporting the incident.

   - Evaluate the suspect device including all peripheral equipment for proper operational characteristics in accordance with specific procedures set forth in the Device Manufacturer's Service Manual, paying particular attention to the noted setup configuration used at the time of the incident. This information shall be included on the original occurrence report filed by the user directly involved in the incident.

- Notify the Risk Manager of the findings of the device evaluation immediately upon completion of the evaluation.
  Upon review by the Risk Manager the Manager of the Clinical Engineering Department shall notify the Food and Drug Administration or device manufacturer **NO LATER THAN TEN (10) WORKING DAYS** of the incident following specific guidelines for such reporting set forth by the Food and Drug Administration Medical Device Reporting (MDR) Program.

8. A copy of this report shall be logged and stored on Computer with appropriate security encryption. A back-up copy shall be maintained by the Clinical Engineering Dept.

9. In accordance with the Modernization Act changes, effective February 19, 1998, a Semi-Annual report of ALL reports for the year submitted by Kaweah Health is no longer required. An annual report shall be submitted no later than January 1st of each year and shall be submitted to the Food and Drug Administration by the Clinical Engineering Dept. or designated reporting agency.

10. The Manager of Clinical Engineering shall report QUARTERLY a summary of all device-related incidences to the Hospital EOC for review and additional action as necessary.

11. Initial Training of the Hospital Safe Medical Device Act / Medical Device Tracking System Policies with documentation shall be provided for new employees during New Hire Orientation.

12. Annual Training for all hospital staff shall include information for identifying and documenting medical device incidents. Records that document this training shall be maintained for each employee.

COMPLIANCE: The Food and Drug Administration provides for severe penalties for any individual who knowingly violates significant portions of this reporting act, or, whose failure to comply results in a risk to Public Health. These penalties range from a Civil Penalty in an amount not to exceed $15,000 for each such violation and not to exceed $1,000,000 for all such violations adjudicated in a single proceeding.

Reference: Safe Medical Device Act of 1990, and Device Tracking Regulations set forth by the Food and Drug Administration.
Also, to specify actions which are necessary to minimize patient risk resulting from medical device related incidences.

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Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 6012	**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)	

Non Healthcare District Equipment Preventative Maintenance and Repair Policy

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

POLICY:
The Clinical Engineering Department of Kaweah Delta Healthcare District hereinafter referred to as Kaweah Health (KH) shall provide Preventive Maintenance and Repair services for Individuals, and Organizations outside the Healthcare District, for specified fees, to be governed by time, available test equipment, and manpower constraints. This service will be restricted to Medical Healthcare Devices used in the Diagnosis, and Treatment of individuals, and the program shall be supervised by the Chief Information Officer.

PROCEDURE:
The Clinical Engineering Department shall receive and process all requests for service, and shall schedule all work according to appropriate priorities. If there are conflicts, or workload considerations take precedence, the request shall be referred to the Chief Information Officer for further disposition, and resolution. Departmental personnel tasked with performing these work requests shall be expected NOT to offer a conflicting service on their own, "off-clock" hours, for pay, due to conflict of interest criteria, unless receiving prior approval from Hospital Administration.

Payment for services by outside parties shall be made to Kaweah Health . When work has been completed, the Director of Clinical Engineering, or designee, shall submit all necessary information, including invoices, to Finance.

Labor rates for services provided by the Clinical Engineering Department staff, shall be determined by the Director of Clinical Engineering, and approved by the Chief Information Officer.

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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.

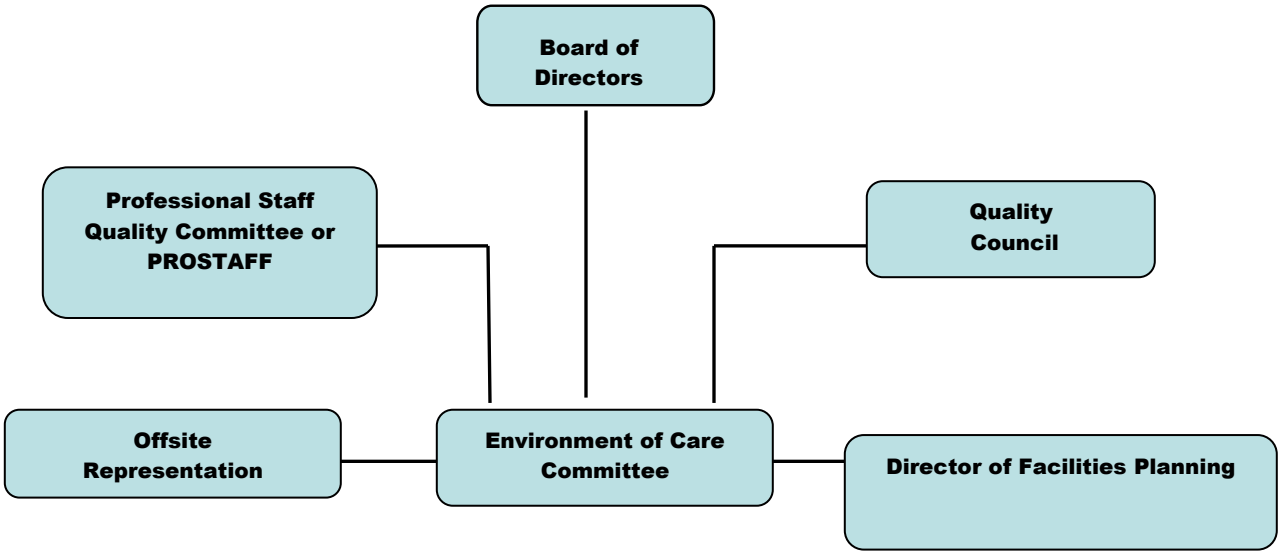
AUTHORITY

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.

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Policy Number: DM 2104	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)	

Emergency Impact Assessment

Policy

Kaweah Delta Health Care District's herein after referred to Kaweah Health (KH) Emergency Management Plan is flexible so that it can be quickly adapted to meet any situation. Defining the location, type and likely impact of an emergency at the time of the incident helps clarify the type and level of response required. The Hospital Command Center (HCC) gathers data from various sources including departments (status reports), Emergency Department (incoming victims), Public Information Officer (news media reports), Liaison Officer (response agency intelligence) and will assess the likely scope and impact of the incident based on critical analysis of these reports.

Procedure

A. Location of emergency and its impact on hospital response

Emergency Location	Definition	Hospital Response
Internal emergency	Emergencies within the hospital (fire, explosions, chemical spill, etc.)	Relocation of patients and staff from threatened or affected areas, as necessary. Confinement of situation to provide for prevention of injuries and for as little disruption of services as possible.
External emergency, within county	Community emergency, from minor (involving a relatively small number of casualties) to major (involving large number of casualties)	Expansion of treatment and patient areas to care for casualties and discharge of inpatients as possible. May require call in of hospital personnel for treatment of casualties. Send personnel and supplies upon request.
External emergency, outside county	Emergencies occurring in other communities	Expansion to receive casualties and inpatients transferred from stricken community. May require call in of hospital personnel for treatment of casualties. Send personnel and supplies upon request.
Emergency threats	To either the hospital or community (fire adjacent to hospital, bomb threats, civil disorders, etc.)	Precautionary evacuation either partial or total when indicated. "Alert" notification to staff and outside cooperating agencies.

B. Emergency Impact Assessment

1. Emergency impact assessment is an ongoing process for the HCC team, initially driven by the Incident Commander and Planning Chief. The HCC Team gathers facts about the emergency situation and response resources. The Planning Chief compiles scenario/resource projections from all Section Chiefs to effect long-range planning. The Planning Chief confirms facts collected and, following analysis, distributes critical information.

   As part of its fact-finding and analysis, the HCC also considers the following factors to assess the impact of each emergency:

Type of Emergency • Is this a known or suspected terrorist event? • If yes, lock down facility and consider potential for secondary attack. Should security sweep be provided? • Is this an emergency that requires relocation or evacuation? • Is the emergency contained (limited to known number of casualties) or is impact unknown, or likely to be greater than what is currently known? • What are the expected mid and longer-term repercussions of this emergency? (A fire in single location has different repercussions than radiological incident with potential for large numbers of casualties over time. A bioterrorism attack with the release of a biological agent may affect just a few people or hundreds.) • Will anticipated response go beyond 24 hours?
Patients • How many casualties are expected? • What is the seriousness of injuries, illness or exposure? • Will rapid discharge be required?
Engineering • Will the emergency allow the hospital to carry on business as usual? • Will additional acute care sites or field hospitals be required? • To what extent and for how long will hospital resources be taxed beyond normal levels? • What hospital resources are likely to be taxed beyond normal levels? (Emergency Department, surgical units, burn unit, respiratory therapy, dealing with hysterical illness, etc.) • Are there impacts on Ambulatory Services sites and Acute Psych Services?
Personnel • Will personnel beyond normal staffing levels be required? • Is there a need to expand or change shift lengths? • Will augmentation of personnel through volunteers or non-employees be required? • Will personnel have injuries, illness, or exposures in the same proportion as the public? • Will staff require education, such as with the release of a little known chemical or biological agent? • What types and frequency of staff updates are needed?

2. The Incident Commander determines the appropriate emergency response level.

   Based on its assessment of the likely impact of emergency on the hospital, the HCC team determines whether an emergency is Minor, Moderate or Catastrophic.

C. Color Code Emergency Response Classification

   Kaweah Health also uses specific color codes to plan for and announce specific types of emergencies, such as fire (Code Red), bomb threat (Code Yellow), and child abduction (Code Purple).

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Policy Number: DM2107	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)	

Media Plan

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

Policy

During a major emergency or disaster, the Kaweah Health (KH) may need to communicate with employees and physicians who are not on campus at the time of an emergency regarding emergency staffing requirements or other staff instructions. The media may provide an efficient and effective means of communication between Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) and off-campus employees.

In order to fulfill its obligation to inform the general public about the scope of the emergency, the media will seek casualty and other disaster-related information from the hospital. KH will cooperate with this community mission to the best of its ability in a manner that will not interfere with patient care or hospital operations.

The Public Information Officer (PIO) is responsible for coordination and release of appropriate and relevant information to the media during an emergency incident or disaster.

II. Procedure

A. Media Releases

The PIO, working as an integral component of the KH Hospital Incident Command System (HICS) Team, will obtain approval from the Incident Commander for media releases during an emergency incident or disaster.

B. Media Relations

The PIO will serve as principal liaison with individual members of the media and will direct media representatives to the designated Media Area, which may be located in the Support Services Building. The PIO will confirm that media representatives have appropriate access to hospital facilities in a manner that will not interfere with patient care or hospital operations as follows:

1. News media persons will be taken to the designated Media Area during activation of the Emergency Management Plan.

2. Media personnel WILL NOT be allowed in Intensive Care, Emergency Department (ED), Operating Room (OR), Morgue Area, Decontamination Areas, any Triage site or the Hospital Command Center (HCC) under any circumstances.

3. Security officers will be assigned to keep the media away from unauthorized areas, as needed.

C. Employee Communications

The PIO will coordinate and assist in preparation of written communication releases to on-duty staff with the Support Branch Director.

The PIO will work directly with news outlets to provide status information to physicians and employees on such issues as contingent staffing needs.

1. Staffing Requests to Off-Campus Employees – The PIO will coordinate with the Labor Pool and Credentialing Unit Leader the release of staffing requests for KH employees off-campus by providing announcements to designated broadcasters for dissemination.

2. On-Campus Employees – The PIO will coordinate with the Situation Unit Leader for dissemination of incident-related information to KH employees on campus.

D. Casualty Interviews

Interviews with casualties admitted to the hospital may be granted only by the Incident Commander following consultation with the attending physician. Any interview may be terminated at the discretion of the physician attending the patient.

E. Media Lists

Media lists, kept current by KH's Marketing Department, will be maintained as Attachments to the PIO Job Action Sheet.

F. Communications Group

The PIO will work with the following HICS positions to coordinate information collection and release: PIO, Situation Unit Leader, Patient Tracking Manager and Support Branch Director.

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Policy Number: DM 2109	Date Created: 09/01/2008
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)	

Program Management- Emergency Management Committee

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

I. Policy

The Emergency Management Committee is a subcommittee of the Kaweah Delta Health Care District, herein after referred to as Kaweah Health (KD). Environment of Care Committee. Under this oversight, it is charged with developing and maintaining KH's Emergency Operations Plan. This shall be done through planning, implementation and evaluation of all elements of the program. The Emergency Management Committee ensures compliance with Federal, State, and other accreditation boards that control regulations regarding emergency management activities.

II. Procedure

A. Responsibility

1. The Emergency Management Committee is responsible for development and maintenance of the Emergency Management Manual, planning and implementation of training exercises, review of all Hospital Incident Command System (HICS) activations, and communication of applicable Emergency Management information to the Environment of Care Committee.

2. Department Managers are responsible for ensuring that all employees within their department are familiar with the main components of the Emergency Operations Plan.

B. Membership of the Committee

1. The Emergency Management Committee is chaired by the District Safety Officer or designee.

2. The Emergency Management Committee is composed of representatives from:

- Emergency Department (Physician and RN)
- Risk Management
- Security
- Maintenance
- Infection Control
- Nutrition Services
- Communications
- Human Resources
- Information Systems
- Nursing
- Marketing
- Environmental Services
- Imaging

Additional KDHCD staff is invited to attend committee meetings as needed to share information and receive updates.

3. The District Safety Officer will be a member of the Environment of Care Committee and act as a liaison between the two committees.

C. Duties of the Emergency Management Committee.

1. Meeting Attendance
Members attend regularly scheduled meetings.

2. Drill Requirements – The Joint Commission
Ensures that the District conducts at least two drills per year (unless there are actual events that would meet our Joint Commission and CMS requirements for Emergency Preparedness). One includes an influx of volunteer or simulated patients. One includes a community wide drill relevant to the priority emergencies identified in the District's Hazard Vulnerability Analysis (HVA) and that assesses communication, coordination, and the effectiveness of the hospital's and the community's command structure. The Emergency Management Committee also performs a post-exercise critique, and ensures written reports evaluate performance per The Joint Commission requirements.

3. Drill Requirements – Title 22 Department of Public Health Services (DPHS) Assures that emergency management drills are performed in compliance with Title 22 requirements (at least once per shift per quarter). Contributes to written reports of all plan activations, including drills or actual events. The report outlines deficiencies, recommends plans of correction or improvement, identify person(s) or department(s) responsible for corrections.

4. Quality Improvement
Approves and acts upon changes recommended as a result of post-exercise critiques. Monitors outcome at its regular meetings.

5. Annual Plan Review
Reviews the Emergency Operations Plan annually, revises as needed, and submits a written report to the Environment of Care Committee.

6. Training
Ensures that all personnel are instructed in the Emergency Operations plan to the degree necessary to assume their role in implementing the Plan.

7. Quarterly Reports
Reports to the Environment of Care Committee, quarterly, all deficiencies and performance improvements.

D. Emergency Management Committee Chair

Liaisons with other community Emergency Operations Planning groups and reports back to the Emergency Management Committee.

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Policy Number: DM 2111	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)	

Dependent Care Plan

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

I. Policy

In the event of a long-lasting external emergency or civil disturbance where personnel will remain at the hospital for long periods, dependents, including children, elderly and disabled persons may be brought to the main campus, and housed in the designated dependent area. If no responsible person is available at home to provide care, these dependents will be housed in the dependent care area for the duration of the disturbance or until other arrangements are made.

II. Procedure

This procedure outlines the process by which the Hospital Incident Command System (HICS) at Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) provides for sheltering and feeding of staff and volunteer dependents during an extended disaster or emergency event.

A. Mobilization – Upon request by the Operations Chief or the Incident Commander, the Family Care Unit Leader shall mobilize sufficient staff and resources to activate a dependent care area removed from patient care areas. Primary location for children age 0 – 18 years is Kaweah Kids (KK Policy #127). Primary location for adult dependents will be Kaweah Delta Rehab Hospital located at 840 S. Akers St. Visalia Ca.

B. Safety Requirements – Prior to activation of the dependent care area, the Family Care Unit Leader, with assistance of the Safety Officer or Designee, shall conduct a safety inspection of the area to remove any unsafe objects and to secure any equipment that could pose a safety hazard.

C. Staff

1. The Dependent Care Area shall be operated by at least two staff that will oversee any other auxiliary volunteers requested from the Labor Pool, two clerical staff for registration. The staff will provide the appropriate ratio of staff to dependents as determined by acuity or age-related needs.

2. Staff and volunteers shall sign in and out when reporting to assist.

3. Staff shall monitor the area continuously for safety issues and respond to dependents' needs.

D. Supplies

The following supplies are needed to set up the Dependent Care Area. Requests for additional supplies should be directed to the Supply Unit Leader:

- Accordion alpha file (or file drawer for dependent records)
- Armbands
- Backpacks
- Camera
- Printer for color photo prints
- Cots
- Dependent Care Binder
- Dependent Care Registration forms
- Diaper changing facilities and supplies
- Diversions for children (VCR, videos, games, toys)
- Emergency lighting
- Flashlights
- Non-sterile gloves, medium and small
- Note pads for documentation
- Red Hazardous Waste Disposal Bags
- Sheets, blankets, pillows, towels and washcloths
- Sticker tags
- Water, bottled
- Waterproof Pads (Chux)

E. Food – Meals and snacks for dependents shall be arranged by the Food Services Unit Leader.

F. Registration

1. Post signs indicating “Dependent Care Area – Responsible Adult Must Register Dependent”.
2. Assign each family a Family Number.
3. All dependents shall be assigned a Dependent Number and shall register using the *Dependent Care Registration* form. Establish the Dependent Number by adding a letter (A, B, C, D, etc.) to the Family Number for each dependent in a given family.
4. Apply an armband to each dependent upon arrival with name and dependent number
5. Take a photo of each dependent with Responsible Adult and attach to *Dependent Care Registration* form.
6. The employee who registered them may sign out dependents or one of the individuals named as an emergency contact on the *Dependent Care Registration* form. The Employee ID badge or other legal form of photo identification must be used.
7. Tag medications, bottles, food and other belongings with dependent’s name and Dependent Number and store appropriately.
8. Assign each dependent to a dependent care provider and record on form.

G. Medications

1. Assure that dependents taking medications have a supply to last during the estimated length of stay.
2. Arrange for a pediatric nurse or other licensed nurse to dispense medications as appropriate.

H. Psychological Support – Arrange for the Employee Health & Well-Being Unit Leader to make routine contact with dependents in the shelter, as well as responding to specific incidents or individual needs.

I. Documentation

1. Document all care provided to individual dependents, such as medications, psychological services, toileting or dressing on the *Dependent Care Record* (on the reverse side of the *Dependent Care Registration* form).
2. Document all other actions and decisions and report routinely to the Support Branch Director.

J. Checking Out of Dependent Care Area

1. When dependent leaves area, compare picture with dependent and Responsible Adult.
2. Check ID, verify name and obtain signature of Responsible Adult picking up dependent.
3. Retrieve and send all medications and personal items with dependent.
4. Collect armbands.

Policy Number: DM 2112	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)	

Elevator Use During Emergency Situations

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

I. Policy

This procedure outlines the safe and appropriate use and securing of elevators at Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) during emergency situations.

II. Procedure

A. Emergencies affecting Kaweah Health Medical Center – no elevator use in affected building

1. During situations such as fire, explosion, toxic cloud or earthquake that effect the hospital facility directly, elevators in the affected buildings must **not** be used by anyone until authorized to do so by the fire department and maintenance staff.

   a. Structural damage from an earthquake, including aftershocks, fire or explosion may cause the elevator to cease functioning, causing entrapment, injury or death.

   b. When a toxic cloud in the vicinity necessitates a Code Shelter-in-Place, the use of elevators may draw toxic air in from the outside.

      1) Once Maintenance can seal off the venting system at the top and bottom of the shaft, one elevator can then be operated for emergency use.
      2) An operator will be designated to run the single elevator and allow it to travel only one floor at a time, opening and closing at each floor to minimize the “piston effect” of the elevator in a closed system.

2. In emergencies affecting the entire hospital facility (and during drills concerning these situations), Maintenance staff will bring the elevators down by manual operation (priority key) to the first floor and secure them.

   a. When elevators are secured in *affected* areas, the Incident Commander may assign a Labor Pool designee to operate the elevators at each of the elevator banks in other *unaffected* areas.

   b. Staff member assigned to elevator bank in unaffected buildings shall ensure priority use of elevators for patient flow and transport for duration of emergency.

B. Emergencies Not Affecting the Hospital Facility – Elevators May Be Used

1. If the hospital has not suffered damage or is not in danger of fire, i.e., an emergency occurring in the community not involving the hospital structure, elevators may be used.

2. Elevators should be used primarily for patient and supply transport during any emergency situation.

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Policy Number: DM 2115	Date Created: 09/01/2008
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)	

Person In Charge (Initial Response Coordinator)

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

I. Policy

In the event of an internal disaster, the Department Manager or designee (in area in which the event occurs) will initiate and coordinate response efforts, until a person with higher authority or expertise takes over.

Background

The initial Person in Charge at the scene of a disaster must be knowledgeable and competent to take charge of the area, or have specific training to respond. An area Department Manager or other such personnel should be prepared to assume a leadership role to coordinate emergency response activities only until such time as the emergency response plan is activated and the Incident Commander or other officials (fire/police) take charge of the situation.

II. Procedure

A. The Person in Charge will direct response activities as follows:

1. Notify PBX at Ext. 44. (Note: departments located outside of main campus dial 9-911 medical or life safety., followed by a call to Ext. 44.)
    a. Announce the Emergency Code overhead, if appropriate.
    b. Alert Administration, via Nursing Supervisor.
2. Assess situation.
    a. Define the event.
    b. Assess risks/hazards.
    c. Determine what is needed to secure the situation.
    d. Check to see if area has appropriate and adequate resources.
3. Provide direction to staff at the scene.
4. Notify appropriate personnel.
5. Alert and coordinate with Administration if the response needs to be escalated or expanded (i.e., “Code Triage”).
6. Document the incident on the *Emergency Occurrence/Drill Critique* and submit to the Safety Office as soon as possible.

B. When the incident is over, the Incident Commander will authorize PBX to announce the appropriate “All Clear” announcement.

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Policy Number: DM2116	Date Created: No Date Set
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)	

Reporting For Duty/Building Access

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

I. Policy

In the event of any area-wide disaster, or emergency event, off-duty employees and District staff (after assuring safety of home and family) may be expected to report to a Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH)facility as directed.

II. Procedure

A. Purpose:

Kaweah Health provides a critical community service during times of local emergency. Therefore, it is imperative that services continue to be provided during adverse conditions.

B. Leadership/Management shall report to their designated Hospital Command Center or worksite.

C. Staff located at a KH facility when emergency occurs:

1. Remain at the facility and be prepared to assist as directed by supervisor.

2. Will be sent to the Labor Pool by the Department Manager, when there is surplus staff.

D.. Staff off-site when emergency occurs:

1. Take actions to protect themselves and their families.

2. Report for work automatically if you are pre-assigned emergency duty through HICS.

3. Stay tuned to television news broadcasts or the following AM radio station: KMJ-580

4. **Be prepared to report for an emergency assignment.**

5. If the broadcast message indicates, or if a broadcast message is not heard within 2 hours after a major event, call the KH Employee Information Phone Line at 559-624-2008.

6. Due to potential staff shortages and prolonged work hours, employees are encouraged to bring bottled water, toiletries and a flashlight for personal use.

7. Identification

   Employees will keep their ID badges with them at all times. In the event of a major disaster or emergency, this badge may enable employees to pass through police lines, roadblocks, etc., as they travel to and from work.

E. Building Access/Where to Report

Under emergency conditions, access to each facility may be limited. Personnel shall use only designated doors; all others shall be locked. The Access Control Unit Leader will coordinate personnel to staff doors to verify need to enter and provide direction/assistance. Elevators and corridors may be monitored, as possible within resources, to assist or restrict movement.

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Policy Number: DM 2117	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)	

Staff Support Plan

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

I. Policy

This procedure outlines the process by which the Hospital Incident Command System (HICS) at Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) provides for sheltering and feeding of staff and volunteers during a disaster or other emergency situation.

II. Procedure

In the event of a long-lasting external emergency or civil disturbance, personnel will remain at KH facilities for long periods and may be housed in designated area(s). A Staff Break and Nutritional Area will be established at each facility.

The Employee Health & Well-Being Unit Leader shall be responsible for coordinating the HICS Staff Break and Nutritional Area activities and assure the provision of logistical and psychological support of District staff.

A. Mobilization – Upon request by the HICS Support Branch Director, the Employee Health & Well-Being Unit Leader will:

1. Establish a Staff Break and Nutritional Area at each facility.
2. Contact the Nutritional Supply Unit Leader for assistance.
3. Provide for calm, relaxing environment.
4. Establish a Staff Information Center in the Support Services Building with the help of the Support Branch Director, Labor Pool and Credentialing Unit Leader.
5. Provide overall emergency information updates for rumor control.
6. Arrange for routine visits/evaluations by the Employee Health & Well-Being Unit Leader.
7. Assist in establishment of separate Staff Debriefing Area in the cafeteria.

B. Staff:

1. The Employee Health & Well-Being Unit Leader oversees the Staff Break and Nutritional Area and will request staff assistance from the Labor Pool as needed. The Employee Health & Well-Being Unit Leader may delegate this responsibility for continuing oversight if needed elsewhere.

2. Staff and volunteers assigned to the Staff Break and Nutritional Area shall sign in and out using HICS 252 *Personnel Time Sheet*.

3. The Staff Break and Nutritional Area staff shall respond to staff needs and shall report any issues that arise to the Employee Health & Well-Being Unit Leader.

C. Supplies – shall be requested through the Supply Unit Leader. A list of probable supplies is listed below:

Supply Type
Support Branch Director storage bin contains: • Support Branch Director Binder • Job Action Sheets (JAS) and clipboards for reporting Unit Leaders • HICS Vests • Office Supplies and note pads for documentation • Flashlights • Directional Signs
Whiteboard
Cots
Sheets, blankets, pillows, towels and washcloths
Water (bottled)
Emergency lighting
Diversions (DVD player, videos, games, books and magazines, music)

D. Signage - Post signs indicating:

Staff Break and Nutritional Area
Visitors – for food and drinks please go to the cafeteria
Staff Sleeping Area
Staff Information Center
Staff Debriefing Area

E. Employee Health -

The Employee Health & Well-Being Unit Leader shall:

1. Arrange with the Employee Health Department to address staff non-emergent yet serious health needs, such as routinely taken critical medications.

2. Arrange with the Casualty Care Unit Leader and Transportation Unit Leader for transport to the Emergency Department for staff experiencing a medical emergency.

F. Staff Sleeping Quarters -

The need for staff sleeping quarters will be determined by the Incident Commander.

The Operations Chief in conjunction with the Support Branch Director will arrange for sleeping facilities for staff remaining on campus for extended periods of time.

G. Transportation -

Individual needs for employee transportation will be coordinated with the Transportation Unit Leader.

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Policy Number: DM 2202	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 Blue/Code White Activation

Policy

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

Definitions:

Code Blue: Adult CPR Medical Emergency

Code White: Pediatric Medical Emergency

Procedure

A. Background

In the event of a cardiopulmonary arrest the assigned Code Blue Team members will respond to the location of the arrest. All other personnel are to stay out of the area unless assigned by the team leader. Please refer to PC.189 policy and procedure in the Patient Care Manual.

B. Response

See attached checklist and flowchart.

CODE BLUE/WHITE – Medical Emergency

Purpose: To provide assistance if you witness or become aware of a medical emergency involving a fellow employee, patient or visitor at the hospital.

STAFF RESPONSE CHECKLIST

When you are the first person to find a patient, visitor or employee who appears to be a victim of a medical emergency or to be in life threatening distress, immediately initiate the following:

If the victim is in an area of the hospital where <u>a physician or nurse is nearby</u>:

- ☐ Yell for help.
- ☐ The physician or nurse will assess the situation.
- ☐ If there is a cardiac/respiratory arrest or medical emergency the Physician or Nurse will direct staff to dial Ext. 44 to report a Code Blue/Code White with the location. Off site facilities will call 9-911.
- ☐ If trained in CPR, initiate.
- ☐ Await the arrival of the Code Blue Team.

If the victim is in an area of the hospital where <u>no physician or nurse is present but other people are present</u>:

- ☐ Yell for help – Direct responder to dial Ext. 44 to report situation and location.
- ☐ Remain with victim until the Code Blue Team arrives. Off site facilities will call 9-911.
- ☐ If trained in CPR, initiate. If not trained in CPR, attempt to arouse victim.

If the victim is in an area of the hospital where <u>no one else is present but you</u>:

- ☐ Go to the nearest phone and dial Ext. 44 to report situation and location.
- ☐ Return to the victim and initiate CPR, if trained, and await Code Blue Team arrival.

If the victim is in an area <u>on campus but not in the main hospital buildings</u>:

- ☐ Go to the nearest phone and dial 911.
- ☐ Return to the victim and initiate CPR, if trained, and await paramedics.

If the victim is in an outside facility - <u>not in the main hospital buildings</u>:

- ☐ Yell for help
- □ Go to the nearest phone and dial 9-911.
- ☐ Return to the victim and initiate CPR, if trained, and await paramedics.

PBX Checklist

- ☐ Announce “Code Blue” or “Code White” (2x) and state the location over PA system.
- ☐ Do not announce over the PA the following locations, OR, CVOR, OBOR.
- ☐ Immediately send out a page via paging system.

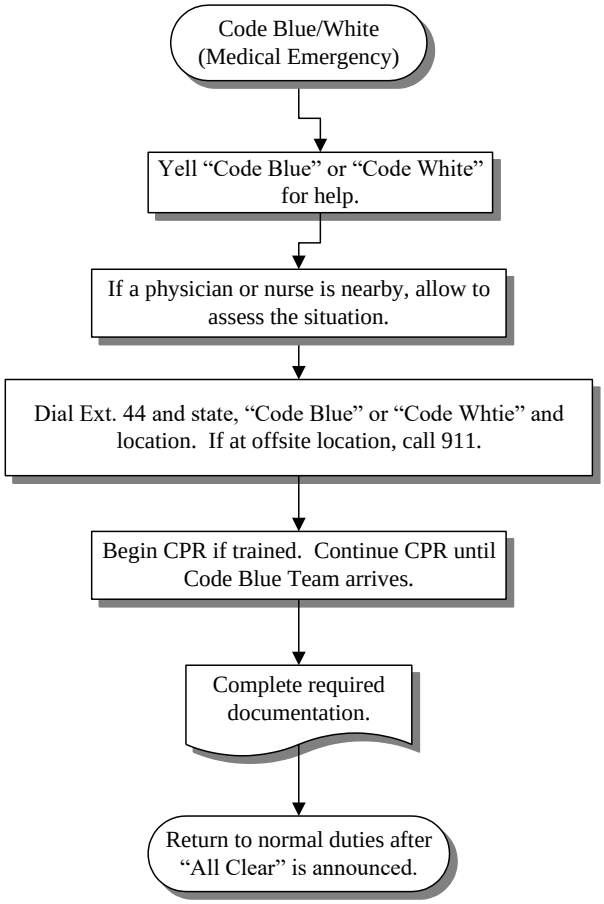
All Clear

After “Code Blue, All Clear” is announced (2x), return to your normal work duties, unless otherwise directed.

Kaweah Health

Emergency Management Manual

Code Blue /White - Medical Emergency



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Policy Number: DM 2203	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 Gray- Activation Plan

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

POLICY
Code Gray is designed to show a coordinated team response to protect our employees and others from any potential aggressor. The hospital has “zero tolerance” for violence.

In situations where hospital staff, physicians, or visitors are not comfortable due to persons becoming aggressive, abusive, or threatening in any manner, a CODE GRAY may be called. This will initiate help, first from any personnel in the immediate area, and secondly from a follow-up team as described below. The intent of declaring a CODE GRAY will be to immediately have additional personnel show up, not necessarily to intervene directly, but to demonstrate a presence of other people in the area. The person calling the CODE GRAY will have the opportunity to request additional help or to dismiss staff responding.

Extremely violent situations will require a different approach. This area should be considered OFF LIMITS by initiating a Code Silver (See Policy #2204 Code Silver). Calling additional staff members to the scene puts additional people at risk. Calling an area OFF LIMITS will signal a STAT page to security and the Nursing Supervisor. The Visalia Police Department would be notified immediately when any person reports that an individual is threatening violence with a weapon.

Procedure

A. Response

See attached checklist and flowchart.

B. Supporting Information

1. Combative or abusive behavior can be displayed by anyone; a patient, a patient’s family member, staff, staff family members, or acquaintances of employees and patients. Combative or abusive behavior can escalate into a more violent episode. A comprehensive workplace violence prevention policy should include procedures and responsibilities to be taken in the event of a violent incident in the workplace.

2. Recognize early warning signs. The following are examples of warning signs but are not all inclusive.

    a. Direct or verbal threats of harm.
    b. Intimidation of others by words and or actions.

c. Refusing to follow policies.
d. Hypersensitivity or extreme suspiciousness.
e. Extreme moral righteousness.
f. Inability to take criticism of job performance.
g. Holding a grudge, especially against supervisor.
h. Often verbalizing hope for something to happen to the other person against whom the individual has the grudge.
i. Expression of extreme desperation over recent problems.
j. Intentional disregard for the safety of others.
k. Destruction of property.

Emergency Management Manual

CODE GRAY – ABUSIVE/ASSAULTIVE BEHAVIOR

Purpose: To provide a safe and secure healthcare environment for patients, visitors, volunteers, physicians and employees. Also, to assist employees in managing and/or de-escalating the situation by a show of support, to gain the cooperation of the abusive or assaultive person, or to subdue and restrain the individual if necessary.

Note: If the situation involves a weapon, immediately notify PBX of “Code Silver and location.”

The Hospital Incident Command System (HICS) is not activated for a Code Gray unless the incident disrupts day-to-day hospital operations.

STAFF RESPONSE CHECKLIST

In the event a situation with an angry, belligerent or threatening person has escalated or has the potential to escalate; or, in the event of imminent danger where there is a potential for a violent or criminal act to occur; or, when a violent or criminal act is in progress:
 Dial the District operator at Ext. 44. Provide the operator with the following:
 Where you are and where the incident is occurring
 Description and number of person(s) involved. Do not hang up until the operator has all your information.

Verbal Abuse:
 Use a calm voice and attempt to verbally de-escalate the situation.
 If verbal abuse continues, call a second person to assist you.
 Move patients away from the hostile person, if safe to do so.
 Step back from person and try to get a barrier between you and the person.
 Direct others away from the area.

Physical Battery:
 Protect yourself and others from blows, attempt to get away from the person/area and defend yourself as necessary for personal safety.
 Put distance and/or barrier between the parties involved – only when safe to do so. Do not attempt to confront the person(s).
 Remove patients, staff and visitors from the immediate area. Remain calm and reassure those around you.
 Provide assistance and medical help for all injured persons when safe to do so.

Documentation to Complete:
 Per normal procedures, if employee is injured:
 Employee completes Incident Report and submits to supervisor, who completes, signs and forwards report to Risk Management

If you hear a “Code Gray” announcement:
 Trained available personnel respond to the Code and take direction from Nursing Supervisor, charge staff or Security Officer.
 Stand by for further instructions.
 Provide assistance as requested.

If you are at an off campus site: In the event a situation has escalated and a violent or criminal act occurs call 9-911.

PBX CHECKLIST

 When notified of a violent or potentially violent situation, immediately overhead page "Code Gray and location" (2x).
 Notify Security via radio.

CHECKLIST-SOUTH CAMPUS

When notified of a violent or potentially violent situation, immediately overhead page to South Campus "Code Gray and location" (2x).
Send out a Berbee page and Berbee message to South Campus.
Notify Security via radio.
Notify Nursing Supervisor. (And notify police if instructed to do so by Nursing Supervisor by dialing 9-911.)

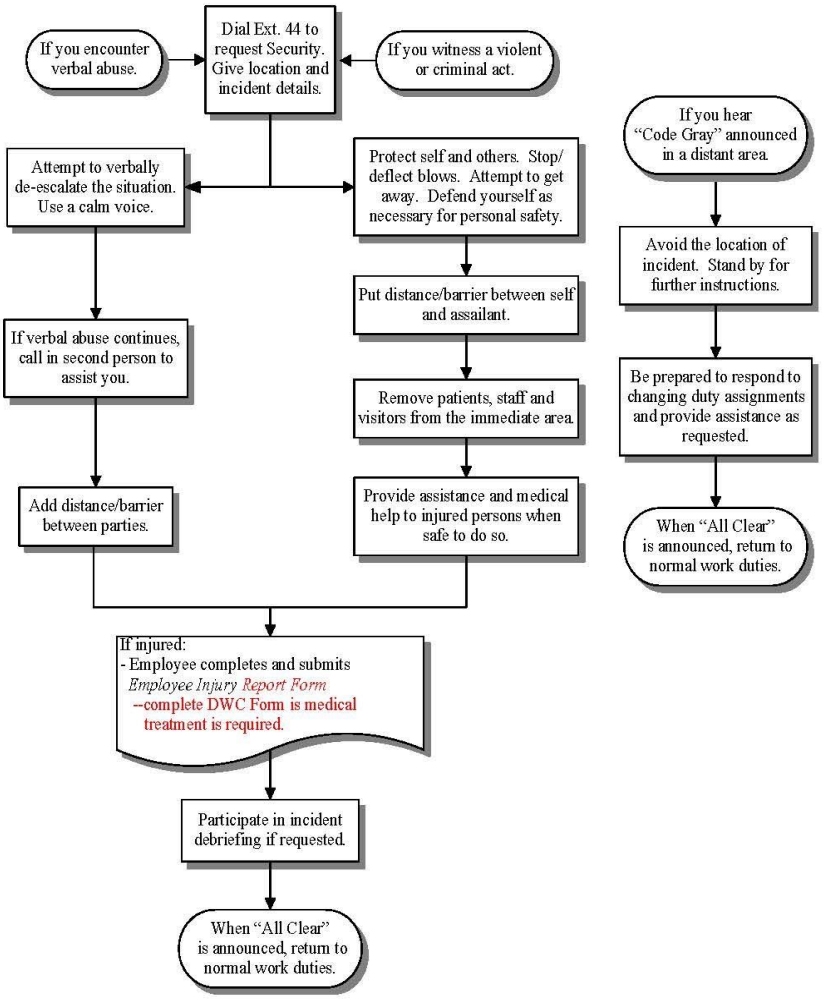
SECURITY CHECKLIST

Upon notification of the potential for or actual occurrence of a violent or criminal act:
Dispatch Security personnel to the location as appropriate.
 When responding to the scene and approach with caution. When using force, Security will use only the minimum amount of physical force necessary to restrain or protect the individual from self-injury and/or from injuring others.
If situation has potential to disrupt hospital operations:
 Notify Nursing Supervisor.
 Direct PBX to announce by overhead page "Code Gray, location."
 Monitor and coordinate incident per department procedures. Control crowds and provide direction at the scene.
 Request help from the police department if necessary or call in extra Security staff for long-term incidents.
 If warranted, the Security Officer will file an Incident Report. Officers will determine if a report should be filed with law enforcement.

Kaweah Health

Emergency Management Manual

Code Gray - Abusive/Assaultive Behavior



DM2203
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Policy Number: DM2204	Date Created: 03/01/2008
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 Silver-Activation Plan

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

I. Policy

To establish guidelines to be followed in the event that an individual is brandishing or using a weapon, or there is a hostage situation.

II. Procedure

When an employee believes an event is occurring in the hospital, with an individual brandishing or using a weapon or a hostage situation, they must notify Security, the Nursing Supervisor and Administration **immediately by dialing Ext. 44** and giving the nature of the incident, the exact location and if possible, the number of suspects, and the names of the hostages to the PBX Operator. **Outside facilities will dial 911 followed by Ext. 44.**

A. The following steps should be taken without delay:

1. PBX Operator will dial 911 and report the situation (i.e. person with a weapon and type of weapon, active shooter, hostage) to the Visalia Police Department.

2. PBX will overhead page “Code Silver and Location”. PBX will notify the ISS Help Desk and they will announce through Berbee message on all Cisco Phones.”

3. PBX Operator will notify Security by two-way radio giving the location and nature of the incident.

4. PBX Operator will notify the Administrator on Call and the Manager of Security.

5. If after hours, the Administrator on Call will be notified by PBX Operator and immediately report to the location of the incident.

6. Staff will follow Staff Response Checklist: evacuate when possible and shelter in place, close all doors and reassure patients and visitors.

7 Security Officers will respond to confirm the event, secure the perimeter and ensure no one enters the area. When possible, Security will rope off with yellow caution tape or secure doors.

8. The Administrator on Call and/or Nursing Supervisor and Security Officer will obtain any information from witnesses, i.e., number of suspects, weapons involved, and number of hostages to be given to the appropriate authority, i.e., Visalia Police Department.

9. The House Supervisor or the Administrator on Call will establish the Hospital Command Center (HCC) in the executive conference room or other designated area and initiate the Hospital Incident Command System (HICS) to the degree necessary.

10. In the event of a hostage situation, at no time will any demands or requests from the assailant be met prior to the arrival of law enforcement agencies.

11. The following members of the management staff will be called by Administrator on call or House Super and meet in the established HCC of the specified location:

    a. Administrator on Call
    b. Director on Call
    c. House Supervisor
    d. Security Manager or designee
    e. Director of Risk Management or designee
    f. Director of Facilities or designee
    g. Safety Officer or designee
    h. Director of Marketing or designee
    i. Director of Chaplain Services or designee

12. Upon the arrival of law enforcement, the Officer in Charge will act as the negotiator with the suspect(s).

13. The hospital's Public Information Officer (PIO) will be assigned a designated area for the gathering of the news media.

14. Hostages' relatives arriving at the hospital will be placed in a secure location away from the news media and the hostage containment area.

    a. Patient Family Services staff will be assigned to assist the hostage's relatives and the Psychological Support Unit Leader will man the area.

15. Hostages' relatives will be kept informed by a member of the administrative team or by a law enforcement representative.

16. No information will be released to the news media without the approval of the Hospital Incident Commander, Public Information Officer (PIO) and law enforcement.

17. Law enforcement, in conjunction with the Hospital Incident Commander, is in charge of the hostage negotiations and the possible need to evacuate and/or halt activities surrounding the hostage area.

CODE SILVER – PERSON WITH A WEAPON AND/OR HOSTAGE SITUATION

Purpose: To provide assistance to anyone who is confronted by a person brandishing a weapon or who has been taken hostage on District property. Weapons include firearms and all other potentially deadly weapons such as knives, bats, batons, etc.

Procedure: In the event someone brandishes a weapon, Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) will activate the following Code Silver procedure to warn personnel and summon the Visalia Police Department.

INCIDENT COMMANDER CHECKLIST

If the scope of the incident requires HICS activation, the hospital Incident Commander assumes overall responsibility for hospital emergency operations, in collaboration with law enforcement.

If the incident has potential to disrupt hospital operations:

- ☐ Activate HICS.
- ☐ Direct PBX regarding all Code Silver-related overhead pages, in collaboration with law enforcement.
- ☐ Direct PIO to contact the families of identified hostages and serve as liaison with media. (Ensure that all official statements are coordinated with the police before being released.)
- ☐ As soon as the incident is cleared, direct PBX to announce by overhead page "Code Silver, All Clear."

STAFF RESPONSE CHECKLIST

If you encounter a person brandishing a weapon:

- ☐ Seek cover/protection and warn others; evacuate if possible.
- ☐ Dial the operator at Ext. 44 and Security will respond. Provide PBX with the following:
  - ☐ Where you are and where incident is occurring.
  - ☐ Description and number of suspects.
  - ☐ Number and location of hostages.
  - ☐ Number and type of weapons involved.
- ☐ Come to the aid of others when safe to do so, removing patients, staff and visitors from immediate area.
- ☐ **Do not** attempt to confront the individual(s). Remain calm; reassure patients, staff and visitors.
- ☐ Attempt to keep others out of the area.

Note: If Code Blue team is needed, call PBX to overhead page "Code Blue" assistance to the scene *when the scene is secure.* **Do not** put Code Blue team at risk.

If you hear "Code Silver":

- ☐ **<u>Stay away from the area</u> specified in "Code Silver."** This is an extremely dangerous and sensitive situation that should only be handled by trained authorities.

Employees in the affected or immediate area of on the same floor adjacent to the "Code Silver" location:

- ☐ Close and barricade doors to patient areas or rooms to "shelter-in-place".
- ☐ Where feasible and safe, evacuation may be initiated by using fire evacuation routes and fire stairwells at the direction of the area Manager or designee. Extreme caution shall be exercised in determining whether or not an evacuation will be initiated.
- ☐

Employees in all other locations shall initiate a shelter-in-place response and remain at the location until an "all clear" announcement is made:

- ☐ Close/secure all patient and unit exit doors. Close and barricade doors leading in the department to "shelter in place". Do not allow visitors or patients to leave the safety of the unit.
- ☐ Remain calm and quiet reassuring patients and visitors the situation is being managed.
- ☐ Refrain from calling the operator or Security Department to inquire about updates. The "all clear" announcement will be made when the incident is stabilized and under control.

- ☐ Do not discuss situation; refer media inquiries to the Public Information Officer (PIO).

If you are taken as a hostage:

- ☐ **Do everything the hostage-taker says to do.**
- ☐ Be especially careful during the first 5 minutes, as the captor is probably as desperate and nervous as the victim.
- ☐ Speak only when spoken to, do not make wisecracks.
- ☐ Try not to show emotions openly, captors play off emotions and take advantage of emotiona weaknesses.
- ☐ Sit down if possible to appear less aggressive.
- ☐ Act relaxed as this may relax the hostage-taker.
- ☐ Weigh carefully any chance to escape to be sure that escape is certain and no one else is endangered.
- ☐ Be patient, help is coming. Have faith in negotiators.
- ☐ Do not make suggestions to the hostage-taker. If they go wrong, the captor will think you were trying to trick him or create problems.

DM 2204

PBX CHECKLIST

- ☐ Upon notification or recognition of a situation involving a person with a weapon, active shooter, or hostage taking, announce by overhead page, "Code Silver" with the location of incident; immediately notify:
  - ☐ Visalia Police Department and provide details of situation:
    - ☐ Location
    - ☐ Number of assailants
    - ☐ Description of assailants
    - ☐ Entrance location to area
    - ☐ Weapons(s)
    - ☐ Number of hostages
- ☐ Maintain a phone connection between the reporting party and Security or responding law enforcement officers to keep officers updated about the situation.
- ☐ Refer staff inquiries regarding incident to the Incident Commander.
  Note: DO NOT dispatch the Code Blue Team to Code Silver area until the police deem it safe to do so.
- ☐ Upon direction from the Incident Commander, announce by overhead page "Code Silver, All Clear."

SECURITY CHECKLIST

☐

When notified of a person on campus with a weapon or a hostage situation, immediately notify the Visalia Police Department (if not already done by PBX).

- ☐ Security will respond to the affected area to ascertain the threat status
- ☐ Security will lockdown the hospital building to prevent the public from entering into a hostile environment, or to keep an outside threat from entering into the facility
  - ☐ Secure area perimeter – keep others from danger. Clear bystanders from the area.
- ☐ When feasible, Security will monitor the closed circuit television to gather suspect information
- ☐ Security will meet with responding law enforcement personnel to:
  - ☐ Describe the specific area and surrounding area.
  - ☐ Number and description of suspects.
  - ☐ Number and description of hostages.
  - ☐ Number and description of weapons, if known.
  - ☐ Names of suspects and hostages, if known.
  - ☐ Preliminary demands or intentions of suspects.
  - ☐ Diagram of the area in question.
- ☐ Monitor and coordinate the incident with the Incident Commander/law enforcement per Security's policies and procedures.
  - ☐ If the HCC is not activated, assist the Incident Commander and law enforcement by establishing a command post for communications and negotiations.

- ☐ Provide law enforcement with facility layout indicating rooms, exits, windows, utility access and phone numbers.
- ☐ Provide logistical and manpower support.

MAINTENANCE CHECKLIST

☐ Gather maps of the affected area and report to Visalia Police Officers in area.

ALL CLEAR – STAFF RESPONSE

- ☐ When it is safe to do so, get medical help to victims if needed.
- ☐ When you hear PBX announce "Code Silver, All Clear," return to your normal work duties, unless otherwise directed.
- ☐ If any employee is involved in a weapons incident, Human Resources must be notified immediately.
- ☐ Participate in incident debriefing as requested. Incident Commander, Security and the Department Person in Charge will complete an *occurrence report*.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall submit an occurrence report.

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Policy Number: DM2205	Date Created: No Date Set
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 Pink- Infant Abduction

Policy

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

II. Procedure

A. Background

In the event of a removal of an infant from Kaweah Health Medical Center by unauthorized persons, Kaweah Health Medical Center will activate its Code Pink procedure. Assigned staff must respond immediately to their assigned exits of the medical center. Other medical center 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 and map.

.0

CODE PINK – INFANT ABDUCTION

Purpose: To protect infants from removal by unauthorized persons and to identify the typical physical description and actions demonstrated by someone attempting to kidnap an infant from a healthcare facility. Additionally, to define healthcare facility response to an infant abduction.

Kidnapper Profile: The typical abductor:

- Usually a female of childbearing age who appears pregnant.
- Most likely compulsive; most often relies on manipulation, lying and deception.
- Frequently indicates she has lost a baby or is incapable of having one.
- Often married or cohabitating; companion's desire for a baby or the abductor's desire to provide her companion with "his" baby may be the motivation for the abduction.
- Usually lives in the community where the abduction takes place.
- Frequently initially visits nursery and maternity units at more than one health care facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire exit stairwell for her escape; and may also try to abduct from the home setting.
- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present to abduct a baby.
- Frequently impersonates a nurse or other allied health care personnel.
- Often becomes familiar with health care staff members, staff member work routines and victim parents.
- Often demonstrates a capability to provide care to the baby once the abduction occurs, within her emotional and physical abilities.

She would be:

- Carrying an infant,
- Carrying a bag large enough to hold an infant,
- Covering the infant with her coat, baby blanket,
- Dressed in other medical attire and carrying an infant.

Infants are discharged from the medical center in the arms of their mother, who is transported via wheelchair and accompanied by a staff member or medical center volunteer. An infant who is being transported between departments will be moved in a crib and accompanied by a staff member.

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 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	Patient Access after 2100 hr CVICU
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
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 – Dietary Exit Door	Food Services
Mineral King Zone L – Ambrosia Exit	Ambrosia Staff after 2000 hr Security
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

Name of Exit or Area	Department To Respond
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.")
- ☐ Identify an object that could conceal an infant (i.e., purse, backpack, gym bag, grocery bag) and report to Security.
- ☐ 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 infant and escape, keep the infant with you and report above information to Security.
- ☐ Do not leave exit until you hear "All Clear."

AFFECTED AREA CHECKLIST

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

Charge Nurse will:

- ☐ Initiate a search on Mother Baby Unit, 2 East, Pediatrics, Broderick, Neonatal Unit, and Newborn Care. 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, OBOR, and cabinets.
- ☐ Relocate the mother to another area leaving all items in the mother's room untouched. Obtain any information regarding the description of the abductor and call this information into the HCC.

- ☐ Relocate infants from any holding area to their mothers' rooms. Explain the situation to the mothers.
- ☐ Contact the attending physician to relay information regarding the incident and request that they respond to the medical center. (Contact the mother's physician and the infant or child's physician.)
- ☐ 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 if required, and collaborate with patient to determine the best location for her and her family to wait. (It is best to remove the patient from the area the abduction took place as soon as possible).
- ☐ Place cord blood on hold. Place lab work on hold, locate and secure infant's/child's medical record, including footprints. Locate and secure photographs where available.
- ☐ 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/ISS HELP DESK CHECKLIST

- ☐ Notify the following

  IF HUGS Alarm:

  - Security
  - Immediately overhead page "Code Pink and location

In the event of a HUGS Alarm Unit Staff or Security can authorize a "Code Pink, All Clear"

Confirmed Infant Abduction-Call:

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

- ☐ Initiate a "No Information" status for this patient.
- ☐ In the event of an infant abduction, only Security or Visalia Police Department will have the authority to call a "Code Pink, 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.
- ☐ Assign Security Officer to Front Entrance.
- ☐ 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 infant abduction.

ADMITTING STAFF CHECKLIST

Admitting staff stationed at Main Lobby:

- ☐ Screen all exiting visitors for kidnap profile.

- ☐ Request permission to search large bags. 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 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 medical center's perimeter.

MARKETING/MEDIA RELATIONS

- ☐ 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), Security or VPD can authorize PBX to page "Code Pink, 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.

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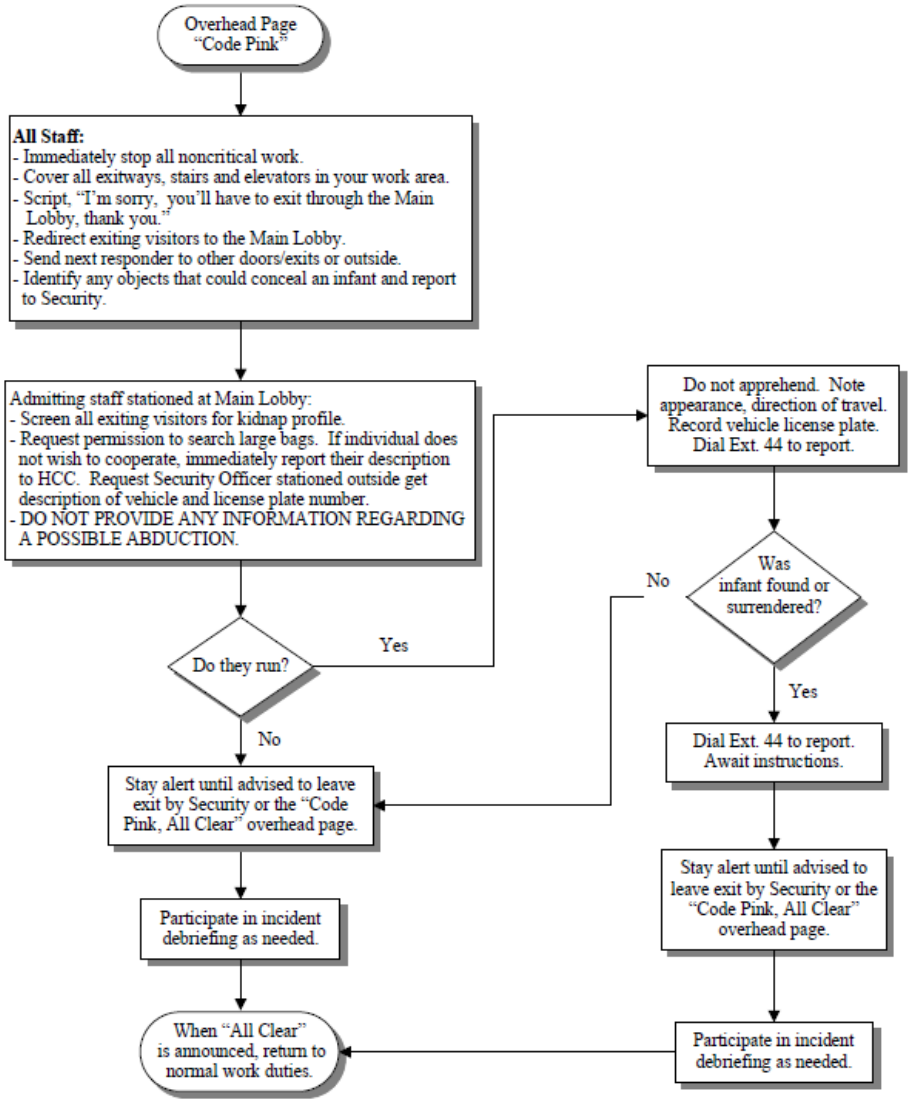
Kaweah Health

Emergency Management Manual
Code Pink - Infant Abduction



Policy Number: DM 2207	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 Red-Activation

Policy

In the event of smoke or a fire, Kaweah Delta Health Care District hereinafter refered to as Kaweah Health (KD) will activate its Code Red procedure (See KH Facility Fire Response Policy #EOC 5001). The Hospital Incident Commander (Nursing Supervisor or Administrator on Call) will assume responsibility for emergency operations and activate the HICS Code Red Team.

Procedure

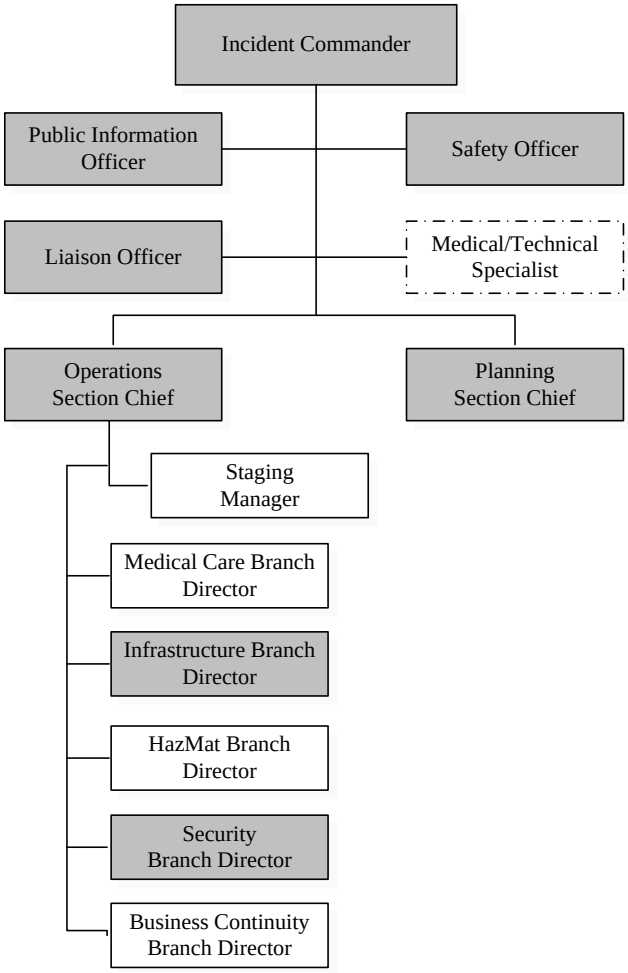
A. The person discovering the fire must immediately:

RACE

1. **Rescue** - REMOVE any persons in immediate danger.
2. **Alarm** - Communicate the presence of fire by immediately activating the nearest fire alarm pull station.
   Call, or designate someone to call the operator by dialing Ext. 44 or 9, 911 if no alarm is available to report the exact location and type of fire. If possible, have someone stay by the pull station to direct the Code Red responders to the site.
3. **Contain –** Close Doors
4. **Extinguish** - The fire should be extinguished if it is small and easily controllable by use of the fire extinguishers; however, all personnel in the fire area must evacuate the area as instructed in their fire response.

B. The following organizational chart represents the minimum level of HICS activation for a fire incident that requires relocation and/or has potential victims.

Fire
Incident Management Team Chart - Immediate



B. Code Red Fire Alarm Response Team

1. Fire Alarm Response member roles and responsibilities:

Fire Alarm Response members are not intended to serve the role of firefighter. They are to provide assistance as required at the site of the alarm as directed by the person in charge of the scene.

General duties include:

- Respond to the site of the fire alarm.
- Use the fire extinguisher only if not directly in danger and trained in fire extinguisher use.
- Assist staff with closing doors and windows.
- Assist staff with clearing hallways of all obstructions.
- Assist with traffic control in the immediate fire area.
- Assist with removing equipment, if applicable.
- Assist in relocating patients if instructed to do so.

2. Fire Alarm Response staff members:

- Engineers

- Environmental Services
- Nursing Supervisor
- Transport Aides
- Security Officers

CODE RED – FIRE RESPONSE (ALL STAFF)

Purpose: To respond safely and effectively to the threat of smoke or fire (or burning odor) within tKH or on its grounds.

Emergency Operations: The Hospital Incident Commander (Nursing Supervisor or Administrator on Call) will assume responsibility for emergency operations and activate the Hospital Incident Command System (HICS) Code Red Team. The Fire Department will respond, assume responsibility for emergency operations and authorize any evacuation. The Hospital Incident Commander will authorize "All Clear."

Note: A large-scale incident may develop into a Code Triage.

INCIDENT COMMANDER CHECKLIST (AOD/NURSING SUPERVISOR)

- ☐ Establish Hospital Command Center (HCC).
- ☐ Determine evacuation route (especially exit stairwell) in consultation with Fire Department/Maintenance.

STAFF RESPONSE CHECKLIST

Immediately upon discovering smoke or fire: (RACE)

- ☐ **R**escue people in danger. (Close door when all occupants have been evacuated. Mark the door with a 10-inch "X" in the center of the door using tape or writing implement.)
- ☐ Remove all patients from corridors.
- ☐ Move all equipment to one (same) side of corridor.
- ☐ **A**ctivate the alarm and dial Ext. 44.
- ☐ **C**ontain fire – close all doors and windows to prevent spread of smoke and flames.
- ☐ **E**xtinguish fire if safe to do so. If the fire is small and you know you can put it out **quickly**, do so using available sources (fire extinguisher). Otherwise, do not attempt to extinguish the fire.
  - ☐ Clothing on fire: instruct person to drop and roll to extinguish flames.
  - ☐ Bed on fire: smother flames with blanket, remove patient and extinguish, if possible.
  - ☐ Unplug any electrical equipment in area of fire, if possible. Turn off wall oxygen in area, if possible.
  - ☐ Evacuate if area becomes unsafe to occupy.

Note: Do not use elevators in the affected building during a "Code Red."

To extinguish a small fire: (PASS)

- ☐ **P**ull the pin on the extinguisher.
- ☐ **A**im the nozzle/hose at the base of the fire.
- ☐ **S**queeze the handle.
- ☐ **S**weep from side to side.

Stand at least 10 feet back while using the fire extinguisher.

To extinguish fire on surgical patient:

- ☐ **S**mother small flames with saline.
- ☐ **A**im water mist nozzle at flames.
- ☐ **C**over wound with saline dressing.

Immediately upon hearing "Code Red" overhead page:

If you are in the area specified by "Code Red":

- ☐ At the direction of the Person in Charge, relocate patients outside the fire zone, beyond the fire/smoke barrier doors per the evacuation direction diagram posted in each department. Close windows/doors and clear corridors, etc.
- ☐ Once unit is secured, make rapid rounds, checking on and reassuring patients.

If you are in an area away from the "Code Red":

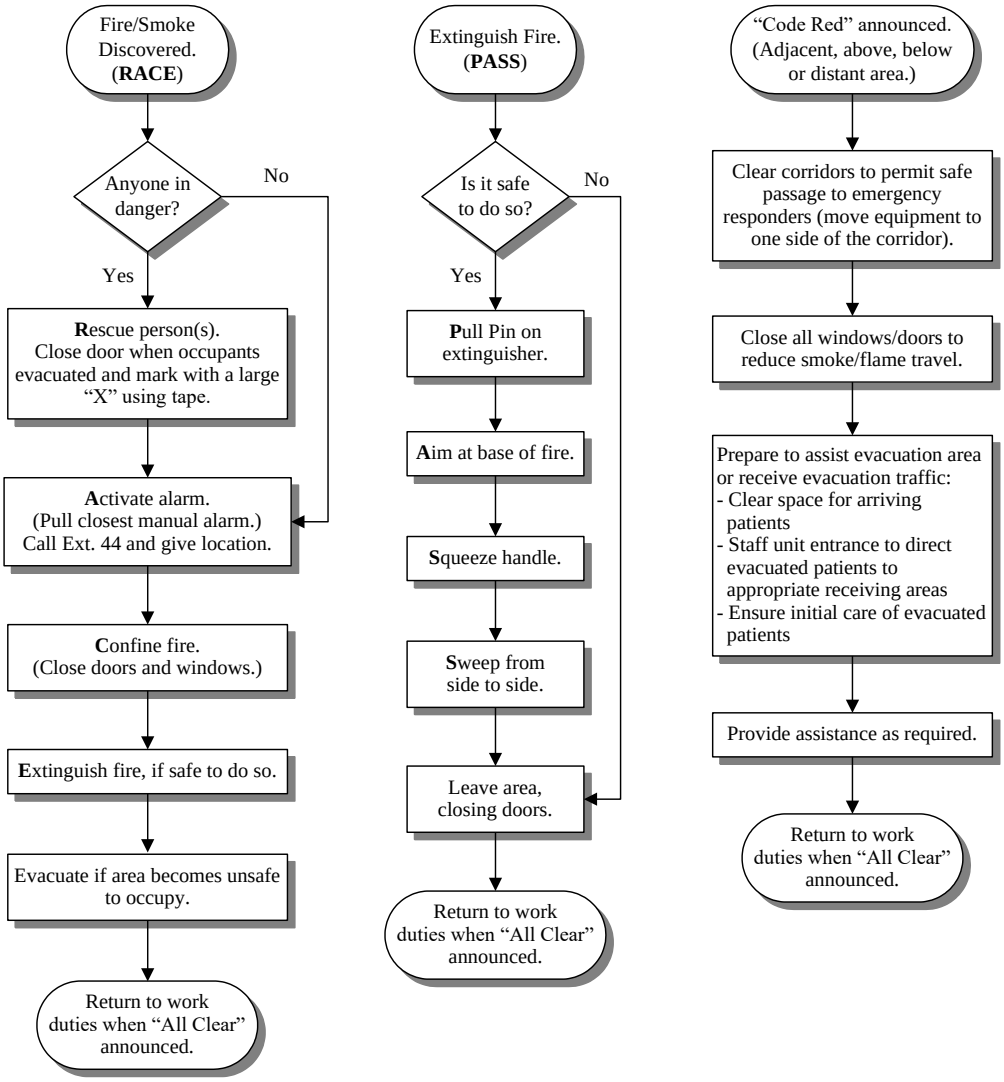
- ☐ Secure unit by placing patients into rooms, closing windows/doors, clearing corridors, etc.
- ☐ Once unit is secured, make rapid rounds, checking on and reassuring patients.
- ☐ If the affected area evacuates to your unit, direct staff to prepare to receive patients. Position one staff member at unit entrance to direct staff arriving with evacuated patients to appropriate areas of receiving unit.
- ☐ Ensure initial care of patients who have been evacuated to your area, if applicable.

ALL CLEAR

When "Code Red, All Clear" is announced, return to your normal work duties unless otherwise directed. Maintenance, Security and the Department Person in Charge will complete an *Incident Report.*

Emergency Management Manual

Code Red - Fire Response



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Policy Number: DM 2208	**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 Yellow – Bomb Threat

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

Policy

All bomb threats are treated as if they are real until proven otherwise.

Procedure-See Checklist on next page

CODE YELLOW – BOMB THREAT

Purpose: To obtain as much information as possible from a caller making a bomb threat and aid in the search for a potential bomb within the hospital or on its grounds. To safely isolate a suspicious item, package, or device that may be a bomb.

Background: Bomb threats received via phone, written note or mail are common; however, it is unlikely that an actual bomb has been placed. Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) will make a thorough search when a bomb threat is received if sufficient information is available to determine the area needing to be searched. There will not be an evacuation unless a suspicious device has been identified.

STAFF RESPONSE CHECKLIST

Immediately upon hearing bomb threat:

- ☐ If by phone:
  - ☐ Listen carefully; keep the caller on the line as long as possible. Record answers to questions on Bomb Threat Report (see Appendix).
  - ☐ Note the time of the call.
  - ☐ Ask the caller when the bomb is to go off. If there is an immediate threat of the bomb going off, conclude the call with as much information as possible and proceed to #6 below.
  - ☐ LISTEN carefully to what the caller is saying and any background noises.
  - ☐ Try to covertly give notification of threat to your co-worker.
  - ☐ Try to gain as much information as possible.
  - ☐ Take notes on a piece of paper as caller speaks.
  - ☐ Fill out Bomb Threat Report form immediately after caller has hung up.
  - ☐ Dial Ext. 44 and report information to the PBX Operator.
  - ☐ Notify your immediate supervisor.
- ☐ If by note:
  - ☐ Handle as little as possible by edges only. Use gloves if possible. Place in a large paper envelope as soon as possible.
  - ☐ Immediately write down the description of the person passing the note on the Bomb Threat Report
  - ☐ Contact PBX at Ext. 44 to report situation.
- ☐ Do not discuss the situation with anyone except your supervisor, law enforcement, or Security.

Upon Discovery of a Suspicious Package:

- ☐ Identifying a package as a bomb is difficult. A bomb may have wires, dynamite stick, and ticking sound or no noise. DO NOT TOUCH OR MOVE PACKAGE
- ☐ Immediately dial Ext. 44 and give PBX Operator the information.
- ☐ Notify security, clear area of patients and isolate object.
- ☐ Leave and secure the room or area and await assistance.

Upon hearing overhead page, "Code Yellow":

- ☐ If you are in the affected area, visually check your entire area quickly and quietly for anything unusual.
- ☐ Turn off radios and cellular phones (except in-house wireless phones).
- ☐ Do not turn light switches on and off when searching. Use flashlights when necessary.
- ☐ Do not evacuate or alert patients (unless instructed to do so by the Incident Commander).
- ☐ Look for and report all suspicious-looking objects. ***Do not touch*** **suspicious items – dial Ext. 44 to report them**.
- ☐ Department Manager or designee is to notify HCC when visual check is complete.

☐ Continue vigilance until “All Clear” notification.

PBX CHECKLIST

Immediately notify:

☐ Notify, by telephone, the Administrator on Call and/or Nursing Supervisor of the impending threat
☐ Notify the Visalia Police Department if directed by Administration.
☐ If directed by the Administrator on call or Nursing Supervisor, announce “Code Yellow” and location.
☐ Transfer any emergency calls during incident to Incident Commander.
☐ Write all pertinent information down regarding the bomb threat, such as, time bomb to go off, location, etc.
☐ Do not use radios, cellular telephones or pagers.
☐ Page codes as directed by hospital Incident Commander.
☐ Notify the HCC in if there are any reports of suspicious items. Be sure to obtain location and the name of the caller reporting the information.
☐ When directed by the Incident Commander, announce “Code Yellow, All Clear.”

INCIDENT COMMANDER/NURSING SUPERVISOR/ADMINISTRATOR ON CALL CHECKLIST

☐ Evaluate the situation and immediately call the police department.
☐ Authorize the PBX Operator to overhead page “Code Yellow and location” (2x). Order PBX Operator to call all Section Chiefs and Security to the Hospital Command Center (HCC). The following personnel will be asked to report to the Hospital Command Center:

a) House Supervisor
b) Administrator on call (If after hours, will be notified of threat immediately.)
c) Police officers, upon arrival.
d) Security
e) Maintenance Department personnel, (bring layout or blueprints of premises and necessary keys).
f) Receiver of bomb threat for interview.

☐ Develop a plan of action with the Section Chiefs.
☐ Order Security to cordon off bomb threat area, if known.
☐ If at offsite location. Maintenance management team to go to bomb threat site.
☐ Implement HICS to the level necessary (not all staff may be needed).
☐ Order search of area of facility, depending on the caller information (area or hospital-wide).
☐ Assign Logistic Chief to be in charge of the search.
☐ Consider evacuation of the area, especially if the bomb location is known.
☐ Coordinate the HCC, and all information concerning the threat (i.e., search results, etc.).

ENGINEERING CHECKLIST

☐ Do not use 2-way radios, pagers or cell phones.
☐ Upon hearing “Code Yellow” and “Code Triage” paged together, the Maintenance Manager and one engineer report to the HCC .
☐ Remaining engineers, return to department and await further instruction.
☐ Maintenance Manager returns to the department with instructions; engineers may assist in house-wide search.
☐ Locate facility maps for search.
☐ Maintenance staff take their instructions from the Facilities Unit Leader.
☐ Report all suspicious objects by dialing Ext. 44.

SECURITY CHECKLIST

- ☐ Respond to the area of the threat. If threat was by telephone, direct staff to complete the *Bomb Threat Report*. Collect the form and any notes from the recipient and submit copies to the Incident Commander and law enforcement.
- ☐ If threat was by note, retrieve note from recipient, avoiding unnecessary handling. Place note in larger envelope or bag and hold for law enforcement.
- ☐ If threat was in person, detain suspect (citizen's arrest) until law enforcement arrives.
- ☐ Assist with search/relocation/evacuation as directed.
- ☐ Do not use 2-way radios.
- ☐ Take directions from Incident Command Center.
- ☐ Cordon off bomb threat area, if known.
- ☐ Prevent unauthorized persons from entering restricted area of the hospital.
- ☐ One Security officer or designee is posted outside the building to await the arrival of the police or bomb squad.
- ☐ Redirect traffic in the area.
- ☐ Whenever a suspicious package is found, clear the area, post a guard and await Bomb Squad.
- ☐ Follow the instructions of the Bomb Squad.
- ☐ Do not allow staff or visitors in any evacuated areas until directed.
- ☐ Complete event report.
- ☐ Participate in incident debriefing as needed.

ALL CLEAR

When it has been determined that there is no evidence of a bomb in the hospital and, in conjunction with the police department, the Incident Commander will direct PBX to announce, if appropriate, "Code Yellow, All Clear" (2x). All departments will return to normal operations.

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BOMB THREAT REPORT

Policy: Any staff receiving a "Bomb Threat" will complete the following form and deliver to the Incident Command Center. The Incident Commander will ask to speak with the person receiving the call at his/her discretion.

Name of person receiving call: _____

Title:_____

Date: _____Time: _____ Phone: _____

Call receipt time: _____ Time caller hung up: _____

As best you can, write the exact words of the caller:

_____

_____

_____

_____

QUESTIONS TO ASK THE CALLER: (Ask them to repeat message.)

Where is the bomb? _____

When will it explode? _____

What kind of bomb is it?_____

What does it look like? _____

Why did you do this? _____

Where are you calling from? _____

Description of the caller's voice:

Male: ____ Female: _____ Age _____

Was their voice familiar? _____ If so, whose?

_____

Circle all that apply:

Voice	**Speech**		
Raspy	Soft	Fast	Distinct
High Pitched	Deep	Slow	Slurred
Pleasant	Loud	Nasal	Distorted
Intoxicated	Other	Stutter	Muffled

Language	**Accent**	**Manner**	
Good	Local	Calm	Rational
Foul	Racial	Angry	Irrational
Poor	Regional	Serious	Incoherent
Other	Foreign **	Tense	Emotional
Sure Righteous			
Unsure Deliberate			
Joking Nervous			
Other Laughing			

**** What country:** _____

Background Noises/ Describe:

Voices	Office Machines	Animals
Music	Factory Machines	Airplanes
Trains	Street Traffic	Quiet

Phone Connection: Clear Static Pay Phone Long Distance

Emergency Management Manual
Bomb Search Area Checklist
(Kaweah Health Medical Center)

Basement	
Blue Room	
E107	
Laboratory	
Storage Room	
West Basement	
First Floor	
Emergency	
Emergency Waiting Room	
Radiology	
Surgery	
PACU	
Flex Care	
PBX	
Medical Staff	
Sterile Processing	
Stairwells	
Public bathrooms	
Pathology/Morgue	
Receiving/Loading Dock	
Endoscopy	
Respiratory	
Dietary	
Cafeteria	
Admitting	
Hall of Fame Wing	
Lobby	
2nd Floor	
2 North	
2 South	
2 West (ICU)	

NICU	
2 East	
3rd Floor	
3 North	
3 South	
3 West	
3 Center	
Broderick Pavilion	
Pediatrics	
Public Restrooms	
4th Floor	
4 North	
4 Center	
4 South	
Patient Transport	
Public Restrooms	
Acequia Wing	
1st Floor	
Front Lobby	
Administration	
Library	
Benefits	
MRI	
CT Scan	
Conference Room	
2ND Floor	
CVOR	
CathLab	
GME Sleep Rooms	
3rd Floor	
Mother Baby	
CVICU	
4th Floor	
Telemetry	
5th Floor	
5T- ICCU	
6th Floor	
NICU	

Basement	
Clinical Engineering	
Materials Warehouse	
Distribution	
Sterile Processing	
Maintenance Shop	

Emergency Management Manual
Bomb Search Area Checklist
(Kaweah Health Mental Health)

Lobby	
Admission Desk	
Administrative Offices	
Cafeteria	
Gym	
Patient Rooms East Wing	
Patient Rooms West Wing	

Emergency Management Manual
Bomb Search Area Checklist
(Kaweah Health Rehab Hospital)

Lobby	
Admin Offices	
Green Hall- 57-64	
Short Stay 34-42	
Blue Hall 15-22	
Red Hall 1-8	
Kitchen	
Cafeteria	
Big Gym	
Short Stay Gym	
Pool	
Therapy Rms/Offices	
Halls/Lobby	
Public Bathroom	
Offices	
Electrical	
Gas	
Water	

Emergency Management Manual
Bomb Search Area Checklist
(Kaweah Health South Campus)

Urgent Care	
KATS	
EAP	
Radiology	
Subacute	
SNF	
Cafeteria	
Misc offices	
Public Restrooms	
Maintenance	

Emergency Management Manual
Bomb Search Area Checklist

(SRCC/ KDIC)

Imaging Lobby	
Imaging Procedure Rooms	
Breast Center	
Radiation Oncology	
Medical Oncology	

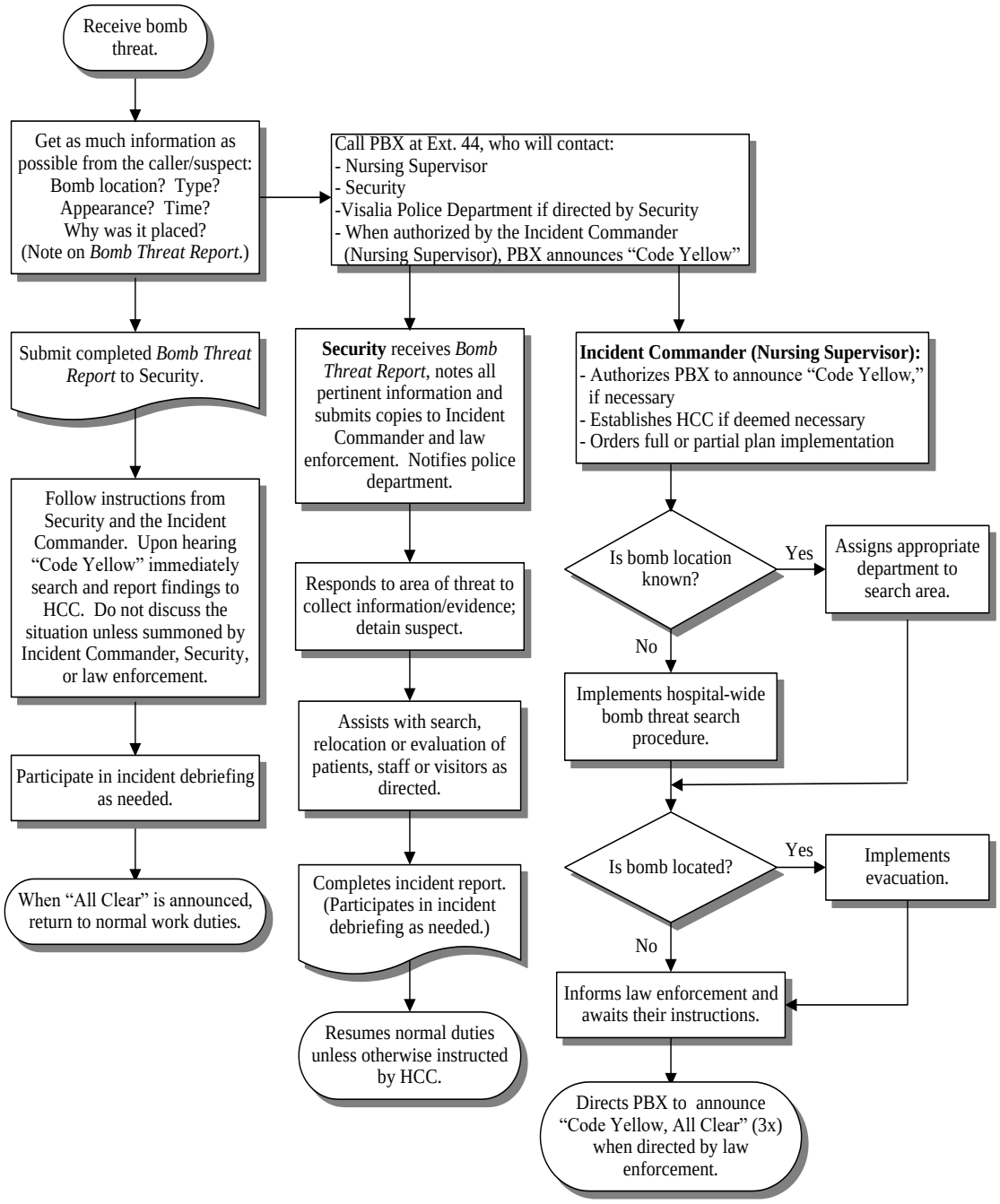
Emergency Management Manual
Bomb Search Area Checklist
Dialysis

Dialysis Treatment Area	
Break Room	
Conference Room	
Offices	
Water Treatment Area	
Storage Room	

Kaweah Delta Health Care District
Delivering excellence.

Emergency Management Manual

Code Yellow - Bomb Threat



Policy Number: DM 2210	**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 Orange- Hazardous Material Spill/Release

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

I. Policy

In the event of a hazardous materials spill/release, Kaweah Delta Healthcare District herin after referred to as Kaweah Health (KH) will activate its Code Orange procedure to provide a coordinate and effective response.

II. Procedure

In the event of a hazardous material release:

A. Response

See attached checklist and flowchart.

B. Definitions

1. Minor Spill

The following is guidance for amounts to be considered as **small**

CHEMICAL	SMALL SPILL AMOUNT
Acid	½ cup or less (Except Hydrochloric acid = ¼ cup)
Base/Caustic	½ gallon or less (Except ammonium hydroxide = ¼ cup)
Bleach	½ gallon or less
Flammable liquids	½ gallon or less (Except methanol = ½ cup)
Formaldehyde (10% Formalin or 3.7% Formaldehyde)	¾ cup or less
Glutaraldehyde (Cidex®, Wavicide)	½ gallon or less
Ortho-phthalaldehyde (Cidex® OPA)	1 gallon or less
All other chemicals (including chemotherapy drugs)	½ gallon or less

a. Only minor spill cleanup will be done in-house by trained staff with appropriate spill kit and Personal Protective Equipment (PPE). User departments are responsible for ensuring their staff are properly trained and equipped to assess minor spills in their department.

2. Major Spill

A major spill has occurred under the following conditions:

- A life threatening condition exists, or there is an immediate danger posed to staff, patients or visitors.
- You are not able to manage the spill on your own, and the condition requires the assistance of emergency personnel
- The condition requires the immediate evacuation of all employees from the area or the building.
- The spill is of a large enough quantity that additional assistance is required (threshold quantities will vary based on the chemical and can be verified on Safe Use Guides or SDSs, but is generally greater than 2.0 liters).
- The contents of the spilled material is unknown.
- The spilled material is highly toxic
- You feel physical symptoms of exposure
- The chemical is bio-hazardous, radioactive or flammable.

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CODE ORANGE – HAZARDOUS MATERIALS SPILL/RELEASE

Purpose: To identify unsafe exposure conditions, safely evacuate area, and protect people from exposure, within the hospital or on its grounds, due to a hazardous material spill/release.

Background: Departments with significant hazardous materials are to develop a Disaster-Specific Plan to support this plan. (Consult Safety Officer if unsure.)

Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.

Note: All District personnel who have been exposed and require treatment **must** report to the Emergency Department (ED). All others exposed who are asymptomatic, must also report to the Employee Health Nurse or the ED after hours.

STAFF RESPONSE CHECKLIST

Immediately upon discovering a hazardous materials spill/release, user department will:

- ☐ If spill is **MINOR**: - The basic response will be **ICIC.**
  - ☐ **I**solate the areas and deny access to others.
  - ☐ **C**ontain the spill (reduce or eliminate spread)
  - ☐ **I**dentify (Chemical name) Obtain and read Safety Data Sheet (SDS) for precautions. Binders are located in each specific department. Department head/managers should know the location of updated SDS document.
  - ☐ **C**lean-up (follow SDS). Use spill kit to clean up spill, if trained to do so.
  - ☐ Notify supervisor or Department Manager, who will notify Hospital Safety Officer
  - ☐ Complete Occurrence Report on KD Central.
- ☐ If spill is **MAJOR**:
  - ☐ Evacuate area.
  - ☐ Call PBX at Ext. 44 and inform them of a "Code Orange" and report:
    - ☐ Spill location
    - ☐ Chemicals involved
    - ☐ Approximate quantity of material spilled
    - ☐ Number of people exposed and/or injured
    - ☐ Your extension
  - ☐ Obtain SDS from MAXCOM.
  - ☐ Notify supervisor or Department Manager.
  - ☐ Contain spill only if trained, equipped, and safe to do so.
    Complete Occurrence Report on KD Central.

Assist those who may have been contaminated – *only if your exposure is unlikely*:

- ☐ **If a chemical has splashed into someone's eyes**, direct that person to the nearest water source/eyewash station, begin immediate rinsing of their eyes with tap water for at least 15 minutes. Avoid direct contact with the contaminated person.
- ☐ **If a person has chemicals on their skin**, direct them to rinse affected area with soap and water for at least 15 minutes, in a shower, if available, otherwise in a sink. Removal of clothes is necessary to complete a thorough dermal decontamination. All clothes are to be placed in a plastic bag. After rinsing, direct person to remain in area until cleared by the Safety Officer. Label plastic bag "hazmat."
- ☐ **If contaminated person(s) unable to self-decontaminate**, wait for trained personnel with Personal Protective Equipment (PPE) to perform decontamination.

Decontamination as follows:

- ☐ Removing your clothing:
  - ☐ Quickly take off clothing that has a chemical on it. Any clothing that has to be pulled over your head should be cut off instead of being pulled over your head.
  - ☐ If you are helping other people remove their clothing, try to avoid touching any contaminated areas, and remove the clothing as quickly as possible.
- ☐ Washing yourself:
  - ☐ As quickly as possible, wash any chemicals from your skin with large amounts of soap and water. Washing with soap and water will help protect you from any chemicals on your body.
  - ☐ If your eyes are burning or your vision is blurred, rinse your eyes with plain water for 10 to 15 minutes. If you wear contacts, remove them and put them with the contaminated clothing. Do not put the contacts back in your eyes (even if they are not disposable contacts). If you wear eyeglasses, wash them with soap and water. You can put your eyeglasses back on after you wash them.
- ☐ Disposing of your clothes:
  - ☐ After you have washed yourself, place your clothing inside a plastic bag. Avoid touching contaminated areas of the clothing. If you can't avoid touching contaminated areas, or you aren't sure where the contaminated areas are, wear rubber gloves or put the clothing in the bag using tongs, tool handles, sticks, or similar objects. Anything that touches the contaminated clothing should also be placed in the bag. If you wear contacts, put them in the plastic bag, too.
  - ☐ Seal the bag, and then seal that bag inside another plastic bag. Disposing of your clothing in this way will help protect you and other people from any chemicals that might be on your clothes.
  - ☐ When the local or state health department or emergency personnel arrive, tell them what you did with your clothes. The health department or emergency personnel will arrange for further disposal. Do not handle the plastic bags yourself.
- ☐ **If person was not splashed with chemicals on their skin or clothes, but is complaining of respiratory or systemic effects** from breathing a hazardous material, immediately escort person to the ED for treatment.

Immediately upon hearing "Code Orange":

If within alert area:

- ☐ Assist those contaminated (only if exposure is unlikely).
- ☐ Assist emergency responders.
- ☐ Secure area to prevent exposure to others.
- ☐ Return to work duties when safe.

If outside alert area:

- ☐ Prepare to provide support as directed.

PBX CHECKLIST

Upon receiving report of "Code Orange," and as directed by the Safety Officer (or AOD after hours), PBX will:

- ☐ Page overhead "Attention, Code Orange" and location (2x) and then repeat 30 seconds later.
  - ☐ Call Environmental Services at ext. 2244.
  - ☐ Call Safety Officer
- ☐ Call House Supervisor (House supervisor will notify Administrator on Call (AOC)

.

- ☐ Announce "Code Orange, All Clear" if authorized by the Safety Officer in coordination with the fire department.

Note: If the fire department is unable to respond, the Safety Officer will contact an outside contractor to clean up "major" spills.

SECURITY CHECKLIST

- ☐ Secure area from pedestrian traffic.

- ☐ Do not allow personnel other than the fire department to enter the isolated area.
- ☐ If the area involved is near an air conditioning intake, advise Maintenance to shut down air conditioning units in the immediate vicinity.

HAZARDOUS MATERIALS COORDINATOR (SAFETY OFFICER) CHECKLIST

- ☐ Report to scene of event and assess situation.
- ☐ Call Visalia Fire Department Hazardous Materials Unit for major spill cleanup.
- ☐ Call Engineering to ventilate/shut down recirculation system, if required
- ☐ Call Security to cordon off immediate area and expand the safety zone, as necessary, to prevent unauthorized exposure to hazardous conditions.
- ☐ Act as a liaison to Fire Department or spill clean-up contractor.
- ☐ Ensure safety of staff, visitors, and patients.
- ☐ Following the all-clear, ensure full documentation of event.
- ☐ Notify appropriate agencies.

  Tulare County Environmental Health 559-624-7400
  Cal EMA (California Emergency Management Agency1-800-852-7550

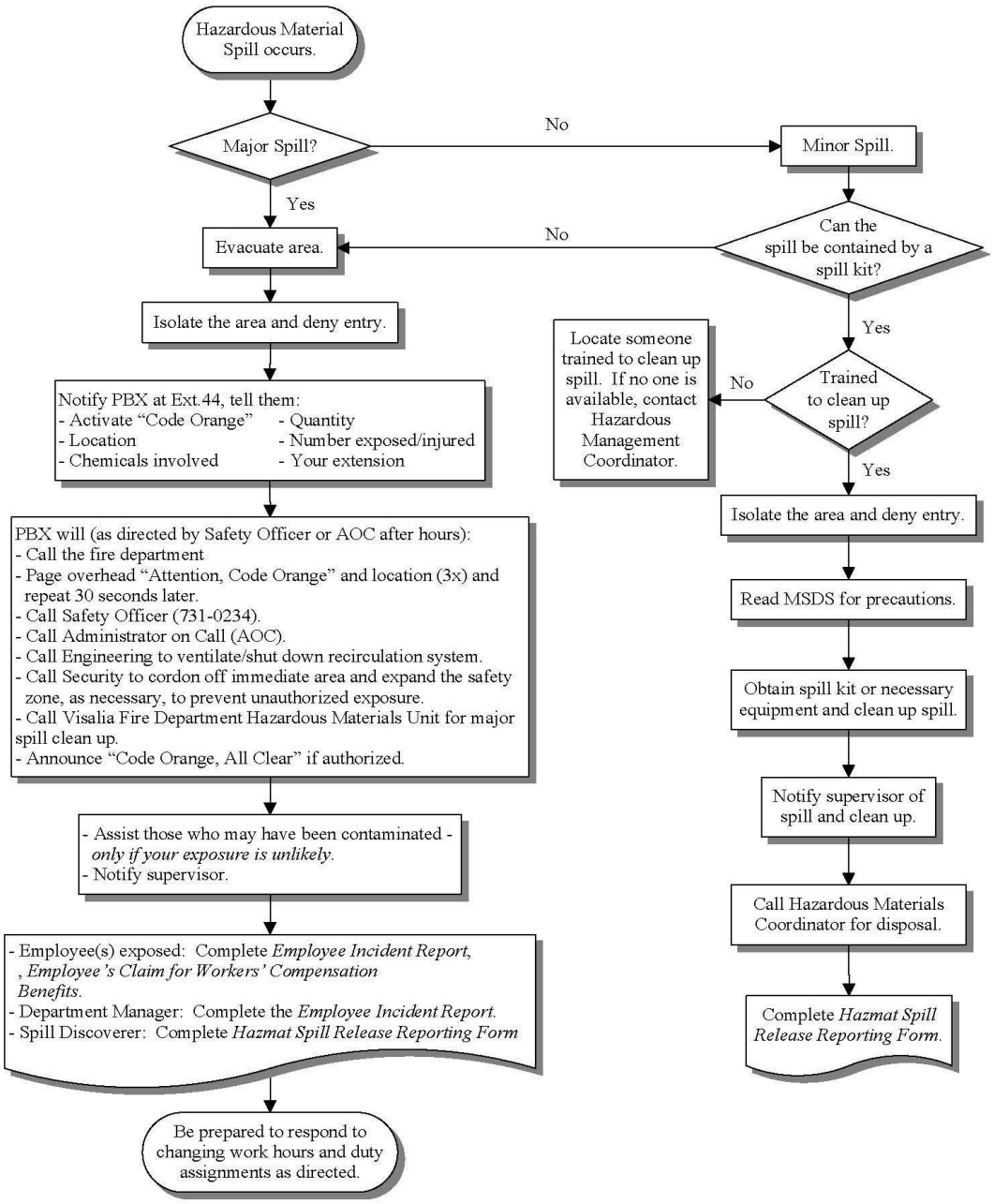
- ☐ Follow up with spill department to evaluate and modify processes as necessary.

ALL CLEAR

After “Code Orange, All Clear” is announced (3x), return to your normal work duties, unless otherwise directed.

Kaweah Health

Code Orange – Hazardous Materials Spill/Response



Policy Number: DM2212	Date Created: No Date Set
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)	

Earthquake Response

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

Policy

In the event of an earthquake that is of sufficient magnitude or duration to cause injury to individuals or damage to the facility, Kaweah Delta Health Care District, hereinafter referred to as Kaweah Health (KH)will activate its earthquake response procedure.

Procedure

A. See attached procedure and flowchart.

B. Training

All employees receive training on emergency preparedness plans and codes at new employee orientation and annually thereafter. All employees are required to complete safety training modules and participate in semiannual Emergency Exercises.

C. Hazard Mitigation

The Hazard Surveillance Team inspects all departments in the hospital for hazards semiannually. This team evaluates equipment bracing, general safety and life safety deficiencies. A report of identified hazards is sent to each department manager and Maintenance for correction. A report of correction is sent to the Safety Department.

A major earthquake in the Central Valley Area could require activation of any one or a combination of the following KH emergency plans for:

- Fire
- Evacuation
- System failures
- HICS/Mass Casualty Incident (MCI)

Attachments:

- Attachment A, “Earthquake Damage Assessment Sheet”
- Attachment B, “Bed Availability & Discharge Form”

Attachment A
Earthquake Damage Assessment sheet

Note: Complete this sheet and be prepared to report the information herein to the Damage Assessment and Control Officer and/or the HCC.

A. DEPARTMENT DATA

Name of Department/Area: _____ Floor: _____ Ext. _____

Person Completing This Form: _____ Floor: _____ Ext. _____

B. STRUCTURAL INTEGRITY

	Collapsed			Collapsed			Collapsed	
	Yes	No		Yes	No		Yes	No
Walls, Exterior	☐	☐	Windows	☐	☐	Shelves	☐	☐
Walls, Interior	☐	☐	Hallways	☐	☐	Bookcases	☐	☐
Ceiling	☐	☐	Exits	☐	☐	Cabinets	☐	☐
Stairs	☐	☐	Doors	☐	☐	Equipment	☐	☐

C. UTILITIES

	Functioning			Functioning			Functioning	
	Yes	No		Yes	No		Yes	No
Electricity	☐	☐	Telephone	☐	☐	Sewer	☐	☐
Water	☐	☐	Plumbing	☐	☐	Gas	☐	☐
Medical Gas	☐	☐	Oxygen	☐	☐	Suction	☐	☐

D. HAZARDOUS MATERIALS SPILL **Yes ☐ No ☐**

Name of Products/Chemicals spilled: _____

_____

_____

_____

E. Special Department Problems (type of equipment not functioning)

_____

_____

_____

_____

G. General Status of Department/Area: Functional ☐ Partially Func. ☐ Non-Func. ☐

Total No. of Casualties _____ **Types:** Delayed ☐ Minor ☐ Deceased ☐ Immediate ☐

Location: _____

_____

_____

Attachment B
Bed Availability & Discharge Form

Department: _____ Time: _____ Date: _____ Person Completing Form: _____ Ext.: _____

Empty Room & Bed No.	Name of Patient Who Can be Discharged	Room & Bed No.	Doctor	Patient's Special Needs	Equipment Needed
				`	

EARTHQUAKE

Purpose: To protect yourself from injury during an earthquake and then provide assistance to others at Kaweah Health.

Background: Recovery from a major, nearby earthquake can take days, weeks, or months, depending on its magnitude.

- All staff who have pre-assigned HICS positions at the Hospital Command Center (HCC) should report to the hospital as quickly as possible without waiting to be called and without waiting to "get in uniform." Be prepared to show your approved hospital identification.
- If you do not have pre-assigned duty, call the KH Disaster Update Line 559-624-2008 for information on facility staffing needs or listen to radio/TV and be prepared to report to the hospital.
- Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.(See Code Triage Plan)

STAFF RESPONSE CHECKLIST

Immediately upon sensing a significant earthquake:

- ☐ Remain in the building. Move away from windows, shelving or other furnishings/equipment that may topple or fall on you. Watch for falling objects such as ceiling tiles or light fixtures. Have patients cover their faces with bed linens for protection from falling glass. DO NOT: run for exits, stand in doorways or use elevators.
- ☐ Protect your head from falling debris. Find shelter under a sturdy desk/table or against an inside wall. **Duck, cover and hold till shaking stops**.
- ☐ If you are outside, get into open space away from buildings or power lines.
- ☐ Triage your immediate area. Identify major potential hazards such as fire, hazardous materials spill/release, flooding, electrical/trip hazards, and injuries to others nearby.
  - ☐ Report significant findings to your supervisor.
  - ☐ Minimize hazards to reduce further damage or injury. Turn off damaged equipment, and clear away debris for safe pathways. Prepare to extinguish a fire, avoid a hazardous materials spill/release, flooding, and evacuate the area as necessary, taking medical records. (See Relocation and Evacuation).
- ☐ Prepare for aftershocks. Move items that are likely to fall or move during an aftershock to a safer location (on the floor out of the path, etc.).
- ☐ Units that have medical gases should be prepared to use emergency shutoff valves if necessary.
- ☐ *Do not* use hospital telephone system to call home or other family members as these lines will most likely be overloaded and urgently needed for hospital business.
- ☐ Be prepared to respond to changing work hours and duty assignments when directed. The hospital reserves the right to cancel vacations and days off, if necessary, in order to maintain critical hospital services.

DEPARTMENTS CHECKLIST

- ☐ Supervisors are to report damages/injuries to HCC on the *Department Status Report* (Fax to 713-2332 or email to hics@kdhcd.org or via runner).
- ☐ If instructed by the HCC, follow evacuation procedures.
- ☐ Do not immediately clean up damage from earthquake until photos have been taken to document damage, except for debris blocking exit hallways or evacuation routes.

ENGINEERING CHECKLIST

- ☐ Assess damage and report the status of all critical utilities (HVAC, electrical, water, sewer, medical air and vacuum systems) to the HCC on the *Facility System Status Report*.

NURSING CHECKLIST

- ☐ Institute emergency life saving procedures and medical attention to personnel and patients on the unit.
- ☐ Be prepared to relocate or evacuate personnel and patients from unit, taking records and medications if possible.
- ☐ Move patients to interior walls, away from windows and glass; pull curtains; lock patient bed wheels (except newborn isolettes or infant cribs, which are prone to tip); place side rails up.
- ☐ Clean up any spilled medication, drugs or other hazardous materials. (See Code Orange.)
- ☐ Ensure that ambulatory patients wear shoes to protect their feet from broken glass or sharp objects.
- ☐ Nursing and surgery personnel evaluate the medical gas and vacuum system in their area and report status to the HCC. It may be necessary to use portable oxygen and back-up anesthesia sources.

ALL CLEAR

Return to your normal work duties, unless otherwise directed. Dial Ext. 44 for all emergencies in hospital. Dial 911 at other locations.

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Policy Number: DM2215	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)	

Internal Flood- Activation Plan

Policy

Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) will develop and maintain an effective flood response plan to manage consequences of internal flood conditions that disrupt the hospital's ability to provide patient care.

II. Procedure

A. Background Information

1. Internal Flooding Caused by Water or Sewer Line Failure

A greater threat would be posed by an internal flood caused by a water or sewer line failure.

B. Flood Response

See attached checklist and flowchart.

FLOOD – INTERNAL

Purpose: To develop and maintain an effective flood response plan to manage the consequences of flood conditions that disrupt the hospital's ability to provide patient care.

INCIDENT COMMANDER CHECKLIST

- ☐ If necessary, authorize PBX to initiate a "Code Triage, Alert" by phone.
- ☐ Direct relocation of patients, if necessary.
- ☐ If catastrophic flooding is anticipated, consider facility evacuation.

STAFF RESPONSE CHECKLIST

- ☐ Dial Ext. 44 immediately to report flooding to Maintenance.
- ☐ If sewer system failure, also notify Environmental Services Ext. 2244 or page overhead. Do not flush toilets or use water. Use hand gel sanitizer. Use designated toilets only or plastic bags provided by Environmental Services for human waste.
- ☐ Prepare to relocate patients, equipment, medical records if necessary.
- ☐ Prepare for possible Water Systems Failure/Disruption.

PBX CHECKLIST

- ☐ As directed, PBX announces "Code Triage, Alert" (3x) to summon key HICS staff to the HCC.
- ☐ At the direction of the Incident Commander, PBX announces "Water Systems Failure/Disruption" (3x) to activate the plan. PBX will notify areas not receiving overhead page via pre-established telephone tree.

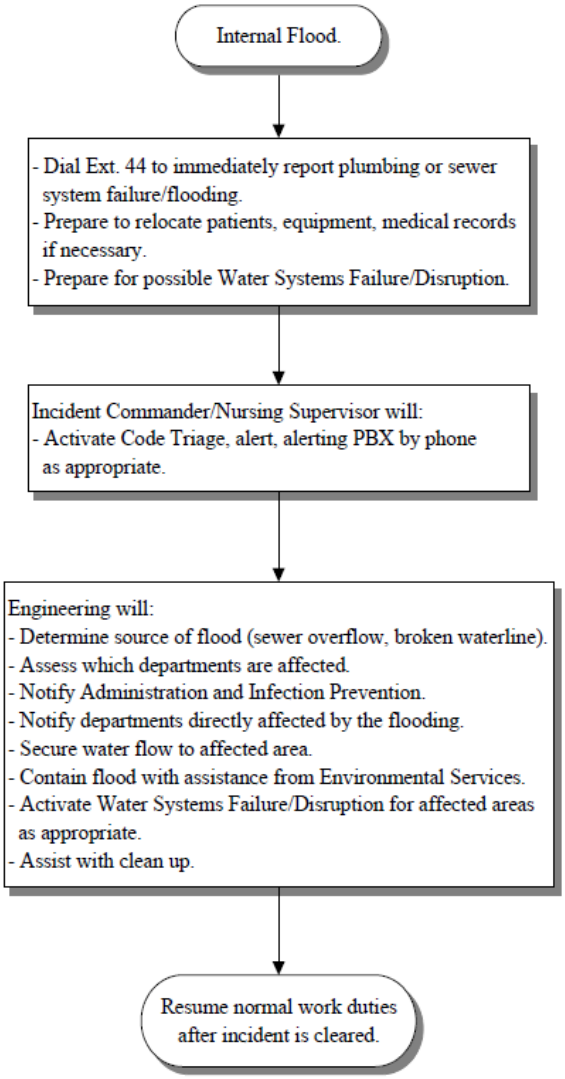
MAINTENANCE CHECKLIST

- ☐ Determine source of flood (sewer overflow, broken waterline).
- ☐ Assess which departments are affected.
- ☐ Notify Administration and Infection Prevention.
- ☐ Notify departments directly affected by the flooding.
- ☐ Secure water flow to affected area.
- ☐ Contain flood with assistance from Environmental Services.
- ☐ Activate Water Systems Failure/Disruption for affected areas as appropriate, authorize PBX to overhead page.
- ☐ Assist with clean up.

Kaweah Health

Emergency Management Manual

Flood - Internal



Policy Number: DM2218	Date Created: 09/01/2008
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)	

Anhydrous Ammonia Safety Procedures

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

Hazards

Anhydrous ammonia is a corrosive gas, and exposure leads to chemical burns. Its affinity for water targets moist skin. Exposure can also lead to frostbite. Its potential health effects are targeted at eyes, skin and respiratory system.

You should never wear contact lenses around ammonia vapor or liquid.

Handling/Storage/Use

Personal Protection

Proper personal protection (PPE) should be used during system start-up and cylinder changes. This should include:

- Opti-Fit full-face Gas Mask Model 7530
- Chemical resistant gloves
- Cotton coverall clothing
- Ammonia Gas Monitor
- Safety vest
- PAPR (Power Air Purifying Respirator)

Safety Systems

The ammonia gas cabinet contains several systems for safety measures. The gas monitor detects the levels and displays the gas detector reading in the maintenance shop. This information is also relayed to the Generator control room. The emergency shutoff valve is located in the manifold and controlled by the local e-stop, the gas detector, and by an operator in the gas generator control room. A limiting orifice is located at the cylinder valve. If levels within the enclosures are too high, the gas detector will automatically switch off the emergency shutoff valve. The enclosure also includes an ex-proof heater to regulate cylinder temperature and a ventilation system.

Trained personnel prior to the time that any delivery is accepted and signed off must don proper PPE and check cylinders with a hand-held detector.

Moving Cylinders

Handling of cylinders can only be done by persons trained in the hazards and handling techniques. When moving cylinders, use material handling equipment, such as cylinder carts. Work in a team with at least two (2) employees and must don proper PPE. Make sure cylinders are tightly secured to the carts. Keep the valve protection cap on the cylinder until it is secured in place and ready for use.

Whenever cylinders are being transported and handled, the handheld ammonia detector must be in continuous operation (attached to a safety vest), ensuring there is no leakage.

Refer to the Airgas "Ammonia Gas Cabinet Operating Manual" for start-up and changing cylinder procedures.

Use
Cylinders must be securely fastened when in use and transport. Cylinders should be changed out when they reach the scale set point of 10 lbs. Cylinder change-out will be announced by an alarm triggered in the control room.

Regular Shift Readings (outside Ammonia)
During regular shift equipment readings, employees are to wear the Ammonia monitor at all times. If the Ammonia Monitor detects the presence of ammonia, the employee should don PPE and determine if the system needs to be shut down or repaired. The employee will call the on call Supervisor immediately.

Emergency Procedures

Emergency Shutoff

In the event that a leak is detected within the ammonia gas cabinet by the gas detector, the system will automatically enact the emergency shut-off valve and the ventilation system can be activated.

In the event that a leak of 25 PPM is detected within the ammonia gas cabinet by the gas detector or the Emergency Break Glass is activated, the following will occur:

1. The system will automatically enact the emergency shut-off valve and the ventilation system can be activated.
2. The blue alarm strobes will turn on and the simplex panel will activate, alerting PBX. Upon notification PBX activates Ammonia Alert calling tree (See Appendix A)
3. Building automation will turn off the engine room supply fans 1, 2, and 3.
4. Building automation will turn off the engine room exhaust fans.
5. The maintenance shop swamp cooler will be turned off by the ammonia alarm.
6. The ammonia cabinets exhaust fan remains off until maintenance or Visalia Fire Department turns the exhaust fan on at key switch next to monitor and scale display in the maintenance shop.
7. After the alarm is cleared the supply fans and the exhaust fans will need to be reset through the building automation system to restart them.

Upon notification Maintenance staff responds as follows (See Appendix A):

1. During business hours Maintenance sends staff to tell Kaweah Kids to shelter in place.
2. Notifies acting maintenance supervisor.
3. Dons appropriate Personal Protective Equipment (Optifit Full face respirator, chemical gloves, and cotton coveralls, monitor, safety vest).
4. Monitors the situation from a remote and safe location.
5. Meets Visalia Fire Department at staging area (North corner of Cogen building). Update the situation with the Fire Department's Hazardous Material Team.
6. Updates House Supervisor.

Upon arrival of the Visalia Fire Department:

1. Is responsible for determining actions.

2. Determines if a full shelter in place is to be ordered.
3. Determines when to call all clear.

Do not open the cabinet unless the monitor indicates that no ammonia is present.

External Ammonia Release

In the event that a leak occurs outside the enclosure, press the emergency shutoff buttons.

In the event that a release of ammonia is detected, first, notify people in the area and evacuate. Next, obtain reading from Ammonia monitor.

If the reading is below 25 ppm:

- Don proper PPE
- Approach area from upwind and enact emergency shutoff valve.
- Then contact emergency response personnel.

If the reading is above 25ppm:

- Notify PBX of an Ammonia release (PBX will notify District Risk Manager).
- Secure the area
- Meet Visalia Fire Department at staging area (North corner of Cogen building). Update the situation with the Fire Department's Hazardous Material Team.

Seismic Precaution

All cylinders are to be secured within the gas cabinet. No cylinders can be stored outside the cabinet.

Fire Extinguishing Procedure

With a source of ignition, anhydrous ammonia is flammable in the range of 15-28% in air. In the case of a fire, stop the flow of vapor if it can be done safely. If possible, Fire Department personnel may remove cylinders from fire zone: optimize water to cool fire-exposed containers. Use water spray to absorb ammonia vapors. Fire Department personnel should wear a self-contained breathing apparatus and other emergency response equipment.

Emergency Response Equipment

Air Monitoring Equipment should be readily available by the Fire Department and used in the case of an emergency, including fire and/or a leak. Do not try to extinguish a fire yourself or enter a potentially dangerous situation. The Visalia Fire Department will arrive with Level A suits and Self-contained breathing apparatus (SCBA)

First Aid Measures

Eye Contact

If vapor or liquid comes into contact with eyes, immediately flush eyes with large amounts of water for at least 15 minutes. Immediately seek medical attention.

Skin Contact

If contact occurs with skin, flush area with large amounts of water for at least 15 minutes, while removing contaminated clothing and shoes. If clothing has frozen to skin, thaw with water before removal. Seek immediate medical aid.

Inhalation

In the event of inhalation, first safely remove victim from exposure. If breathing has stopped or is difficult, administer artificial respiration or oxygen as needed. Seek immediate medical aid.

Emergency Release Reporting

The release of 100 pounds or more of ammonia must be reported immediately to:

- National Response Center at (800) 424-8802,

Any release must be reported to:

- Fire Department HazMat Division 911
- Tulare County Environmental Health 733-6441
  - California Office of Emergency Services (800)852-7550
  - Tulare County Office of Emergency Services 624-7498
    Cell 559-972-0160
  - AirGas 733-3443
  - Risk Management Director will contact the California Department of Public Health.

"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."

ANHYDROUS AMMONIA RELEASE RESPONSE

Purpose: To identify unsafe exposure conditions, safely evacuate the area, and protect people from exposure, within the hospital or on its grounds, due to a release of Anhydrous Ammonia.

Background: Departments with significant hazardous materials are to develop a Disaster-Specific Plan to support this plan. (Consult Safety Officer if unsure.)

Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.

Note: All District personnel who have been exposed and require treatment **must** report to the ED. All others exposed who are asymptomatic, must also report to the Employee Health Nurse or the ED after hours.

STAFF RESPONSE CHECKLIST

Immediately upon discovering a hazardous materials spill/release, user department will:

- ☐ During business hours Maintenance sends staff to tell Kaweah Kids to shelter-in-place should know the location of updated SDS document.
- ☐ Notifies on call maintenance supervisor.
- ☐ Dons appropriate Personal Protective Equipment (Optifit full face respirator, chemical gloves, and cotton overalls)
- ☐ Monitors the situation from a remote and safe location
- ☐ Meets Visalia Fire Department sat staging area (north corner of Maintenance Building)
- ☐ Updates House Supervisor. Follows VFD directions.

Assist those who may have been contaminated – *only if your exposure is unlikely*:

- ☐ **If a chemical has splashed into someone's eyes**, direct that person to the nearest water source/eyewash station, and begin immediately flushing of the eyes with large amounts of water for at least 15 minutes. Immediately seek medical attention.
- ☐ **If a person has chemicals on their skin**, direct them to flush the area with large amounts of water for at least 15 minutes, while removing contaminated clothing and shoes. If clothing has frozen to skin, thaw with water before removal. Seek immediate medical aid.
- ☐ **If a person has inhaled the ammonia,** first safety remove victim from exposure. If breathing has stopped or is difficult, administer artificial respiration or oxygen as needed. Seek immediate medical aid.

PBX CHECKLIST

Upon receiving report of an "Ammonia Release: PBX will:

- ☐ Call 911, Visalia Fire Department Hazardous Materials Unit
- ☐ Call Maintenance staff on duty
- ☐ Call Security.
- ☐ Call Kaweah Kids Center to Shelter-in-place.
- ☐ Call the Safety Officer (623-5385)
- ☐ Call the House Supervisor or Administrator on Duty.
- ☐ Call the Risk Management Department 624-5284

SECURITY CHECKLIST

- ☐ Respond to staging area (North corner of Maintenance Building).
- ☐ Do not allow personnel other than the fire department to enter the isolated area.
- ☐ Assist Visalia Fire Department.

HAZARDOUS MATERIALS COORDINATOR (SAFETY OFFICER) CHECKLIST

- ☐ Report to scene of event and assess situation.
- ☐ Act as a liaison to Fire Department or spill clean-up contractor.
- ☐ Ensure safety of staff, visitors, and patients.
- ☐ Following the all-clear, ensure full documentation of event on *Occurrence Report online through Kaweah Compass*
- ☐ Notify appropriate agencies.
- ☐ Follow up with spill department to evaluate and modify processes as necessary.

MAINTENANCE Manager OR SAFETY OFFICER – EMERGENCY RELEASE REPORTING

The release of 100 pounds or more of ammonia must be reported immediately to:

- ☐ National Response Center at (800)424-8802.

The release of ammonia at any level must be reported to:

☐ Visalia Fire Department HazMat Unit	911
☐ Tulare County Environmental Health	733-6441
☐ California Office of Emergency Services	(800)852-7550
☐ Tulare County Office of Emergency Services	office 624-7498 Cell 972-0160
☐ AirGas	733-3443

**Risk Management Director will contact the California Department of Public Health.

ALL CLEAR

The Visalia Fire Department will determine when “all is clear”.

Policy Number: DM2230	Date Created: 09/01/2007
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)	

Radioactive Disaster Management

GENERAL INFORMATION ON CLINICAL MANAGEMENT OF RADIATION ACCIDENT

PATIENTS

1. ONLY when a patient has been contaminated with radioactive material does the medical care of that patient differ from any other type of injury as seen by the Emergency Department.

2. Types of radiation injuries to be covered range from internal radiation from ingested or inhaled radioactivity; to surface radioactivity contamination by liquids and dust, both with and without surface wounds. This will include the immediate care (what to do first) and special care needed that is unique to this type accident. The definition of lethal dose and description of the acute radiation syndrome, care of the same will be described.

PRINCIPALS OF CARE

1. The medical needs of the victim always take precedence over the control of radioactive contamination.

2. Three basic principles help you to limit the radiation exposure to attending personnel and victims:
   - TIME - Minimize the amount of time any person is near the site of active contamination.
   - DISTANCE - Maximize the distance from the site of active contamination for any time period a person is required to be in that area.
   - SHIELDING - Use any available heavy object or lead/concrete walls to minimize exposure to personnel in the vicinity.

STANDARDS AND OBJECTIVES

1. Definition: Decontamination of patients refers to those techniques used to remove radioactive materials from the surface of or in the body of a patient.

2. The level of radioactive contamination that is acceptable on patients ideally is zero or "no radiation level above background." However, in an emergency situation it may be necessary to postpone any or complete decontamination in order to perform functions that are lifesaving.

3. It may be that decontamination of skin surfaces will become ineffective at radiation levels two or three times background. In these cases, rather than risk skin injury by

continuing active decontamination, wait 24 hours and resurvey. Usually the radiation level will have dropped to background levels.

GENERAL CONSIDERATION

1. Evaluation of extent and degree of contamination must be done initially and recurrently in order to guide personnel in decontamination procedures. This is even more important where there is possibility of internal deposition of radionuclide within the body of the patient.

2. Adequate records of contamination and decontamination must be kept.

3. All patients who are contaminated shall have their urine collected for a number of successive 24-hour periods for determination of internally deposited radioactive nuclides.

4. Major efforts shall be made to prevent body absorption of radioactive materials. The prime barrier minimizing body absorption of radioactive material is the skin. Do not injure the skin.

5. Skin breaks, abrasions, lacerations etc. shall be kept free of radioactive materials. If already contaminated, skin breaks shall receive priority decontamination.

6. In decontamination, with the exception of contaminated skin breaks start to decontaminate the areas where higher levels of contamination are present.

7. Localization of contaminated areas with drapes and tape shall be done to prevent spread of radioactive nuclides to "clear" areas or areas of lesser contamination. Cover and protect areas not being immediately decontaminated.

8. Repeatedly check degree of contamination of those reagents and equipment used in decontamination. You cannot clean up a "low level" area with a highly contaminated brush or detergent.

9. PATIENTS CAN BE CATEGORIZED IN THE FOLLOWING WAY:

No Contamination: A patient involved in a radiation incident that does not become contaminated, but is transported to a hospital as a precautionary measure.

External Radiation Exposure Only: The individual who has received whole or partial body external radiation exposure, regardless of dose is no contamination hazard to hospital personnel, other patients, or the environment. The management of this patient depends upon the absorbed dose of radiation and could be similar to the management of a radiation therapy or chemotherapy patient.

Internal Contamination: Such contamination results from inhalation or ingestion of radioactive material. (Inhalation and ingestion almost always occur together). This patient is usually no hazard to personnel, other patients or the environment. Following cleansing of minor amounts of contaminated material deposited on the body from an exposure to airborne radioactivity, this person could be handled similar to a case involving exposure to a chemical poison such as lead. The patient's body wastes must be collected and saved in order that measurements of the amount of radioactive materials

present can be made to assist in determining the total radiation dose received and the appropriate therapy.

External Contamination: External contamination of the body surface and/or clothing by radioactive material presents problems similar to cases of vermin infestation. Surgical isolation and decontamination techniques, to protect other patients and the Kaweah Delta Health Care District environment, must be employed in order to confine and control any potential hazard.

10. If probable external contamination is indicated, save all clothing and bedding from ambulance, blood, urine, stool, vomitus and all metal objects (i.e., jewelry, belt buckle, dental plates, etc.). Label with name, body location, time and date. Save each in appropriate containers marked clearly ... "RADIOACTIVE ... DO NOT DISCARD."

11. Careful removal of patient's clothing will remove most of the external contamination. If clothing is grossly contaminated, it might be a good idea to moisten the clothing before removal or clothing may be cut off to minimize spread of contamination during normal removal.

EMERGENCY DEPARTMENT MANAGEMENT OF RADIATION ACCIDENT VICTIM(S)

When a known or suspected patient with radioactive material contamination exposure is brought into the Emergency Department:

1. The Emergency Department's Charge Nurse notifies the Director of Radiology (Administrative Director) and the Radiation Safety Officer (a qualified medical radiation physicist) and/or Nuclear Medicine Technologist. (If it is after hours, the on-call/on-duty Radiology Technologist).

2. Emergency telephone assistance can be obtained from the Radiologic Health Branch, State Of California at 800-852-7550 (24 hours/day) or 916-445-0931 during normal business hours. These numbers may be updated periodically.

3. Additionally, NCRP Report #65 titled “Management of Persons Accidentally Contaminated with Radionuclides” is located on site for consultation.

4. While they are in route to the hospital, the Radiology Technologist obtains the Geiger Counters (CVD 700) and the Dosimeters (CVD 715) from the Nuclear Medicine Department and takes them to the Triage Area; and obtains the Decontamination Packs from the Emergency Department Storage Area. NOTE: Be sure to cover the probe of the Geiger Counter with a plastic/rubber glove before use to prevent contamination of the probe, rendering it useless.

5. The Emergency Department Charge Nurse/Delegate notifies the following of the potential radiation incident: Chief Executive Officer/Designee, Nursing Supervisor, Environmental Services, Security Services, and Maintenance Department.

6. NOTE: If a disaster has occurred in conjunction with the radiation accident, the Chief Executive Officer or designee declares it is a disaster and has the Operator "page" an "INTERNAL TRIAGE"; and appropriate personnel are contacted.

7. While awaiting the aforementioned individuals, the Emergency Department nurse requests the ambulance personnel to remove and "bag" the clothing the patient is wearing and place him/her in two (2) clean sheets or blankets. (This can reduce the radioactive contamination by 70%). This is especially important if the incident is called in from the scene that this be done right away.

EMERGENCY DEPARTMENT PREPARATIONS:

1. Evacuation of Emergency Department. A clear path must be created from the ambulance entrance to the decontamination room by moving patients and any other persons as necessary from the area. Patients with non-critical problems will be moved to waiting rooms or other suitable areas.

2. Preparation for arrival of victims: Floors of rooms will be prepared by placing tape on the floor separating the decontamination side from the non-contaminated side.

3. Route from ambulance entrance to decontamination room will be covered with a roll of plastic, paper, or with sheets. Covering will be secured to floor with tape. Above route will be marked off with ropes, if necessary, and marked radioactive until cleared by Radiation Safety Officer.

4. Decontamination rooms will be prepared within the Emergency Department. Rooms shall have separate ventilation systems. If they do not, have the ventilation system turned off by the hospital Engineering Department personnel.

5. Floor will be covered smoothly with plastic, paper floor covering, or sheets and secured to the floor with tape. Nonessential equipment will be removed from the room or covered with plastic. Light switches and handles on cabinets and doors will be covered with tape.

6. The Charge Nurse will designate an individual to stand outside and receive supplies for medical and decontamination teams.

7. A trough will be made on the decontamination table with plastic sheeting. Large plastic or metal containers with plastic bags shall be provided to receive discarded contaminated clothes, gauze, supplies, etc.

8. Environmental Services Role: They, along with the Emergency Department's staff, will begin setting up either or both of the Decontamination Areas.

9. Additional help can be obtained by contacting the Nursing Supervisor. Depending on the information received prior to the arrival of the victim(s), have necessary life-support equipment on hand if necessary.

10. Security's Role: They shall clear the area outside around the Decontamination Areas, and plan for alternate placement of cars and traffic.

11. Maintenance Department's Role: They will obtain supplies, such as rope, etc., and assist with the set-up and security as determined by other priorities and needs at the time.

12. Decontamination Packs: The packs are kept in the Emergency Department Storage Area. They are clearly marked with the contents on the outside of the box. They shall be brought to the area where the decontamination process will be conducted, and the equipment can be set up.

13. The staff who will be monitoring/decontaminating the patient shall begin to gown and glove up. (This is usually performed by the Radiologist, Medical Physicist and/or the Nuclear Medicine Technologist.)

14. Physician, nurse, radiology personnel and/or monitors shall wear the following: gown, gloves, mask, hat, plastic boots with tape around the ankles and wrists. They will proceed to the Decontamination Triage Area to evaluate the degree of physical injury and the level of radioactivity of the arriving victims. Check the ABC's: Airway, Breathing, and Circulation and if necessary, stabilize the patient first. NOTE: If emergency lifesaving equipment/procedures are required, delay the radiation monitoring; place the patient on a clean, covered gurney, and proceed into the Decontamination Room where emergency equipment will be available.

15. If the patient is stable, but injured, place him/her on a covered gurney and monitor him/her behind the "hot line" at the entrance. If the patient is uninjured and able to stand; have him/her stand on the "hot pad."

MONITORING THE PATIENT:

1. Begin with the hands; then work from the head down; front of the patient, then the back, having the patient turn around. Perform the assessment as quickly as possible, passing the probe 1-inch above the skin (cover the probe with a plastic glove to prevent skin contamination of the probe rendering it useless). List the levels of radiation obtained over the various parts of the patient's body.

2. After the initial monitoring of any uninjured patient(s), transport them to the adjacent decontamination room located within the Emergency Department. If the patient is not radioactive, he/she may be taken to any other regular ED room.

3. Once the patient has been stabilized (if necessary) and evaluated, the personnel involved in the transportation of the victims shall be monitored for contamination, and shall not leave the area until this is done and they are released. The vehicle/ambulance and its contents shall be thoroughly monitored and decontaminated if required.

4. The personnel who will be involved in the monitoring of the victims or the actual decontamination process shall be dressed as follows:
    - Gown
    - Pairs of light gloves
    - Taped with masking tape at the wrist
    - Plastic cap
    - Waterproof shoe covers taped at the ankles with masking tape
    - An x-ray film badge or a dosimeter.

5. Patient Transfer. If hospital admission is required, place the patient on a clean gurney. Transfer him/her through the buffer zone during which he/she is resurveyed. Have a

"clean" staff person receive the patient outside the buffer zone and transport to his/her room.

6. Waste Disposal: contaminated water will be flushed into the ordinary drains. Faucets will be left open to ensure adequate dilution. Contaminated disposable supplies will be put into plastic bags for disposition. Contaminated equipment will remain in the control area until decontaminated.

7. Personnel Disposition: All persons entering the control area will be dressed and equipped. All persons in the control area will shower and change clothing before leaving the control area. All persons upon leaving the control area will present themselves at the control point for pre-exit survey.

8. In case showering facilities outside of the radiation control area are utilized, these secondary showers will be considered a control area. If secondary showering facilities are utilized, persons in the radiation control area will still change clothes and present themselves for survey at the control point in the Emergency Department. They will then be escorted singly or in-groups to the secondary showering facility.

9. All personnel when dressed in their street clothes will again report to a control point for a final survey, which will be recorded. All personnel will be requested to collect three successive 24-hour urine specimens for analysis of radioactivity.

ROLE OF DIAGNOSTIC RADIOLOGY DEPARTMENT IN DECONTAMINATION

1. When the Diagnostic Radiology Department is notified of the arrival of a radioactive material contaminated victim, the Nuclear Medicine Technologist is to be contacted. If the Nuclear Medicine Technologist is not in the hospital, the Radiology Technologist on staff obtains the available Geiger counters and dosimeters from the Nuclear Medicine Department and proceeds to the Triage Area for evaluation of the arriving victims.
2. If more than one technologist is available, he/she will go to the Decontamination Area and assist with setting up the equipment and dressing for the decontamination. Due to the interfacing of the roles of the Diagnostic Radiology Department and Emergency Department; the Diagnostic Radiology personnel are to become familiar with the role of Emergency Department personnel.

ROLE OF NURSING SUPERVISOR IN DECONTAMINATION

1. Upon being notified of a contamination event by the E.D. Charge Nurse, the Nursing Supervisor evaluates the situation, and if necessary, announces "Code II Mobilize." He/she begins to notify the Chief Executive Officer and Department Director/ Manager, or delegates this to a responsible person. The Nursing Supervisor works with Housekeeping Services to obtain the stored supplies and kits for the necessary decontamination room and halls to be set up and used.

2. Uninjured victims: first left rooms upon entrance. Injured Victims: first right rooms upon entrance. Additional Rooms: right rooms as needed. Halls: entrance to Emergency Department from Willow St.
NOTE: The RED TAPE is used to designate the Hot Lines and the Buffer Zones. Depending on the degree of the disaster, the Supervisor and the E.D. Charge Nurse determine the type/amount of extra staff needed.

SECURITY'S ROLE IN RADIATION DISASTER

1. Upon being notified by the Emergency Department Charge Nurse of the arrival of contaminated victims, assigned Security personnel proceed to the side of the hospital and clears the area near the entrance to the Emergency Department (Triage Area), of cars and people.

2. A security officer will await the arrival of the ambulance and directs it to the Triage Area and later on the ED entrance.

3. Charge Nurse or designee will coordinate staging area for Injured-Uninjured Victims and appropriate entrance to the Emergency Department.

4. The Security Officer restricts access to the area and to the possibly contaminated ambulance.

5. Assigned Security personnel will be available to be utilized as directed by the individual in charge.

HOUSEKEEPING SERVICES ROLE IN RADIATION DISASTER

1. The person in charge of Housekeeping Services assigns Housekeeping personnel to begin preparing the areas to be used:

2. Emergency Department entrance and hallway going into Emergency Department. Remember to cover the air vents so contaminant does not travel through the air system.

3. The "Controlled Areas" will be roped off.

4. If possible, other Housekeeping personnel will be stationed at the entrance to the "Control Areas," to monitor those who enter and/or leave, and keep visitors out of the area.
KEEP UNNECESSARY PEOPLE OUT OF THE CONTROL AREA!

5. The Nursing Supervisor, if able, will assist Housekeeping Services in organizing and setting up equipment.

6. After the decontamination process is completed, Housekeeping Services under the guidance of the Radiologic Health Branch personnel and/or Maintenance Department will decontaminate the area and handle the waste disposal as required.

WASTE DISPOSAL

1. Contaminated waste will be flushed into the ordinary drains. Faucets will be left open to ensure adequate dilution. Contaminated disposable supplies will be put into plastic bags and labeled "Radioactive Material" for disposition. Contaminated equipment will remain in the Control Area until decontaminated.

2. Personnel in Control Area: All persons in the Control Area will shower and change clothing before leaving the Control Area. All persons upon leaving the Control Area will present themselves at the Control Point for a pre-exit survey.

ROLE OF MAINTENANCE DEPARTMENT IN DECONTAMINATION

1. When the Maintenance Department is notified of the arrival of a contaminated victim, the engineer on duty will:

   Contact the Department Supervisor and advice of the situation. If possible, supervise and/or assist Security in traffic control. If trained in the use of radioactive detection equipment/material (Geiger counter): Assist at the Triage Area with evaluation of patients. Evaluate persons leaving Control Area. Assist and guide Housekeeping Services with waste disposal. Assist VFD HAZMAT TEAM with waste disposal.

CONTAMINATED CORPSES:

1. Contaminated corpses must be wrapped in plastic and put on ice in a large container.

LIMITS OF PERSONNEL EXTERNAL RADIATION EXPOSURE

1. All practical efforts will be made to reduce personnel exposure to less than 300 mrem. In those instances when the situation demands the allowance of greater personnel exposures, hospital personnel will be considered in the same category as occupationally exposed workers and the quarterly radiation limit set by the California Radiation Control Regulations of 1250 mrem will pertain.

LETHAL DOSE

1. May occur in-Patient who has received full or partial body external radiation exposure.

2. L.D. 50 in man approximately 400 REM.

3. L.D. 100 in man approximately 800 REM.

4. Definition of L.D. 50 - dose which will produce an acute illness (A.R.S.) followed by death in 30 - 60 days in 50% of the people thus exposed.

5. Triage will be necessary if widespread accident such as in a major nuclear disaster or war attack to segregate Patients and keep those exposed to an L.D. 100 comfortable but save supplies and manpower for persons in which there is some hope for recovery. Also emergency assistance from the state and federal government is available and required. Contact the California State Department of Health Services Radiologic Health Branch at 865-576-1005 and the Reactor Emergency Action Center (REAC-TC) at 916-558-1784.

6. Lower doses (L.D. 30, L.D. 10)

7. Effect of lower dose is proportionately less. At 100 REM only 15% of people develop any symptoms.

8. At 25 - 50 REM no clinical findings are present and the syndrome is only diagnosable by laboratory tests (blood count changes).

ACUTE RADIATION SYNDROME:

1. Assume a dose of 400 REM (L.D. 50). This dose almost invariably would be from external radiation.

2. Smaller doses would show an attenuated A.R.S. both in time and severity of symptoms.

3. Early Phase: (1 hour to 2 days). Nausea plus or minus vomiting. Malaise plus or minus hyperexcitability of reflexes.

4. Asymptomatic Phase: (2 hours to 2 days). Patient feels well but tissue damage is progressing. WBC drops during first day, first lymphocytes then granulocytes to the range of 1000 cells per cc. This is followed by a drop in RBC's and platelets. Internal bleeding. G.I. Skin.

5. Height of Disease (2 to 3 weeks). Elevated temperature in the range of 103 to 104 degrees. Exhaustion Weight loss Reddened skin Loss of hair. Hemorrhages in skin. Ulcerated mucous membrane. G.I. hemorrhages. Infection, may be ultimate cause of death. Fluid imbalance.

6. Delayed effects in survivors: Hair loss Cataracts Anemia Leukopenia may go on to Leukemia. Impaired spermatogenesis premature aging shortened life span.

7. Internal contamination: The total body dose will be lower. No acute radiation syndrome is ordinarily seen. The disease tends to be a chronic matter with toxicity and damage from the agent. Bone seekers Thyroid seekers, etc. Treatment is mainly directed to eliminate the isotope from the body as quickly as possible and particularly in bone seekers to use the well-known treatments for heavy metal poisoning.

Policy Number: DM2231	Date Created: 09/01/2007
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)	

Radioactive Disaster Procedure

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

PURPOSE:

To ensure correct response to a radiation accident emergency

POLICY STATEMENT:

Maintain the Kaweah Health (KH) and the Radiology Department at an appropriate response level in the event of a radiation accident.

RESPONSIBILITY:

A. It isKH's responsibility to notify appropriate regulatory agencies if assistance is needed. Initially, the Emergency Department Charge Nurse/Delegate notifies the following of the potential radiation incident: Initiate 911 request for a radiation accident, Chief Executive Officer / Designee, Nursing Supervisor, the Director of Radiology (Administrative Director) and the Radiation Safety Officer and/or Nuclear Medicine Technologist, Environmental Services, Security Services, Maintenance Department, KH Safety Officer, KH EMS Coordinator, KH Decontamination Team, Emergency Department Manager on call, Central California EMS Agency Duty Officer 559-600-7406.

B. For additional information, contact the California State Department of Health Services, Radiologic Health Branch at 800-852-7550 24 hrs/day or 916-445-0931 during the day and, as appropriate the Reactor Emergency Action Center (REAC-TC) at 865-576-1005.

PROCEDURE:

SURVEY (GEIGER COUNTER) METERS

The Department of Nuclear Medicine has two (2) meters and Sequoia Regional Cancer Center has one (1) meter.

1. The Nuclear Medicine Technologist or the Radiology Technologist obtains the Geiger Counters (CVD 700) and the Dosimeters (CVD 715) from the Nuclear Medicine Department and takes them to the Triage Area.

2. The Nuclear Medicine Technologist or the Radiology Technologist also obtains the Decontamination Packs from the Emergency Department Storage Area. NOTE: Be sure to cover the probe of the Geiger Counter with a plastic/rubber glove before use to prevent contamination of the probe, rendering it useless.

EMERGENCY DEPARTMENT PREPARATIONS

Preparation for arrival of victims:

1) Decontamination Team to set up HazMat decontamination equipment out in the ambulance bay or other location as designated by the Decontamination Team Unit Leader.

2) Coordinate operations with the Radiation Safety Officer and/or Nuclear Medicine Technologist and Fire Department personnel

3) The Decontamination area will be marked off with ropes or caution tape, and marked radioactive until cleared by Radiation Safety Officer..

4) The ED Charge Nurse will designate an individual to stand outside and receive supplies for medical and decontamination teams.

5) Housekeeping Services Role: They, along with the Emergency Department's staff, will assist with setting up the Decontamination Area.

6) Additional help can be obtained by contacting the Nursing Supervisor. Depending on the information received prior to the arrival of the victim(s), have necessary life-support equipment on hand if necessary.

7) Security's Role: They shall clear the area outside around the Decontamination Areas, and plan for alternate placement of cars and traffic.

8) Maintenance Department's Role: They will obtain decontamination trailer(s), supplies,, etc., and assist with the set-up.

9) Decontamination will only be performed by active members of the KH Decontamination Team.

DECONTAMINATION TECHNIQUE - SKIN:

STEP I – EVALUATION
Determine which areas that will be decontaminated and in what order giving priority to skin breaks and highest levels of contamination.
Remove covering of contaminated area to be cleaned.
Survey area with "smear," "swab" or GM Counter. Record survey results.

STEP II - DECONTAMINATION: INTACT SURFACE
Localize area of contamination with plastic sheet and tape to prevent further contamination of Patient.
Gently wipe off loose contamination with gauze moistened with soap and warm water. Discard contaminated gauze into waste disposal bag.
Repeat cleansing using cotton balls or cotton tipped applicators moistened with soap and warm water. Rub skin gently to produce good detergent action. Do not produce skin redness.

MONITORING THE PATIENT

1. Begin with the hands; then work from the head down; front of the Patient, then the back, having the Patient turn around. Perform the assessment as quickly as possible, passing the probe 1-inch above the skin (cover the probe with a plastic glove to prevent skin contamination of the probe rendering it useless). List the levels of radiation obtained over the various parts of the Patient's body.
2. After the initial monitoring of any uninjured Patient(s), transport them to the adjacent decontamination room located within the Emergency Department. If the Patient is not radioactive, he/she may be taken to any other regular ED room.
3. Once the Patient has been stabilized (if necessary) and evaluated, the personnel involved in the transportation of the victims shall be monitored for contamination, and shall not leave the area until this is done and they are released. The vehicle/ambulance and its contents shall be thoroughly monitored and decontaminated if required.

4. The Decontamination Team personnel who will be involved in the monitoring of the victims or the actual decontamination process shall be dressed in full HazMat decontamination PPE & an x-ray film badge or a dosimeter.
5. Resurvey area and soap container. Repeat cleansing until contamination is removed or until level of contamination does not decrease appreciably. In case where contamination is still present skip to STEP III. Where contamination has been removed apply cream, cover area and proceed to next area for decontamination.

NOTE: Surveys between cleansings shall be done every 2 or 3 minutes and recorded. Never dip cleansing instrument into soap. Pour the soap into the gauze or brush

STEP III IF SECOND CLEANSING IS NEEDED

1. Repeat STEP II using another detergent such as Tide, Dreft, Oxydol, etc. and soft skin brush. Do not use lava soap. If contamination is still present go to STEP IV.

STEP IV IF CONTAMINATION IS STILL PRESENT

ED Pharmacist will procure and prepare the agents listed below for the Decontamination Team:

1. Prepare 4% Potassium Permanganate solution.
2. Prepare 4% Sodium Bisulfite solution.
3. Paint contaminated area with Potassium Permanganate.
4. Allow solution to dry on skin. Repeat painting procedure until skin is almost black using new applicators each time.
5. Rub the darkened skin area with Sodium Bisulfite solution discarding applicators after each use.
6. Repeat previous step until skin has just a light brown coloration.
7. Remove Sodium Bisulfite with water moistened gauze or cotton.
8. Cleanse area with soap and warm water. Survey. If contamination remains, repeat Potassium Permanganate solution treatment and subsequent items once more.
9. If contamination persists, repeat these items but substitute Hydrogen Peroxide for soap in STEP II. After removal of contamination apply cream and cover area.

DECONTAMINATION TECHNIQUE: SKIN BREAKS

1. STEP I INITIAL PROCEDURES
   - Survey and record findings using a moistened cotton applicator. Irrigate wound with copious amounts of water making sure no contamination is washed into the wound.
   - Carefully decontaminate intact skin surface around wound. Resurvey wound and record. Continue irrigation with water and survey until no radioactivity is detectable.
   - Treat wound in usual medical fashion. Cover wound and seal with plastic and tape - make sure covering is waterproof.
   - Do not flush with antiseptics unless this is part of your usual medical treatment. Do not flush wound with chelating agents.
   - If wound contamination persists, continue to STEP II.

2. STEP II IF CONTAMINATION IS STILL PRESENT
   - Be certain irrigation is no longer effective in decontaminating the wound.
   - The Medical Physicist or his/her designee will evaluate the internal body burden expected from the residual contamination. He/she or designee in conjunction with a surgeon determines the feasibility and necessity of removing contaminated tissue.
   - If surgery is decided upon, the area around the wound is decontaminated completely. If possible a "block dissection" of the wound is done. All tissue is closed and covered. The wound is closed and covered.

NOTE: At times it has been necessary to close the contaminated wound and return at later date for excision.

DECONTAMINATION TECHNIQUE: GENERAL BODY

1. STEP I INITIAL PROCEDURES

- Survey entire body and record. Mark with lipstick very high level areas to receive priority.
- Contaminated persons shall shower using soap preparation. Make effort not to contaminate hairy areas if free of radioactivity initially.
- Use precautions to prevent contamination from entering body openings. Survey entire body again marking highest levels found.
- Repeat these steps. Repeat the process until contamination is removed or continue to STEP 2.

2. STEP II IF CONTAMINATION IS STILL PRESENT

- For general body contamination with high levels of radioactivity, localized areas of contamination usually remain. When showering becomes ineffective and localized as of contamination remain; shift to localized skin contamination technique.
- Repeat surveys and record results frequently.

DECONTAMINATION TECHNIQUE: EYES

- Irrigate with copious amounts of water. Shift to normal saline as soon as possible. Survey irrigation fluid at frequent intervals and record results.
- After decontamination treat irrigation induced conjunctivitis as usual.

DECONTAMINATION TECHNIQUE: BODY ENTRANCE CAVITIES

- Survey and record results. Make sure that cavity is really contaminated and not surrounding area.
- Evaluate and decontaminate surrounding area. Irrigate with copious amounts of water or normal saline.
- Gently swab with moistened cotton tipped applicator. Resurvey. Repeat the irrigation and swabbing.
- Transfer the Patient. If hospital admission is required, place the Patient on a clean gurney. Transfer him/her through the buffer zone during which he/she is resurveyed. Have a “clean" staff person receive the Patient outside the buffer zone and transport to his/her room.

DECONTAMINATION TEAM Post actions:
Decontamination Unit Leader will:
1) Consult with Tulare County Environmental Services for direction on handling and/or disposal of waste water & decontamination equipment.
2) Ensure Decontamination Team receives evaluation of level of exposure and ensure an ED Medical Screening exam has been performed if indicated or requested by a Decontamination Team member involved in the incident.
3) Consult with the Radiation Safety Officer and/or Nuclear Medicine Technologist and Fire Department personnel to determine if any other actions are necessary.

"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: DM2411	Date Created: No Date Set
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)	

Volunteer Practitioners in the Event of a Disaster

PURPOSE:

Individuals who are qualified to practice in a health care profession, e.g., M.D., D.O. D.P.M, P.A. or N.P., and who are not employees of Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) may be engaged in the provision of care and services at any district facility during an "emergency" (defined as any officially declared emergency, whether it is local, state, or national).

POLICY:

During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, the Chief Executive Officer/designee may assign disaster responsibilities. The responsible individual is expected to make such decisions on a case-by-case basis in accordance with the needs of the hospital and its patients, and on the qualifications of its volunteer practitioners (those that are required by law and regulation to have a license, certification, or registration to practice their profession). The credentialed Medical Staff oversee the professional performance of volunteer practitioners, either by direct observation, mentoring or clinical record review.

Once the immediate disaster situation is under control, the assignment of disaster responsibilities is terminated.

PROCEDURE:

1. The volunteer practitioner must:

   A. Complete the application form (attachment A). This form includes the applicant's statement that he/she has a current unrestricted license certification and training, knowledges and competency to practice in their specialty.

   B. Present a valid government issued photo identification issued by a state or federal agency, e.g., driver's license or passport, and at least one of the following:

   - A current picture hospital ID card that clearly identifies professional designation
   - A current license, certification to practice
   - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC)

2. Assignment of volunteer practitioners to appropriate areas is accomplished by the CEO/designee in concert with the Chief of Staff (COS)/designee.

3. The application for volunteer practitioners shall be forwarded as soon as possible to the medical staff office to immediately verify as much information as possible, including verification of licensure certification A record of this information will be retained by the Medical Staff Services Office and forwarded to Human Resources department, as appropriate. If not completed immediately, primary source verification of license certification begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.

4. The CEO/designee in concert with the COS/designee makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster responsibilities initially assigned.

5. To ensure oversight of the professional performance of volunteer practitioners:

   If hospital staff is available, concurrent mentoring will occur; the volunteer will be paired with an appropriate medical staff, e.g., Physician with Physician. Medical Directors of the area the practitioner is assigned to will oversee appropriateness of care and competency of volunteer.

   a. -

   b. Any information gathered that is not consistent with that provided by the individual must be referred to the CEO/designee immediately, who will determine any additional necessary action. A volunteer practitioner's assignment approved during a disaster will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

   c. Each volunteer practitioner will be required to wear a hospital badge signifying that the volunteer is authorized.

"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 Medical Staff

ATTACHMENT A

Disaster Privileges Application

Name of Provider			
Email Address			
Primary Office Address			
Cell Phone			
Type of Licensure	☐ Physician ☐ Psychologist ☐ Nurse Anesthetist	☐ Nurse Practitioner ☐ Physician Assistant ☐ Other _____	
State of Licensure *		**License # ***	
NPI #	**SSN:**	**DOB:**	
Do you have a current DEA certificate?	☐ Yes If yes, please provide DEA #: ☐ No		
Practice Specialty			
Current Government Issued Photo ID (provide copy)	☐ State Driver's License ☐ Passport ☐ Other _____		
Past Work Experience Includes: (Check all that apply)	☐ ER ☐ ICU	☐ Hospitalists / Internal Medicine ☐ Outpatient Clinics	
Extended Experience Includes: (Check all that apply)	☐ Central Line Insertion ☐ Mechanic Ventilator Management ☐ Management of Hospital Patients	☐ Trauma ☐ Shock Resuscitation ☐ Intubation	

* *Information not required to be entered if copy of license is provided and attached*

I certify that the above information is correct and that I have no restrictions on my license to practice in the State listed above or any other State.

I also certify that I have the training, knowledge and competency to practice in my specialty and have no restrictions on clinical privileges at any hospital/facility where clinical privileges have been or are currently granted.

I volunteer to provide clinical services to Kaweah Delta Health Care District during this disaster and agree to practice as directed and under the supervision of an assigned practitioner. I agree to wear my Disaster Privileges ID Badge at all times when functioning under these disaster privileges to enable staff and patients to readily identify my status.

I agree to maintain confidentiality of patient information, per current HIPAA requirements related to the protection and confidential handling of protected health information.

I understand that I will be notified when the organization's emergency plan is no longer in effect and I understand that the disaster privileges at this organization will immediately terminate. I also agree that these privileges may be terminated at any time without cause or reason during the disaster and that I have no right to a hearing or

review. Email completed form along with copy of current government issued photo ID to: medstaff@kdhcd.org.

_____

Signature of Provider ***Date***

DISASTER PRIVILEGE VERIFICATION & RECOMMENDATION FORM

_____

Name

The information provided by the Provider has been reviewed and will be verified, as soon as possible, as outlined in the Medical Staff Bylaws and related policies and procedures. On this basis, this Provider is granted disaster privileges to treat patients as directed by his/her assigned Kaweah Delta provider during this emergency.

_____

Chief of Staff, CEO or Designee ***Date***

Provider Assigned to Disaster Volunteer	

Review 72 hours after provider begins exercising disaster privileges:

☐ Continue disaster privileges as assigned based on no concerns identified.
Additional assignment areas:
_____

☐ Discontinue disaster privileges:
_____

Chief of Staff, CEO or Designee: _____ Date: _____

MEDICAL STAFF SERVICES OFFICE USE ONLY

Checklist (please obtain copies if possible and attach to this document):

☐ Government-Issued ID (Driver's License or Passport)

AND – ONE OF THE FOLLOWING

☐ Current picture ID from a healthcare organization
☐ Current license to practice
☐ DMAT (Disaster Medical Assistance Team)
☐ MRC (Medical Reserve Corps)

_____

Name Date

_____

Title

☐ State License Verified *	Current	☐ or Received	Photo Taken
☐ Entry	MD-Staff	☐ Requested	ID Badge
☐ Entry	HR Online	☐ Doc Master Changes	Email to ISS
☐ Financials Entry	Soarian	☐ Doctor Master File Changes	Email to
☐ Privileges After 72 Hour Review	Continue	☐ Privileges After 72 Hour Review	Discontinue

Out-of-state licenses need the approval of the EMS Authority.

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Employee Health

Policy Number: EHS 05	**Date Created: 04/18/2018**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: 05/11/2021**
Approvers: Dianne Cox (Chief Human Resources Officer)	
Influenza Prevention	

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

Policy:

All Kaweah health care personnel are required to receive the seasonal influenza vaccine and disease prevention education annually. This mandatory requirement is a condition of employment. Kaweah Health recognizes a limited number of clearly defined exemptions from this policy.

Definitions:

Influenza: An acute viral upper respiratory illness which is characterized by nasal congestion, fever, cough, headache, myalgia, coryza, sore throat, and malaise. Transmission is by droplet spread or hand to mouth contact with respiratory secretions of an infected person. Incubation period is short, usually 1-3 days.

Influenza vaccine: The seasonal vaccine product licensed for use and manufactured in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations for the strains selected for a given season. The vaccine procured will be subject to availability. Manufacturing and supplier constraints may cause this policy to be altered or amended as required during unforeseen disruptions of supply.

Health Care Personnel (HCP): All Kaweah Health employees, medical staff, volunteers, students from training programs using our facilities for clinical instruction, and licensed independent practitioners affiliated with Kaweah Health. It may also include contracted personnel and registered vendors.

Licensed independent practitioners (LIP's): Physicians (MD, DO) and midlevel providers who are affiliated with the healthcare facility, but are not directly employed by it.

Procedure:

1. The Influenza Prevention Program is coordinated by Employee Health Services.
2. Employee Health will collaborate with the Kaweah Health Marketing team to promote influenza vaccination with the goal of increasing awareness and vaccination rates amongst Kaweah Health HCP's
3. All Kaweah Health employees, volunteers and physicians will be offered the seasonal influenza vaccine, free of charge.
4. All vaccinated Health Care Personnel will be provided and wear a designation on their badge, indicating that they have received a current influenza vaccination.
5. New employees who begin during the Influenza season must be vaccinated at the

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time of their post-offer physical, present documentation of current seasonal vaccine or submit an exemption application prior to starting work. In the event that Employee Health Services does not have the flu vaccine at time of new hire appointment, the employee will be contacted and scheduled to come back in when vaccine is available. They may also receive the vaccine elsewhere and provide record of vaccination to Employee Health Services by the timeframe determined by Employee Health Services, usually November 1st.

6. The scheduled annual influenza timeframe begins November 1 and ends March 31st unless otherwise determined by the Infection Prevention Team and/or Public Health Officer.
7. Individuals who are vaccinated through services other than Employee Health Services (i.e. private physician offices, public clinics, other hospitals) are to provide record of vaccination to Employee Health Services by beginning of flu season, date to be determined yearly. Students must provide proof of current vaccination through their program.
8. Any employee who refuses available seasonal influenza vaccine and does not provide a signed declination by November 1st of each year will be subject to disciplinary action up to and including termination.
9. Influenza outbreak will be identified by Tulare County Health Officer and/or Daniel Boken, M.D. of Infection Control.

EXEMPTIONS:

Consideration for exemption from receiving the influenza vaccine will be given to:

A. Individuals with documented contraindications to receiving the influenza vaccine due to allergies to components, previous severe adverse reactions, history of an episode of Guillain-Barre syndrome within 6 weeks of a past influenza vaccination, and/or other medical condition.
B. Individuals may request an exemption from the mandatory vaccination as an accommodation to a sincerely held religious or philosophical belief or practice.
C. Healthcare Personnel (HCP) who have been granted an exemption and do not receive the current influenza vaccination, must take other precautions, including wearing a mask during the defined influenza season.
D. The mask must be worn on all Kaweah Health properties, during all working hours, except during meal breaks, and may be removed once the individual leaves the premises at the end of the shift.
E. The mask shall be disposed of in the regular trash and shall not be worn around the neck or other part of body once used. A new mask must be applied upon return to the defined work area if the mask becomes soiled or damp during normal wear.
F. Department managers, supervisors, team leaders and house supervisors will be responsible for monitoring and enforcing compliance with the masking requirement for non-vaccinated HCP's.

PROCEDURES:

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Education: Employee Health Services will provide current Vaccine Information Sheet (VIS) from the Center for Disease Control and Prevention (CDC) for review prior to vaccination.

Illness: Health Care Personnel who have symptoms of febrile respiratory tract infection suggestive of influenza will be removed from duties regardless of vaccine status. e.g. temperature of 100.4° or greater and respiratory symptoms.

A. An employee who is afebrile with symptoms of respiratory tract infection will be evaluated by their manager and may work but must follow strict respiratory hygiene precautions while at work regardless of vaccine status.

B. Employees with acute influenza are encouraged to see their primary care physicians within 24 hours of onset to consider using antiviral treatment.

Vaccinations: Seasonal influenza vaccination campaign will begin once sufficient vaccine supplies are available (usually September or October).

All Kaweah Health employees, volunteers and medical staff will be offered the seasonal influenza vaccine free of charge.

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In the event of a vaccine shortage, immunization will be prioritized by risk group.

Badge Indicator, indicating a current influenza vaccination, must be worn at all times while in Kaweah Health facilities or performing Kaweah Health services by vaccinated HCP's.

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1) Badge indicator will be obtained from Employee Health Services upon verification of vaccination status.
2) Badge Indicator must be visible.

HCP's not displaying the designated badge indicator will be required to take all other influenza precautions, including wearing a mask during the defined influenza season.

Consent:

1) Flu consent form must be signed prior to receiving the flu vaccine.
2) HCP receiving seasonal influenza vaccine at Kaweah Health Employee Health Services will receive a document that confirms receipt of the vaccine upon request.

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Contraindications:

1) Hypersensitivity to any component of the vaccine.
2) Other contraindications as listed in the manufacturer's information. Immunization will be delayed due to the following: Acute febrile illness until temporary symptoms and/or signs have abated.

Dosage and administration:

1) Dosage and the administration of the influenza vaccine will be given per Manufacturer's instructions, Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control (CDC) guidelines.

References:

Benenson, AS. Control of Communicable Diseases in Man, 16th ed. APHA. 1995. p. 245.

Centers for Disease Control and Prevention, Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009, MMWR, 58 (2009) 1-52.

Centers for Disease Control and Prevention, Influenza vaccination of health-care personnel, MMWR, 55 (2006) 1-16.

Centers for Disease Control and Prevention, Interventions to increase influenza vaccination of health-care workers- California and Minnesota, MMWR, 54(08) (2005) 196-199.

Joint Commission on Accreditation of Healthcare Organizations, New infection control requirement for offering influenza vaccination to staff and licensed independent practitioners, Joint Commission Perspectives, 26 (2006) 10-11.

National Quality Forum. National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations. Http://www.qualityforum.org/Publications/2008/12/National_Voluntary_Consensus_Standards_for_Influenza_and_Pneumococcal_Immunizations.aspx 1-68. 2008. Washington DC, National Quality Forum. 8-12-2009.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Employee Health

Policy Number: EHS 06	**Date Created: 06/01/2007**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: 11/12/2020**
Approvers: Dianne Cox (Chief Human Resources Officer)	
Work Related Injury and Illness and Workers' Compensation	

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

PURPOSE:

To provide the employee with Workers' Compensation benefits in the event of employment-related injury or illness. To comply with California Code of Regulations, Title 8, 342 Reporting Work-Connected Fatalities and Serious Injuries and Occupational Safety and Health Administration (OHSA) Regulation 1904.39: Reporting fatalities, hospitalizations, amputations, and losses of an eye as a result of work-related incidents to OSHA.

POLICY:

Kaweah Health provides coverage under the Workers' Compensation Act of the state of California for employees who are injured in the course of employment. Workers' Compensation is a no-fault insurance designed to provide employees with compensation for work-related injuries or illness, regardless of fault. Workers' Compensation covers all employees of Kaweah Health for work-related injuries and illnesses. Kaweah Health contracts with a Third-Party Administrator, to provide claims management services for injured workers, i.e. medical claims, temporary disability wages, mileage to medical appointments, etc.

A Transitional Work Program (TWP) may be available to employees who have suffered an on-the-job injury or have temporary limitations rendering them unable to return to their regular positions, but have released to restricted duty by their provider(s).

BENEFITS:

1. Medical bills are paid as long as the bills were incurred for services that were reasonable and necessary to cure or relieve the effects of the work-related illness or injury.
2. If an employee cannot work, temporary disability compensation is paid directly to the claimant through Kaweah Health's Third Party Administrator, in compliance with the state of California requirements. The maximum that can be paid is set by the state of California and is not determined by Kaweah Health. The employee may use accrued Extended Illness Bank (EIB) and Paid Time Off (PTO) to supplement their pay to equal base earnings each pay period, exclusive of any shift differentials.

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PROCEDURE FOR WORK RELATED INJURY/ILLNESS:

1. If medical care is required for an employee who has sustained a work-related injury or illness, the supervisor or employee is required to contact Employee Health Services, house supervisor, or in the case of a clear emergency, the Emergency Department. If treated in the Emergency Department or Urgent Care Facility, the employee must contact their manager and Employee Health Services the next business day Employee Health Services is open.

2. Employees may pre-designate a medical provider for work related injuries or illnesses. These forms are maintained in the employee's employee health file.

3. If the injury involves a sterile (unused) sharp object, no treatment or testing is usually necessary. If injury/exposure involves contact with blood or body fluids, refer to EHS 02: Employee Exposure to Bloodborne Pathogens Policy when treating the employee. The supervisor or employee is required to contact Employee Health Services, house supervisor, or in the case of an emergency, the Emergency Department. If treated in the Emergency Department, the employee must contact their manager and Employee Health Services on the next business day Employee Health Services is open.

4. It is the supervisor or manager's responsibility to have the employee complete and sign the Work-Related Injury/Illness Report Form within 24 hours of knowledge of injury if they are the first point of contact for the injured employee. This form is located on the organization's intranet site and in Employee Health Services. A DWC-1 claim form must also be completed in Employee Health if it is believed that this injury will be more than first aid treatment. These forms must be completed and provided to Employee Health immediately so the claim filing process can begin. If Employee Health is not open at the time of the injury, management shall report the injury by email to Employee Health Services, on the Employee Health Services voicemail by calling extension 2458, or by faxing the forms to Employee Health Services at 559-635-6233. In the event that the injury is such that the employee must be seen by a provider immediately, the house supervisor will instruct the employee to report to Kaweah Health Clinic to be seen by Work Comp provider or in an emergency, to the Emergency Department.

5. The supervisor or manager is to notify Employee Health regarding any lost time from work by an employee so disability payments can be determined. Any employee sent home the day of an injury will be paid his/her full base wage for that day if the provider determines the employee is not able to return to work at that time. Employee Health will also notify the supervisor or manager of any information received directly.

6. Employees must keep their supervisor or manager and Employee Health informed with a written statement from the treating provider for time lost from work for job related illnesses/injuries. They must present to Employee Health a provider's written statement allowing them to return to work giving specific limitations, if any. The Employee Health nurse may contact the provider if clarification is needed on the work limitations.

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7. Employees must schedule appointments with providers, physical therapy, and any special testing during off duty time, whenever possible. Employees must give their manager a minimum of 24 hours of notice if an appointment must be scheduled during work time. Employees must clock in and out for appointments and may use available Paid Time Off (PTO) for appointments.

8. The manager will record the days missed on the employee's timecard so accurate records are maintained and reflect scheduled days missed.

9. Employee Health will coordinate all claims with the Workers' Compensation Third Party Administrator.

PROCEDURE FOR TRANSITIONAL WORK PROGRAM (TWP):

1. Employees returning to work with specific limitations must contact employee health.

2. An employee who is released to return to work with specific limitations may be accommodated. Employee Health Services and/or Human Resources will work with the employee's manager to establish a Transitional Work Program for the employee. A Transitional Work Program contract must be signed.

3. Every attempt is made by the accommodating RN case manager to place the TWP employees in their home department; however, an employee may be placed in an alternative department. If an employee refuses a TWP placement, they may not be eligible for benefits.

4. TWP employees are assigned and must comply with specific work duties within their provider-set limitations.

    a. Employees participating in the TWP are responsible to report to the assigned work area at the designated time, dressed appropriately for the job, and work the designated hours. Employees must comply with all Kaweah Health policies and procedures.
    b. The TWP manager is responsible for ensuring that an employee's transitional position does not exceed the specific restrictions of duties or time limits of the TWP position. The employee is also responsible to ensure that they work within those restrictions.
    c. The TWP manager will provide the training and orientation of the TWP employee. He/she will supervise the employee as regular staff.
    d. Once assigned, failure to report for TWP or to contact the designated manager may result in the same counseling for progressive discipline process as applicable to all other employees.
    e. The TWP assignment is a temporary assignment and Kaweah Health reserves the right to terminate assignments at any time.

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5. Employees released from the TWP to full duty by their provider will be reinstated in their former position, at the same rate of pay, or to a comparable position for which the employee is qualified, unless circumstances have changed which make it impossible or unreasonable to reinstate the employee. If the employee cannot be reinstated, the employee will be placed on Workers' compensation leave of absence.

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PROCEDURE FOR WORKERS' COMPENSATION LEAVE OF ABSENCE:

1. Reason for Leave:

   Kaweah Health will grant a Workers' Compensation Disability Leave to employees with occupational illnesses or injuries in accordance with state law. As previously stated, as an alternative, Kaweah Health will try to reasonably accommodate such employees with transitional work. A Workers' Compensation Disability Leave will be concurrently charged as a Medical Leave under the federal and state Family Medical Leave laws (FMLA and CFRA) if the injury qualifies as a "serious health condition."

2. Notice and Certification Requirements:

   a. Notice:

      If, as a result of the injury, the attending provider directs the employee to remain off work, the off-work order must be brought to Employee Health Services immediately. Employee Health Services will monitor status and follow-up with employee as appropriate. Provider "return to work orders" must be brought to Employee Health Services 24-48 hours prior to the employee's first day back to work following an injury. If, as a result of the injury, the provider directs the employee to return to work with restrictions the employee needs to immediately communicate this to Employee Health Services. This will begin the process for the employee to request a reasonable accommodation under the Americans with Disabilities Act (ADA).

   b. Certification:

      Kaweah Health requires a written statement from a provider, which must include the following:

      i. That the employee is unable to perform the regular job duties;
      ii. The date on which the impairment commenced; and
      iii. The expected date of the employee's ability to return to work.

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3. Compensation During Leave

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Refer to the pamphlet from the Employment Development Department (EDD) entitled "For Your Benefit: California's Program for the Unemployed" for more information.

a. If injured on the job employees will be paid full scheduled shift for that day of injury. If subsequent days off are needed from scheduled shifts prior to the third calendar day waiting period, accrued Extended Illness Bank time may be utilized up to 24-hours. If additional hours of non-productive, hours are needed Paid Time Off hours may be used at the discretion of the employee. PTO may be utilized for pre-approved appointments and intermittent leave requests. In the circumstance of an immediate hospitalization or surgery, an employee may be paid from accrued EIB from their first full day off. EIB must be used for coordination with SDI or Workers' Compensation Temporary Disability Payments; PTO time may be used only after all EIB has been exhausted. Coordinated amounts will not exceed the regular amount of pay normally earned by the employee.
b. It is the employee's responsibility to notify Payroll of the amount they receive from SDI or Workers' Compensation to ensure the correct amount of EIB.

4. Benefit Accrual:

The employee will continue to accrue PTO/EIB as long as he/she is being paid using accrued PTO hours by Kaweah Health (receiving a paycheck).

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5. Performance Review Date:

The performance review date will remain unchanged when on a leave of absence. Review dates occur annually between the common review date, mid-October of each year

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6. Benefits During Leave:

a. An employee taking leave will continue to receive the same level of coverage they had prior to taking leave under the Kaweah Health's employee benefit plans for up to a maximum of 16 weeks in a rolling calendar year. Kaweah Health will continue during that maximum of 16 weeks on leave to make the same premium contribution as if the employee had continued working.

b. Insurance premiums (health, vision, dental, life, etc.) are to be paid by the employee and Kaweah Health, under the same conditions as existed prior to leave, for a maximum of 16 weeks in a rolling calendar year period.

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c. If on paid status (utilizing PTO/EIB), an employee may continue his/her normal premiums through payroll deduction. If on unpaid status, he/she is required to pay the Kaweah Health his/her portion of the premiums while on a leave of absence for a total of 16 weeks. After 16 weeks, employees will be offered COBRA Continuation Coverage for applicable benefits.

d. An employee whose insurance is canceled due to nonpayment of premiums will have to satisfy a new waiting period after returning to work and will be considered a "new employee" for insurance purposes and as such, the employee may have to provide proof of insurability.

e. An employee may cancel his/her insurance within 30 days of the end of his/her paid leave and will be re-enrolled upon return without a waiting period. Cancellation must be done in writing to the Human Resources Department. The employee must reinstate coverage within 30 days of his/her return from work.

f. Group medical, dental and vision insurance coverage will cease on the last day of the month in which an employee reaches 16 weeks of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan.

g. If the employee fails to return to work at the expiration of the leave, he/she must repay any health insurance premiums paid by Kaweah Health while on leave, unless failure to return to work is due to a continuation of his/her own serious health condition or other reasons beyond his/her control.

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7. Reinstatement:

a. A doctor's release and a clearance with Employee Health Services will be required when an employee is returning from a Workers' Compensation Leave of Absence. Upon the submission of a medical certification that the employee is able to return to work, the employee will be reinstated in accordance with applicable law. If an employee is disabled due to an industrial injury, the Kaweah Health will attempt to accommodate the employee. If the employee is returning from a Workers' Compensation Disability Leave that runs concurrently with a Family and Medical Leave, then the provisions of the Family and Medical Leave policies will also apply.

b. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS and TB testing, as

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applicable) prior to a return to work. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all Kaweah Health policies, rules and procedures.

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c. Kaweah Health reviews job status while an employee is on a leave of absence and may replace positions when a leave extends to beyond 16 weeks. In this case, the employee on a leave of absence due to a work injury remains employed for up to two years. When able to return to work, we review opportunities and options with the employee if available.

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PROCEDURE FOR GUILD MEMBERS AND VOLUNTEERS INJURED WHILE VOLUNTEERING AT KAWEAH HEALTH:

1. If a guild member sustains an injury while on the job, the guild member will immediately report to his/her supervisor, the House Supervisor, and Employee Health. The Work Injury Report will be completed and injured guild member will report to Employee Health Services with the completed form. Employee Health Services will provide first aid treatment and, if necessary, refer the injured guild member to either the Emergency Department or to a Kaweah Health Clinic.

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2. Charges incurred as a result of first aid provided in Employee Health Services, Kaweah Health Clinics, or where indicated, an initial Emergency Department visit, will be covered under this program. Charges incurred as a result of additional or follow-up care will be the responsibility of the injured individual's personal insurance.

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PROCEDURE FOR SERIOUS INJURY OR WORK-RELATED DEATH REPORTING:

1. Reporting Work-Connected Fatalities and Serious Injuries:
   a. Every employer shall report immediately to the Division of Occupational Safety and Health (OSHA) any serious injury or illness, or death, of an employee in a place of employment or in connection with any employment.
   b. Death of an employee must be reported to OSHA within 8 hours of the fatality. Refer to California Code of Regulations, Title 8, Section 342 and OSHA Regulation 1904.39 for more details.
   c. In-patient hospitalization, an employee's amputation, or an employee's loss of eye, as a result of a work-related incident must be reported within 24 hours to OSHA.
   d. When an employee suffers serious injury, illness or death, the Employee Health Services manager or designee will be notified via email through daily admissions report or by phone or email from the employee's supervisor. Employee Health manager or designee will report immediately

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to the Division of Occupational Safety and Health. If the Employee Health manager is not notified right away of the fatality, in-patient hospitalization, amputation or loss of eye, report must be made within the following timeframe after Employee Health Manager or designee learns of the incident: 8 hours for fatality, 24 hours for hospitalization, amputation, and eye loss.

e. Report can be made by telephone call to OSHA (1-800-321-6742), or by electronic submission on OSHA's public website (www.osha.gov). Refer to OSHA Regulation 1904.39 for more details.

f. TPA will be notified by EHS.

PROCEDURE FOR EXPOSURES TO COMMUNICABLE DISEASES:

1. Employees exposed, or believed to have been exposed to any communicable disease from work, shall report the exposure to their supervisor or manager and Employee Health Services. The Infection Prevention department will be advised or consulted as necessary. Employees exposed to highly communicable diseases for example: Pertussis, Meningococcal Meningitis, Pulmonary Tuberculosis, Viral Hepatitis), Chickenpox, and Covid 19 must be reported as guided by Infection Prevention Department in accordance with California Department of Public Health Code of Regulations. The Employee Health nurse will determine the necessity of further treatment or referrals to a provider. The susceptible employee may be taken off of work or away from patient care as guided by EHS 04: Infectious Disease Guidelines For Employees Policy.

NON-WORK RELATED INJURY OR ILLNESS:

1. Kaweah Health, or its insurance carrier will not be liable for the payment of Workers' Compensation benefits for any injury which arises out of any employee's voluntary participation in any off-duty recreational, social, or athletic activity which is not part of the employee's work-related duties.

2. Falsification of any facts regarding an incident or injury, or failure to report an incident promptly may be grounds for progressive discipline, up to and including termination of employment. Furthermore, the law requires that the Kaweah Health notify the Third Party Administrator of any concerns of false of fraudulent claims. Any person who makes or causes misrepresentation for the purpose of obtaining or denying Workers' Compensation benefits or payments is guilty of a felony. A violation of this law is punishable by imprisonment for one to five years, or by a fine. Additional civil penalties may be in order.

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References:

Department of Industrial Relations Cal/OSHA Title 8 Regulations: Ch 3.2 California Occupational Safety and Health Regulations (CAL/OSHA), Subchapter 2 Regulations of the Division of Occupational Safety and Health, Article 3 Reporting Work-Connected Injuries, 342 Reporting Work-Connected Fatalities and Serious Injuries URL: https://www.dir.ca.gov/title8/342.html

United States Department of Labor: Occupational Safety and Health Administration Regulation Standard 1904.39 Reporting fatalities, hospitalizations, amputations, and losses of eye as a result of work-related incidents to OSHA URL: https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.39

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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<#>Reason for Leave:¶
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The District will grant a Worker's Compensation Disability Leave to employees with occupational illnesses or injuries in accordance with State law. As an alternative, the District will try to reasonably accommodate such employees with transitional work. A Worker's Compensation Disability Leave will be concurrently charged as a Medical Leave under the federal and state Family Medical Leave laws (FMLA and CFRA) if the injury qualifies as a "serious health condition."¶
¶
<#>Notice and Certification Requirements:¶
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<#>Notice:¶
If, as a result of the injury, the attending physician directs the employee to remain off work, the off-work order must be brought to Employee Health Services immediately. Employee Health Services will monitor status and follow-up with employee as appropriate. Physicians' "return to work orders" must be brought to Employee Health Services 24-48 hours prior to the employee's first day back to work following an injury. If, as a result of the injury, the attending physician directs the employee to return to work with restrictions the employee needs to immediately communicate this back to Employee Health Services. This will begin the process for the employee to request a reasonable accommodation under the Americans with Disabilities Act (ADA).¶
¶
<#>Certification:¶
The District requires a written statement from a physician, which must include the following:¶
<#>That the employee is unable to perform the regular job duties;¶
<#>The date on which the impairment commenced; and ¶
<#>The expected date of the employee's ability to return to work.¶
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<#>Compensation During Leave¶
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Refer to the pamphlet from the Employment Development Department (EDD) entitled "For Your Benefit: California's Program for the Unemployed" for more information. ¶
<#>If injured on the job employees will be paid full scheduled shift for that day of injury. If subsequent days off are needed from scheduled shifts prior to the third calendar day waiting period, accrued Extended Illness Bank time may be utilized up to 24-hours. If additional hours of non-productive, hours are needed Paid Time Off hours may be used at the discretion of the employee. PTO may be utilized for pre-approved appointments and intermittent leave requests. In the circumstance of an immediate hospitalization or surgery, an employee may be paid from accrued EIB from their first full day off. EIB must be used for coordination with SDI or Workers' Compensation Temporary Disability Payments; PTO time may be used only after all EIB has been exhausted. Coordinated amounts will not exceed the regular amount of pay normally earned by the employee. ¶
<#>It is the employee's responsibility to notify Payroll of the amount they receive from SDI or Workers' Compensation to ensure the correct amount of EIB. ¶ ...

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Employee Health

Policy Number: EHS 11	**Date Created: 08/21/2018**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: 04/18/2023**
Approvers: Dianne	
Immunization Requirements for Health Care Workers	

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

Policy:

Healthcare Personnel (HCPs) are at risk for exposure to and possible transmission of vaccine-preventable diseases because of their contact with patients or infective material from patients. The Centers for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP) recommend the following requirements for all Healthcare Personnel Immunizations.

Procedure:

Hepatitis B Vaccine:

- Documented evidence of complete hepatitis B series and a positive hepatitis B surface antibody titer (HBSAB titer) or positive HBSAB titer alone for all healthcare personnel who have an occupational risk for exposure to blood and/or other body fluids.
- Vaccination for hepatitis B can be either a 3-dose series of Recombivax HB or Engerix-B (dose #1 now, #2 in 1 month, #3 in 6 months after dose #1) or a 2-dose series of Heplisav-B, with the doses separated by at least 4 weeks.
- If the HCP has had the complete series already but does not have evidence of a positive/reactive HBSAB titer, draw an HBSAB titer. If the HBSAB is nonreactive, meaning no or low immunity to the hepatitis B virus, give one hepatitis B booster, then recheck HBSAB in 8 weeks. If the healthcare personnel's HBSAB remains nonreactive, complete the full series of hepatitis B vaccine. Retest HBSAB 8 weeks following the competed series.
- Administration of more than two complete hepatitis B series is generally not recommended, expect for people on hemodialysis.

Influenza Vaccine:

- One dose of influenza vaccine annually. See Policy EHS 05: Influenza Prevention.

Measles, Mumps, Rubella Vaccine (MMR):

- Proof of two documented doses of measles-and mumps-containing vaccine and 1 documented dose of rubella-containing vaccine or proof of positive titers.

- For healthcare personnel who do not have serologic evidence of immunity or prior vaccination, give 2 doses of MMR (4 weeks apart).
- If the healthcare personnel provides proof of two documented measles-and mumps-containing vaccinations and also has a negative or equivocal titer(s) result for measles or mumps, it is not recommended that they receive an additional dose of MMR vaccine. Such people should be considered to have acceptable evidence of measles or mumps immunity; retesting is not necessary.

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- If healthcare personnel (except for women of childbearing age) who have 1 documented dose of rubella-containing vaccine are tested serologically and have a negative or equivocal titer result for rubella, it is not recommended that they receive an additional dose of MMR vaccine. Such people should be considered to have acceptable evidence of rubella immunity.

Varicella Vaccine (Chicken Pox):

- Proof of two documented doses of varicella vaccine or a positive titer. If no evidence of vaccination or positive titer, draw titer. If results negative, give two doses of varicella 4 weeks apart. No follow up titer is necessary.
- Documented receipt of 2 doses of varicella vaccine supersedes result of subsequent serologic testing (commercial assays are not sensitive enough to always detect antibodies after vaccination).

Tetanus, Diphtheria, and Pertussis Vaccine (Tdap):

- One time dose of Tdap for high risk areas. See Policy EHS 07: Tdap Policy for Healthcare Personnel.

Covid 19 vaccine:

- Two dose series or approved one dose vaccine plus one booster.

Tuberculosis testing (TB):

- A two-step TB skin test is required for all new hire healthcare personnel, or one Quantiferon Gold (QFG), and then an annual TB test thereafter.
- If the healthcare personnel provides documentation of a TB skin test within the last year, it will be counted as #1 of the two step TB skin test. If documentation is provided of a second TB skin test that was placed and read within the last 3 months, it will be accepted as #2 TB skin test. Otherwise the healthcare personnel will need a current TB skin test placed and read to begin orientation.
- If the HCP has had a previous documented positive TB test, they will need a chest x-ray performed (proof of chest x-ray within the last year is acceptable) and annual TB symptom questionnaire completed.

References:

Immunization of Health Care Personnel: Recommendations of the Advisory Committee in Immunization Practices (ACIP) November 25, 2011 / 60(RR07); 1-45 (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf)

Centers for Disease Control and Prevention Website: Recommended Vaccines for Healthcare Workers. Last Reviewed May 2, 2016. (https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html)

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Kaweah Health
MORE THAN MEDICINE. LIFE.

Employee Health

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Policy Number: EHS 14	**Date Created: 06/25/2021**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: 07/09/2021**
Approvers: Dianne Cox (Chief Human Resources Officer), Gaby Robles (Employee Health Svcs Manager)	
Covid 19 Prevention Program	

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

Policy: COVID-19 Prevention Program (CPP) for Kaweah Health

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Procedure: This CPP is designed to control exposures to the SARS-CoV-2 virus that may occur in our workplace.

Authority and Responsibility

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Employee Health Services has overall authority and responsibility for implementing the provisions of this CPP in our workplace. In addition, all managers and supervisors are responsible for implementing and maintaining the CPP in their assigned work areas and for ensuring employees receive answers to questions about the program in a language they understand.

All employees are responsible for using safe work practices, following all directives, policies and procedures, and assisting in maintaining a safe work environment.

Identification and Evaluation of COVID-19 Hazards

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We will implement the following in our workplace:

- Conduct workplace-specific evaluations using the **Appendix A: Identification of COVID-19 Hazards** form as needed.
- Evaluate employees' potential workplace exposures to all persons at, or who may enter, our workplace.
- Review applicable orders and general and industry-specific guidance from the State of California, Cal/OSHA, and the local health department related to COVID-19 hazards and prevention.
- Evaluate existing COVID-19 prevention controls in our workplace and the need for different or additional controls.
- Conduct periodic inspections using the **Appendix B: COVID-19 Inspections form** as needed to identify unhealthy conditions, work practices, and work procedures related to COVID-19 and to ensure compliance with our COVID-19 policies and procedures.

Employee participation

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Employees are encouraged to participate in the identification and evaluation of COVID-19 hazards by: Bringing concerns forwards through scheduled safety meetings.

Employee screening

Deleted: We screen our employees directly when they come to work according to CDPH guidelines by taking temperature with non-contact thermometer, and symptom questionnaire. We ensure that face coverings are used during screening by both screeners and employees if they are not fully vaccinated.

Employees self-screen prior to coming to work. If symptomatic, employee will stay home and call manager to inform them they are sick. If the employee needs to get tested for covid-19 they will call employee health services

to schedule covid-19 test. If employee health services is closed, employee can go to urgent care or testing location of their preference and call and update employee health services on the next business day.

Correction of COVID-19 Hazards

Unsafe or unhealthy work conditions, practices or procedures will be documented on the **Appendix B: COVID-19 Inspections** form, and corrected in a timely manner based on the severity of the hazards, as follows: The severity of the hazard will be assessed and correction time frames assigned, accordingly. Individual employees may identify and immediately correct hazards. If a hazard requires assistance, for example, maintenance, the employee will be responsible for notifying the leader. The leader will reassess the hazard to ensure its correction within a timely manner.

Control of COVID-19 Hazards

Face Coverings

Employees will be provided face coverings and required to wear them when required by a CDPH regulation or order. This includes spaces within vehicles when a CDPH regulation or order requires face coverings indoors. Face coverings will be clean, undamaged, and worn over the nose and mouth. Face shields are not a replacements for face coverings, although they can be worn together for additional protection.

The following are exceptions to the use of face coverings in our workplace when required by CDPH regulation or order:

1. When an employee is alone in a room or vehicle.
2. While eating or drinking at the workplace, provided employees are at least six feet apart and, if indoors, the supply of outside or filtered air has been maximized to the extent feasible.
3. While employees are wearing respirators required by the employer and used in compliance with CCR, Title 8 section 5144.
4. Employees who cannot wear face coverings due to a medical or mental health condition or disability, or who are hearing-impaired or communicating with a hearing-impaired person. Such employees shall wear an effective non-restrictive alternative, such as a face shield with a drape on the bottom, if the condition or disability permits it. Alternatives will be considered on a case-by-case basis.
5. During specific tasks which cannot feasibly be performed with a face covering. This exception is limited to the time period in which such tasks are actually being performed.

If an employee is not wearing a face covering due to exceptions (4) and (5), above, the COVID-19 hazards will be assessed, and action taken as necessary. Employees will not be prevented from wearing a face covering, including a respirator, when not required by this section, unless it creates a safety hazard.

When face coverings are not required by this section or by sections 3205.1 through 3205.4, employers shall provide face coverings to employees upon request, regardless of vaccination status
Engineering controls
We maximize the amount of outside air to the extent feasible, unless there is poor outside air quality (an Air Quality index of 100 or higher for any pollutant) or some other hazard to employees such as excessive heat or cold. It is Kaweah Health Medical Center's policy to test the following spaces for air exchange rates and pressure differentials on a semi-annual basis. Testing will be completed by a qualified professional. All spaces that do not meet the testing minimum requirements will be repaired and re-tested as soon as possible. See EOC Policy 1046 Air Pressure Relationship Testing. Newly converted negative pressure rooms are checked daily for negative air pressure per Policy IP 1.30 Tuberculosis Control Plan.

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Cleaning and disinfecting

We implement the following cleaning and disinfection measures for frequently touched surfaces:

We identify and regularly clean frequently touched surfaces and objects, such as doorknobs, elevator buttons, equipment, tools, handrails, handles, controls, phones, headsets, bathroom surfaces, and steering wheels.

COVID-19 cleaning protocols will be implemented according to specified procedure by Environmental Services staff. Environmental Services Supervisor/designee will routinely conduct inspections. See Policy Covid 03 Covid Cleaning Protocols.

Should we have a COVID-19 case in our workplace, we will implement the following procedures: For staff members assigned to non patient care areas, EVS Supervisor will provide staff with pertinent work order and/or details relative to COVID -19 cleaning needs as requested. See Policy Covid 03.

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Shared tools, equipment and personal protective equipment (PPE)

PPE must not be shared, e.g., gloves, goggles and face shields. See Policy Covid 13 Covid PPE : Reuse and Storage.

Hand sanitizing

We implement effective hand sanitizing procedures by:

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- Evaluating handwashing facilities.
- Determining the need for additional facilities.
- Encouraging and allowing time for employee handwashing.
- Providing employees with an effective hand sanitizer, and prohibit hand sanitizers that contain methanol (i.e. methyl alcohol).
- Encouraging employees to wash their hands for at least 20 seconds each time.

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Personal protective equipment (PPE) used to control employees' exposure to COVID-19

We evaluate the need for PPE, including but not limited to gloves, eye protection and respiratory protection as required by CAL/OSHA standards (as required by CCR Title 8, section 3380, and provide such PPE as needed).

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Upon request, employees are provided respirators for voluntary use in compliance with subsection 5144(c)(2) to all employees who are working indoors or in vehicles with more than one person. Whenever an employer makes respirators for voluntary use available, under this section or sections 3205.1 through 3205.4, the employer shall encourage their use and shall ensure that employees are provided with a respirator of the correct size.

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We provide and ensure use of eye protection and respiratory protection in accordance with section 5144 when employees are exposed to procedures that may aerosolize potentially infectious material such as saliva or respiratory tract fluids.

Investigating and Responding to COVID-19 Cases

In lieu of using Appendix C from the Covid-19 Prevention Plan Model, we will use Infection Prevention's Outbreak Investigation form in Policy IP 1.11 Outbreak Investigation Plan to investigate and respond to Covid-19 cases.

Employees who had potential COVID-19 exposure in our workplace will be:

- Offered COVID-19 testing at no cost during their working hours.
- The information on benefits described in Training and Instruction, and Exclusion of COVID-19 Cases, below, will be provided to them via Policy Tech.

System for Communicating

Our goal is to ensure that we have effective two-way communication with our employees, in a form they can readily understand, and that it includes the following information:

- How employees should report COVID-19 symptoms and possible hazards to, and how: Report to Employee Health Services by calling the covid line at 559-624-2458.
- That employees can report symptoms and hazards without fear of reprisal.
- Our procedures or policies for accommodating employees with medical or other conditions that put them at increased risk of severe COVID-19 illness.
- Where testing is not required, how employees can access COVID-19 testing
- In the event we are required to provide testing because of a workplace exposure or outbreak, we will communicate the plan for providing testing and inform affected employees of the reason for the testing and the possible consequences of a positive test. Employee Health Services will call and notify Employees of their need to be tested, and schedule them, or provide details to self schedule. See Policy Covid 30 Covid Testing Workflow Clinics.
- Information about COVID-19 hazards employees (including other employers and individuals in contact with our workplace) may be exposed to, what is being done to control those hazards, and our COVID-19 policies and procedures.

Training and Instruction

We will provide effective training and instruction that includes:

- Our COVID-19 policies and procedures to protect employees from COVID-19 hazards.
- Information regarding COVID-19-related benefits to which the employee may be entitled under applicable federal, state, or local laws. Updates will be sent via district email and intranet site.
- The fact that:
  - COVID-19 is an infectious disease that can be spread through the air.
  - COVID-19 may be transmitted when a person touches a contaminated object and then touches their eyes, nose, or mouth.
  - An infectious person may have no symptoms.
- The fact that particles containing the virus can travel more than six feet, especially indoors, so physical distancing must be combined with other controls, including face coverings and hand hygiene, to be effective.
- The importance of frequent hand washing with soap and water for at least 20 seconds and using hand sanitizer when employees do not have immediate access to a sink or hand washing facility, and that hand sanitizer does not work if the hands are soiled.
- Proper use of face coverings and the fact that face coverings are not respiratory protective equipment - face coverings are intended to primarily protect other individuals from the wearer of the face covering.
- COVID-19 symptoms, and the importance of obtaining a COVID-19 test and not coming to work if the employee has COVID-19 symptoms.
- This training will be done through Kaweah Health's Net Learning Online training program. Roster of trained employees can be obtained through Net Learning.

Exclusion of COVID-19 Cases

Where we have a COVID-19 case in our workplace, we will limit transmission by:

- Ensuring that COVID-19 cases are excluded from the workplace until our return-to-work requirements are met.
- Continuing and maintaining an employee's earnings, seniority, and all other employee rights and

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benefits whenever we've demonstrated that the COVID-19 exposure is work related. This will be accomplished by employer-provided employee sick leave benefits, payments from public sources or other means of maintaining earnings, rights and benefits, where permitted by law and when not covered by workers' compensation.
- Providing employees at the time of exclusion with information on available benefits.

Reporting, Recordkeeping, and Access

It is our policy to:

- Report information about COVID-19 cases at our workplace to the local health department when required by law, and provide any related information requested by the local health department.
- Maintain records of the steps taken to implement our written COVID-19 Prevention Program in accordance with CCR Title 8 section 3203(b).
- Make our written COVID-19 Prevention Program available at the workplace to employees, authorized employee representatives, and to representatives of Cal/OSHA immediately upon request.
  - In lieu of using CPP Model's Appendix C form to keep a record of and track all COVID-19 cases, Kaweah Health will use the Outbreak Investigation form in Policy IP 1.11 Outbreak Investigation Plan.
  - Notification will be sent via email to employees, leaders, and vendors within 24 hours when exposures have been identified.

Return-to-Work Criteria

- Follow the most recent CDPH guidelines defined by Kaweah Health. Refer to most updated Kaweah Health flyer "Restrictions for Individuals with COVID-19 Infection of Exposure" for details.

Dianne Cox, VP, Human Resources

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

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<#>At least 24 hours have passed since a fever of 100.4 or higher has resolved without the use of fever-reducing medications.¶
<#>COVID-19 symptoms have improved.¶
<#>At least 10 days have passed since COVID-19 symptoms first appeared.¶
<#>COVID-19 cases who tested positive but never developed COVID-19 symptoms will not return to work until a minimum of 10 days have passed since the date of specimen collection of their first positive COVID-19 test.¶
<#>A negative COVID-19 test will not be required for an employee to return to work.¶
<#>If an order to isolate or quarantine an employee is issued by a local or state health official, the employee will not return to work until the period of isolation or quarantine is completed or the order is lifted. If no period was specified, then the period will be 10 days from the time the order to isolate was effective, or 14 days from the time the order to quarantine was effective.

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Appendix A: Identification of COVID-19 Hazards

All persons, regardless of symptoms or negative COVID-19 test results, will be considered potentially infectious. Particular attention will be paid to areas where people may congregate or come in contact with one another, regardless of whether employees are performing an assigned work task or not. For example: meetings, entrances, bathrooms, hallways, aisles, walkways, elevators, break or eating areas, cool-down areas, and waiting areas.

Evaluation of potential workplace exposure will be to all persons at the workplace or who may enter the workplace, including coworkers, employees of other entities, members of the public, customers or clients, and independent contractors. We will consider how employees and other persons enter, leave, and travel through the workplace, in addition to addressing fixed work locations.

Person conducting the evaluation:

Date:

Interaction, area, activity, work task, process, equipment and material that potentially exposes employees to COVID-19 hazards	**Places and times**	**Potential for COVID-19 exposures and employees affected, including members of the public and employees of other employers**	**Existing and/or additional COVID-19 prevention controls, including barriers, partitions and ventilation**

Appendix B: COVID-19 Inspections

Date:

Name of person conducting the inspection:

Work location evaluated:

Exposure Controls	Status	Person Assigned to Correct	Date Corrected
Engineering			
Barriers/partitions			
Ventilation (amount of fresh air and filtration maximized)			
Additional room air filtration			
Administrative			
Physical distancing			
Surface cleaning and disinfection (frequently enough and adequate supplies)			
Hand washing facilities (adequate numbers and supplies)			
Disinfecting and hand sanitizing solutions being used according to manufacturer instructions			
PPE (not shared, available and being worn)			
Face coverings (cleaned sufficiently often)			
Gloves			
Face shields/goggles			
Respiratory protection			

Kaweah Delta Health Care District

Employee Health

Policy Number: EHS 17	**Date Created: 02/05/2021**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: 07/19/2021**
Approvers: Dianne Cox (Chief Human Resources Officer)	
Aerosol Transmissible Diseases Exposure Control Plan	

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

ATD Exposure Control Plan for Kaweah Delta Health Care District

Date Created: 2/5/21
Date of Last Review: 2/5/21
Our ATD Exposure Control Plan contains the following sections:

Contents

Definitions

An aerosol transmissible disease (ATD) is a disease that is transmitted either by inhalation of infectious particles/droplets or direct contact of the particles/droplets with mucous membranes in the respiratory tract or eyes. Our employees have occupational exposure to ATDs in the course of conducting their job duties, whether at the work facility or offsite. In accordance with California Code of Regulations, title 8, section 5199, Aerosol Transmissible Diseases, we have implemented this written exposure control plan to reduce our employees' risk of contracting these infections and so that we may respond in an appropriate and timely manner when exposure incidents occur.

An AirID is the abbreviation for Airborne Infectious Disease.

An AIIR is the abbreviation for Airborne Infection Isolation Room.

PAPR is the abbreviation for a Powered Airway Purifying Respirator.

HEPA is the abbreviation for a high-efficiency particulate air filter.

PLHCP is the abbreviation for Physician or Licensed Health Care Provider.

RATD is the abbreviation for a reportable aerosol transmissible disease.

ATP-L is the abbreviation for an aerosol transmissible pathogen – laboratory.

Scope

This policy is both comprehensive and inclusive as it applies to all Kaweah Delta Healthcare District facilities and services to include, offsite facilities such as long-term, subacute/short-stay care, acute rehabilitation services, outpatient dialysis, mental health, rural health, and specialty clinic settings in addition to the acute care facility.

Designation of Responsibility

Employers are required to designate one person to have overall responsibility to administer this plan. We have ensured that this person is knowledgeable in infection control principles and practice as they apply to our facility, service, and operation.

The administrator of our ATD Exposure Control Plan is Employee Health Services.

Responsibilities

A. Employee Health

1. Assist in review of the Aerosol Transmissible Disease (ATDs) Exposure Plan and revise as necessary.
2. Ensure policy congruence between supporting Employee Health Policies and ATD Exposure Plan.
3. Conduct the monitoring, tracking, and documentation for TB testing program. Conduct the monitoring, tracking, and documentation for Aerosol Transmissible Disease vaccinations for susceptible healthcare workers.
4. Coordinate the post-exposure follow-up with Infection Prevention. Report results of post-exposure TB testing to Infection Prevention and the Infection Prevention Committee.
5. Assist with the development of the educational program for employees and staff.
6. Medical evaluation of all employees required to wear a respirator will occur by medical questionnaire and evaluation at New Hire Physical evaluation and annually after that with annual fit testing.
7. Direct the respiratory protection education and fit-testing program for hospital employees. Fit testing will occur at New Hire Physical evaluation, and every calendar year following that for all employees who come into contact with patients in isolation rooms. Fit testing of tight fitting respirators involves a medical questionnaire, and testing of respirator with a qualitative fit test method.
8. Qualitative fit testing is a pass/fail test method that uses your sense of taste or smell, or your reaction to an irritant in order to detect leakage into the respirator face piece. Whether the respirator passes or fails the test is based simply on you detecting leakage of the test substance into your face piece.
9. Procedure for proper use of respirators in routine and reasonably foreseeable emergency situations, including but not limited to N95's and PAPR's, will be taught, demonstrated, and documented at New Hire Physical evaluation, and every calendar year with fit testing.
10. Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance, will occur at New Hire Physical evaluation and yearly. Training will also occur at Employee Health Services at any time an Employee is newly required to use a respirator.

11. Employee Health will use Agility/Net Health to manage recordkeeping and documentation of Respiratory Fit Testing for our employees.

B. Infection Prevention

1. Ensure policy congruence between supporting Infection Prevention Policies and ATD Exposure Control Plan.
2. Monitor departmental compliance with the TB Control Plan and ATD Exposure Control Plan.
3. Direct the TB education program for hospital employees and staff.
4. Initiate post-exposure reporting notification system and assist Employee Health with follow-up as necessary.
5. Report TB and reportable ATD to the local health department
6. Procedures for selecting respirator use, in conjunction with Employee Health Services.

C. Department Directors:

1. Ensure full compliance with the provisions of the ATD Exposure Control Plan.
2. Facilitate the required training for all employees and staff.
3. Compile and forward the post exposure list to Infection Prevention and Employee Health.
4. As part of our annual review process to update this ATD Exposure Control Plan, Department Directors will obtain the active involvement of their employees. Active involvement means more than merely having a form available that employees can fill out at their leisure. Directors, Managers, and Supervisors will actively ask employees for input in staff meetings, solicit input during unit safety huddles, and include employees on the committee to annually review and update the plan.
5. Ensure employee exposure notification and follow-up is completed in a timely manner.
6. Ensure cooperation of TB testing and respiratory health survey of all employees as scheduled.

D. Employees:

1. Comply with all elements of the ATD Exposure Control Plan, including the wearing of appropriate respirators and personal protective equipment (PPE).
2. Perform work practices and procedures in accordance with the ATD Exposure Control Plan.
3. Report all exposures, or suspected exposures, to your Supervisor or Manager, Infection Prevention and Employee Health.

E. Facilities Management:

1. Provide guidance for the use of engineering controls; for example, negative airflow, room exhaust to outside vent and air exchanges per hour, and portable HEPA filters.
2. Clinical Engineering will PM Powered Air Purifying Respirator (PAPRs) yearly.
3. Daily monitor negative airflow room used for ATD isolation.
   a. Monitoring of negative pressure rooms is maintained via electronic and manual processes.
   b. Nursing staff notifies Facilities Management after first checking door and anteroom and alarm does not reset.

F. Respiratory Department:

1. Ensure that Powered Air Purifying Respirator (P.A.P.R.) is made available to employees/staff that perform high-risk procedures or cannot be fitted with an N95 respirator. P.A.P.R's are located on various units throughout the hospital. Respiratory Therapy is aware of these locations. Call Respiratory Therapy to request from closest unit. Directions for use are inside P.A.P.R bags.
2. RT is responsible for procedure and schedule for cleaning, disinfecting, storing, repairing, and otherwise maintaining PAPR's. If PAPR's are loaned out to specific unit, they will be provided with a log in which to record the following: Date/ Time, Unit, Employee name, disinfection date, inspection of PAPR, and return date.

List of All Job Classifications in Which Employees Have Occupational Exposure

Employees are considered to have occupational exposure to aerosol transmissible diseases if their work activity or work conditions are reasonably anticipated to present an elevated risk of contracting these diseases without protective measures in place. "Elevated" means higher than what is considered ordinary for other employees who have direct contact with the general public in occupations that are not covered under the scope of this standard, such as bus drivers and retail employees.

We have conducted a risk assessment and determined that employees in the following job classifications have occupational exposure to aerosol transmissible disease while performing their job duties:

Jobcode Description
7040018 Aide
7010171 Anesthesia Tech

3000640 Assistant Nurse Manager
7011389 ASW/AMFT
7061586 Biomedical Technician I
7010384 Biomedical Technician II
7011511 Cardiac Sonographer-Registered
7011516 Cardiac Sonographer-Unreg
4001335 Case Management Supervisor
7010365 Cath Lab Tech
7010178 Certified Hemodialysis Tech
7040459 Certified Nursing Assistant
7011005 Chaplain
6021615 Charge Nurse
7010193 Clinical UR Specialist
7010321 CT Technologist
7010892 Diabetes Educator
7061545 Dialysis Equipment Technician
2000305 DON-Rehab and Skilled Nursing
7060543 Driver/Cust Sv Rep/Gurney Tran
7041276 ED Tech I
7040734 ED Tech II
4001929 ED Tech Supervisor
7010329 EEG Tech
7011431 EEG Tech- Registered
7061290 Environmental Services Aide
3001250 Environmental Services Manager
4000208 Environmental Svcs Supervisor
7061920 EVS Floor Tech
7061919 EVS-Operating Room
3001261 Facilities Manager
2001539 Director of GME
3001812 GME Manager
7011499 GME Program Coordinator
7091587 GME Resident
7011472 Health Educator
7010841 Health Promotion Instructor
7040033 Home Health Aide
7061057 Homemaker
4000293 House Supervisor
4001369 Imaging Office Supervisor
7011902 Imaging Procedure Coordinator
7041784 Imaging Services Aide
3001063 Imaging Services Manager
4001837 Imaging Services Supervisor
7041845 Imaging Services Tech Asst
7011234 Imaging Specialist
7011233 Imaging Tech-In Patient

7010333 Imaging Technologist
5041664 Imaging Transport Coordinator
3001600 Infection Prevention Manager
7051171 Interpreter
7051909 Interpreter II
3001308 Interpreter Services Manager
7051210 Interpreter Services Rep
4001943 KDMF Maintenance Supervisor
7011714 KDMF Sleep Lab Coordinator
7041314 Lab Aide I
7040571 Lab Aide II
3000588 Lab Manager
4001904 Lab Supervisor
7011907 Lab Support Services Educator
3001908 Lab Support Services Manager
7011841 Laboratory Technician
7010258 LCSW/LMFT
6010217 Lead Dialysis Equipment Tech
6010323 Lead Ultrasound Tech
7010750 Licensed Psych Tech
7030206 Licensed Vocational Nurse
7011585 Life Safety Coordinator
7031780 LVN Care Coordinator
7031515 LVN/CHT
4001648 LVN-Clinical Supervisor
7011631 LVN-Discharge Advocate
7061608 Maintenance I (driving)
7060155 Maintenance II
7061399 Maintenance II (d)
7061400 Maintenance III (d)
6061552 Maintenance Lead
7011232 Mammography Specialist
7041037 Medical Assistant
7041967 Medical Assistant II
7010241 Medical Social Worker
7041001 Mental Health Worker
7011781 MRI Safety Officer
7010390 MRI Technologist
7051118 Newborn Tech
7061486 NICU Nutrition Associate
3001033 Non-Invasive Cardiology Mgr
7010382 Nuclear Med Tech
3000886 Nurse Manager
7081783 Nurse Pract/Physician Asst-SIH
3001833 Nurse Practitioner Manager
7081924 Nurse Practitioner-Clinic Lead

7080861 Nurse Practitioner-Clinics
7020336 Nurse-Interim Permittee
7041993 Nursing Assistant
7010359 Occupational Therapist
7010399 Occupational Therapist II
7011418 Occupational Therapist II (d)
7010400 Occupational Therapist III
7011430 Occupational Therapist III (d)
3000663 OP Pharmacy Manager
7051998 OP Registration/Cust Svc Rep
3001869 Palliative Care Manager
3000910 Patient & Family Services Mgr
7050992 Patient Access Specialist
4001581 Patient Access Supervisor
7050117 Patient Account Specialist
7011755 Patient Care Pharmacy Tech
7041782 Patient Transport Aide
7040428 Personal Care Aide
7010360 Pharmacist-Clinical
3001983 Pharmacy Business Manager
7011927 Pharmacy Charge Integrity Tech
5011626 Pharmacy Coordinator
7091627 Pharmacy Resident
7040574 Phlebotomist I
7040589 Phlebotomist II
7010392 Physical Therapist
7010391 Physical Therapist II
7010387 Physical Therapist III
7010373 Physical Therapy Assistant
7011818 Physical Therapy Assistant II
7011819 Physical Therapy Assistant III
7081461 Physician Assistant
5050880 Physician/Clinic Office Coord
7010394 Polysomno Technologist-Reg
3001867 Psych Assessment Team Manager
7011363 PT Assistant- Lic Applicant
7010494 Recreation Therapist
7011407 Recreation Therapist (driving)
5011115 Recreation Therapy Coordinator
7020339 Registered Nurse
7021884 Registered Nurse (d)
7040166 Rehab Aide
7041414 Rehab Aide (driving)
3000846 Respiratory Care Manager
7010370 Respiratory Therapist
7010381 Respiratory Therapist-Reg

7021800 RN-Acute Wound Care Nurse II
7021801 RN-Acute Wound Care Nurse III
7011388 RN-Advanced Practice Nurse
7021921 RN-Cardiac First Assistant
7010608 RN-Case Manager
7010727 RN-Clinical Educator
7011240 RN-Clinical Educator with ACLS
7010702 RN-Employee Health Nurse
7011174 RN-Field Infection Prevention
7021082 RN-First Assistant
7011247 RN-Intake/Utilization
6021865 RN-Lead Mentor
7011439 RN-NICU Care Coordinator
7010346 RN-Nurse Liaison
7081541 RN-Nurse Practitioner
7021798 RN-PICC Procedure Nurse II
7021799 RN-PICC Procedure Nurse III
7021852 RN-Rapid Response Nurse
3001855 Safety Officer/Life Safety Mgr
7011880 Safety Specialist
7061333 Security Officer
6061542 Security Officer Lead
3001332 Security Services Manager
4001435 Security Services Supervisor
3000327 Sleep/Neurodiagnostics Manager
7051195 Social Work Assistant
7010242 Social Worker-Nephrology
7090170 SP Tech Certified
6090176 SP Tech Certified Lead
7090164 SP Tech I Non-Certified
7091571 SP Tech II Non-Certified
7011359 Speech Path- Temporary RPE Lic
7010377 Speech Pathologist
7011071 Speech Pathologist II
7011288 Speech Pathologist III
7090034 Student Nurse Aide
7090177 Student Nurse Intern
7040568 Surgical Team Assistant
7010189 Surgical Tech
3000361 Therapy Manager
4001656 Therapy Supervisor
7060965 Transport Driver
7010467 Ultrasound Tech-Registered
7051411 Unit Sec/ CNA- Skilled Nursing

List of All High Hazard Procedures

High hazard procedures are procedures performed on an ATD case or suspected case where the potential for being exposed to an aerosol transmissible pathogen (ATP) is increased due to the reasonably anticipated generation of aerosolized pathogens. A procedure is also considered high hazard if generation of aerosolized pathogens is reasonably anticipated when performed on a laboratory specimen suspected of containing an aerosol transmissible pathogen-laboratory (ATP-L).

We have analyzed the job tasks that our employees perform and determined which are high hazard procedures. We have entered them in the list below.

Sputum induction
Bronchoscopy
Aerosolized administration of medications, and BiPAP
Pulmonary function testing
Autopsy, clinical, surgical, and laboratory procedures that may aerosolize pathogens

We have also determined the job classifications and operations in which employees are exposed to those high hazard procedures and entered them in the list below:

Jobcode Description
7040018 Aide
7010171 Anesthesia Tech
3000640 Assistant Nurse Manager
7011511 Cardiac Sonographer-Registered
7011516 Cardiac Sonographer-Unreg
7010365 Cath Lab Tech
7040459 Certified Nursing Assistant
6021615 Charge Nurse
7010321 CT Technologist
7060543 Driver/Cust Sv Rep/Gurney Tran
3001812 GME Manager
7011499 GME Program Coordinator
7091587 GME Resident
4000293 House Supervisor
7041784 Imaging Services Aide
3001063 Imaging Services Manager
4001837 Imaging Services Supervisor
7041845 Imaging Services Tech Asst
7011234 Imaging Specialist
7011233 Imaging Tech-In Patient
7010333 Imaging Technologist

7011841 Laboratory Technician
7010382 Nuclear Med Tech
3000886 Nurse Manager
7081783 Nurse Pract/Physician Asst-SIH
7081924 Nurse Practitioner-Clinic Lead
7080861 Nurse Practitioner-Clinics
7020336 Nurse-Interim Permittee
7041782 Patient Transport Aide
7010360 Pharmacist-Clinical
7040574 Phlebotomist I
7040589 Phlebotomist II
7081461 Physician Assistant
7010394 Polysomno Technologist-Reg
7020339 Registered Nurse
7021884 Registered Nurse (d)
3000846 Respiratory Care Manager
7010370 Respiratory Therapist
7010381 Respiratory Therapist-Reg
7021800 RN-Acute Wound Care Nurse II
7021801 RN-Acute Wound Care Nurse III
7011388 RN-Advanced Practice Nurse
7021921 RN-Cardiac First Assistant
7011240 RN-Clinical Educator with ACLS
7011174 RN-Field Infection Prevention
7021082 RN-First Assistant
7010346 RN-Nurse Liaison
7081541 RN-Nurse Practitioner
7021798 RN-PICC Procedure Nurse II
7021799 RN-PICC Procedure Nurse III
7021852 RN-Rapid Response Nurse
7090170 SP Tech Certified
6090176 SP Tech Certified Lead
7090164 SP Tech I Non-Certified
7091571 SP Tech II Non-Certified
7040568 Surgical Team Assistant
7010189 Surgical Tech
7010467 Ultrasound Tech-Registered

List of All Assignments or Tasks Requiring Personal or Respiratory Protection

We use feasible engineering controls and work practice controls to reduce employee exposure to aerosol transmissible pathogens. However, when those controls are not sufficient, we are also required to provide personal protection or respiratory protection to the employees performing those

tasks. In some cases, the minimum requirement of an N95 respirator is sufficient, but in other cases, higher-level protection is required, such as a powered air-purifying respirator (PAPR).

We require employees to wear personal or respiratory protection when conducting certain assignments or tasks, as listed in the following table:

Assignment or Task	**Personal Protection required (*list type[s]*)**	**Respiratory Protection required (*list type*)**
Routine patient care and support operations	Gloves, gown, mask	At least N95
High hazard procedures (see list above)	Gloves, gown, mask - N95 / PAPR	N95 / PAPR

Methods of Implementation

In this section, we describe our methods of implementing requirements for engineering and work practice controls, PPE, respiratory protection, medical services, training, and recordkeeping. The table at the end of this section, under the Summary of Control Measures subheading, lists specific control measures for each operation or work area in which occupational exposure occurs.

Engineering and Work Practice Controls and PPE

The best method to control employee exposure to aerosol transmissible pathogens is to use engineering controls and work practice controls. If those do not provide sufficient protection, then we are required to provide personal protective equipment (PPE) and/or respiratory protection and ensure that employees use them. For some tasks, use of both respiratory protection and engineering or work practice controls is required by the ATD standard.

Work practices will be implemented in accordance with Appendix A of section 5199, which categorizes pathogens as requiring either airborne or droplet precautions. Where Appendix A does not address the exposure, we will use protections in accordance with the CDC Guideline for Isolation Precautions for droplet and contact precautions. For airborne precautions, our procedures will be in accordance with the CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings.

(See Infection Control Policies IP 1.1 Standard and Transmission-Based Precautions; IP.TBP 2014 A Transmission Based Precautions Table 2014; IP 1.30 Tuberculosis Control Plan)

Where neither of these sources addresses the exposure or where special cases arise, we use the current recommendations of the CDC, the California Department of Public Health, and Cal/OSHA.

We use the following types of engineering and work practice controls to protect our employees from ATD exposures: Refer to Policy EOC 1046 Air Pressure Relationship Testing; Policy M100135 Biosafety Cabinet.
When working with an AirID or suspected AirID case, our employees will wear proper personal protective equipment, including the following: disposable gowns, N95 disposable respirators, PAPRs, disposable gloves.

Surfaces may become contaminated with ATPs after contact with individuals with AirID. Contaminated surfaces enable the spread of infectious disease agents and can be a source of infection to employees until they are cleaned and disinfected. We ensure that employees use appropriate EPA-registered disinfectant(s) to clean and disinfect the following surfaces, vehicles, and equipment as soon as feasible after contact with infectious persons and during scheduled cleaning activities in accordance with hospital policy EOC 1019 Equipment Cleaning and Low/Intermediate Level Disinfection.

At our facility, we use negative pressure airborne infection isolation rooms or areas (AIIRs) to isolate airborne infectious disease (AirID) patients from staff and other patients.

If our AIIRs are not available to accommodate a transfer, we will follow our procedures to transfer AirID cases and suspected cases to an AIIR at another facility. The procedures are described in detail in the "Referral and Transfer of AirID Cases" section of this program.

The location(s) of our airborne infection isolation rooms are:

NEGATIVE PRESSURE PATIENT ROOMS: 12 exchanges per hour	
Mineral King Intensive Care Unit Room #1	Mineral King 3E Room #9 (Peds)
Mineral King Intensive Care Unit Room #18	Broderick Pavilion 3E Room #17
Mineral King 3E Room #5 (Peds)	Acequia Wing Mother Baby Room #1357
Mineral King 3E Room #6 (Peds)	Acequia Wing 4T Room #1417
Mental Health Room #24	3 West Room #1
ED Zone 5 Room #50	Acequia Wing NICU Room #6
ED Zone 5 Room #51	Acequia Wing NICU Room #7
Acequia Wing CV ICCU Room #1517	Acequia Wing NICU Room # 17
Acequia Wing Cardiovascular Intensive Care Unit Room #1306	

All high hazard procedures performed on a confirmed or suspected AirID case are conducted in airborne infection isolation rooms or areas.

Deleted:

NEGATIVE PRESSI
Mineral King Intensive Care Unit Room #1
Mineral King Intensive Care Unit Room #18
Mineral King 3E Room #5 (Peds)
Mineral King 3E Room #6 (Peds)
Mental Health Room #24
Acequia Wing Ca

Deleted: AW 5th Floor Room- 1517¶
AW 6th Floor Room ¶
NICU Rooms 6, 7 &17¶

Deleted: ¶

During high hazard procedures, employees may also need to use respiratory protection. See the "Respiratory Protection" section below for details.

Airborne infection isolation rooms must be kept at a negative pressure (at least -0.01"H_2O) to prevent pathogens from escaping to the adjacent hallway or other rooms. The ventilation rate will be 12 air changes per hour (ACH).

AIIRs actually exhaust and resupply the room air 12 times per hour to maintain the required 12 ACH.

In the event that an AIIR is not available, alternative measures to enhance removal of pathogenic particles will be deployed using the following actions:

- Portable ventilation unit with HEPA filtration with room modifications to provide exhaust outdoors
- Portable ventilation unit with HEPA filtration (no exhaust) room door closed
- Reposition outdoor air dampers (increase outdoor inflow and outflow)

We also use other local exhaust control measures for certain procedures:

- Using outside tents for screening of patients with potential ATD

During the time that an AIIR is used for airborne infection isolation, its doors and windows will be kept closed except when the doors are opened for entering and exiting the room and when windows provide some of the ventilation to achieve the required level of negative pressure.

During the time that an AIIR is being used for isolation of an AirID patient, we perform daily visual checks of the airflow using smoke tubes or other equally effective method to ensure that the room is under negative pressure. To accomplish this, we use the following procedure:

Designated staff (i.e. Registered Nurse and/or Maintenance personnel will perform a "tissue test" to physically verify negative airflow is function properly at startup of precautions and every 24 hours while in active use with a patient in Airborne Precautions.

Maintenance personnel perform these visual checks monthly when the AIIR is not being used for airborne infection isolation.

Maintenance personnel perform inspection and maintenance on our airborne infection isolation rooms. This includes monitoring the performance of the

system, including exhaust, recirculation filter loading, and leakage. This is performed at least annually, whenever filters are changed, and more often if necessary to maintain effectiveness.

If any problems are found, we will ensure that they are corrected in a reasonable period-of-time. If the problem(s) prevent the room from providing effective airborne infection isolation, then we will not use the room for that purpose until the condition is corrected.

If HEPA filters are used, we change the filters after each use. Units are cleaned and new filters are installed.

We will also ensure that the AIIR and accompanying ductwork are installed in a manner consistent with requirements so that the equipment run properly and the air exhausts properly, away from people and HVAC air intakes, so we do not inadvertently expose more people to contaminants.

When an AirID case or suspected case vacates an AII room or area, we will ensure that the AIIR is ventilated for the minimum amount of time required for 99.9% of potential airborne contaminants to be exhausted or filtered from the air prior to allowing anyone to enter without respiratory protection. The minimum timeframes are listed in Table 1 of the CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. At 12 air changes per hour, this requires running the ventilation system with no one in the room for a minimum of 35 minutes. Our policy is to ventilate the AIIR for 60 minutes.

We have employees who work in field operations or in settings where home health care or home-based hospice care is provided. In these settings, we are not required to place AirID cases or suspected cases in an AIIR. Instead, we have our employees working in these settings use the following engineering or work practice controls and/or respiratory protection:

- Use an N95 respirator that has been fit-tested to the employee.
- Social distancing when making a visit to the home.
- Opening windows in the home when weather allows and when it doesn't exacerbate the patient's condition.
- Switching on available fans in the home to improve air circulation.
- Allowing outside light into the home, external UV light from the Sun helps to inactivate/kill pathogenic microorganisms.

Respiratory Protection

When our employees must wear respiratory protection to guard against aerosol transmissible pathogens, we will ensure that they only use NIOSH-certified respirators that are approved for that purpose. We will also implement our written Respiratory Protection Program that meets the requirements of title 8 CCR 5144, including use, care, storage, and training procedures.

In most situations where respiratory protection is needed, we will ensure that employees use a respirator at least as protective as an N95 filtering facepiece respirator. However, for high hazard procedures (aerosol-generating procedures) performed on AirID cases or suspected cases and high hazard procedures performed on cadavers potentially infected with aerosol transmissible pathogens, we will utilize PAPRs with high-efficiency particulate air (HEPA) filters or equivalent or better unless we determine that this would interfere with the success of the procedure or task.

Any such determinations will be reviewed during our annual ATD exposure control plan review.

Cal/OSHA and the California Department of Public Health encourage health care employers to make N95 respirators available to employees for work in close proximity to patients requiring droplet precautions, though it is not required except in specific cases, such as Ebola. We also stay apprised of current recommendations for specific diseases.

We provide the following type(s) of respirator(s) to our employees for high hazard procedures performed on patients requiring droplet precautions: N95 respirators, PAPRs, gowns, gloves, face shields.

The diseases requiring droplet precautions for which we will use respiratory protection when conducting high hazard procedures include all those disease listed in Appendix A under droplet precautions.

We provide the following type(s) of respirator(s) to our employees for high hazard procedures performed on airborne infectious disease cases or suspected cases: N95’s, PAPRs.

These types of respirators are provided to our employees for high hazard procedures performed on cadavers potentially infected with aerosol transmissible pathogens. Aerosol transmissible pathogens include pathogens for which droplet or airborne precautions are required.

We provide and require our employees to wear respirators at least as effective as N95 filtering facepiece respirators when conducting certain

procedures on or around ATD patients, as required by section 5199. Even when that standard does not require a respirator, such as in the case of high hazard procedures performed on patients requiring droplet precautions, we evaluate each situation, including the pathogens, to determine whether to require respiratory protection. We provide N95 respirators or PAPRs to our employees conducting the non-high hazard tasks where respiratory protection is required by either the ATD standard or by our management.

Procedure	Type(s) of Respiratory Protection Used
Entering AIIR in use for airborne infection isolation	N95 Respirator or PAPR
Being present during the performance of procedures or services for an AirID case or suspected case	N95 Respirator or PAPR
Repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens	N95 Respirator
Working in an area occupied by an AirID case or suspected case	N95 Respirator or PAPR
Decontaminating an area after an AirID case or suspected case has left the area or being present during the decontamination	N95 Respirator
Entering an AIIR while it is being ventilated after an AirID case or suspected case has vacated	N95 Respirator or PAPR
Working in a residence where an AirID case or suspected case is known to be present	N95 Respirator
Being present during the performance of aerosol generating procedures on cadavers that are suspected of, or confirmed as, being infected with aerosol transmissible pathogens	N95 Respirator or PAPR
Transporting an AirID case or suspected case within the facility or in an enclosed vehicle when the patient is not masked	N95 Respirator

Before having our employees use a respirator, we will provide them with a no-cost medical evaluation designed to determine if they are medically capable of wearing a respirator without overburdening them. This will be completed before the employee is fit tested.

Medical Evaluations for Respirator Use

We provide the medical evaluation to our employees by using the Respirator Medical Evaluation Questionnaire in Appendix B.

We will have the medical evaluation questionnaire reviewed by the following physician or other licensed health care provider (PLHCP), medical facility, or department: Employee Health Services

If employees need a follow-up examination based on the questionnaire responses, we send them to the following PLHCP, medical facility, or department: Employee Health Services

We will provide the respirator medical evaluation to our employees by sending them to the following PLHCP, medical facility, or department: Employee Health Services

Fit Tests

We conduct fit testing for employees before they will be required to wear a respirator. An employee's fit test will be performed using the same size, make, model, and style of respirator that the employee would actually wear. The fit test is performed by Employee Health Services.

If done in-house, we will use a qualitative method. If fit testing single use respirators for multiple employees, we will ensure that each employee is fit tested using a new respirator.

We will conduct fit tests for each employee according to the following schedule:

- At the time of initial fitting;
- When a different size, make, model, or style of respirator is used;
- At least annually thereafter (unless a special allowance for extension is approved by CDPH); and
- When the employee reports, or when we, a physician or other licensed health care provider (PLHCP), supervisor, or program administrator makes visual observations of changes in the employee's physical condition that could affect respirator fit, such as facial scarring, dental changes, cosmetic surgery, or obvious change in body weight.

If after passing a fit test, an employee notifies us, the program administrator, supervisor, or PLHCP that the respirator is not acceptable, then we will provide the employee the opportunity to select a different respirator facepiece and to be re-fit tested.

We provide all employees required to wear a respirator with training on the following topics:

- Why the respirator is necessary and how improper fit, usage, or maintenance can compromise the protective effect of the respirator.
- What the limitations and capabilities of the respirator are.
- How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions.
- How to inspect, put on and remove, use, and check the seals of the respirator.
- What the procedures are for maintenance and storage of the respirator.
- How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.
- The general requirements of this section.

This training is provided to employees when they are initially required to wear a respirator and annually thereafter. We will also retrain employees if changes in the workplace or the type of respirator render previous training obsolete or if inadequacies in the employee's knowledge or use of the respirator indicate that the employee has not retained the information or skill.

Medical Services

We provide our employees with medical services in-house, including vaccinations, TB testing, and post-exposure medical services and follow-up. We make these available to the employees at no cost to them. Employees will be sent to this department: Employee Health Services

Details about the medical services related to ATDs that we offer to employees are in the “Medical Services” section of this written plan.

Laboratory Operations

We have employees engaged in laboratory operations that include procedures that may aerosolize aerosol transmissible pathogens-laboratory (ATP-L), as defined in section 5199. For these operations, our methods of implementation for subsection (f) are included in our separate written Bio-

Safety Procedure. We have conducted a risk assessment in accordance with the Biosafety in Microbiological and Biomedical Laboratories (BMBL) and determined that we must use Biosafety Level II.

Training

We provide training to our employees who have occupational exposure to aerosol transmissible diseases according to the following schedule:

- At the time of initial assignment to tasks where occupational exposure may take place;
- At least annually thereafter, not to exceed 12 months from the previous training;
- For employees who have received training on aerosol transmissible diseases in the year preceding the effective date of the standard, only training with respect to the provisions of the standard that were not included previously need to be provided;
- When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.

This training is provided by the following methods:

- Initial employee orientation.
- Live, in-person presentation by Employee Health Services.

Recordkeeping

We keep the following records in accordance with the aerosol transmissible diseases regulation:

Record	Location of Record
Vaccination status of employees including any signed declinations	Employee Health Services
PLHCP written opinions	Employee Health Services
Results of TB assessments	Employee Health Services
Copies of information regarding exposure incidents provided to the PLHCP	Employee Health Services & Infection Prevention
Training records	Employee Health Services
Record of annual review of ATD Exposure Control Plan/Biosafety Plan	Employee Health Services & Clinical Laboratory

Record	Location of Record
Records of exposure incidents (exposure analysis; any determinations of no post-exposure follow-up needed)	Employee Health Services & Infection Prevention
Records of unavailability of vaccines	Employee Health Services & Pharmacy
Records of unavailability of AII rooms or areas	Risk Management (Occurrence Reporting System)
Records of decisions not to transfer a patient to another facility for AII due to medical reasons	Risk Management (Occurrence Reporting System)
Records of inspection, testing, and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems	Facilities Maintenance & Clinical Engineering
Records of the respiratory protection program	Employee Health Services
Determinations that a PAPR would interfere with successful performance of certain high hazard tasks	Employee Health Services

Source Control Measures

Early identification of ATD cases or suspected cases is critical to ensure that employees have as little unprotected contact as possible, thereby reducing the risk of becoming infected. Our procedure for early ATD identification is described in Infection Prevention policy IP 1.30 Tuberculosis Control Plan. Additionally routine surveillance for potential ATPs is performed by the Infection Prevention department and rapidly addressed through deployment of standard and transmission based precautions.

If we observe respiratory infection symptoms in a patient or other person in our care, we will utilize source control measures to protect our employees from contracting the illness while the suspected ATD case is in our facility. These include a combination of engineering controls, such as placing the patient in a separate room or area; procedures, such as providing and having the suspected ATD case wear a surgical mask; and work practice controls, such as limiting contact with the suspected ATD case.

We are a district health care organization with several facilities located throughout Tulare County. We incorporate the recommendations contained in the CDC's Respiratory Hygiene/Cough Etiquette in Health Care Settings. These recommendations are available on the CDC Respiratory Hygiene/Cough Etiquette in Health Care Settings webpage and addressed in Infection Prevention Policy IP 1.1 Standard and Transmission-Based Precautions. The same guidance is used in our Home Health, Private Home Care, and Hospice services to the extent that it is reasonably practicable.

Our employees utilize the following source control measures to prevent spread of aerosol transmissible pathogens. We use visual alerts (*e.g., signs telling people to cover their cough*). We will post a sign requesting that patients and persons accompanying them inform the receptionist if they have a persistent cough. We place the visual alerts at entrances. We ensure that the patient care access staff who may be the first employees to encounter a patient or other person entering the facility, are knowledgeable in observing for signs and symptoms of ATD. Facial tissues are made available in waiting areas with a waste receptacle for disposal of used supplies. Handwashing facilities including soap and water are accessible to patients and visitors, as is alcohol-based hand sanitizer or other antiseptic hand wash in waiting areas.

Individuals exhibiting symptoms of aerosol transmissible disease are provided with a surgical mask or procedure mask and instruction on proper use for wearing the mask.

We separate symptomatic individuals from others by distance in the same room (at least 3 to 6 feet away from others) because our facility does not have a separate room in which to temporarily place the individual(s). We always encourage limiting contact with symptomatic individuals.

Our source control procedures also include the following:

- Social distancing 3 to 6 feet between individuals
- Availability of a surgical/procedure masks and facial tissue to cover the nose and mouth

We inform patients and others who enter our facility of our source control measures using the following signage present on the respiratory etiquette/cough hygiene kiosks and displays.

If a patient who may have a droplet-transmitted disease refuses to or cannot comply with our source control measures, our employees will observe droplet precautions at a minimum, including wearing a surgical mask, if in close contact. We may also encourage staff to wear N95 respirators for which they have been medically evaluated and fit tested.

If a known or suspected AirID case refuses to or cannot comply with our source control measures, our employees will wear N95 respirators for which they have been medically evaluated and fit tested when in an area or residence where the known or suspected AirID case is or has been recently.

We are required to provide information about infectious disease hazards to contractors who provide us with temporary or contract employees who may be reasonably anticipated to have occupational exposure so that these employers may take precautions to protect their employees. Standard and transmission-based precautions are communicated and deployed for employees, contracted employees, and visitors to any of our district facilities.

Referral and Transfer of AirID Cases to AII Rooms or Facilities

In order to best protect our employees from contracting infections from AirID cases or suspected cases, the Infection Prevention department strives to identify these cases as quickly as possible through communicable disease and syndromic surveillance.

After identifying an individual as an AirID case or suspected case, we will continue to use the previously described source control measures and isolate

the patient by masking them or placing them in a location where they will not contact employees who are not wearing respiratory protection until we can transfer them to an airborne infection isolation room.

However, in field operations and settings where home health care or home-based hospice care are provided, we are not required to provide disposable tissues and hand hygiene materials to the AirID case or suspected case or mask them or place them in a manner to minimize employee exposure. In these settings, we are also not required to transfer the patient to an AIIR.

We will take the following measures to reduce the risk of ATD transmission to our employees. This includes constant observation of standard precautions as well as other protective measures.

We temporarily isolate the person requiring transfer or isolation in an airborne infection isolation room or area if we have one available. We will make sure this transfer occurs in a timely manner within five hours of identification of the case.

If the person requiring referral does not comply with our established source control measures, our employees will wear NIOSH-certified N95 filtering facepiece or PAPR when entering that room or area.

If we do not have an AIIR available in that timeframe, we will ensure that AirID cases and suspected cases are transferred to another suitable facility within five hours of being identified as a case or suspected case. If no suitable facility with AIIR is available to accommodate the patient, we will contact the local health officer at the end of the five-hour timeframe. We will continue to contact the local health officer and other medical facilities inside and outside of our local health officer's jurisdiction every 24 hours until an AIIR becomes available. When an AIIR becomes available, we will ensure that the patient is transferred to the AIIR.

With each unsuccessful attempt at transfer, we will document in the Occurrence Reporting System, at the end of the 5-hour period, and at least every 24 hours thereafter, each of the following:

- We have contacted the local health officer.
- There is no AII room or area available within that jurisdiction.
- Reasonable efforts have been made to contact establishments outside of that jurisdiction, as provided in the Plan.
- All applicable measures recommended by the local health officer or the Infection Control PLHCP have been implemented.

- All employees who enter the room or area housing the individual are provided with, and use, appropriate personal protective equipment and respiratory protection in accordance with subsection (g) and section 5144, Respiratory Protection of these orders.

The following are exceptions to the requirement for timely transfer of AirID cases or suspected cases:

- Where the treating physician determines that transfer would be detrimental to a patient's condition, the patient need not be transferred. In that case, we will ensure that employees use respiratory protection when entering the room or area housing the individual. The patient's condition will be reviewed at least every 24 hours to determine if transfer is safe, and the determination will be documented. Once transfer is determined to be safe, we will ensure that the transfer is made within the required timeframes described above.

  In the event that the treating physician determines that a transfer would be detrimental to a patient’s condition, we will document this determination using the Occurence Reporting System.

- Where it is not feasible to provide AII rooms or areas to individuals suspected or confirmed to be infected with or carriers of novel or unknown ATPs, we will provide other effective control measures to reduce the risk of transmission to employees, which shall include the use of respiratory protection.

  The other effective control measures we will take during the period that the AirID case is not in an airborne infection isolation room include employees using an N95 respirator or PAPR when working with the patient. Additionally, the door to the room the patient is placed will remain close with Airborne Isolation signage affixed to the door and appropriate PPE made available at point-of-care.

The person responsible for contacting the local health officer and nearby medical facilities is Infection Prevention department personnel.

The phone number or other contact information for the local health officer is: Karen Haught, MD Tulare County Public Health Officer and/or Jeremy Kempf, RN, PHN Communicable Disease Coordinator, phone (559) 685-5720, After hours: (559) 471-7092.

These are the names and contact information for facilities with AII rooms or areas within the local area that will be contacted in the event of referral

Facility	Contact Information
Sierra View Medical Center	Admissions 559-791-4752
Hanford Central Adventist Medical Center	House Supervision 559-537-1712

These are the names and contact information for facilities with AII rooms or areas outside the local jurisdiction that will be contacted in the event of referral and no AII rooms are available within our local jurisdiction

Facility	Contact Information
Fresno Community Regional Medical Center	Transfer Center 559-459-5555
Clovis Medical Center	Transfer Center 559-459-5555

If we are unable to transfer the AirID case to an AIIR within five hours of identification, the Administrator (or designee) will document in the Occurence Reporting System each attempt to locate a facility with an available AIIR to which to transfer the symptomatic individual.

Medical Services

We provide medical services at no cost to our employees who have occupational exposure to aerosol transmissible disease. These medical services, including vaccinations, tests, examinations, evaluations, determinations, procedures, and medical management and follow-up, will meet the following conditions:

- Performed by or under the supervision of a physician or other licensed health care provider (PLHCP).
- Provided according to applicable public health guidelines.
- Provided in a manner that ensures the confidentiality of employees and patients. Test results and other information regarding exposure incidents and TB conversions shall be provided without providing the name of the source individual.

Vaccinations

Vaccination is a safe, effective, and reliable method of controlling the spread of infectious diseases where a vaccine is available. When the number of susceptible health care workers is decreased by vaccination, it also helps to prevent transmission of illness to patients and others. Therefore, we make

vaccinations available to employees at no cost and encourage employees to receive them.

We are required to offer all vaccinations for aerosol transmissible diseases that are recommended by the CDPH to our susceptible health care workers. These vaccinations are listed in the table below along with the recommended dose schedule for each. We make them available to employees after they receive training and within 10 working days of initial assignment unless one of the following conditions exists:

- The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose.
- A PLHCP has determined that the employee is immune in accordance with applicable public health guidelines.
- The vaccine(s) is contraindicated for medical reasons.

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	One dose
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses

We send our health care worker employees to the following medical facility or department within our establishment to receive the vaccinations: Employee Health Services.

These will be provided at the doses and by the schedules recommended by the CDPH.

We will make additional vaccine doses available to employees within 120 days of the issuance of any new applicable public health guidelines recommending the additional dose.

We do not require our employees to participate in a prescreening serology program prior to receiving a vaccine unless applicable public health guidelines recommend prescreening prior to administration of the vaccine.

We train our employees on the benefits of receiving vaccinations and strongly encourage them to receive them. However, employees have the option to decline to receive any of the recommended vaccinations. If an employee declines a vaccination, they must sign the appropriate declination form, which will be kept in their employee file.

If an employee declines any of the vaccinations listed in the box above, we will have them sign the following declination statements: See Appendix A

LTBI Assessment

A latent tuberculosis infection (LTBI) is a condition when the individual infected with the *M. tuberculosis* bacteria does not exhibit symptoms and cannot spread the infection to others. However, approximately 5 to 10% of these people will develop active, potentially contagious TB disease if untreated. LTBI screening helps to ensure that employees are provided with appropriate treatment for new TB infections and to identify previously unidentified occupational exposures so that we may correct any deficiencies in our ATD exposure control plan.

We offer latent TB infection screening (the TB skin test, TB blood test, or TB screening questionnaire) annually to all employees with reasonably foreseeable occupational exposures to ATD. We include employees if their occupational exposure risk is greater than that of employees in public contact operations that are not included within the scope of the ATD standard.

The person responsible for implementing our TB screening procedures is Employee Health Services.

If applicable public health guidelines or the local health officer recommends more frequent testing, then we will comply with the recommendation.

We send our employees to this facility for the LTBI screening: Employee Health Services

Employees with a baseline positive TB test will receive an annual symptom screening questionnaire. If questionnaire results indicate further testing is needed, then we offer that employee a follow up screening (PPD, blood test,

or chest x-ray) using the following procedures: For newly positive TB test, Employees fill out a symptom questionnaire and are sent for a Chest Xray.

If employees experience a TB conversion, we will refer them to the following PLHCP knowledgeable about TB for evaluation: Infection Prevention, and the Infection Prevention Physician.

In the event of a TB conversion, we will also do the following:

1. Provide the PLHCP with a copy of this standard and the employee's TB test records. If we have determined the source of the infection, we will also provide any available diagnostic test results including drug susceptibility patterns relating to the source patient.
2. We will request that the PLHCP, with the employee's consent, perform any necessary diagnostic tests and inform the employee about appropriate treatment options.
3. We shall request that the PLHCP determine if the employee is a TB case or suspected case, and to do all of the following, if the employee is a case or suspected case:
    a. Inform the employee and the local health officer in accordance with title 17.
    b. Consult with the local health officer and inform us of any infection control recommendations related to the employee's activity in the workplace.
    c. Make a recommendation to us regarding precautionary removal due to suspect active disease, in accordance with subsection (h)(8), and provide us with a written opinion in accordance with subsection (h)(9).

The person who will receive information from the PLHCP regarding infection control recommendations related to employees who are TB cases or suspected cases is the Medical Director for Employee Health Services, who will then communicate the recommendations to the following managers or staff members, if applicable: Employee Health Services Manager.

In the event of a TB conversion, we will also record the case on the Cal/OSHA Form 300 Log of Work-Related Injuries and Illnesses by placing a check in the “respiratory condition” column and entering “privacy case” in the space normally used for the employee’s name. We will also investigate the circumstances of the conversion and correct any deficiencies in the procedures, engineering controls, or PPE that were involved. The following staff are involved in investigating the circumstances of the conversion and correcting deficiencies that may have led to the conversion.

- Employee Health Services
- Infection Prevention Officer/designee
- Safety Officer/designee
- Risk Management
- Facilities Maintenance
- Clinical Engineering

We will also document the investigation using the following procedure: Agility/ Net Health Software.

Exposure Incidents

In the event of an exposure incident, it is critical to inform exposed employees quickly and provide medical services in a timely manner to mitigate the severity of illness and limit the spread of infection. An "exposure incident" is an event where all of the following have occurred:

1. An employee has been exposed to an individual who is a case or suspected case of a reportable ATD, or to a work area or equipment that is reasonably expected to contain an aerosol transmissible pathogen associated with a reportable ATD.
2. The exposure occurred without the benefit of applicable exposure controls required by the Cal/OSHA ATD regulation title 8 CCR 5199.It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

A reportable ATD (RATD) is an aerosol transmissible disease that a health care provider is required to report to the local health officer, in accordance with title 17 CCR, Division 1, Chapter 4.

In the context of the ATD regulation, a "health care provider" is a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

The California Department of Public Health, Division of Communicable Disease Control home page includes the current list of RATDs. Contact information for the local health departments are also available on the CDPH webpage for the California Conference of Local Health Officers.

We are a health care provider. Therefore, when we determine that a person is an RATD case or suspected case, we will report the case to the local health officer, in accordance with title 17, observing the different time deadlines for different diseases.

Infection Prevention department personnel are responsible for reporting cases to the local health officer.

The person responsible for contacting the local health officer and nearby facilities is the hospital Administrator (or designee).

Contact information for the local health officer: Thomas Overton, MD Tulare County Public Health Officer and/or Jeremy Kempf, RN, PHN Communicable Disease Coordinator, phone (559) 685-5720, After hours: (559) 471-7092.

We are required to notify our own employees who had significant exposure to the ATD case or suspected case. First, we conduct an analysis of the exposure scenario to determine which of our employees had significant exposure. This analysis will be completed within a timeframe reasonable for the specific disease, but no later than 72 hours after either our report to the local health officer or our receipt of notification from another facility or local health officer of the exposure. The Employee will be notified via email of the exposure.

Conducting the analysis of an exposure to a confirmed/suspected ATD is primarily the role of the Infection Preventionist; however, exposure investigations are often carried out as a dual process with the Infection Preventionist and Employee Health Nurse working from their own particular focus related to the exposure to determine if an exposure took place. There is an Employee Health provider and Infectious Disease provider available for consult regarding employee exposures.

Our procedures for conducting this analysis are available in the following policies: Infection Prevention policy IP 1.32 Communicable Disease Exposure to Healthcare Workers and Patients and IP 1.11 Outbreak Investigation Plan.

We will document the analysis, recording the names and any other employee identifier used at the workplace of persons who were included in the analysis. We will also document the name of the person who made the determination and the identity of any PLHCP or local health officer consulted in making the determination.

If the analysis determines that either of the following conditions exist for an employee, then that employee does not require post-exposure follow-up, and we will also document the basis for the determination:

- The employee did not have significant exposure.
- Physician or other licensed health care provider (PLHCP) determined that the employee is immune to the infection.

We will make the exposure analysis available to the local health officer upon request.

We will also determine, to the extent that the information is available in our records, whether any employees of other employers may have been exposed to the case or suspected case. If so, we will notify the other employer(s) within a reasonable timeframe but no later than 72 hours after the report to the local health officer. This allows the other employer(s) time to conduct their own analysis to determine which of their employees had significant exposure and to provide their employee(s) with timely, effective medical intervention to prevent disease or mitigate the disease course.

See the "Communicating with Other Employers Regarding Exposure Incidents" section below for our procedures to notify other employers that their employees may have had significant exposure while working at our facility.

Upon determining which of our own employees had significant exposure, we will notify them of the date, time, and nature of their exposure, within a timeframe reasonable for the specific disease but no later than 96 hours of becoming aware of the potential exposure.

Our procedures to notify our Employee Health Services of any employees potentially having significant exposure to an ATD and other communicable diseases is available in Infection Prevention policy IP 1.32 Communicable Disease Exposure to Healthcare Workers and Patients.

Employee Health Services notifies individual employees of their exposure upon receipt of a list of potentially exposed contacts provided by Infection Prevention.

As soon as feasible, we will provide all of our employees who had a significant exposure a post-exposure medical evaluation by a PLHCP knowledgeable about the specific disease, including appropriate vaccination, prophylaxis, and treatment. For *M. tuberculosis* (the group of different bacterial species that cause tuberculosis) and for other pathogens where recommended by applicable public health guidelines, this includes testing of the isolate from the source individual or material for drug susceptibility, unless the PLHCP determines that it is not feasible.

We will notify employees that they have the right to decline to receive the medical evaluation from us, and we will ensure that the employee receives post-exposure evaluation and follow-up from an outside PLHCP.

We will send employees to the following PLHCP for post-exposure medical evaluation and follow-up unless the employee declines: Employee Health Services, and EHS Medical Director.

Employee Health Services will provide the following information to the PLHCP:

1. A description of the exposed employee's duties as they relate to the exposure incident;
2. The circumstances under which the exposure incident occurred;
3. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management of the employee;
4. All of the employer's medical records for the employee that are relevant to the management of the employee, including tuberculin skin test results and other relevant tests for ATP infections, vaccination status, and determinations of immunity; and
5. A copy of title 8 CCR 5199 and applicable public health guidelines.

We will request from the evaluating PLHCP an opinion on whether precautionary removal from the employee's regular job assignment is necessary to prevent the employee from spreading the disease agent and what type of alternative work assignment may be provided. We will request that any recommendation for precautionary removal be made immediately by phone or fax and also in writing.

The person responsible for requesting and receiving the written opinion is: Employee Health Services Manager.

We will obtain and provide the employee a copy of the PLHCP written opinion within 15 working days of completion of all required medical evaluations.

This is our method of providing the copy of the written opinion to the employee: In person or via email.

If the PLHCP or local health officer recommends precautionary removal, we will maintain the employee's earnings, seniority, and all other employee rights and benefits until the employee is determined to be noninfectious. This includes the employee's right to return to their former job status as if they had not been removed or otherwise medically limited.

For TB conversions and all RATD and ATP-L exposure incidents, the written opinion will consist of only the following information:

1. The employee's TB test status or applicable RATD test status for the exposure of concern.
2. The employee's infectivity status.
3. A statement that the employee has been informed of the results of the medical evaluation and has been offered any applicable vaccinations, prophylaxis, or treatment.
4. A statement that the employee has been told about any medical conditions resulting from exposure to TB, other RATD, or ATP-L that require further evaluation or treatment and that the employee has been informed of treatment options.
5. Any recommendations for precautionary removal from the employee's regular assignment.

Evaluation of Exposure Incidents

After ensuring that the exposed employees receive required medical evaluations and follow-up, we will also investigate the exposure incidents to determine the cause and to revise existing procedures in order to prevent recurrence of the incidents.

The personnel who will conduct the evaluation of exposure incidents includes:

- Employee Health Services
- Infection Prevention Officer/designee
- Safety Officer/designee
- Risk Management
- Facilities Maintenance
- Clinical Engineering

Our procedures to evaluate exposure incidents to determine causation and identify ways to prevent future exposures are as follows: Interviewing the Employee to discover exposure possibilities, inspecting equipment that was involved, reviewing whether proper procedures and policies were followed.

Upon completion of the evaluation, we will also revise our procedures to ensure that similar exposure incidents do not occur again. These are our procedures to revise our ATD exposure control plan:

Plan a meeting with:

- Employee Health Services
- Infection Prevention Officer/designee
- Safety Officer/designee
- Risk Management

- Facilities Maintenance
- Clinical Engineering

Discuss the areas which contributed to the exposure and make appropriate adjustments and changes.

Procedures to Communicate with Our Employees and Other Employers Regarding Infectious Disease Status of Patients

To ensure our employees use appropriate precautions, we will communicate with them regarding the suspected or confirmed infectious disease status of persons to whom they are exposed in the course of their duties. We will also communicate this status with other employers whose employees were also exposed to the individual, such as those involved with transportation or care of the patient.

To communicate with our own staff, we use the following procedures:

Making notes in the patient's chart and maintaining a policy that our employees are to check the patient's chart before proceeding with their tasks.

Staff huddle at the start of each shift where patient infectious status will be discussed.

When we place a patient in isolation, we communicate the isolation status of the patient with employees and visitors by posting a sign at the room. We also make a note of the isolation precautions in the patient's chart so that if the patient is transferred to another department, such as Radiology, then those employees in the other department will be notified of the extra precautions required.

To communicate with other employers regarding the infectious disease status of patients, we implement the procedures described in Infection Prevention policy IP 1.21 Communicable Disease Exposure to Emergency Response Employee (ERE).

Communicating with Other Employers Regarding Exposure Incidents

Upon establishing that a patient is a reportable ATD case or suspected case, we will determine whether any employees of other employers had contact with the individual, using the following policies: Infection Prevention policy IP 1.32 Communicable Disease Exposure to Healthcare Workers and Patients, IP 1.21 Communicable Disease Exposure to Emergency Response Employees (ERE), IP 1.7 Reporting Infection/Communicable Disease.

Upon making that determination, we will notify the other employer(s) within a timeframe that will allow reasonable time for them to promptly investigate to identify employees who had significant exposure and for those employee(s) to receive effective medical intervention. We will make the notification no later than 72 hours after our report to the local health officer.

Our notification will include the following information:

- Date and time of the potential exposure.
- The nature of the potential exposure.
- Any other information that is necessary for the other employer(s) to evaluate the potential exposure of their employees.
- The contact information for the diagnosing PLHCP.

The notification will not include the identity of the source patient due to privacy laws.

Infection Prevention department personnel notify other employers that their employee(s) may have had contact with an ATD case or suspected case. Information about whether an exposure occurred is shared without source patient identifiers.

Infection Prevention department staff will in accordance with policy IP-Plan Infection Prevention Plan (see section B.2 & 3) notify health care providers and receive notification from them regarding the disease status of patients referred or transferred between our facilities or care, in accordance with subsection (h) of 8 CCR 5199.

Ensuring Adequate Supply of PPE and Other Equipment

To ensure that employees wear the required PPE, such as gowns, gloves, and respiratory protection, we must ensure that we have adequate supplies under normal operations and in foreseeable emergencies.

These PPE will be stocked by Central Logistics and supplied to our employees using the following procedure: PPE will be maintained on the department par

level. Volumes will be adjusted up or down depending on usage. If the supplies are sourced outside of our normal inventory system, Central Logistics will manually maintain supplies and deliver to the departments as required. For areas that do not have par levels, they are asked to email or call Central Logistics giving the department 24 hours' notice. The supplies will be gathered and available for pickup. These supplies will be managed at the department level for distribution to employees.

These are our procedures for maintaining adequate supplies of PPE: Central Logistics works with our distributor to maintain and deliver supplies as requested, based on trended volumes. The distributor will deliver supplies when ordered during our normal ordering cycle. This occurs between 3-5 times a week. Central Logistics also maintains a backup supply of needed PPE for emergency needs. This is stored, managed and rotated, so that no product is wasted due to outdates. Current storage is located in several locations throughout Visalia. We continually monitor the types of PPE and other supplies for our emergency storage. If there is an emergency/pandemic, we review our inventory, adjust and order what is needed. During and emergency the supply levels are monitored 5 days a week. If our current distributor is not able to provide our needed volumes, we communicate with our secondary distributor. If they are not able to help, we work with our Group Purchasing Organization and our other traditional and non-traditional vendors to secure the needed supplies. For short term need we work with other hospitals.

These are our procedures for maintaining adequate supplies of other equipment necessary to minimize employee exposure to aerosol transmissible pathogens: HEPA filters are kept on site at all times. If more are needed, we are able to partner with local companies for rental of extra units.

Training

We will train all of our employees who have been determined to have potential occupational exposure to ATPs, as listed at the beginning of this program. This training will be provided to employees in those job categories when they are initially assigned to tasks where they may have occupational exposure and at least annually thereafter, within 12 months of the previous training.

This is how we ensure employees receive initial training: Training on ATD's is initially presented in New Hire Orientation when Employees are hired. For those who require RFT's, they are re-educated annually with RFT and medical evaluation questionnaire in Employee Health Services. They are

provided with a training hand out during the annual RFT. Training may also occur as needed when it is discovered Policies or Procedures are not being followed.

This is how we ensure employees receive their annual training within 12 months of their initial training: Required annual RFT.

If employees are absent on the day of their scheduled training, we use the following procedure to ensure that they receive a make-up training: The Employee is contacted by EHS or their Manager to make an appointment at EHS to come in for the annual RFT and training.

The trainings will include an opportunity for employees to ask questions.

The trainings are provided in-person and questions are answered during the training by the instructor, who is knowledgeable in the subject matter as it relates to our workplace and who is also knowledgeable in our ATD Exposure Control Plan.

Other methods of providing training, including an opportunity for interactive questions and answers during scheduled Safety Liaison Committee meetings.

Training includes the following:

1. An accessible copy of the regulatory text of this standard and an explanation of its contents.
2. A general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation.
3. An explanation of the modes of transmission of ATPs or ATPs-L and applicable source control procedures.
4. An explanation of the employer's ATD Exposure Control Plan and/or Biosafety Plan, and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.
5. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to ATPs or ATPs-L.
6. An explanation of the use and limitations of methods that will prevent or reduce exposure to ATPs or ATPs-L including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
7. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use,

location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.

8. A description of the employer's TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for LTBI.

   EXCEPTION: Research and production laboratories do not need to include training on surveillance for LTBI if *M. tuberculosis* containing materials are not reasonably anticipated to be present in the laboratory.

9. Training meeting the requirements of Section 5144(k) of these orders for employees whose assignment includes the use of a respirator.
10. Information on the vaccines made available by the employer, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
11. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.
12. Information on the employer's surge plan as it pertains to the duties that employees will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

Recordkeeping

To ensure that we are taking all necessary steps to protect our employees, we are required to keep various records, including employee medical records, training records, and other records of implementation of this ATD Exposure Control Plan.

Medical records will be kept confidential. Employees will have access to their own medical records. Anyone with written consent of the employee, Cal/OSHA representatives, NIOSH, and the local health officer will also be given access to employee medical records in accordance with applicable regulations.

Medical Records

We will keep all required medical records for each employee with occupational exposure, including the following information:

1. The employee's name and any other employee identifier used at our workplace.
2. The employee's vaccination status for all vaccines required by title 8 CCR 5199.
3. All PLHCP's written opinions and results of TB assessments.
4. A copy of the information regarding an exposure incident that was provided to the PLHCP.

We will retain these records for the duration of the employee's employment plus 30 years. These records will be kept separately from the employee's non-medical personnel records. This is how employees may request copies of their records: In person at Employee Health Services.

Vaccination Records

We are required to keep vaccination records for all employees with occupational exposure. This includes both records of vaccinations that we provide them and that the employees received prior to employment with our organization. These records also include any signed declination forms.

We follow these procedures to ensure that we obtain employee ATD vaccination records from prior to their employment with us: Employee Health Services requests Immunization records at time of New Hire Physical. Any missing vaccinations are assessed, or titers to determine immunity are drawn at no cost to the Employee through Employee Health Services.

These are our procedures for keeping records of ATD vaccinations that we provide to our employees: Documentation through Agility/ Net Health, record keeping program in Employee Health Services.

PLHCP Written Opinions and Results of TB Assessments

When physicians or other licensed health care providers examine employees for either latent TB infection or post-exposure medical evaluation and follow-up after exposure incidents, they must provide us their written opinions, as required by 8 CCR 5199(h)(9). We will follow these procedures to ensure that we keep these records for each employee: Records are kept in the employees EHS chart.

Copy of Information Given to PLHCP Regarding Exposure Incidents

We will also ensure to keep a copy of the information we give to the PLHCP related to exposure incidents, following these procedures and storing the records in the following manner: Records are stored in the Employees paper chart in Employee Health Services.

Training Records

We will keep documentation of all trainings provided to our employees regarding ATD. Each training record will include the following information:

1. The date(s) of the training.
2. The contents or a summary of the training.
3. The names and qualifications of persons conducting the training or who are designated to respond to interactive questions.
4. The names and job titles of all persons attending the training.

These are the procedures we follow to document the trainings and maintain the records: Documentation on the Medical Evaluation Questionnaire that they employee was provided with training.

We will retain these records for three years from the date the training occurred.

Other Records

Annual review of our ATD Exposure Control Plan

Records of annual review of the ATD Exposure Control Plan will include the following information:

1. Names of the people conducting the review.
2. Dates the review was conducted and completed.
3. Names and work areas of employees involved.
4. Summary of the conclusions.

We will retain the record for three years using the following procedures: Through IP Liaison Committee notes.

Exposure incidents

In addition to maintaining medical records of employees involved in exposure incidents, we will maintain the following documentation of exposure incidents:

1. The date of the exposure incident.

2. The names, and any other employee identifiers used in the workplace, of employees who were included in the exposure evaluation.
3. The disease or pathogen to which employees may have been exposed.
4. The name and job title of the person performing the evaluation.
5. The identity of any local health officer and/or PLHCP consulted.
6. The date of the evaluation.
7. The date of contact and contact information for any other employer who either notified the employer or was notified by the employer regarding potential employee exposure.

We will maintain these records and ensure they are available to the employees as employee exposure records for at least 30 years, using the following procedures: Employee Health chart is stored for 30 years in Employee Health Storage. Charts are also scanned into a PDF file, stored in Employee Health's Computer files.

Unavailability of vaccines

We will retain records of the unavailability of vaccines. These shall include the following information:

1. Name of the person who determined that the vaccine was not available.
2. Name and affiliation of the person providing the vaccine availability information.
3. Date of the contact.

The person responsible for maintaining these records is: Employee Health Services Manager.

We will retain these records for three years, using the following procedures: Scanned into a Medication file in Employee Health G Drive.

Unavailability of AII rooms or areas (Appendix C)

Any time we require an AII room or area but are unable to locate an available one, we will document the unavailability. In these cases, we will record the following information:

1. Name of the person who determined that an AII room or area was not available.
2. Names and the affiliation of persons contacted for transfer possibilities.
3. Date of contacting the persons for transfer possibilities.
4. Name and contact information for the local health officer providing assistance.

5. Times and dates of contacting the local health officer.

We will not record a patient's individually identifiable medical information as a part of this record. We will retain these records for three years.

Decisions not to transfer a patient for AII (Appendix C)

We will maintain records of any decisions not to transfer a patient to another facility for AII for medical reasons. These will be documented in the patient's chart, and we will also provide a summary to the Plan Administrator providing only the following information:

1. Name of the physician determining that the patient was not able to be transferred.
2. Date and time of the initial decision.
3. Date and time of each daily review and identity of the person(s) who performed them.

This summary record will not include a patient's individually identifiable medical information. We will retain these records for three years.

Inspection, testing, and maintenance of non-disposable engineering controls

We will maintain records of inspection, testing, and maintenance of non-disposable engineering controls, including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems.

We will maintain these records for a minimum of five years, including the following information:

1. Name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance.
2. Date.
3. Any significant findings and actions that were taken.

Respiratory protection program

We will establish and maintain records of our respiratory protection program in accordance with title 8 CCR 5144, Respiratory Protection. These include records of employee medical evaluations, fit test records, and training records.

Obtaining Active Involvement of Employees to Update the Plan

As part of our annual review process to update this ATD Exposure Control Plan, we obtain the active involvement of employees and not just managers and supervisors. Active involvement means more than merely having a form available that employees can fill out at their leisure. Representatives from all departments/units throughout the healthcare district sit on the Safety Liaison Committee and perform an annual review of the ATD Exposure Control Plan in person.

Surge Procedures

Our employees will provide services in surge conditions, such as large outbreaks of aerosol transmissible disease or release of a biological agent. When the event arises, we will implement the surge procedures described below in Infection Prevention policy IP 1.29 Management of Influx of Communicable Disease Patients and policy IP 31 Management of a Novel or Highly Infectious Disease Patient.

Related Documents: Appendix A

Kaweah Delta HEALTH CARE DISTRICT

Varicella Vaccine

Employee Health Services
202 W. Willow, Ste. 305
Visalia, Ca. 93292
Phone: (559) 624-2458 Fax: (559) 635-6233

Employee Name: _____Employee ID #:_____
D.O.B._____ Department: _____

Varicella (chickenpox) is a highly contagious virus. Adults often experience longer, more severe cases of chicken pox, with mortality rates 15-25 times higher than in pediatric patients. Chickenpox can be disruptive and a significant cause of lost work days. Patient and staff nosocomial exposure can be costly.

The vaccine is a series of two injections given 1-2 months apart. The vaccine is a preparation of the strain of live, attenuated varicella virus.

Please initial the following below:
_____I am not pregnant nor do I plan on conceiving in the next 4 weeks.
_____I consent to have the Varivax vaccine.

#1 Merck Varivax Lot #_____Exp:_____Date/Time:_____

SQ_____Arm HCP Signature: _____

#2 Merck Varivax Lot #_____Exp:_____Date/Time:_____

SQ_____Arm HCP Signature: _____

_____I decline to have the Varivax vaccine.
I understand that due to my occupational exposure to Varicella (chickenpox) I may be at risk of acquiring the disease. I have been given the opportunity to be vaccinated with Varivax, at no charge to myself. However, I decline the vaccine at this time. I understand that by declining this vaccine, I continue to be a risk of acquiring chickenpox. If in the future I continue to have occupational exposure to chickenpox and I want to be vaccinated with Varivax, I can receive the vaccination series at no charge as long as it is a requirement of my position with Kaweah Delta Health Care District.

_____ _____
Employee Signature Date/Time

□ **(VIS Given)**

Rev: 8/29/19 VW

Kaweah Delta
HEALTH CARE DISTRICT

MMR VACCINE

Employee Health Services
202 W. Willow, Ste. 305
Visalia, Ca. 93292
Phone: (559) 624-2458 Fax: (559) 635-6233

Print Name: _____ ID# _____

Dept: _____D.O.B. _____

Please initial:

_____I am not pregnant nor do I plan on conceiving in the next 4 weeks.

_____I consent to have the MMR vaccine.

1.) Date/Time: _____Mfg: _____Lot#_____ Exp: _____

SQ: _____ HCP Signature: _____

2.) Date/Time: _____Mfg: _____Lot#_____ Exp: _____

SQ: _____ HCP Signature: _____

_____I have elected NOT to receive the (MMR) vaccine at this time. I understand that I may elect to receive the MMR vaccine at a later date as long as it is a requirement of my position with Kaweah Delta Health Care District.

Employee Signature: _____ Date/Time _____

( ) VIS given Rev: 3/10/20 VW

Tetanus, Diphtheria, and Pertussis (Tdap)

Employee Health Services
202 W. Willow, Ste. 305
Visalia, Ca. 93292
Phone: (559) 624-2458 Fax: (559) 635-6233

Name: (Print) _____

D.O.B: _____Emp.ID#_____

I have had the opportunity to review the latest CDC VIS (Vaccine Information Sheet) and asked questions regarding the Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine.

Contraindications: If initialed, do not administer:

_____ Allergy to any component of the Tdap Vaccine.

_____ History of Guillain-Barre Syndrome (GBS)

_____ Currently I'll (wait until recovered)

_____ Any other disease of health issue as defined in **VIS** _____

Please initial one of the following:

____ I consent to receive the Tdap Vaccination:

MFG: _____Lot #: _____ Exp. _____
IM: _____Date/Time: _____

HCP: _____

____ I have elected NOT to receive the TDAP vaccine at this time. I understand that I will be required to wear a mask in all high risk areas (see Policy #EH 07). I understand that I may elect to receive the Tdap Vaccine at a later date if it is a requirement of my position with Kaweah Delta Health Care District.

Employee Signature_____ Date/Time: _____

( ) VIS Given Rev: 8/29/19 VW

Declination of Seasonal Influenza Vaccination For Medical Contraindication or Philosophical declination

_____ _____
Employee Name (print) Employee ID Number & D.O.B.

Seasonal influenza vaccination is a condition of employment for all health care workers. Depending on type of vaccination offered, specific medical contraindications may exist for certain individuals. Medical contraindication must be re-assessed each year and an updated declination form will be placed in the employee's file yearly.

This Medical Contraindication/Philosophical Declination form must be completed by the Employee and returned to Employee Health Services before November 1, 2020.

My employer, **Kaweah Delta Health Care District**, has recommended that I receive seasonal influenza vaccination in order to protect myself and the patients I serve.

I understand that because I work in a health care environment I may place patients and co-workers at risk if I work while infected with the influenza virus.

I understand that since I have an evidence-based medical contraindication to influenza vaccination that I will be required to wear a mask at all times during a scheduled shift through the duration of the influenza season (**2020-2021**).

I have one or more of the following contraindications:

☐ Documented severe allergy to eggs or egg products- **Egg Free is available.**
☐ Personal history of Guillain-Barre Syndrome within 6 weeks of receiving influenza vaccine
☐ Severe allergic reaction to previous influenza vaccine
☐ Other: (please explain –

_____
_____

OR,

☐ I have a philosophical reason for declining the flu vaccination and understand I will have to wear a mask during any shift for the duration of the flu season.

_____ _____
Employee Signature Date/Time

Appendix B:

KAWEAH DELTA HEALTH CARE DISTRICT
EMPLOYEE HEALTH SERVICES
Initial and Annual N-95 MASK FIT TEST

Please Print

Last Name:	**First Name:**	**Birthdate:**
Emp ID:	**Job title:**	**Dept:**

Medical Questionnaire:
This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator (mask). We anticipate being able to approve most people for respirator fit testing based on this questionnaire alone. In some cases, we may ask for more information.

Have you ever had any of the following?

Lung Disease: Yes_____ No_____ **Asthma: Yes_____ No_____**
Heart Disease: Yes_____ No_____ **Hypertension: Yes_____ No_____**

Explain "Yes" answers:_____

Do you have a: ☐ **Beard** ☐ **Goatee** ☐ **5 O'Clock shadow at Work**

Smoking History: ☐ **Never Smoked** ☐ **Ex-smoker** ☐ **Presently a smoker**

1. **Do you get short of breath or wheeze with exertion?** ☐ **Yes** ☐ **No**
2. **Do you ever get chest pain?** ☐ **Yes** ☐ **No**
3. **Do you have any medical problems that might interfere with the wearing of a Respirator /mask?** ☐ **Yes** ☐ **No**
4. **Do you take any medications for treatment of cardiac, respiratory, or blood Pressure problems?** ☐ **Yes** ☐ **No**
5. **Have you ever had problems wearing a respirator/mask?** ☐ **Yes** ☐ **No**

Explain "Yes" answers: _____

Employee Signature: _____ **Date:_____**

Brand & Model Number	***3M 1860S***	***3M 1860***	***3M 1870***	***3M 9205+***	***Other:***

Fitting:

☐Satisfactory Qualitative Saccharin Fit Test ☐Instructions for use reviewed ☐Donning and Removal

☐ Training information given

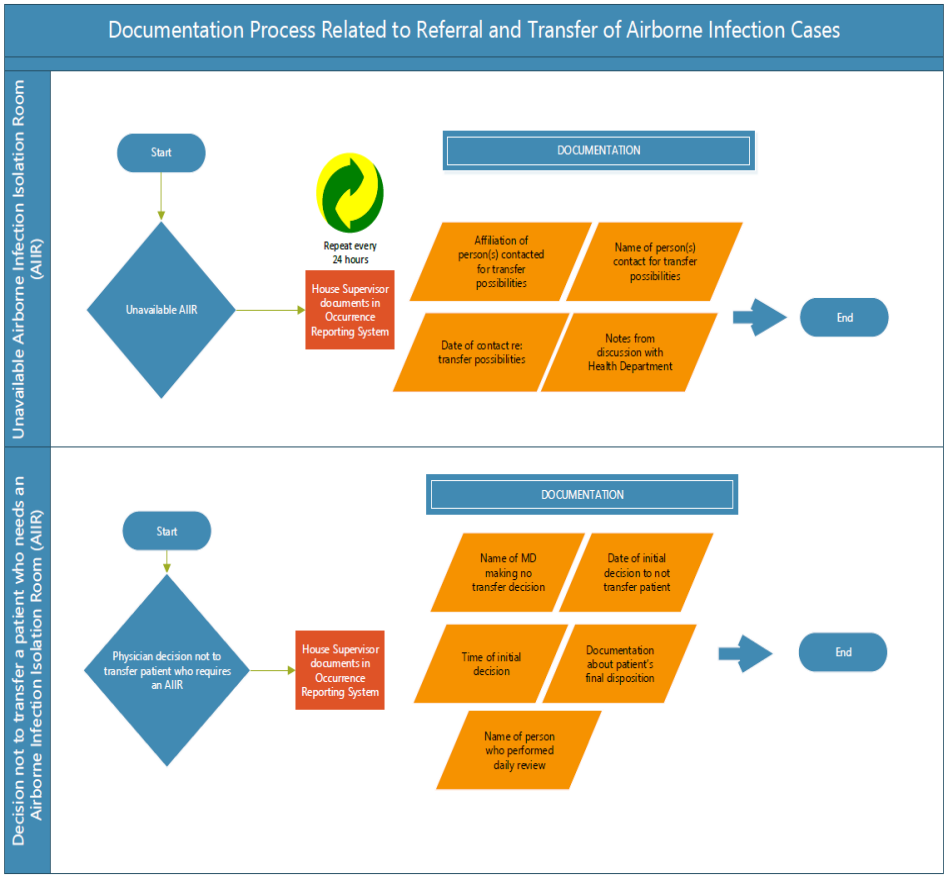
☐Pass

☐ Fail -Explain:_____

☐ **Information given on PAPR**

Signature of test administrator:_____ Date:_____
Rvsd:3/4/21 sa

Appendix C:



References:

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

Policy Number: EHS 03	Date Created: Not Set
Document Owner: Ellason Schales (RN-Employee Health Nurse)	Date Approved: 12/17/2020
Approvers: Dianne Cox (Chief Human Resources Officer)	
Ergonomics	

Purpose:

Kaweah Delta Health Care District (KDHCD) has adopted this ergonomic program to minimize repetitive motion injuries (RMIs) through worksite evaluations, appropriate modification of work stations and equipment, and educating employees.

Policy:

Definitions:

- RMIs: 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 RMIs to more than one employee reported within a twelve-month period. A licensed physician must perform the identification and diagnosis of a RMI.
- Identical work: Employee performs the same repetitive motion tasks, such as typing.
- Potentially Exposed Employee: An employee working a job, process or operation of identical work activities in which more than one RMI has been reported within a 12-month period.
- Predominant cause: Means that 50% or more of the injury was caused by a repetitive job, process or operation of identical work activity.

Worksite Evaluation:

Where more than one RMI is reported as described above, the applicable job, process, or operation of identical work will be evaluated. The evaluation identifies potential exposures and determines methods the District will use to control or minimize the exposures. Potentially exposed employees will be informed of the potential exposure and provided with education.

Control of Exposures Which Have Caused RMIs:

It is the District's policy to timely correct exposures that have caused RMIs, or if the exposure is not capable of being corrected, it is the District's policy to minimize the exposure to the extent feasible.

It is the District's policy to consider engineering and administrative controls determining how to correct or minimize exposures. These may include, but are not limited to work station redesign, adjustable fixtures, or alternative work breaks. The District may also consider any other reasonable, cost-effective engineering or administrative controls, and/or the District will consider minimizing exposure through the use of personal protective equipment (monitor risers, chairs, etc.).

Education:

All employees will be provided with training that includes an explanation of:

A. The Ergonomics Program
B. Exposures which have been associated with RMI
C. The symptoms and consequences of injuries caused by repetitive motion
D. The importance of reporting injuries
E. The methods used by the employer to minimize RMIs

Education Frequency:

Education is provided to potentially affected employees as follows:

A. Initial education is provided as part of the District's General Orientation.
B. Upon completion of a worksite evaluation which identifies exposures which may have caused RMIs.

Employee Reporting Obligation:

To ensure that the District supports and maintains a healthy work environment and workforce compliance with Cal OSHA guidelines for our Workplace Injury and Illness Prevention Program, all employees are required to report any injury immediately to their supervisor, manager, or director, or a House Supervisor, and Employee Health.

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

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Human Resources

Policy Number: HR.04	**Date Created: 12/19/2019**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 12/22/2022**
Approvers: Board of Directors (Human Resources)	
Special Pay Practices	

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

Designated departments may have special pay practices which provide for competitive compensation and/or incentives for employees to work varying shifts or additional shifts. All special pay practices are approved by the Hospital and are subject to change at any time. In all cases, Wage and Hour Law will apply.

Pay Practices:

Other Hours- Base rate of pay for additional hours or shifts worked.

Eligible Job Codes:

- Pharmacy: 0360, 0972, 1940
  2094, 2093 (hours)
- RN-Nurse Practitioner: 1541 (shift)
- Nurse Practitioner Manager 1833 (shift)

MICN $1.50 for active MICN cert

$1.50 for active TNCC cert

Eligible job codes:

- RN: 0339 0746 in ED
- Charge Nurse: 1615 in ED
- Assistant Nurse Manager: 0640 in ED

Sleep Pay Hourly rate paid to Surgery and Cath Lab employees for those who require an 8-hour gap between the current shift worked and the next scheduled shift. The employee will be paid at the start of the next scheduled shift but is not expected to work until the 9th hour after finishing prior shift

Private Home Care Holiday Rate is based on where the employee travels. Holiday differential is received for Kaweah Health observed holidays, in addition to Mother's Day and Easter.

Private Home Care On-Call

Eligible Job Codes:

- PHC Staffing Coordinator: 0123 (Base rate of pay for a minimum of 1-hour for on-call)

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Policy Number: HR.12	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 09/03/2020**
Approvers: Board of Directors (Administration)	
Equal Employment Opportunity (EEO)	

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

POLICY:

Kaweah Health maintains a policy of nondiscrimination with employees and applicants for employment, student interns and volunteers. Kaweah Health policy prohibits unlawful discrimination or retaliation based on race, color, ancestry, religion, religious creed (including religious dress and grooming), sex, (including breastfeeding and related medical conditions), an individual's reproductive health decision making, sexual orientation (including those who identify as transgender, transgender transitioning, gender expression, gender roles, gender identity), sexual harassment, victim of domestic violence, sexual assault or stalking, hate imagery, national origin, disability, medical condition, mental health conditions such as depression and post-traumatic stress disorder, genetic information (GINA Act of 2008), marital status, pregnancy, age, military and veteran services, or any other characteristic protected by law.

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This policy applies to all employees and individuals involved in the operations of Kaweah Health, including but not limited to, employees, vendors, independent contractors, individuals working through a temporary service, unpaid interns, students, or volunteers, and others doing business with Kaweah Health.

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Retaliation is prohibited:

a. against an individual for filing a charge of discrimination, participating in an investigation, opposing discriminatory practices, and/or coverage under the State's Whistleblower Statute (prohibiting employers from retaliating against employees who report a violation to their employer, rather than the government, protecting employees from "anticipatory retaliation," expanding the protections of the law to include individuals who disclose the information/make the complaint as part of their job duties, covering employees who report violations of local laws, and covering employees who provide information to public bodies).

b. against an employee who is a family member of a person who has or is perceived to have engaged in protected activities such as managing complaints about working conditions, pay, or whistleblowing;

c. against employees who request an accommodation regardless of

whether the accommodation is granted;

All aspects of pre-employment and employment within Kaweah Health will be governed on the basis of merit, competence, and qualifications. Decisions made with respect to recruitment, hiring and job placement for all positions will be made solely on the basis of the individual qualifications related to the requirements of the position. Likewise, the administration of all other personnel matters such as compensation, assignment, or classification of employees; transfer, promotion, termination, layoff, or recall; job advertisements; testing; use of company facilities; training and apprenticeship programs; fringe benefits; pay, retirement plans, and disability leave; discharge; or other terms and conditions of employment will be free from illegal discriminatory practices.

a) Employment decisions based on stereotypes or assumptions about the abilities, traits, or performance of individuals of a certain sex, race, including traits historically associated with race, including, but not limited to, hair texture and protective hairstyles, defined as braids, locks and twists, age, religion, or ethnic group, or individuals with disabilities;

b) Denying employment opportunities to a person because of marriage to, or association with, an individual protected by this policy. Discrimination is also prohibited because of participation in schools or places of worship associated with a particular racial, ethnic, or religious group;

c) In accordance with California AB 1443 Kaweah Health will not tolerate discrimination against any person in the selection, termination, training, or other terms or treatment of that person in an unpaid internship, or another limited duration program to provide unpaid work experience for that person, or the harassment of an unpaid intern or volunteer because of any of the protected categories.

d) Any other consideration made unlawful by Federal, State or local laws.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, Kaweah Health will make reasonable accommodations for known physical or mental limitations whether an applicant or an employee, unless undue hardship would result. A leave of absence may be considered as a type of reasonable accommodation. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact their supervisor, department head, or Human Resources and make a request to participate in a timely interactive process to explore reasonable accommodations. The individual with the disability is invited to identify what accommodation is needed to perform the job. Kaweah Health will take steps to identify the barriers that make it difficult for the applicant or

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employee to perform the job, and will identify possible accommodations, if any, that will enable the individual to perform the essential functions of the job. If the accommodation is reasonable and will not impose an undue hardship, Kaweah Health will meet the request.

Kaweah Health is committed to complying with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in the operations of Kaweah Health and prohibits unlawful discrimination by any employee of Kaweah Health, including management personnel, supervisors, co- workers and third parties.

If an employee believes that they have been subjected to any form of unlawful harassment or discrimination, they are to report their concerns to any Kaweah Health department head, manager, supervisor, Compliance Officer (or directly through the Compliance Call Line), Vice President, the Chief Executive Officer or the Chief Human Resources Officer as soon as possible after the incident.The concerns should include details of the incident or incidents, names of the individuals involved and names of any witnesses. It is helpful that any such reports of harassment be in writing so that there is no misunderstanding as to the nature of the conduct in question. Department heads, managers or supervisors will refer all harassment complaints to the Chief Human Resources Officer or the Chief Executive Officer. Kaweah Health will immediately undertake an effective, thorough and objective investigation of the harassment or discrimination allegations and provide:

- Confidentiality to the extent possible
- Timely response
- Impartial and timely investigations by qualified personnel
- Document and tracking for reasonable progress
- Options for remedial actions and resolutions
- Timely closure

If Kaweah Health determines that a violation of this policy has occurred, effective remedial action will be taken in accordance with the circumstances involved.
Any employee determined by Kaweah Health to have violated this policy will be subject to appropriate Disciplinary Action, up to and including termination of employment. Kaweah Health will not retaliate against an employee for filing a complaint and will not tolerate or permit known retaliation by management, employees or co-workers.

Kaweah Health encourages all employees to report any incidents of harassment or discrimination forbidden by this policy immediately so that complaints and concerns can be quickly and fairly resolved. Complaints may also be made to the Department of Fair Employment and Housing and/or the Equal Employment Opportunity Commission.

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I. Human Resources will be responsible for formulating, implementing, coordinating and monitoring all efforts in the area of EEO. Human Resource duties relating to EEO compliance will include, but is not necessarily limited to:

A. assisting management in collecting and analyzing employment data;

B. collecting necessary information and completing an Employer Information Report (EEO-4) for annual submission to the government;

C. developing policy statements and recruitment procedures designed to comply with Kaweah Heath's equal employment philosophy; and

D. complying with various reporting requirements and posting notices required to ensure full compliance with all employment-related laws and regulations.

II. Human Resources will also provide all applicants for employment a California Employment Applicant Data Form and maintain those forms in a place separate from applications and/or Personnel files.

III. Any communication from an applicant for employment, an employee, a government agency or an attorney concerning any Equal Employment Opportunity (EEO) matter will be referred to the Chief Human Resources Officer.

IV. Any questions regarding the interpretation of this manual should be referred to the Chief Human Resources Officer. No changes will be made in any policy and procedure or any deviations authorized without the express written permission of the Chief Executive Officer.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Policy Number: HR.31	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 12/22/2022**
Approvers: Board of Directors (Administration), Dianne Cox (Chief Human Resources Officer)	

Transfers

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

POLICY:

Employees of Kaweah Delta Health Care District who have successfully completed one year of employment in their current position may request a transfer to a posted position. Employees must complete an online Employment Application. The one-year employment requirement may be waived with approval of both department leadership and Human Resources.

Employees may initiate a transfer request when in Disciplinary Action, as long as the potential department leader is made aware of all performance issues.

Each request for transfer will be reviewed, comparing the employee's qualifications with the requirements of the job. If two or more applicants are equally qualified for the position, preference will be given to in-house employees. When two or more equally qualified in-house employees are being considered for the position, past performance and length of service will contribute to the final decision.

PROCEDURE:

1. Employees who have successfully completed one year of employment may apply for any posted position by completing an Employment Application. The one-year period may be waived with the approval of the involved department leadership and/or vice presidents.

2. All employee transfers will be processed in the following manner:

   A. Each request will be sent to the hiring department leader, who will compare the employee's qualifications with the requirements of the job. The review includes a Human Resources file check for past performance and current or previous disciplinary action.

   B. The most qualified candidates will be interviewed.

   C. It is the employee's responsibility to notify his/her department leaders that he/she is a final candidate when confirmed a pending job offer. This discussion must occur prior to finalization of the transfer request.

1. A minimum of two to four weeks written notice will be given by the employee to the present department leader. The actual length of time between written notice and the transfer will be determined jointly by the employee's prior and new department leaders.

2. The rate of pay will be determined in accordance with the current Compensation Program.

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A. All transfers may result in a new performance evaluation date if the position duties subsequently changed or the transfer results in reporting to a new leader.

B. If a demotion or voluntary move to a position that has a grade that is at least 4% lower, the evaluation date will be adjusted to one year from the date of the transfer. A pro-rated merit may not apply based on internal equity. If internal equity indicates a reduction of $.25 or less, no reduction will apply. If the employee is moving to a different leader or substantially different position, the prior leader must complete a performance evaluation to meet Title XXII requirements. If this transfer is less than 90 days from the last performance evaluation, HR can use the prior evaluation percentage if a pro-rated merit applies. Refer to the Intent to Demote Policy.

ADD: If the employee receives a promotion between July 1 - October 14, they will be excluded from merit and their next merit will be effective October of the following year.

C. If the employee is moving to a position that is within 4% of the current grade (as measured by the midpoints), the pay rate will be evaluated for internal equity; a pro-rated merit may apply. If the employee is moving to a different leader or substantially different position, the prior leader must complete a performance evaluation to meet Title XXII requirements. The 90-day exception will apply.

D. If the employee is moving to a position that has a grade that is at least 4% higher, the prior leader will complete an evaluation, the evaluation date will be adjusted to one year from the date of the transfer, the pro-rated merit may apply as well as an increase applicable to the change in position, applying internal equity. The 90-day exception will apply.

3. The department leader is responsible for initiating a status change form to transfer the employee and completing the appropriate sections of the form.

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Human Resources

Policy Number: HR.28	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 10/31/2019**
Approvers: Board of Directors (Administration)	
Recruitment and Selection of Staff Members	

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

POLICY:

Kaweah Health personnel will be employed on the basis of their training, experience, skill, aptitude, reliability, past performance and other indications of their ability to perform the essential functions and requirements of the job, and their willingness to partner with Kaweah Health in the provision of high quality patient care in accordance with established employment policies.

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It is the policy of Kaweah Health to select the strongest candidates for employment by ensuring that the following steps are taken prior to extending an offer of employment:

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A. Ensure a complete and accurate Job Description, including Physical Requirements, is on file with Human Resources;
B. Ensure the essential functions of the job have been identified;
C. Ensure the prospective employee meets the minimum requirements of the position.

Further, it is the policy of Kaweah Health to adhere to the philosophy and principles of Equal Employment Opportunity and comply with all local, state, and federal laws applicable to recruiting, interviewing, and selecting employees. All candidates for employment, internal and external, must apply through the Human Resources Department in order to ensure proper screening and consideration, as well as to maintain the appropriate applicant documentation. Further, management will refer all contacts with applicants and employment agencies to Human Resources. (See HR.12- Equal Employment Opportunity.)

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All offers of employment will be contingent upon successful completion of a background screening, employer sponsored post offer/pre-employment medical examination, including drug screen, and proof of candidate's legal ability to work in the United States. (See HR.36- New Hire Processing.)

PROCEDURE:

I. Responsibility of Management/Human Resources

A. Hiring Manager must submit a request for a job requisition with approvals from appropriate Manager, Director and Chief Officer for recruitment of new and replacement positions.

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B. Upon receipt of an approved requisition, Human Resources will post position and source qualified applicants, including internal candidates. External candidates apply through the career site and internals apply through Workday on the Jobs

Hub.

C. New and replacement positions will be posted online for a minimum of five days to allow equal opportunity for applicant consideration. Internal departmental postings are acceptable when position is limited to current employees within the department or include changes in Shift or Status. The internal posting will allow departments to adjust to changing staffing needs within the department.

D. Human Resources will maintain a recruitment program that meets the needs of the organization and will continually search for new means and sources to expand our workforce and support patient care.

E. Human Resources will ensure that all job applicants complete an application for employment. (Will provide accommodation to any applicant who experiences difficulty with the application process and requests reasonable accommodation.)

F. Human Resources will review qualified applicants and forward selected candidates to the appropriate hiring manager.

G. Hiring Manager will interview, assess and select candidates to determine the preferred candidate utilizing effective and legal practices. During the interview process, hiring leader will ensure application for employment is complete and accurate, as well as confirm prospective candidate meets minimum position requirements. (An interview panel must be coordinated for all management and director vacancies.)

H. Following interviews, the hiring manager will notify Human Resources of selection decision.

I. Human Resources will be responsible for extending the contingent offer to the selected candidate, including hourly rate, benefit eligibility, start date and other relevant information. Human Resources will provide an appropriate starting pay rate based on Kaweah Health's current Compensation Program.

J. Human Resources will notify the hiring manager on job offer acceptance and pre-employment clearances and start date.

K. Human Resources will validate job requirements (licensure/certification, degree, driving record, etc.) and will ensure that post-offer background screening (including regulatory components, criminal convictions, employment verifications and professional references), pre-employment medical examination and drug screen are satisfactorily completed prior to the employee's start date.

L. The Hiring Manager will notify candidates who have been interviewed and not chosen for the position.

M. Human Resources will maintain internal/external applications received and appropriate records of the selection process for two years from application date.

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II. Eligibility for Rehire

If a qualified applicant has been employed previously by Kaweah Health, a review of the former Human Resources file must be completed to determine eligibility for re-employment. Review will include assessment of employment record and circumstances of the termination

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Applications from former employees will be considered case-by-case with consideration of the job opening and other relevant factors.

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Human Resources

Policy Number: HR.36	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 11/04/2019**
Approvers: Board of Directors (Administration)	
New Hire Processing	

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

POLICY:

All applicants who have accepted an offer of employment with Kaweah Health will be required to successfully complete all steps of the new hire process prior to their first day of work, including background check, post offer/pre-employment medical exam, drug screen, and new hire paperwork. This process maintains compliance with The Joint Commission, Title XXII, OSHA requirements, The Americans with Disabilities Act, and all Federal, State and Local regulations. Applicants who refuse any part of the medical exam, drug screen or new hire processing will not be hired.

PROCEDURE:

I. Background Check Results

After the contingent job offer is extended and accepted, applicants are asked to disclose information to Human Resources concerning criminal conviction history. Analysis of criminal convictions will be individually assessed by Human Resources based on the nature and gravity of the offense or conduct, the time that has passed since the offense, conduct and/or completion of the sentence, and the nature of the job held or sought.

Following acceptance of the contingent job offer, a third-party background check is initiated for completion. Applicants are then provided with an electronic email link from the background vendor providing their legal rights concerning consumer reports (background check), and submit authorization allowing Kaweah Health to run background check.

When background results are returned to Human Resources, they are reviewed for consistency with the information disclosed by applicant within the disclosure form and employment application. If results are consistent with what was disclosed and if the criminal history results are not relevant to employment at Kaweah Health, Human Resources will clear the background check and continue with the new hire process.

When background results are not consistent with what was disclosed by applicant, or if the report contains information that raises concern regarding work performance, an assessment will be undertaken by Human Resources. If the results of the assessment determine that the offer may be withdrawn, the adverse action process may be initiated.

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II. Adverse Action Process

The third-party vendor completing the background check is considered a consumer reporting agency. As such, per the federal Fair Credit Reporting Act, before taking an adverse action based on information contained in a consumer report (background check), Human Resources will:

1. Provide the subject of the report a "Pre-Adverse Action" notice, a copy of the report, and a copy of the document "A Summary of Your Rights Under the Fair Credit Reporting Act" and any applicable state law notices.

2. Allow ten (10) days for the applicant to review the report and contact the third-party background company to dispute any information the consumer believes to be inaccurate or incomplete.

3. If the applicant does not file a dispute (or based on the results of a dispute investigation), Human Resources may take adverse action. The applicant will be provided with a "Final Adverse Action" Notice, a copy of the report, and a copy of the document "A Summary of Your Rights Under the Fair Credit Reporting Act". Adverse action will result in the withdrawal or rescission of the job offer.

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III. Medical Exam and Drug Screen

Upon clearance of the background check, prospective new hires will be scheduled
for a post-offer/pre-employment medical examination at Employee Health Services within 30 days of start date.

The exam is performed utilizing the physical requirements outlined in the job description. The exam will include but not be limited to: drug screen, TB skin test (PPD), diagnostic lab work and immunizations if determined to be necessary by the position to be hired for and the examining practitioner. (See Policy EHS 11- Immunization Requirements for Health Care Workers.)
In the event that Employee Health receives a report indicating temporary or permanent work restrictions or presence of a communicable disease, the Employee Health Services Manager, with Medical Director guidance, will make the decision as to whether or not the individual is cleared to be hired for the position offered. If the applicant is deemed to be unable to perform his/her job duties, the applicant will be given the opportunity to request a reasonable accommodation that would allow the new hire with a qualified disability to perform the essential functions of the job, unless the accommodation would create an undue hardship for the organization. (Please refer to HR.16 Reasonable Accommodation & Medical Fitness for Work.)

Employee Health Services notifies Human Resources of clearance or non-clearance results after completion of the post-offer/pre-employment medical examination and drug screen. Prospective new hires will receive notification from Human Resources if it is determined that they are not fit for employment as a result of the medical exam and/or drug screen.

IV. New Hire Processing

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Upon clearance of the background check, prospective new hires will be scheduled for a processing meeting in Human Resources. New hires will be required to show proof of their right to work in the United States, provide social security card (for payroll and tax purposes only), as well as original licenses, certifications or registrations required for their job.

Deleted: This meeting will include completion of all paperwork required for new hires.

Electronic new hire paperwork will become available for the new hire to complete in Workday in advance of their start date and is expected to be completed no later than day one of employment.

V. Rescinded Job Offers

Job offers may be withdrawn or rescinded due to reasons including results of the background report or drug screen, failure to verify ability to work in the United States, failure to fulfill all components of the employment process in a timely professional manner, and in some cases, the results of the post-offer/pre-employment medical examination (per HR.16- Reasonable Accommodation & Medical Fitness for Work).

VI. Proof of right to work in the United States

Kaweah Health will comply with the Immigration Reform and Control Act of 1986 which prohibits the employment of unauthorized aliens and requires all employers to implement an employment verification system.

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VII. E-Verify

Kaweah Health participates in E-Verify (effective 7/10/2023) and will provide the federal government with Form I-9 information from each new hire to confirm work authorization.

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Human Resources

Policy Number: HR.49	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources)	**Date Approved:01/20/2022**
Approvers: Board of Directors (Administration), Dianne Cox (Chief Human Resources)	

Education Assistance

- **Tuition, Books and Fees Reimbursement or Loan Repayment**
- **Educational Programs and Compensation**
- **Continuing Education and Conferences**
- **Professional Certification Fee Reimbursement and Awards**

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

POLICY:

Kaweah Health recognizes the importance of growth and development of all employees to improve work performance and increase job knowledge and skill. As an employee benefit and in support of the recruitment and retention of qualified employees, Kaweah Health offers a number of programs and opportunities as described in this policy.

Certain amounts reimbursed up to $5,250 in a calendar year received under this Educational Assistance program are excluded from wages and other compensation. Monies are reimbursed without being subject to taxes. These programs include reimbursement for tuition, books and fees and for fees related to obtaining certifications. Loan Repayment is currently excluded from wages through 12/31/2025 due to the CARES Act. Employees are responsible to ensure their annual tax withholdings and disclosures are appropriate.

Education Assistance - Tuition, Books and Fees Reimbursement or Loan Repayment

Full-time and part-time employees may apply for reimbursement of tuition, books and fees or loan repayment for educational programs applicable to positions at Kaweah Health. An employee must have completed 2080 hours (1872 hours for 12-hour shift employees) of active employment and have received at least one performance evaluation before submitting a request for Tuition, Books, and Fees or Loan Repayment. Employees who have received a performance evaluation below an overall "Successful" rating or a Level II or III Performance Correction Notice within the prior 12 months are not eligible for that year, even if they had been previously eligible. If performance in a subsequent year meets expectations and there are no Performance Correction Notices, the employee is eligible again for reimbursement or loan repayment. No retroactive payments will be made; the lifetime amounts remain the same as long as eligibility and all requirements are met.

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Lifetime maximum amounts for reimbursement or outstanding student loan repayments combined for each degree:

- Up to $2,500 for Associates Degree or educational programs leading to a certification required for a position at Kaweah Health.

- Up to $10,000 for a Baccalaureate Degrees, limited to $2,500 per calendar year. Payments are made over four or more years if employee remains employed in an active full-time or part-time-benefitted status.

- Up to $15,000 for a Masters' Degree, limited to $5,000 per calendar year. Payments are made over three or more years if employee remains employed in an active full-time or part-time-benefited status. If receiving reimbursement for a Baccalaureate Degree, reimbursable monies for a Master's Degree will begin once the Baccalaureate Degree reimbursement is completed.

  Up to $20,000 for Doctoral Degree (Pharmacy, Physical Therapy and Nursing Director or Manager, DNP or PhD in Nursing, or RN with BSN in a program for Nurse Practitioner that requires DNP), limited to $5,000 per calendar year. Payments are made over four years if employee remains employed in an active full-time or part-time-benefited status. If receiving reimbursement for a Bachelors' or Masters' Degree, reimbursable monies for a Doctoral Degree will begin once the Masters' Degree reimbursement is completed.

For all reimbursements or loan repayments, employees are required to exhaust all school, program, federal or state grant, scholarship and loan repayment opportunities offered prior to submitting a Reimbursement Form or Loan Repayment Form to Kaweah Health. These include, but are not limited to:

- Nurse Corps
- Health Professions Education Foundation
- CSLRP Loan Repayment Program only applicable to certain approved specialites and must be Primary Care
- Public Service Loan Forgiveness

In no case will an employee receive more than $5,000 in a calendar year.

An employee may request pre-approval for the Tuition Reimbursement portion of this policy. If so, the employee must submit the form two weeks prior to the beginning of class or the program. A letter of approval/disapproval will be sent to the employee. If pre-approval is granted, all conditions of successful completion of the class or program must still be achieved to remain eligible for reimbursement.
Reimbursement or Loan Repayment Forms are due upon course completion or annually each year following the successful completion of the performance evaluation.

The Reimbursement Form and original receipts as well as grades verifying course completion must be submitted to Human Resources. A grade of C or better in graded courses and/or a grade of "Credit" in a Credit/No Credit course indicates successful completion. For loan repayment, a current outstanding educational loan statement must be attached to the application. If prior loan repayments have been issued, at least 2/3 of the monies received from Kaweah

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Health must show as a credit on the statement for the prior period. If not, there is no payment for the current year. The employee may reapply in future years providing evidence of loan payments

All signatures on applications are required to be obtained prior to submitting the application to Human Resources, including the employee's Director or Chief Officer for Directors submitting for reimbursement, and the designated Human Resources Director.

Kaweah Health Sponsored Programs

Kaweah Health has partnership agreements in place with several school programs for difficult to fill positions. Kaweah Health employees selected for sponsorship are subject to the details of the applicable program agreement.

Terms and Conditions

Nothing in this policy shall be construed to bind either Kaweah Health or the employee to any period of employment with the other. Each party recognizes that employment is terminable at the will of either party.

Class attendance and completion of study assignments will be accomplished outside of the employee's regularly scheduled working hours. It is expected that educational activities will not interfere with the employee's work.

EDUCATIONAL PROGRAMS AND COMPENSATION

Kaweah Health provides various educational programs and opportunities for employees including but not limited to formal hospital/departmental/unit specific orientation, annual requirements, in-services related to new equipment or procedures, maintenance of certifications as required for identified positions, and staff meetings. Appropriate compensation will be provided in accordance with regulatory and Kaweah Health established guidelines.

Mandatory Education

- Programs may be designed as mandatory by Kaweah Health, a Chief Officer, a Director or a Manager. These programs may be offered during scheduled working hours or outside of scheduled working hours.

- Mandatory programs such as meetings, courses, and orientations will be compensated by Kaweah Health. Education hours will be considered productive time and as such will be paid in compliance with applicable wage and labor regulations and policy and are subject to adherence to the policies and procedures that govern productive time, i.e. – dress code, attendance, etc. (Refer to Policies HR.184—Attendance and Punctuality, HR.197 Dress Code - Professional Appearance Guidelines.)

- Courses may consist of instructor led training, computer based learning/testing, or blended learning defined as computer based learning followed by instructor led discussion or skills testing.

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Commented [MJT2]: BIG QUESTION: Do we want to start a Service Commitment requirement for installments? I.e. Once installment is made must remain with KH 1 year or must repay all or prorated monies received?

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- With the exception of illness, approved absence or scheduled vacation, all employees must attend mandatory meetings. Reasonable notice is to be provided to employees of upcoming mandatory meetings. If the employee is unable to attend, he/she should request an absence. An employee who is unable to attend may be required to read and initial the meeting minutes or attend an additional meeting or program.

- Employees are to give 48 hours' notice for cancellation of any class or program in which they are enrolled, voluntary or mandatory. Failure to give advance notice or arrive on time may count as an occurrence under the Attendance policy. (See HR.184 – Attendance and Punctuality)

- Assignment to attend during regular work hours will be made at the discretion of the department leader. Any deviations from mandatory attendance will be made at the discretion of the department leader.

COMPENSATION FOR KAWEAH HEALTH ASSIGNED JOB REQUIREMENTS

Employees who participate in courses will be paid for such time if the course is required for their position or they have obtained manager approval prior to participating in the course.

- ***Courses should be scheduled on non-work days and overtime should be avoided to the extent possible.***

- ***If the course is offered at Kaweah Health, no reimbursement will be provided for programs taken elsewhere unless manager approval is obtained prior to attending an outside course.***

- ***Instructor led training will be paid for actual time spent in the classroom. Staff who arrive late or unprepared will not be allowed to participate in the course and will not be paid for the attempt to participate.***

- ***Computer based courses/testing completed onsite will be paid for actual time spent completing the course/test. Computer based courses/testing completed off-site will be paid based on a predetermined amount of time. Fees charged to access online courses will not be reimbursed unless management approval is obtained prior to purchasing the course.***

- ***Time spent by employees attending training programs, lectures and meetings are not counted as hours worked if attendance is voluntary on the part of the employee or the course is not related to the employee's job.***

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Commented [MJT3]: Per Rich, " *Question: if they attend a Kaweah Health course and clock in and out can we require them to have passed? What would apply if Manager approved off site course? I believe we have to pay for their time but not reimburse the cost of an outside course. "*

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Employees must use the current time keeping system to record actual time for instructor led training and previously established hours for online training in order to receive compensation for education hours.

Established compensation for successful completion of online training includes but is not limited to the following:

Online Training	Hours Paid
HeartCode BLS	3
ACLS/PALS required pre-course self-assessment	2
NRP	4
STABLE	2
NDNQI Pressure Ulcer Training	1 (per module/max 4 modules)
NIHSS Stroke Certification	4
Off Duty completion of performance evaluation – self evaluation	1
Off Duty completion of NetLearning Modules/Testing	Variable based on module length, TBD prior to module release
Completion of Peer Evaluations	Not eligible – Must be done on duty

CONTINUING EDUCATION AND CONFERENCES

With the assistance of Human Resources and Clinical Education, department leaders plan, develop, and present educational offerings to Kaweah Health employees on a continuous and on-going basis. Continuing education includes all forms of job-related training, whether offered by Kaweah Health or by an outside organization.

Many different methods are utilized for staff education such as formal continuing education classes, in-services, web-based education, one-on-one instruction, teleconferences, self- learning modules, and conferences. Reference materials for staff education are available within their respective departments, Kaweah Health Library, KDCentral and/or KDNet and resources online.

Types of educational offerings are determined as a result of Performance Improvement and Risk Management activities, new and changing technology, therapeutic and pharmacological intervention, regulatory and accreditation bodies, and identified or stated learning needs of employees.

Continuing education events may be required by Kaweah Health and if mandatory, the costs and time for attendance will be paid. If a program is voluntary, any payment or reimbursement of expenses and time for attendance will be determined by the department leader.

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Conferences

A department may budget for short-term conference or seminar-type trainings for employees. It is the responsibility of the employee to complete the Travel Reimbursement Form and secure approval in advance of the training for all anticipated expenses, including approval for the hours to attend and whether hours in attendance will be paid. Conferences may be required by Kaweah Health and if mandatory, the costs and time for attendance will be paid.

Refer to AP19 Travel, Per Diem and Other Employee Reimbursements

PROFESSIONAL CERTIFICATION FEE REIMBURSEMENT AND AWARDS

As determined by the area Chief Officer, pre-approved professional certification fees are available to full-time and part-time employees attaining and/or maintaining professional certification(s) in their vocational area.
Employees must have successfully completed six months of employment to be eligible for this reimbursement or awards.

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Professional Certification Criteria: To be reimbursed for examination fees and to qualify for the monetary award, the professional certification attained by the employee must:

- Not be a requirement for the staff members job code;
- Be sponsored by a national professional organization
- Involve an initial written examination that is available nationally and tests a professional body of knowledge (i.e., not technical such as ACLS, BCLS, etc.);
- Specify a defined recertification interval

Professional Certification Exclusions: Certification necessary as a condition of employment or as a minimum requirement for the position in which the employee is employed with Kaweah Health is not eligible under this program.

Employees may request reimbursement for exam and renewal fees associated with the examination up to a maximum of $250; the maximum an employee may receive for all exam and renewal fees under this program is $250 per calendar year. These fees are not taxable as long as the annual maximum received in reimbursement for tuition, books and fees and Loan Repayment is under $5,250. Expenses which are not eligible for reimbursement, include but are not limited to travel, food, and lodging. The continuing education costs themselves and renewal fees without an exam or continuing education requirement are not eligible. Reimbursements must be submitted to Human Resources within 30 days of obtaining certification. Reimbursement monies will be included on the employee's next paycheck.

Employees receiving an initial certification or renewal are eligible for a monetary award in recognition of their accomplishment. Full-time and part-time employees will receive an award of $500. The maximum amount of award per calendar year is $500. Award monies are taxable in accordance with employee exemptions on file.

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Employees requesting reimbursement for examination or renewal fees and/or a monetary award may request the appropriate form through Human Resources.

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All signatures on applications are required to be obtained prior to submitting the application to Human Resources, including the employee's Director or Chief Officer for Directors submitting for reimbursement, and the Director of Human Resources.

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Any exceptions to this policy must be approved by the Chief Human Resources Officer.

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"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Exhibit A

Note: Attach Current Form Updated 02.07/2020 probably need to review the form as well

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¶
Kaweah HealthCare District¶
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¶
Name: __ . Employee Number: ___ Job Title: __ . Department: ___ Professional Certification: ___ Certifying Organization: _.___.¶
Eligibility for Reimbursement:¶
-Full and part time must be employed for six (6) months¶
-Must not be a requirement for employee's current job code¶
-Must be a national certification¶
-Must require a test to earn certification¶
-Must be submitted within 30 days of obtaining certification¶
-Must enhance the employee's current role with Kaweah Health¶
For examples and information regarding payment, please see reverse side
Reimbursement Details:¶
Examination Expenses: $ __¶
RECEIPTS MUST BE ATTACHED¶
¶
This represents:¶
Examination Expenses (Maximum $250.00 for Full-Time and Part-Time employees) Certification Bonus (Maximum $500.00 for Full-Time and Part-Time employees)¶
¶
In accordance with the provisions of Human Resources policy HR.49, Professional Certification, I herby request reimbursement for examination fees and/or payment of a one-time bonus. I certify that all statements and submissions in support of this reimbursement/payment are true and correct to the best of my knowledge. Further, I understand that the certification I've received and sponsoring certifying body must be on the approved listing in order to qualify for reimbursement.¶
¶
¶
Staff Member's Signature¶
¶
¶
Date¶
Approvals: (all signatures required)¶
¶
Supervisor: __(sign) __(print) Date: __ Director: ___ (sign) __(print) Date: __ HR: __(sign) ___(print) Date: ___¶
¶

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Reimbursement Procedure: Reimbursements and bonuses will be included in your paycheck. A completed Professional Certification Reimbursement Form must be submitted to Human Resources. Once approved, your reimbursement will be included in your next paycheck.

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<#>Imaging Tech is not eligible to receive reimbursement for obtaining or maintaining their CRT since this is required for all Imaging Techs.¶
A Cook who earns Phlebotomy Certification is not eligible to receive reimbursement for obtaining or maintaining this certification because it

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Human Resources

Policy Number: HR.62	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 01/20/2022**
Approvers: Board of Directors (Administration), Board of Directors (Human Resources), Dianne Cox (Chief Human Resources Officer)	
Exempt Employees Pay/Salary Basis Safe Harbor Provision	

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

POLICY:

In accordance with the Fair Labor Standards Act exempt employees of Kaweah Health are required to be paid on a salary basis. That means that an exempt employee must regularly receive a predetermined amount of compensation each week without regard to the number of days or hours worked in a day (subject to the exceptions below). The District has a general expectation that regular business hours are 8:00am-5:00pm Monday through Friday. Arrival and departure time for exempt staff are determined by business needs and schedules of each department. Exempt employees need not be paid for any workweek in which they perform no work.

Exempt employees may hold concurrent jobs within Kaweah Health but may not work more than twenty (20) hours of non-exempt work in a week.

PROCEDURE:

I. Exceptions to the Salary Basis Rule

The requirement to provide a predetermined amount of compensation each week, is subject to the following exceptions:

A. Accrued and unused Paid Time Off (PTO) must be utilized for absences of a full day. If the employee does not have PTO accrued to cover the absence the employee will be allowed to go into the negative for a short time, until accrual is earned back in successive pay periods.

B. The District can offset any amounts received by the employee as jury or witness fees or military pay for a particular week against the salary paid that week by the District for the leave in question.

C. Deductions from pay may be made for unpaid disciplinary suspensions of one or more full days imposed in good faith for workplace conduct rule

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infractions. Employees with accrued and unused PTO may utilize this benefit during a disciplinary suspension.

D. The District is permitted to pay a proportionate part of an exempt employee's full weekly salary for the time actually worked in the first and last week of employment.

E. Partial day deductions are only allowed for unpaid leave taken in accordance with the Family and Medical Leave Act. Managers/timekeepers have the ability to enter this time for payroll purposes.

II. Deductions from an exempt employee's pay during a work week cannot be made as a result of absences due to the circumstances listed below.

A. Jury duty.

B. Attendance as a witness in a court proceeding.

C. Temporary military leave.

III. All exempt employees accrue Paid Time Off (PTO) and Extended Illness Bank (EIB) time beginning on the first pay period of employment.

IV. Managers, Directors, Executives, and Executive Assistants may take one day of "flextime" between January 1 and June 30, and July 1 and December 31 of each calendar year.

V. An exempt employee will be required to use accrued Extended Illness Bank (EIB) for time off from work when applicable(i.e. EIB-Kin and coordination with temporary disability or state disability insurance).

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Absences of less than a full week caused by the operating requirements of the business.¶

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Policy Number: HR.63	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved: 06/28/2021
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Timekeeping of Payroll Hours

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

POLICY:

It is the policy of Kaweah Health to pay employees according to applicable State and Federal regulatory requirements. To ensure accuracy and timeliness of timekeeping, all Directors will be accountable for review of staff member's timecards each pay period, including the appropriate use of pay codes. Delegation of this accountability may only occur if Directors are certain their delegates are trained (pay codes and employee sign offs).

All employees must record their time worked for payroll and benefit purposes. Kaweah Health utilizes the automated time and attendance TimeKeeper system with exception of Hospice, Private Home Care, Interpreters, and Home Health Employees.

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The Timekeeper system records all productive and non-productive hours for the pay period. Each staff member is required to verify these hours for accuracy. Access to the TimeKeeper system is available through wall readers using the staff member's ID badge or network computers using their network login. Non- exempt staff members must record the time work begins and ends, as well as the beginning and ending time of any departure from work for any non-work-related reason. Staff members must clock out and in for off-duty meal periods. Staff members may also enter all non-productive time as preferred by the leader in the work area (PTO, Jury Duty, Bereavement, etc.).

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Employees are not allowed to work off the clock. Work should not be performed until the actual start of the shift nor after the end of the shift. It is expected that employees will be ready to work at their expected work time. Clocking in early may be considered a violation of this policy. It is expected that employees will clock in and out as close to their start and end times as is physically possible. Clocking in late may be considered a tardy.

Staff members are not allowed to clock in or out for others. Altering, falsifying, or tampering with time records is prohibited and will result in disciplinary action up to and including termination of employment.

Exempt employees are required to record and report full days of absence from work for reasons such as Paid Time Off, etc.

PROCEDURE:

I. Payroll Period Calendar

The payroll period consists of two weeks. The pay period starts on Sunday at 00:00 and ends 14 days later at 23:59. Payday is the following Friday (unless it falls on a holiday). Each work week starts on Sunday at 00:00 and ends on Saturday at 23:59.

II. TimeKeeper

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TimeKeeper shows the hours worked (regular time and overtime, callback time, etc.) that the staff member actually clocked in and out of the TimeKeeper system. When the TimeKeeper system

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is not functional, employees may not be able to clock using a computer, but will be able to clock using a wall reader.

If the Timekeeper system is down, the wall reader is not available, or the staff member forgets to clock, they are required to submit a missed punch/time entry correction form in Workday. It is expected that employees use the wall readers or computers to clock in and out.

Leaders are expected to communicate their expectations of how to enter/code other unproductive hours; standby time, Paid Time Off/Extended Illness Bank, jury duty time, bereavement, other hours, other dollars etc. Employees can input their own PTO/PSL and EIB codes to ensure compliance with annual limitations.

III. Failure to Clock

Employees are required to use the Timekeeper system consistently for recording their hours worked and for meal periods. After communication and education on the use of the system, more than one missed punch per pay period may be considered excessive. Continuous failure to clock may result in disciplinary action up to and including termination of employment.

IV. Authorizing Hours

Time must be approved utilizing the sign-off tab by all employees at the end of their last shift for the pay period. Approval can be made at the wall reader but due to time it may take to review their pay period entries, it is encouraged to approve using Workday system. The authorizing leader must assure that all time has been entered correctly.

All time must be approved by leaders or their designees by 11:00 a.m. on a payroll processing Monday. Final lockout for managers is 11:00 a.m. In special situations, payroll processing on weeks when holidays occur may require a different deadline be established by the Payroll department.

Under regulatory requirements, employers must keep certain records for nonexempt employees, including hours worked each day and total hours worked each workweek. For this reason, employers have the ability to change staff member time records but must ensure that the records accurately reflect the time actually worked. Comments explaining the reason for making the changes are to be noted.

Discrepancies found after the time approving deadline will be reported through a payroll correction by the manager or designee. There may be no “red boxes” noted in any prior or current timecard of a staff member. Manual edit reports are to be reviewed each pay period by leaders. Failure to appropriately review, correct, and approve staff member timecards by leaders may lead to disciplinary action.

“Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee’s responsibility to review and understand all Kaweah Health Policies and Procedures.”

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Human Resources

Policy Number: HR.70 **Date Created:** 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer) **Date Approved:** 12/22/2022

Approvers: Board of Directors (Administration), Dianne Cox (Chief Human Resources Officer)

Meal Periods, Rest Breaks and Breastfeeding, and/or Lactation Accommodation

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

PURPOSE:

It is important that Kaweah Health employees receive their meal periods and rest breaks. These assist staff in attending to personal matters as well as downtime. Kaweah Health will facilitate meal periods and rest breaks by relieving employees of duties for specified amounts of time. In addition, Kaweah Health will provide rest and recovery periods related to heat illness for occupations that may be affected by same (i.e. Maintenance employees who work outdoors). Kaweah Health supports new mothers who desire to express milk for their infants while at work. Kaweah Health will provide the use of a room, or other location to the nursing mothers work area for expressing milk.

MEAL PERIOD POLICY AND PROCEDURE:

For non-exempt employees working more than five hours per day, including 8-, 9-, or 10-hour shift employees, Kaweah Health will provide, and employees are expected to take a 30-minute duty-free meal period. The meal period will be scheduled to start within the first five hours of each shift, i.e. the meal period must start before the end of the fifth hour in the shift. An employee who works routinely six hours or less per day may voluntarily choose to waive the meal period in writing.

For non-exempt employees working more than ten hours per day, including 12-hour shift employees, Kaweah Health will provide, and employees are expected to take a second 30-minute duty-free meal period; this meal period must start before the end of the tenth hour of the shift. Employees working more than ten hours, but less than twelve hours may choose to waive, in writing, one of the two meal periods provided. If one of the two meal periods is waived, the single meal period will be scheduled approximately in the middle of the workday as practicable. An employee working more than 12 hours is authorized and expected to take a third 30-minute meal period.

Meal periods will be made available and provided by Kaweah Health Leaders; it is each employee's responsibility to ensure that they are taking appropriate meal periods as set forth in the policy. If an employee voluntarily delays a meal period that is permitted. Kaweah Health retains the right to set work schedules, including meal periods and rest break schedules.

Meal periods will be unpaid only if the employee is relieved of all duty for at least 30 minutes and the employee is not interrupted during the meal period with work-related requests. Non-exempt employees may leave the organization premises during meal periods, but are to notify their supervisor if they do leave, and inform them when they return.

Employees who are not provided a 30- minute meal period of uninterrupted time in a timely manner as described are entitled to one hour of pay at their regular rate of pay (pay code MPRB1hour). An employee who is not provided with a meal period according to policy must,

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on the day of the missed and/or interrupted meal period complete a time adjustment sheet and notify their leader. The leader will authorize payment of premium pay in the timekeeping system. Note that if the employee voluntary delays their meal period, no additional pay of one hour will be paid.

In particular circumstances and based solely on the nature of the work, and with approval of Human Resources, a revocable On-Duty Meal Period Agreement can be completed by the employee and Kaweah Health. This typically applies when there are few employees in a department or night shift is limited.

The beginning and end of each meal period must be accurately recorded on the time card or timekeeping system.

REST BREAK POLICY AND PROCEDURE:
By way of this policy non-exempt employees are also authorized, permitted and expected to take a 10-minute rest break for every four hours of work or major fraction thereof. Employees must work at least 3.5 hours to be entitled to a rest break. Rest breaks should be taken in the middle of each 4- hour period in so far as it is practicable. These rest breaks are authorized by Kaweah Health; but it is each employee's responsibility to ensure that they are taking appropriate rest breaks.

Rest breaks are considered paid-time, and employees do not clock-out and clock-in for taking such breaks. Leaving the organization premises is not permitted during a rest break.

If for some reason, an employee's rest break is not authorized or permitted, the employee will be entitled to one hour of pay at their regular rate of pay. An employee who is not authorized or permitted to take a rest break according to policy must, on the day of the unauthorized rest break complete a time adjustment sheet and notify their leader. Only one premium payment per day will be paid for missing one or more rest breaks.

ADDITIONAL INFORMATION:
An employee may be entitled to no more than two hours of premium pay per day (one for a meal period that was not provided and one for one or more rest breaks that were not authorized or permitted). Employees are required to submit time adjustment sheets on the day of the missed or interrupted meal break or unauthorized rest break listing the reason or reasons for a missed or shortened meal period or a missed rest break.

Employees may not shorten the normal workday by not taking or combining breaks, nor may employees combine rest breaks and meal periods for an extended break or meal period

Non-Exempt employees are entitled to rest breaks as follows:

- Less Than 3.5 Hours: An employee who works less than three-and-a-half is not entitled to a rest break.
- 3.5 Hours or More: An employee who works three-and-a-half hours or more is entitled to one ten-minute rest period.
- More than 6 Hours: An employee who works more than six hours is entitled to two ten-minute rest periods, for a total of 20 minutes of resting time during their shift.
- More than 10 Hours: An employee who works more than ten hours is entitled to three ten-minute rest periods, for a total of 30 minutes of resting time during their shift.

Deleted: Meal Periods, Rest Breaks and Breastfeeding, and/or Lactation Accommodation

- And so on… An employee is entitled to another ten-minute rest period every time they pass another four-hour, or major fraction thereof, milestone.

How Many Meal Breaks Must be Taken:

- 5 Hours or Less: An employee who works five hours or less is not entitled to a meal break.
- More than 5 Hours: An employee who works more than five hours is entitled to one 30- minute meal break.
- More than 10 Hours: An employee who works more than ten hours is entitled to a second 30-minute meal break.

BREASTFEEDING AND/OR LACTATION ACCOMMODATION

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Kaweah Health is compliant with the Pregnant Workers Fairness Act (PWFA) requirements and the Providing Urgent Maternal Protections for Nursing Mothers Act (PUMP Act). Kaweah Health will provide a reasonable amount of break time to allow an employee to express breast milk for that employee's infant child. The break time will run concurrently, if possible, with any rest break or meal period time already provided to the nursing mother. If it is not possible for the break time that is already provided to the employee, the break time shall be unpaid.

Kaweah Health will make reasonable efforts to provide the nursing mother with the use of a room or other location in close proximity to their work area for the nursing mother to express milk in private. If a refrigerator cannot be provided, Kaweah Health may provide another cooling device suitable for storing milk, such as a lunch cooler.

There are several designated lactation rooms that may be found throughout Kaweah Health. Their locations are the following:

a) Mineral King Wing, 1st Floor MK lobby by Lab Station
b) Mineral King Wing, 2nd Floor on the left heading to ICU
c) Mineral King Wing, 3rd Floor on the left just past the stairwell
d) Acequia Wing, Mother/Baby Department
e) Support Services Building, 3rd Floor, (Computer available)
f) South Campus, next to Urgent Care Lobby
g) Imaging Center/Breast Center Office (Computer available)
h) Mental Health Hospital, Breakroom Suite
i) Visalia Dialysis, Conference Room, (Computer available)
j) Exeter Health Clinic, Family Practice Department, (Computer available)
k) Woodlake Health Clinic, (Computer available)
l) Dinuba Health Clinic, (Computer available)
m) Lindsay Health Clinic, (Computer available)
n) Rehabilitation Hospital, next to Outpatient Speech Therapy Office

Deleted: Imaging Center, Dexa Exam Room

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"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.145	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 04/26/2023**
Approvers: Board of Directors (Administration)	

Family Medical Leave Act (FMLA) / California Family Rights Act (CFRA) Leave of Absence

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

POLICY:

To allow time off to eligible employees. To establish a system to continue to receive compensation through accessible benefits, such as Extended Illness Bank (EIB), Paid Time Off (PTO), State Disability Insurance, and Workers' Compensation. To advise employees of their rights and responsibilities.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, Kaweah Health will make reasonable accommodations for known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee, unless undue hardship would result. A leave of absence may be considered as a type of reasonable accommodation. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact their supervisor, department head, or Human Resources and make a request to participate in a timely interactive process to explore reasonable accommodations. The individual with the disability is invited to identify what accommodation he or she needs to perform the job. Kaweah Health will take steps to identify the barriers that make it difficult for the applicant or employee to perform his or her job, and will identify possible accommodations, if any, that will enable the individual to perform the essential functions of his or her job. If the accommodation is reasonable and will not impose an undue hardship, Kaweah Health will meet the request.

NOTE: Due to coordination of information between departments and outside agencies, and the requirement that certain records be maintained to demonstrate compliance with State and Federal law, it is important that paperwork and documentation be completed and submitted to Human Resources in a timely manner by department heads and employees.

PROCEDURE:

This policy is based on the California Family Rights Act, as amended in 1993 (CFRA), and the Federal Family and Medical Leave Act of 1993 (FMLA), and is intended to provide eligible employees with all of the benefits mandated by these laws. However, in the event that these laws or the regulations implementing these laws are hereafter amended or modified, this policy may be amended or modified to conform with any change or clarification in the law.

1. Reason for Leave

Family leaves are subject to the eligibility requirements and rules set forth in this policy statement, and as provided by State and Federal regulations.

a. FMLA requires covered employers to provide up to 12 weeks of unpaid, job- protected leave to eligible employees for the following reasons:

i. For incapacity due to pregnancy, prenatal medical care or childbirth;

ii. Leave taken for the birth, adoption or placement of a child for foster care must be concluded within 12 months immediately following the birth, adoption or placement. The minimum duration for such leave is two (2) weeks. However, leave for less than two (2) weeks can be taken on two occasions only. Kaweah Health has the right to approve intermittent leave. Under CFRA, bonding leave may be taken at the end of Pregnancy Disability Leave for up to 12 weeks, and concluded within 12 months immediately following the birth.

iii. To care for the employee's spouse, registered domestic partner, son or daughter, step son or daughter, or parent, step parent, grandparent, foster parent, adoptive parent, who has a serious health condition, including a son or daughter 18 years of age or older if the adult son or daughter has a disability as defined by the Americans with Disability Act (ADA); or

iv. For a serious health condition that makes the employee unable to perform the employee's job.

v. Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status deployed to a foreign country may use Leave to prepare for short-notice deployment, attend military events, arrange for childcare, address financial and legal arrangements, attend counseling sessions, and allow for rest, recuperation and post-deployment activities, among other events.

vi. A special leave entitlement is available that permits eligible employees to take up to 26 weeks of leave to care for a covered service member who is the spouse, son, daughter, parent, or next of kin. Certain conditions apply.

CFRA: In addition to the protections listed above, CFRA allows an employee to take up to 12 workweeks of unpaid protected leave during any 12-month period to bond with a new child of the employee or to take care for a designated person (any individual related by blood or whose association with the employee is the equivalent of a family member (one per 12-month period)), grandparent, grandchild, sibling, spouse, or domestic partner. If Kaweah Health employs both of the parents of a child, both are covered by this policy if eligibility requirements are met. Kaweah Health will grant a request by an eligible employee to take up to 12 workweeks of unpaid protected leave during any 12-month period due to a qualifying exigency related to the covered active duty or call to covered active duty of an employee's spouse, domestic partner, child, or parent in the Armed Forces of the United States. Leaves for this reason are, for the most part, covered under the FMLA, so these leaves may run concurrently with leave under the FMLA if the leave qualifies for protection under both laws.

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b. A "serious health condition" is an illness, injury, impairment or physical or mental condition which involves:

i. inpatient care (i.e., an overnight stay) in a medical care facility; or

ii. continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

iii. The continuing treatment may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may qualify.

2. Employee Eligibility

Family leave is available to employees who have worked at least 12 months for Kaweah Health and have worked more than 1,250 hours during the previous 12 months.

Leave Available

An employee may take up to twelve (12) weeks of leave during a 12-month period. A 12- month period begins on the date of an employee's first use of FMLA/CFRA leave. Successive 12- month periods commence on the date of an employee's first use of such leave after the preceding 12-month period has ended. FMLA and CFRA counts against the amount of Medical Leave available and vice versa.

a. If certified to be medically necessary, leave to care for a family member's serious health condition may be taken intermittently or the employee may request a reduced work schedule. See below for more information.

b. Leave taken for the birth, adoption or placement of a child for foster care must be concluded within 12 months immediately following the birth, adoption or placement. The minimum duration for such leave is two (2) weeks. However, leave for less than two (2) weeks can be taken on two occasions only. Kaweah Health has the right to approve intermittent leave. Under CFRA, bonding leave may be taken at the end of Pregnancy Disability Leave for up to 12 weeks, and concluded within 12 months immediately following the birth.

Employees with pregnancy-related disabilities may have the right to take a Pregnancy Disability Leave in addition to a Family Leave.

3. Intermittent or Reduced Leave Schedule:

a. If certified to be medically necessary, for self or leave to care for a family member's serious health condition may be taken intermittently or the employee may request a reduced work schedule. Increments of time may not be less than one hour.

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b. Employees requesting intermittent leave or a reduced work schedule may be requested to transfer to an alternate job position. Such a transfer will be to a job position better able to accommodate recurring periods of absence but which provides equivalent compensation and benefits.

c. In any case, employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.

d. Leaves to care for a newborn child or a child placed for adoption of foster care may not be taken intermittently or on a reduced leave schedule under FMLA/CFRA.

e. Exempt employees taking an intermittent or reduced leave will be paid for all hours actually worked. For example: An exempt employee is restricted to working three hours a day. The employee will be paid for three hours of productive time and five hours of PTO without impacting their exempt status. If the employee doesn't have PTO, the five hours will be unpaid.

f. Accrued PTO hours are required to be used for intermittent leaves.

4. Notice, Certification and Reporting Requirements

a. Timing:

If the need for the leave is foreseeable, an employee must provide 30 days written notice prior to the requested start of the leave. When 30 days is not possible, the employee must provide notice as soon as practicable and generally must comply with Kaweah Health's normal call-in procedures.

If the need for the leave is foreseeable due to a planned medical treatment or supervision, the employee must make a reasonable effort to schedule the treatment or supervision in order to avoid disruption to the operations of Kaweah Health.

b. Certification:

i. An employee requesting leave to care for a family member with a serious health condition must provide a health-care provider's certification that it is medically necessary for the employee to assist in caring for the family member with the serious health

condition. The certification must include the following:

1. The date on which the serious health condition commenced;
2. The probable duration of the condition;
3. An estimate of the amount of time that the health care provider believes the employee needs to care for the individual requiring the care; and
4. A statement that the serious health condition warrants the participation of a family member to provide care during a period of the treatment or supervision of the individual requiring care.

ii. Upon expiration of the time estimated by the health-care provider needed for the leave, Kaweah Health may require the employee to obtain recertification in accordance with the above requirements as certifications expire.

iii. In addition, an employee requesting an Intermittent Leave or reduced work schedule must provide a health-care provider's certification stating the following:

1. The date on which the treatment is expected to be given and the duration of the treatment.
2. That the employee's Intermittent Leave or reduced work schedule is necessary for the care of a spouse, child or parent with a serious health condition or that such leave will assist in the individual's recovery; and
3. The expected duration of the need for an Intermittent Leave or reduced work schedule.

iv. Department heads may not contact the employee's health care provider to obtain information on a leave. They are to refer any questions to Human Resources or Employee Health Services who may contact the provider.

c. Employee Periodic Reports:

During a leave, an employee must provide periodic reports regarding the employee's status to the department head and Human Resources, including any change in the employee's plans to return to work. Failure to provide updates may cause Kaweah Health to apply a voluntary resignation from employment.

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During an approved Intermittent Leave, the employee must call their department head or designee and Human Resources each day or partial day that is requested as Intermittent Leave time.

5. Compensation During Leave:

   Refer to the pamphlet from the Employment Development Department (EDD) entitled "For Your Benefit: California's Program for the Unemployed" for more information. Also refer to the Paid Family Leave policy in the manual.

   a. For a medical leave of absence longer than seven days which is to be coordinated with State Disability Insurance (SDI), or a Workers' Compensation leave of absence, accrued EIB hours are paid after 24 hours off. The initial three 24 hours are paid through accrued PTO, if available, at the employee's discretion. In the circumstance of an immediate hospitalization or surgery, an employee may be paid from accrued EIB from their first full day off. EIB must be used for coordination with SDI or Workers' Compensation Temporary Disability Payments; PTO time may be used only after all Extended Illness Bank (EIB) has been exhausted. Coordinated amounts will not exceed the regular amount of pay normally earned by the employee.

   b. It is the employee's responsibility to notify Payroll of the amount they receive from SDI or Workers' Compensation to ensure the correct amount of EIB coordination.

   c. Applying the EIB utilization guidelines, EIB may be used for Kin Care for the same eligible members noted on page one. Up to 50% of the annual EIB accrual can be used if the employee has worked a full 12 months; otherwise the utilization will be limited to 50% of the employee's accrued EIB. A maximum of 50% of accrued hours in a 12-month period may be utilized.

6. Benefit Accrual:

   The employee will continue to accrue PTO as long as they are being paid by Kaweah Health (receiving a paycheck) during integration of benefits on continuous leave of absence.

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7. Merit Review Date:

   The merit review date will not change during a leave of absence.

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8. Benefits During Leave:

   a. An employee taking leave will continue to receive coverage under Kaweah Health 's employee benefit plans for up to a maximum of four (4) months per 12-month period at the level and under the conditions of coverage as if the employee had continued in employment continuously for the duration of such leave. Kaweah Health will continue to make the same premium contribution as if the employee had continued working.

   b. Insurance premiums (health, vision, dental, life, etc.) are to be paid by the employee and Kaweah Health, under the same conditions as existed prior to the leave, for a maximum period of four (4) months in a 12-month period.

   c. If on paid status (utilizing PTO/EIB), an employee may continue his/her

normal premiums through payroll deduction. If on unpaid status, he/she is required to pay Kaweah Health his/her portion of the premiums while on a leave of absence for a total of four months. After four months, employees will be offered COBRA Continuation Coverage for applicable benefits.

d. In the case where Pregnancy Disability Leave (FMLA) combined with CFRA bonding leave applies, if an employee is on paid status (utilizing PTO/EIB), the employee may continue her normal premiums through payroll deduction. If on unpaid status, she is required to pay Kaweah Health her portion of the premiums monthly while on a leave of absence for a total of up to seven months; COBRA rules then apply.

e. An employee whose insurance is canceled due to nonpayment of premiums will have to satisfy a new waiting period after returning to work and will be considered a "new employee" for insurance purposes and as such, the employee may have to provide proof of insurability and will be subject to the pre-existing rules which apply at the time of the leave.

f. An employee may cancel his/her insurance(s) within 30 days of the end of his/her paid leave and will be re-enrolled upon return without a waiting period. Cancellation must be done in writing to the Human Resources Department. The employee must reinstate coverage within 30 days of his/her return from work.

g. Group medical, dental, vision insurance coverage and the medical spending account will cease on the last day of the month in which an employee reaches four months of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan.

h. If the employee fails to return to work at the expiration of the leave, he/she must repay any health insurance premiums paid by Kaweah Health while on leave, unless failure to return to work is due to a continuation of his/her own serious health condition or other reasons beyond his/her control.

9. Reinstatement:

a. A doctor's release and a clearance with Employee Health Services will be required when an employee is returning from a medical leave of absence. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within 2 weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all District policies, rules and procedures.

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b. Under most circumstances, upon return from Family or Medical Leave,

an employee will be reinstated to his or her previous position, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions. However, an employee returning from a Family or Medical Leave has no greater right to reinstatement that if the employee had been continuously employed rather than on leave. For example, if an employee on Family and Medical Leave would have been laid off had he/she not gone on leave, or if and employee's position is eliminated during the leave, then the employee would not be entitled to reinstatement.

c. An employee's use of Family and Medical Leave will not result in the loss of any employment benefit that the employee earned or was entitled to before using Family or Medical Leave.

d. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within 2 weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all District policies, rules and procedures.

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Kaweah Health
MORE THAN MEDICINE. LIFE.

Human Resources

Policy Number: HR.149	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 04/26/2023**
Approvers: Board of Directors (Administration)	
Bereavement Leave	

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

PURPOSE:

To allow employees who have experienced a death in the immediate family to take the time to make necessary arrangements and to observe a period of grieving.

POLICY:

All Full-Time and Part-Time Benefitted employees shall be granted paid bereavement time in the event of a death in their immediate family. As of January 1, 2023, an employee may take up to five shifts of bereavement leave upon the death of a qualifying family member, 24 hours of which will be paid under prior Kaweah Health Policy for employees who receive benefits (the remaining shifts would be unpaid or paid through accrued PTO).

An employee is eligible for bereavement leave once they have been employed for at least 30 days prior to the commencement of leave. A qualifying family member includes spouse, child, parent, sibling, grandparent, grandchild, domestic partner, or parent-in-law. The five shifts of bereavement leave do not need to be taken consecutively; they can be intermittent.

The employee must complete the bereavement leave within three months of the family member's date of death. The employer may require that the employee provide documentation of the death of the family member including a death certificate, published obituary, funeral home, burial society, crematorium, religious institution, or governmental agency. The documentation, if requested by the employer, must be provided within 30 days of the first day of bereavement leave.

PROCEDURE:

1. Immediate family can be defined with the list below; however, the California Family Rights Act (CFRA) defines there may be instances where a loss of a significant other, designated person, and/or close relative would be considered. This classification may be considered as one event for bereavement leave every 12 months and will be left up to the discretion of each Director of Executive.

Immediate Family Members:

Mother	Reg. Domestic Partner	Mother-in-law	Daughter-in-law
Father	Child	Father-in-law	Step Child
Sister	Grandchild	Sister-in-law	Step Parent
Brother	Grandparent	Brother-in-law	Step Brother
Spouse	Legal Guardian	Son-in-law	Step Sister
Miscarriage			

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2. The employee must notify their leader of the need for time off.

3. For full-time and part-time benefitted employees, bereavement time is to be recorded via timekeeping as Bereavement pay up to 24 hours. PTO-Bereavement for the 25 hour through the 5th shift, Bereavement-No Pay if preferred. For Per-Diem or non-benefited employees, Bereavement time is coded as Bereavement-No Pay.

4. Additional leave utilizing Paid Time Off (PTO) or unpaid time off may be arranged upon request and with approval of management.

5. Bereavement time is to be recorded via timekeeping in Workday.

6. Where a pattern of use is established, documentation of death may be required. Failure to provide such documentation upon return to work may result in the leave being considered as an unauthorized absence without pay.

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Policy Number: HR.184	**Date Created: 03/14/2014**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 04/26/2023**
Approvers: Board of Directors (Administration)	
Attendance & Punctuality	

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

POLICY:

Attendance and punctuality is important to Kaweah Health's mission to deliver high quality service to our patients and the community. It is each employee's responsibility to maintain a good attendance record. Regular attendance and promptness are considered part of an employee's essential job functions. Employees with excessive absenteeism may be subject to Progressive Discipline.

Employees with disabilities may be granted reasonable accommodation to assist them in meeting essential functions under any provision in this policy. In cases of disability, appropriate documentation from a healthcare provider is required. A Leave of Absence may be considered as a reasonable accommodation. Please refer to Leave of Absence and the Reasonable Accommodation Policy for more information.

All absences will be recorded on an attendance record (utilizing specific comments in the timekeeping system), which will be used to identify acceptable or unacceptable attendance patterns. The focus of this policy is on the frequency of absences and is to ensure reliability of employees to their work schedule and/or work requirements.

Employees are also expected to report to work punctually at the beginning of the scheduled shift and when returning from meals and breaks.

An employee who misrepresents any reason for taking time off may be subject to disciplinary action up to and including termination of employment. See HR.216 Progressive Discipline.

PROCEDURE:

Absenteeism is not being at work or attending a Kaweah Health paid workshop when scheduled unless the absence is protected by law.

The following number of occurrences, including full shift absences, tardies and leaving early, will be considered excessive and will be grounds for counseling and disciplinary action up to and including termination. During the new hire introductory period (see HR.37 Introductory Period), unacceptable attendance may result in the employee being placed in an advanced step of disciplinary action up to and including termination of employment.

Occurrence:

- An occurrence is defined as a full day or consecutive days of unscheduled, unapproved, unprotected time off. If makeup time is authorized on the same day or within the week of the occurrence, the absence is still counted as an occurrence.

- For the purpose of this policy, a "tardy" results when an employee fails to report to their work area ready for work at the start of their shift or fails to return from lunch or break at the appropriate time.

- Two tardies or leaving early that have not been pre-approved count as one occurrence. One tardy and one time leaving early can also count as one occurrence, as well as two unscheduled events of leaving early will count as one occurrence.

- An employee is required to call in absences two hours prior to the start of their scheduled shift.

- Please note that attendance and punctuality is considered an important factor of overall performance and will be considered in performance. As such, if an employee has or is to receive disciplinary actions other than attendance, the levels as noted below will escalate. The entire performance of an employee is considered when establishing levels and Kaweah Health may apply any level or immediate termination if warranted due to the circumstance.

Number of Occurrences in a Rolling 12-Month Period

Counseling	Occurrences	Introductory Period
Verbal Warning	4	4
Level I Written Warning	5	NA
Level II Written Warning	6	
Level III Written Warning	7	
Termination	8	5

Pattern Absenteeism:

Employees will be considered to have a pattern of unscheduled absences if their absences tend to occur immediately before or after scheduled days off, before or after holidays or weekends, occur at regular intervals or on consistent days, occur immediately following disciplinary action, or occur on days that the employee requested off but were denied such request. Patterned absences will be considered misconduct and will be grounds for Progressive Discipline.

Absences not to be considered under this policy are noted below. Reasonable notice of these absences is requested and in some cases required. Progressive Discipline

may apply where reasonable notice or requested proof of time off documentation is not provided.

a. Work-related accident/illness.

b. Pre-scheduled Paid Time Off (PTO).

c. Pre-scheduled personal time.

d. Time off to vote or for duty as an election official. This provision will be limited to federal and statewide elections exclusively and shall not be extended to include local, city or county elections. Employees requesting time off to vote will submit the request in writing. The request should state specifically why the employee is not able to vote during non-working hours. Unless otherwise agreed, this time must be taken at the beginning or ending of the employee's shift to minimize the time away from work.

e. Time off for adult literacy programs.

f. Time off if a victim of a crime, or if a family member is the victim of a crime, when they take time off following the crime. Protections are for an employee who is a victim of domestic violence, sexual assault, or stalking for taking time off from work for any specified purpose, including seeking medical attention, for injuries caused by the domestic violence, assault, or stalking and appearing in court pursuant to a subpoena. In addition, protections include taking time off from work to obtain or attempt to obtain any relief. Relief includes, but is not limited to, a temporary restraining order, restraining order, obtaining psychological counseling, engaging in safety planning, seeking other injunctive relief, and to help ensure the health, safety or welfare of the victim or their child. Furthermore, protections include if the employee provides certification that they were receiving services for injuries relating to the crime or abuse or if the employee was a victim advocate.

g. Time off to attend judicial proceedings as a victim of a crime, the family member, registered domestic partner or child of a registered domestic partner who is a victim of a crime. Victim means any person who suffers direct or threatened physical, psychological, or financial harm as a result of the commission or attempted commission of specified crime or their spouse, parent, child, sibling, or guardian.

h. Employees who enter uniformed military service of the Armed Forces of the United States for active duty or training.

i. Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation.

j. Time off of up to fourteen (14) days per calendar year for volunteer

firefighter, reserve peace officer, or emergency rescue personnel training or duties.

k. Time off to attend school or child care activities for their children, grandchildren or guardians (limited to 40 hours per year not exceeding eight hours in any calendar month). Applies to children in grades 1 through 12 or in a licensed child care facility. Additional protections apply for required appearances after suspension of a child from school. Effective January 1, 2016, employees may take time off from work to find a school or a licensed child care provider and to enroll or re-enroll a child, and time off to address child care provider or school emergencies.

l. Bereavement time related to Policy.

m. Jury Duty or Witness Duty.

n. Leaves pursuant to legislative requirements Family and Medical Leave Act of 1993 (FMLA); California Family Rights Act of 1991 (CFRA); Pregnancy Disability Leave (PDL); Organ and Bone Marrow Donation Leave; and Workers' Compensation (WC).

o. Kin Care: Kin Care authorizes eligible employees to use up to one-half (½) of the Extended Illness Bank (EIB) that they accrue annually, in a calendar year, to take time off to care for a sick family member. Employees who accrue EIB are eligible for Kin Care. Employees who are not eligible for EIB are not eligible for Kin Care. No more than one-half of an employee's EIB accrual in a calendar year period can be counted as Kin Care. For example, for full-time employees this would mean no more than 24 hours can be utilized as Kin Care in a calendar year period. An employee must have EIB available to use on the day of the absence for that absence to be covered under Kin Care. An employee who has exhausted his/her EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care. Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, parents, parents-in-law, siblings, grandchildren and grandparents. A Leave of Absence form does not need to be submitted unless the employee will be absent and use sick leave for more than three continuous workdays. In addition, an employee taking Kin Care does not need to submit a doctor's note or medical certification. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a doctor's note.

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Absence for Religious Observation

Kaweah Health will attempt to accommodate employees requesting absence for religious observation, however, in certain circumstances accommodation may not be possible or reasonable.

Notification of Late Arrival

An employee is required to call in absences two hours prior to the start of their scheduled shift.

Workers' Rights in Emergencies

Kaweah Health is compliant with California SB1044 and prohibits taking adverse action against an employee for refusing to report to or leaving work during an emergency condition. prohibits from preventing an employee from accessing a mobile device during that time. This is specified as:

- Conditions of disaster or extreme peril to the safety of persons or property at the workplace or worksite caused by natural forces or a criminal act.
- An order to evacuate a workplace, a worksite, a worker's home, or the school of a worker's child due to natural disaster or a criminal act.

This paragraph does not apply to the following:

An employee or contractor of a health care facility who provides direct patient care, provides services supporting patient care operations during an emergency, or is required by law or policy to participate in emergency response or evacuation.

When feasible, an employee shall notify the employer of the emergency condition requiring the employee to leave or refuse to report to the workplace or worksite prior to leaving or refusing to report.

Schedules

a. Employees are scheduled to work during specified hours. Unless approved by management, those hours may not be adjusted to accommodate early or late arrival or departure.

b. Employees who arrive for work early may not leave before the end of their scheduled work period unless authorized to do so by their management. Employees may be subject to discipline for incurring unauthorized overtime by reporting to work prior to their scheduled start time. Employees who arrive for work late may not remain on duty beyond the regular scheduled work time to make up the lost time unless authorized to do so by their management. Employees who are absent without approval but are allowed to makeup time will continue to be subject to disciplinary action for lack of reliability.

c. Employees are only paid for actual hours worked.

d. Employees may not shorten the normal workday by not taking or by combining full meal periods and rest break periods and may not leave before the end of their scheduled shift without the authorization of a supervisor.

e. Any employee who leaves Kaweah Health premises during work hours must notify and obtain approval from management and/or their designee prior to departure. Employees must clock out and in for their absence.

f. Employees are to give advanced notice for cancellation of any class or program in which they are enrolled, whether voluntary or mandatory. Advanced notice for

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cancellation defined as the following:

1. If class is on Tuesday through Friday, cancel the day before by 8:00am. EXAMPLE: Class is Wednesday at noon- must cancel before Tuesday 8:00 am.
2. If class is on Monday, cancel prior to 23:59 on Saturday
3. Classes need to be cancelled through our Learning Management System (LMS)
4. If the employee cannot cancel in our LMS or they are past the defined time for advanced notice, the employee must contact their manager via phone or email letting them know they cannot attend.

g. Employees must be on time.

h. Failure to give advance notice may count as an occurrence under the Attendance Policy HR.184. Refer to Progressive Discipline policy HR 216.

i. Employees who are absent from work for three days and have not contacted their department manager or supervisor will be assumed to have voluntarily terminated their employment. Employees who are

absent from work without authorization and without providing proper notification to management may be considered to have abandoned their job and will be terminated from employment.

j. Weekend Makeup Policy – Employees who call in on weekends may be required to make up weekend shifts missed.[1][1] Weekend shifts will be scheduled for makeup on a successive schedule at the discretion of the scheduling coordinator/supervisor per staffing needs.

k. Holiday Makeup Policy – Employees who call in on a [2][2]holiday will be required to work another holiday or an extra weekend shift at the discretion of the scheduling coordinator/supervisor per staffing needs.

Loitering

Kaweah Health employees may not arrive to work greater than thirty (30) minutes prior to the start of their shift and may not remain within Kaweah Health facilities greater than thirty (30) minutes beyond the end of their shift without specific purpose and/or authorization to do so.

Clocking

Employees should not clock in, may not begin work before the start of their scheduled shift and must discontinue work and clock out at the conclusion of their scheduled shift, unless instructed otherwise by their management. Employees may not work off-the- clock, including use of electronic communication.

Further information regarding this policy is available through your department manager or the Human Resources Department

[1][1] Weekend shift starts Fridays at 1800 and ends Mondays at 0600.
[2][2] Holiday is from 1800 the day before the holiday and ends 0600 the morning after the holiday.

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Human Resources

Policy Number: HR.213	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved:06/28/2021
Approvers: Board of Directors (Administration)	

Performance Management and Competency Assessment Program

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

POLICY:

It is the policy of Kaweah Health to assess, maintain, develop and improve employee performance and competence on an ongoing basis. Performance is formally evaluated on an annual basis through an employee self-evaluation, peer evaluations as appropriate, and a manager evaluation. Competency is the demonstrated ability to integrate the knowledge, skills, and attitudes required in a designated role or setting. Competency is verified through utilization of techniques such as demonstration, review of policy/procedure, verbalization, and/or written testing.

The performance evaluation and competency assessment process ensures that the requirements of the position are met, that each individual is provided opportunities for professional development, and allows for merit increase opportunities consistent with the compensation program in place at the time of the performance evaluation. The performance evaluation process for all eligible employees will start in July of each year. Employees with a hire date on or before June 30 will included in the evaluation cycle.

Kaweah Health requires annual mandatory training in compliance with regulatory agency requirements as well as Kaweah Health policy. Documentation of completion is recorded in the HR systems and written documentation may be maintained in Human Resources or department employee's files. Management is responsible for ensuring employees complete the requirements and for obtaining and maintaining documentation of completion. However, employees are ultimately responsible for meeting job requirements and mandatory training by established due dates. Failure to complete requirements and mandatory training may result in suspension and Disciplinary Action up to and including termination of employment.

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Commented [MH3]: Still true since it's generic enough

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Commented [BT5]: Hannah, Please review.

PROCEDURE:

Annual Performance Evaluations:

1. The annual Performance Evaluation is a tool utilized by both management and the employee to identify and communicate the performance of the employee and the future annual expectations of the position, and to determine ways to improve performance or to gain advanced knowledge, including development opportunities. The Performance Evaluation is to be discussed with the employee in a face-to-face meeting. The employee is encouraged to provide additional feedback, written comments, and share development interests.

2. The Performance Evaluation includes an assessment of overall job performance, attendance, and behavioral standards of performance. It also includes comments, goals to be used for training and development, and to describe actions which will be used to develop skills and improve the employee's performance, such as additional training or work assignments.

3. Employees are required to complete an honest and timely self-evaluation of their performance. Management may also request peer evaluation for feedback of the employee's performance in their role and alignment of behaviors to the vision, mission and behavioral standards.

4. The final review will be electronically signed by both the employee and individual completing the evaluation. The evaluation must include feedback on clinical duties by a person who has the expertise at least equal to the individual being observed or tested.

5. At the completion of the annual evaluation, the overall performance rating will be consistent with the definitions noted on the performance evaluation tool. Failure to successfully meet expectations of performance may result in the employee being placed on Disciplinary Action, up to and including termination of employment.

Review Date and Applicable Merit Increases:

1. Self-evaluations for all employees are sent out by HR in July and due no later than July 31. The manager evaluation and employee electronic acknowledgement is due by September 30. It is the responsibility of employees to complete a timely and thoughtful self-evaluation. After July 31, the self-evaluation will no longer be available for the employee to complete. It is expected that department management will complete evaluations on time to ensure merit increases are not delayed for eligible employees.

2. At the time the employee is hired or changes to a different position, he/she will be provided with a copy of the Job Description that will be used to evaluate his/her performance. The employee completes an electronic acknowledgment of receipt. For job changes/transfers that are considered a promotion and effective July 1 through the merit effective date, the merit increase will be

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pushed out to October of the following year.

3. Completion of the annual review is defined as the employee's electronic signature in the Human Resources system. Human Resources will process any associated merit increase. Merit increases are effective the first day of the second pay period in October for all eligible employees.

4. Merit increases are based on the salary range and merit increase percentages in effect on the due date of the evaluation, not the day the evaluation is presented to Human Resources. The merit increase will be paid retroactively if the evaluation is completed late.

5. Per Diem Employees on a Critical Flat will receive a performance evaluation, but will not be eligible for annual performance merit adjustment.

6. Per Diem Employees on the Range will receive a performance evaluation, and will be eligible for annual performance merit adjustments.

7. Merit increases that place an employee's rate at the maximum of the range will result in the application of a Merit Lump Sum amount, equivalent to the employee's productive and non-productive hours (excluding standby, overtime, double time or callback hours) multiplied by the hourly rate in place for the employee prior to the evaluation. An employee may receive a partial merit increase to the maximum of salary range and a partial Merit Lump Sum.

Competence Assessment:

1. During the first of 48 hours of employment, all employees will complete the 48-hour checklist for departmental orientation.

2. Competency is the demonstrated ability to integrate the knowledge, skills, and attitudes required for performance in a designated role or setting. Competency is verified through utilization of techniques such as demonstration, review of policy/procedure, verbalization, written testing, etc. For the initial competency evaluation at the time of hire or transfer, a face-to face discussion will occur to assess and document the initial competency of an employee who provides patient care. Initial competency documentation is maintained in the department files or Human Resources as determined by the department. All items must be reviewed, checked and signed for competency by a person who has the expertise at least equal to the individual being observed or tested. An employee must be deemed competent to perform a skill prior to them performing the skill independently.

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(12) weeks (84 days) in a twelve-month rolling period, the employee's review date may be adjusted by the number of calendar days exceeding 85 days. This provision will not apply in the case of an employee who is on an approved Short- Term (Reserve) Military Training and/or Military Leave of Absence.

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3. Patient care and related employees will complete an annual clinical competency assessment for their position as applicable. All items must be reviewed, documented and signed for competency by a person who has the expertise at least equal to the individual being observed or tested.

4. In addition, employees must be deemed competent when new procedures or equipment is introduced into the clinical setting, and this information will be maintained in the Human Resources or department file.

Remediation:

1. If an employee falls below expected levels of performance or is not deemed competent of a requirement or skill, the employee will be provided with opportunities for improvement.

2. The remediation plan may be included in a Disciplinary Action/Performance Notice, or a separate remediation plan may be developed. Time frames for follow up and requirements will be noted as applicable, and may include meetings, testing, review of policies, and other appropriate actions to ensure performance and competency. Failure to comply with or successfully complete the plan may result in further Disciplinary Action up to and including termination of employment.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Deleted: *"Responsibility for the review and revision of this Policy is assigned to the Vice President of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Delta will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Delta Policies and Procedures."*

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Human Resources

Policy Number: HR.216	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 12/22/2022**
Approvers: Board of Directors (Administration)	
Progressive Discipline	

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

POLICY:

Kaweah Health uses positive measures and a process of progressive discipline to address employee performance and/or behavioral problems. Kaweah Health recognizes that the circumstances of each situation must be evaluated individually to determine whether to discipline progressively or to impose more advanced discipline immediately. This policy applies to all District employees, except residents enrolled in the District's Graduate Medical Education (GME) program. Disciplinary actions related to residents in the GME program are handled by the Office of the GME as described in the Resident Handbook.

The primary purpose of Disciplinary Action is to assure compliance with policies, procedures and/or Behavioral Standards of Performance of the District. Orderly and efficient operation of our District requires that employees maintain appropriate standards of conduct and service excellence. Maintaining proper standards of conduct is necessary to protect the health and safety of all patients, employees, and visitors, to maintain uninterrupted operations, and to protect the District's goodwill and property. Because the purpose of disciplinary action is to address performance issues, it should be administered as soon after the incident(s) as possible. Therefore, depending on the seriousness of the offense and all pertinent facts and circumstances, disciplinary action will be administered promptly.

Certain violations are considered major and require more immediate and severe action such as suspension and/or termination. Lesser violations will generally be subject to Progressive Discipline.

Any employee who is in Progressive Discipline is eligible for transfer or promotion within Kaweah Health with review and approval by the hiring manager and Human Resources.

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Progressive Discipline shall be the application of corrective measures by increasing degrees, designed to assist the employee to understand and comply with the required expectations of performance. All performance of an employee will be considered when applying Progressive Discipline.

In its sole discretion, Kaweah Health reserves the right to deviate from Progressive Discipline or act without Progressive Discipline whenever it determines that the circumstances warrant.

PROCEDURE:

I. The process of Progressive Discipline may include the following, depending on the seriousness of the offense and all pertinent facts and circumstances:

A. Warnings

1. Verbal Warning:

A Verbal Warning explains why the employee's conduct/performance is unacceptable and what is necessary to correct the conduct/performance.

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B. Written Warning:

A Written Warning provides the nature of the issue and outlines the expectations of performance/conduct or what is necessary to correct the situation. This Warning becomes part of the employee's personnel file, along with any pertinent back-up documentation available, and will inform the employee that failure to meet the job standards/requirements of the Warning will necessitate further disciplinary action, up to and including termination.

The department management, in concert with Human Resources, determines the level of corrective disciplinary action that will take place based upon the seriousness of the offense, the existence of any prior disciplinary actions and the entirety of the employee's work record.

1. Level I
Any employee who receives a Level I is subject to further Written Warnings as stated in this policy.

2. Level II
Any employee who receives a Level II is subject to further Written Warnings as stated in this policy.

3. Level III
A Level III is considered Final Written Warning to the employee involved, and includes a written explanation of what is necessary to meet the expectation of performance. A Level III Warning may be accompanied by a suspension. A suspension

may be without pay and is generally up to five days or forty hours.

C. Administrative Leave

In the discretion of the District, an employee may be placed on Administrative Leave at any time to give Kaweah Health time to conduct an investigation or for other circumstances considered appropriate by the District. Management may impose an Administrative Leave at any time for an employee(s) if they believe there is a risk to employee or patient safety. Management will notify Human Resources immediately if an Administrative Leave is enforced. When an employee is placed on Administrative Leave, Kaweah Health will make every effort to complete the investigation of the matter within five business days. If Kaweah Health is unable to complete an investigation of the matter within five days the Administrative Leave may be extended.

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After the investigation has been completed, the employee may be returned to work and, in the discretion of Kaweah Health and depending on the circumstances, may be reimbursed for all or part of the period of the leave. If it is determined that the employee should be terminated, compensation may, in the discretion of the District, be paid until the Post Determination Review process has been completed. (See policy HR.218).

D. Dismissal Without Prior Disciplinary History

As noted, Kaweah Health may determine, in its sole discretion, that the employee's conduct or performance may warrant dismissal without prior Progressive Discipline. Examples of conduct that may warrant immediate dismissal, suspension or demotion include acts that endanger others, job abandonment, and misappropriation of District resources. This is not an exclusive list and other types of misconduct/poor performance, may also result in immediate dismissal, suspension or demotion. See Employee Conduct below.

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E. Employee Conduct

This list of prohibited conduct is illustrative only; other types of conduct injurious to security, personal safety, employee welfare or the District's operations may also be prohibited. This includes behavior or behaviors that undermine a culture of safety. Employee conduct that will be subject to Progressive Discipline up to and including immediate involuntary termination of employment includes but is not limited to:.

1. Falsifying or altering of any record (e.g., employment application, medical history form, work records, time cards, business or patient records and/or charts).

2. Giving false or misleading information during a Human Resources investigation;

3. Theft of property or inappropriate removal from premises or unauthorized possession of property that belongs to the District, employees, patients, or their families or visitors;

4. Damaging or defacing materials or property of the District, employees, patients, or their families or visitors;

5. Possession, distribution, sale, diversion, or use of alcohol or any unlawful drug while on duty or while on District premises, or reporting to work or operating a company vehicle under the influence of alcohol or any unlawful drug;

6. Fighting, initiating a fight, threats, abusive or vulgar language, intimidation or coercion or attempting bodily injury to another person on District property or while on duty. Reference policy AP161 Workplace Violence Prevention Program;

7. Workplace bullying which can adversely affect an employee's work or work environment, Reference policy HR.13 Anti-Harassment and Abusive Conduct.

8. Bringing or possessing firearms, weapons, or any other hazardous or dangerous devices on District property without proper authorization;

9. Endangering the life, safety, or health of others;

10. Intentional violation of patients' rights (e.g., as stated in Title XXII);

11. Insubordination and/or refusal to carry out a reasonable directive issued by an employee's manager (inappropriate communication as to content, tone, and/or language)

12. Communicating confidential District or Medical Staff information, except as required to fulfill job duties;

13. Sleeping or giving the appearance of sleeping while on duty;

14. An act of sexual harassment as defined in the policy entitled Anti-Harassment and Abusive Conduct HR.13;

15. Improper or unauthorized use of District property or facilities;

16. Improper access to or use of the computer system or breach of password security;

17. Improper access, communication, disclosure, or other use of patient information. Accessing medical records with no business need is a violation of state and federal law and as such is considered a terminable offense by KDHCD.

18. Unreliable attendance (See Attendance and Punctuality HR.184)

19. Violations of Kaweah Health Behavioral Standards of Performance.

20. Unintentional breaches and/or disclosures of patient information may be a violation of patient privacy laws. Unintentional breaches and/or disclosures include misdirecting patient information to the wrong intended party via fax transmission, mailing or by face-to-face interactions.

21. Access to personal or family PHI is prohibited.

22. Refusing to care for patients in the event mandated staffing ratios are exceeded due to a healthcare emergency.

23. Working off the clock at any time. However, employees are not permitted to work until their scheduled start time.

24. Failure to work overtime.

25. Use of personal cell phones while on duty if, unrelated to job duties anywhere in Kaweah Health.

26. Excessive or inappropriate use of the telephone, cell phones, computer systems, email, internet or intranet.

27. Any criminal conduct off the job that reflects adversely on the District.

28. Making entries on another employee's time record or allowing someone else to misuse the District's timekeeping system.

29. Bringing children to work, or leaving children unattended on District premises during the work time of the employee.

30. Immoral or inappropriate conduct on District property.

31. Unprofessional, rude, intimidating, condescending, or abrupt verbal communication or body language.

32. Unsatisfactory job performance.

33. Horseplay or any other action that disrupts work,

34. Smoking within Kaweah Health and/or in violation of the policy.

35. Failure to report an accident involving a patient, visitor or employee.

36. Absence from work without proper notification or adequate explanation, leaving the assigned work area without permission from the supervisor, or absence of three or more days without notice or authorization.

37. Unauthorized gambling on District premises.

38. Failure to detect or report to Kaweah Health conduct by an employee that a reasonable person should know is improper or criminal.

39. Providing materially false information to the District, or a government agency, patient, insurer or the like.

40. Spreading gossip or rumors which cause a hostile work environment for the target of the rumor.

41. Impersonating a licensed provider.

42. Obtaining employment based on false or misleading information, falsifying information or making material omissions on documents or records.

43. Violation of Professional Appearance Guidelines

44. Being in areas not open to the general public during non-working hours without the permission of the supervisor or interfering with the work of employees.

45. Failure to complete all job related mandatory requirements as noted on the job description and as issued throughout a year (i.e. Mandatory Annual Training, TB/Flu, etc.).

46. Mandatory utilization of BioVigil.

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Further information regarding this policy is available through your department manager or the Human Resources Department.

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Policy Number: HR.234	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 06/25/2023**
Approvers: Board of Directors (Administration)	
Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014	

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

POLICY:

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Workplace Act of 2014 – Paid Sick Leave (PSL) benefits are offered to all employees as defined in this policy. PTO is offered to full-time and part-time benefit eligible employees for leisure, celebration of holidays, short-term illness and other personal needs. EIB is offered to full-time and part-time benefit eligible employees for extended illness and Kin Care. Private Home Care staff, temporary staff/interims and Per Diem staff are not eligible for PTO or EIB but are eligible for Paid Sick Leave (PSL) as defined in this policy. Excessive occurrences of unapproved time off may result in disciplinary action. See Policy HR.184 Attendance and Punctuality.

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This policy does not apply to Graduate Medical Education

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PROCEDURE:

Eligibility and Accrual for PTO and EIB

Full-time and part-time benefited employees are eligible to receive PTO and EIB as of the first pay period of eligibility (date of hire or transfer). If an eligible employee is changed to a non-eligible status, the PTO and EIB time accrual will cease. The employee will receive a lump-sum payment for all accrued PTO paid at 100% of their hourly rate of pay prior to the status change. During the non-eligible status, the employee will accrue PSL.

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If a non-eligible employee is changed to an eligible status, the employee begins accruing PTO and EIB as of the first pay period in which the status change became effective; PSL accrual will cease. At no time will an employee accrue PTO and EIB as well as PSL. An employee accrues either PTO and EIB or PSL.

EIB accrual will be reinstated for employees who leave Kaweah Health and are rehired as follows:

- If left as non-benefited and rehired as a non-benefited, we will reinstate the ending available EIB balance into a reserve bucket. These hours are available for use.
- If terminated as a benefited and rehired as benefited, we will reinstate the ending EIB balance.
- If terminated as non-benefited and rehired as benefited, we will reinstate the

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ending available EIB balance from the reserved EIB balance (if any).

- If terminated as a benefited and rehired as non-benefited, we will reinstate the ending available EIB balance up to the 48-hour maximum, placing the excess EIB balance into a reserve bucket. These hours are not available for use.

The rate of PTO and EIB accrual received is based on years of service. The accruals received per pay period will vary dependent on actual hours worked or paid. Qualified service hours which count towards a year of service for the accrual rate include the following: regular hours worked (non-overtime), Education Reduced Shift, Flex Time Off, PTO FMLA, PTO unscheduled, PTO/PSL, PTO Sick/Pregnancy, PTO Holiday, PTO/Workers Compensation, Sitter Pay, Sleep Pay, PTO hours, bereavement hours, jury duty hours, training/workshop hours, orientation hours, and mandatory dock hours. Neither EIB nor PTO accruals will be earned while employees are being paid EIB hours.

Employees					Directors		Chiefs				
Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Hours accrued per pay period	PTO Days	Accrual Rate	PTO Days	Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Hours Accrued per pay period	PTO Days
0.0	4.9	0.084625	6.77	22	8.3	27	0.0	1.0	0.103875	8.3	27
5.0	9.9	0.103875	8.31	27	9.8	32	1.1	4.0	0.123000	9.8	32
10.0	14.9	0.123000	9.84	32	11.4	37	4.1	9.0	0.142250	11.4	37
15	19.9	0.126875	10.15	33	11.7	38	9.1	13.5	0.146125	11.7	38
20	24.9	0.130750	10.46	34	12.0	39	13.6	18.0	0.150000	12.0	39
25	26.9	0.134625	10.77	35	12.3	40	18.1	22.5	0.153875	12.3	40
27	28.9	0.138500	11.08	36	12.6	41	22.6	27.0	0.157750	12.6	41
29+		0.142375	11.39	37	12.9	42	27.1		0.161625	12.9	42

Eligibility and Accrual for PSL

PSL eligible employees include Per-Diem, Private Home Care, and Part-Time non-benefit eligible employees. PSL eligible employees will accrue at the rate of one hour per every 30 hours worked (.033333 per hour); accrual begins as of the first pay period. A new employee is entitled to use PSL beginning on the first day of employment. Employees are limited to 24 hours of use of accrued time in each calendar year. PSL will carry over to the following calendar year not to exceed 48 hours of accrual in any calendar year.

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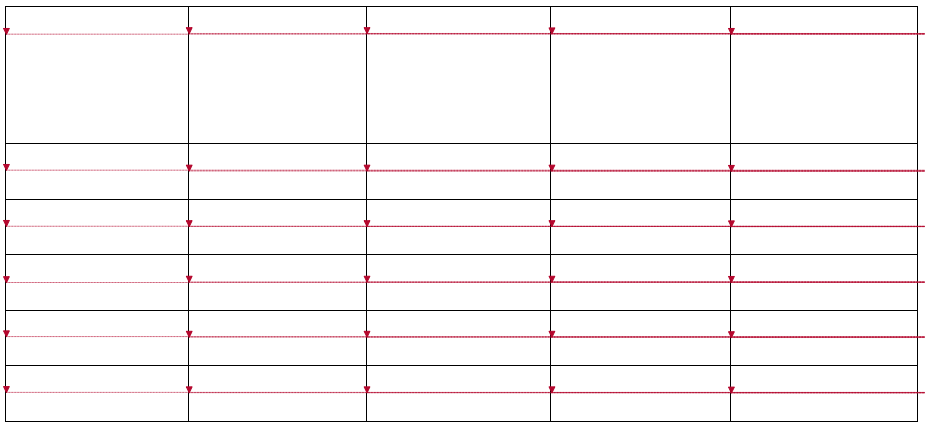
Accrual¶
(8 & 10hrs up to 80 eligible hrs a pp) (12hrsup to 72 eligible hrs a pp)



Maximum Accruals

The maximum PTO accrual allowed is 400 hours. The accrual will cease once the maximum accrual is reached until PTO hours are used or cashed out. The maximum EIB accrual is 2000 hours; the maximum PSL accrual is 48 hours in a calendar year. No payment is made for accrued EIB or PSL time when employment with Kaweah Health ends for any reason.

Requesting, Scheduling, and Access to PTO, EIB and PSL

Employees are required to use accrued PTO for time off for illness or unexpected absence occurrences.

Routine unpaid time off is not allowed. Any requests for unpaid time should be considered only on a case-by-case basis taking into consideration the need for additional staffing to replace the employee and other departmental impacts. It is the responsibility of management to monitor compliance. Employees should be aware that unpaid time off could potentially affect their eligibility for benefits.

Any planned request for PTO time, whether for traditional holiday, for vacation time, or otherwise must be approved in advance by management. Management will consider the employee's request as well as the needs of the department. In unusual circumstances, management may need to change the PTO requests of employees based upon the business and operational needs of Kaweah Health. In such situations, Kaweah Health is not responsible for costs employees may incur as a result of a change in their scheduled PTO time.

AB 1522 Healthy Workplace Healthy Families Act of 2014

An employee may utilize up to 24 hours of PTO or PSL in a calendar year (January-December) period for the following purposes:

a) Diagnosis, care, or treatment of an existing health condition, or preventative care for an employee or an employee's designated person, family member, as defined as employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, and siblings.

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Accrual rate during first 90¶
days in eligible status

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(96hrs)

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PT Staff

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b) "Family Member" means any of the following:
   i. A child, which for purposes of this policy means a biological, adopted or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis; this definition of child is applicable regardless of age or dependency status.
   ii. A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.
   iii. A spouse
   iv. A registered domestic partner
   v. A grandparent
   vi. A grandchild
   vii. A sibling

c) Designated Person means the following:
   i. Under the California Family Rights Act (CFRA) and California Healthy Workplaces Health Families Act (HWHFA) an employee will be able to identify a designated person for whom they want to use leave when they request unpaid CFRA or paid HWHFA.

d) For an employee who is a victim of domestic violence, sexual assault or stalking, as specified.

There is no cash out provision for the PSL accrual, including upon termination of employment or with a status change to a benefit eligible position. However, if an employee separates from Kaweah Health and is rehired within one year, previously accrued and unused PSL will be reinstated.

PSL and PTO time shall be utilized at a minimum of 1-hour increments and no more than the length of the employee's shift.

PTO and PSL time taken under this section is not subject to the Progressive Discipline Policy HR.216.

Time Off Due To Extended Illness

Employees who are absent due to illness for more than three (3) consecutive work days should notify their manager and contact the Human Resources Department to determine if they are eligible for a leave of absence. Accrued EIB can be utilized for an approved continuous leave of absence beyond 24 hours and if admitted to a hospital or have a medical procedure under anesthesia. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a doctor's note.

Employees who are absent due to illness for more than seven (7) consecutive days should file a claim for California State Disability Insurance. Claim forms are available in Human Resources. State Disability payments will be supplemented with any accrued EIB time by the Payroll Department, and PTO at the employee's

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request.

Employees who are absent with an Jntermittent Leave under FMLA/CFRA are required to use accrued PTO for their absences, at no less than one hour and no more than the regular length of the shift.

Time Off Due to Kin Care

Kin Care allows eligible employees to use up to one-half (1/2) of the Extended Illness Bank (EIB) that they accrue annually in a calendar year to take time off to care for a sick family member. Only employees who accrue EIB are eligible for Kin Care. No more than one-half of an employee's EIB accrual in a calendar year period can be counted as Kin Care. An employee who has exhausted his/her EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care. Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, "child" means a biological, foster, or adopted child, a stepchild, a legal ward, a child of a domestic partner, or a child or a person standing in loco parentis, parents, parents- in-law, siblings, grandchildren and grandparents.
EIB time taken under this section to care for an immediate family member is not subject to the Progressive Discipline Policy HR.216.

Holidays

Kaweah Health observes 72 holiday hours each year. Eligible employees may be scheduled a day off and will be paid provided adequate accrual exists within their PTO bank account for each observed holiday. Time off for the observance of holidays will always be in accordance Kaweah Health needs.

1. New Year's Day (January 1st)
2. President's Day (Third Monday in February)
3. Memorial Day (Last Monday in May)
4. Independence Day (July 4th)
5. Labor Day (First Monday in September)
6. Thanksgiving Day (Fourth Thursday in November)
7. Day after Thanksgiving Day (Friday following Thanksgiving)
8. Christmas Day (December 25th)
9. Personal Day

Business departments and/or non-patient care areas will typically be closed in observance of the noted holidays. Where this is the case, employees assigned to and working in these departments will be scheduled for a day off on the day the department is closed. Employees affected by department closures for holidays should maintain an adequate number of hours within their PTO banks to ensure that time off is with pay.

In business departments and/or non-patient care areas, holidays, which fall on Saturday, will typically be observed on the Friday preceding the actual holiday and holidays, which fall on Sunday, will be observed on the Monday following the actual holiday.

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Deleted: For example, for full-time employees this would mean no more than 24 hours can be utilized as Kin Care in a rolling 12-month period. An employee must have EIB available to use on the day of the absence for that absence to be covered under Kin Care.

Deleted: A Leave of Absence form does not need to be submitted unless the employee will be absent and use sick leave for more than three continuous workdays. In addition, an employee taking Kin Care does not need to submit a doctor's note or medical certification. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a¶ doctor's note.¶

Deleted: In the first 90 days of employment, benefit eligible employees who have not accrued sufficient PTO to cover holidays may be paid and their PTO accrual bank will go into the negative, until accrual is earned back in successive pay periods, unless otherwise specified by the employee.¶

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Employees who work hours on some of these holidays may be eligible for holiday differential. For more information of eligibility, see policy HR.75 Differential Pay-Shift, Holiday, and Weekend.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases. Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the staff member's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Kaweah Health
MORE THAN MEDICINE. LIFE.

Human Resources

Policy Number: HR.239	**Date Created: 06/20/2019**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 9/24/2018**
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	
Extended Illness Bank (EIB) Donations	

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

POLICY:

To provide a program where employees can donate personal Extended Illness Bank (EIB) hours to other EIB eligible employees because of a life threatening or serious extended illness for themselves or their dependent/minor children.

Deleted: This benefit will extend to the children of benefit eligible parents.

Upon review and approval of the Director, Chiefs and Chief Human Resources Officer, Human Resources will establish EIB Donation Agreements for those employees who wish to donate a portion of their accrued EIB hours to a EIB eligible employee who has need of additional time (salary continuation) because of a life-threatening or serious extended illness.

PROCEDURE:

1. The request to establish EIB donation agreements will be made by a department director and Chief Human Resources Officer.

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2. EIB hours may be donated under the following guidelines:

    a. The donor employee is limited to a donation of 25% of their EIB balance, up to 40 hours per calendar year. The donor employee must retain a minimum balance of 80 hours in their EIB bank. EIB donations used are non-refundable to the donating employee.

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    b. EIB hours will be utilized evenly by all donated employees each pay period to supplement the recipients wages, up to their normal status.

    c. EIB donations are converted from the donor employee's rate of pay to the recipient's rate of pay, so that appropriate taxes are applied.

d. The recipient may receive donated hours at amounts equal to their own coordination with SDI/Workers' Compensation, after their EIB/PTO bank has been exhausted and as long as donated EIB hours are available. Employees will not be paid more than their normal status.

e. The anonymity of the donation is at the donor's discretion.

3. Any employee donating EIB will complete an "Extended Illness Bank Transfer Agreement."

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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Kaweah Health
MORE THAN MEDICINE. LIFE.

Human Resources

Policy Number: HR.241	**Date Created: 10/26/2015**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 12/21/20**
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	
Paid Time Off (PTO) Cash Out	

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

Kaweah Health encourages employees to take vacation time; however, Kaweah Health recognizes that, in a 24-hour setting, employees may not take the amount of Paid Time Off (PTO) they are generally granted yearly, thus accruing maximum amounts in their PTO bank.

Procedure:

Employees who meet eligibility requirements have the option of cashing out a portion of their PTO. However, to meet Internal Revenue Service regulations, calendar year PTO cash-out elections are made during a special Open Enrollment in the December preceding each calendar year.

I. All hours are cashed-out at the employee's base rate of pay.

II. During the Open Enrollment, the employee must complete an irrevocable PTO Cash-Out Election in Workday.

III. The maximum cash-out for the calendar year is determined yearly in December. The election for payout will occur in the next calendar year. There are three dates available for cash-outs and any amount of hours may be requested so long as the minimum and maximum rules are met. PTO cash-outs are paid to the employee with their regular paycheck on the dates indicated in Workday. Kaweah Health requires that an employee keep available a "minimum utilization" of 40 hours of PTO in their accrual bank at the time of the cash-out, and cash-outs will be modified if 40 hours are not available.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

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August 23, 2023

Sent via Certified Mail No. 7016034000002566844
Return Receipt Required

Victor M. Perez, ESQ.
Vicente Ramos,ESQ.
Perez Law Firm
1304 W. Center Avenue
Visalia, CA 93291

RE: Notice of Rejection of Claim of Carolyn Zamudio vs. Kaweah Delta Health Care District

Notice is hereby given that the claim, which you presented to the Board of Directors of Kaweah Health on July 27, 2023, was rejected on its merits by the Board of Directors on August 23, 2023

WARNING

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

Sincerely,

Mike Olmos
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

Kaweah Delta
HEALTH CARE DISTRICT

August 23, 2023

Sent via Certified Mail
No.70160340000002566875
Returned Receipt Requested

Marty Potts
2275 N Kensington Way
Hanford, CA 93230

RE: Claim of Marty Potts vs. Kaweah Delta Health Care District

NOTICE IS HEREBY GIVEN that the claim dated August 1, 2023, you presented to Kaweah Delta Health Care District is being returned because it was not presented within six (6) months after the event or occurrence as required by law. See 901 and 911.2 of the Government Code. Because the claim was not presented within the time allowed by law, no action was taken on the claim.

Your only recourse at this time is to apply, without delay, to Kaweah Delta Health Care District for leave to present a late claim. See Sections 911.4 to 912.2, inclusive, and Section 946.6 of the Government Code. Under some circumstances, leave to present a late claim will be granted. See Section 911.6 of the Government Code.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Mike Olmos
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

Kaweah Delta
HEALTH CARE DISTRICT

August 23, 2023

Sent via Certified Mail
No.70160340000002566882
Returned Receipt Requested

Deanna Potts
2275 N Kensington Way
Hanford, CA 93230

RE: Claim of Deanna Potts vs. Kaweah Delta Health Care District

NOTICE IS HEREBY GIVEN that the claim dated August 1, 2023, you presented to Kaweah Delta Health Care District is being returned because it was not presented within six (6) months after the event or occurrence as required by law. See 901 and 911.2 of the Government Code. Because the claim was not presented within the time allowed by law, no action was taken on the claim.

Your only recourse at this time is to apply, without delay, to Kaweah Delta Health Care District for leave to present a late claim. See Sections 911.4 to 912.2, inclusive, and Section 946.6 of the Government Code. Under some circumstances, leave to present a late claim will be granted. See Section 911.6 of the Government Code.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Mike Olmos
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

Privileges in Neurology

Name: _____ Date: _____

Please Print

NEUROLOGY

Education & Training: M.D. or D.O. and successful completion of an accredited residency/fellowship in Internal Medicine or a subspecialty in Psychiatry & Neurology approved by the ACGME, AOA or by the Royal College of Physician & Surgeons of Canada *(if board certified by an ABPN or AOPN Board or actively pursuing ABPN or AOBPN Board Certification)* AND Current certification or active participation in the examination process leading to certification in Neurology by the American Board of Psychiatry Neurology or American Osteopathic Board of Neurology, with certification obtained within 5 years of completion of residency.

Initial Criteria for Sleep Studies/Polysomnography: Completion of a clinical fellowship approved by the American Academy of Sleep Medicine (AASM) or ACGME AND Board Certification or active participation in the examination process leading to certification in Sleep Medicine by the AASM or ACGME; AND 5 hours CME per year as pertains to sleep studies.

Initial Clinical Experience: Provision of care to at least 25 patient contacts in the past 2 years or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

Renewal Criteria: 12 patient contacts in the past two years; ~~AND a minimum of 24 EEG interpretation in the past two years~~ AND Maintenance of Board Certification in Neurology.

FPPE: 6 concurrent or retrospective chart reviews representative of privileges requested.

Request	NEUROLOGY CORE PRIVILEGES	Approve
☐	Perform H&P evaluate, diagnose, treat and provide consultation to patients 16 years and older with diseases, disorders, or impaired function of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system and blood vessels that relate to these structures, including, but not limited to: • Performance and Interpretation of EEG and EMG and nerve conduction studies • Lumbar Puncture • Sleep studies/Polysomnography • Transcranial Doppler (TCD) ultrasonography • Botulinum toxin injection	☐
☐	Admitting Privileges (must request Active staff status)	☐
☐	Interpretation **ONLY** of neurological tests (i.e., EEG, EMG)	☐
☐	TeleHealth: Provide interpretative, diagnostic or treatment services by means of telemedicine devices (including interactive audio, video or data communications)	☐

GENERAL INTERNAL MEDICINE CORE PRIVILEGES

Request	Privileges/Procedures	Renewal Criteria	FPPE	Approve
☐	Perform H&P, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with common and complex illnesses, diseases and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric and genitourinary systems.	Maintenance of Board Certification in Internal Medicine.	6 concurrent or retrospective chart reviews	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Procedural Sedation	Completion of Kaweah Health Procedural Sedation Exam	Completion of Kaweah Health Procedural Sedation Exam	None	☐
☐	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 __Specialty Clinic**	Initial Core Criteria AND Contract for Outpatient Clinical services with Kaweah Delta Health Care District.	Maintain initial criteria	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.

Signature: _____ _____

Applicant *Date*

Signature: _____ _____

Department of Psychiatry and Neurosciences Chair *Date*

Policy Number: MS 29	Date Created: 06/01/2010
Document Owner: April McKee (Director of Medical Staff Svcs)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee	

Documenting Current Clinical Competence (Co-Manage/Co-Admit)

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

Policy:

It shall be the policy of Kaweah Health Medical Staff to provide credentialing options when an applicant does not meet volume requirements for current clinical competence.

Procedure:

When an application is submitted and current clinical competence cannot be documented, the following options may be considered on a case-by-case basis.

1. For medical specialties - dependent exercise of privileges whereby another fully qualified member of the medical staff agrees to co-admit and co-manage the minimum volume requirements as specified per established initial privileging criteria.

2. For surgical specialties/special procedures – dependent exercise of privilege with increasing responsibility based on actual observations by co-managing surgeon. Must meet minimum volume requirements as specified per established initial privileging criteria.

3. For Department of Family Medicine requesting OB privileges – 100% real time co-admission/co-management with another member of the Medical Staff with current OB privileges for the minimum volume requirements as specified per established initial privileging criteria. This applies to Department of Family Medicine members who have not done OB deliveries in the past 24 months.

4. For Department of Anesthesiology – dependent exercise of privilege with increasing responsibility based on actual observations by co-managing anesthesiologist. Must meet minimum volume requirements as specified per established initial privileging criteria.

5. For Kaweah Health Employed Nurse Practitioner and Physician Assistant applicants that have completed their advanced training program within 4 years of submitting a completed application to the Kaweah Health Medical Staff Officer and cannot document current clinical competency, the following pathway may be considered:

a. For NP/PA: 100% real time co-management with supervising physician credentialed in the area of "Specialty" in a Kaweah Health Owned Facility.
b. The Licensed Physician shall be required to co-sign 100% of notes written by the NP/PA prior to the encounter being closed.
c. 100% of orders written by the NP/PA while the co-management agreement is in effect will be pended until the supervising physician co-signs the orders.
~~4.~~d. The Co-Management agreement shall remain in effect until satisfactory completion, but for no longer than 6 months. If not completed within 6 months the practitioners privileges will expire.

~~5.~~6. Applicants will not be given admitting privileges until:

a. Documentation has been submitted to the medical staff office noting that the new member or advanced practice provider is qualified to independently exercise the privileges requested and that the co-admission and co-management status are no longer necessary.

b. The department chair reviews the documentation and approves the recommendation.

~~6.~~ If co-management has been completed within the last 6 months at KDHCD, with favorable reports, proctoring will not be required.

"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: MS 47	**Date Created: 07/12/2023**
Document Owner: April McKee (Director of Medical Staff Svcs)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Director of Medical Staff Svcs), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Code of Conduct For Medical Staff & Advanced Practice Providers

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

Purpose:

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

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

Policy:

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

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

I. DEFINITIONS

A. “Ethical behavior” includes behavior that demonstrates adherence to Medical Staff Bylaws, Rules and Regulations, Policies, Kaweah Health behavior standards and State and Federal laws.

B. “Appropriate behavior” includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition

with the hospital. Appropriate behavior is not subject to discipline under the bylaws.

C. "Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as disruptive behavior.

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

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

F. "Sexual harassment" means unwelcome advances, requests for sexual favors, or verbal or physical activity of a sexual nature when: (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or work performance, or creates an offensive, intimidating, or otherwise hostile work environment.

G. "Practitioner" means a Medical Staff member or Advanced Practice Provider who have been granted membership and/or privileges at Kaweah Health by the Board of Directors.

II. TYPES OF CONDUCT

A. Appropriate Behavior

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

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

B. Inappropriate Behavior

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

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

C. Disruptive Behavior

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

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

D. Unethical Behavior

Unethical Behavior includes behavior that is unprofessional and or illegal. Examples of unethical behavior include, but are not limited to the following:

- Fraudulent billing practices
- Theft or destruction of hospital property, including diversion of drugs or supplies;
- Violation of patient privacy laws; and
- Knowingly providing false information to the Medical Staff or hospital.

III. PROCEDURE

A. Delegation by Chief of Staff

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

B. Initiation of Complaints
Complaints about a Practitioner regarding allegedly inappropriate or disruptive behavior are encouraged to be entered into the event reporting system or conveyed to the Medical Staff Peer Review Manager or Peer Review Coordinator (Peer Review Personnel. Information should include:

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

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

C. Processing Behavioral Event Reports
The process whereby the event report is processed is as follows (see attached flow chart):

1. The incident report is submitted through MIDAS or directly to the Peer Review Personnel. MIDAS reports involving Practitioners will be immediately routed to the Medical Staff Peer Review Personnel. On a daily basis, the Provider METER Committee reviews, ranks, and triages provider-related non-clinical events and escalates events per the MS.58 Provider Midas Reporting Policy. ~~the Peer Review Personnel will forward such MIDAS reports by email to the Medical Staff Officers and the Director of Medical Staff Services~~. Reports alleging hostile work environment or harassment directed toward hospital employees will also be reported to the Vice President of Human Resources. Incidents involving an allegation of abuse, illegal activity, or unethical behavior will be forwarded to Risk Management.
2. The Peer Review Personnel will perform an initial screening of the allegations in the event report and, if validated, will process in the following manner, utilizing the Just Culture Physician Behavior Scoring System:
    a. 1st Degree variances – Track & Trend
    b. 2nd and 3rd Degree variances – Referral to the Department Chair to complete the Code of Conduct Investigation form within two weeks
    c. 4th and 5th Degree variances –

i. Immediate notification to the Medical Staff Officers, Chief Medical Officer, and Director of Medical Staff Services.
ii. Subject to detailed review by the Peer Review Personnel, which must include communicating with the complainant and the Practitioner who is the subject of the report.
iii. The results will be reported to the Medical Staff Officers, Chief Medical Officer, and Director of Medical Staff Services.
iv. The following actions may be taken as determined by the Chief of Staff, or designee:
    1. Prompt collegial intervention by the Chief of Staff or designee;
    2. Referral to the Department Chair for collegial intervention;
    3. Requesting a written response to the allegations from the Practitioner within 15 days;
    4. Referral to the Medical Staff Behavior Committee, composed of the Medical Staff Officers and the Chief Medical Officer. Possible actions include but are not limited to
        a. Dismiss as unfounded or if unable to substantiate;
        b. Track and trend;
        c. In-person meeting with Practitioner and Behavior Committee or subset of members;
        d. Request for further inquiry and follow up;
        e. Focused Professional Practice Evaluation overseen by the Department chair or other designee;
        f. Letter of education, warning, or reprimand;
        g. Referral to the Well Being Committee; and/or
        h. Referral to the Medical Executive Committee.
    5. Direct Referral to the Medical Executive Committee for consideration of further action consistent with the Medical Staff Bylaws, including but not limited to:
        a. Referral to the Well Being Committee;
        b. Letter of warning or reprimand;
        c. Imposition of a Professional Conduct Agreement;
        d. Requirement to attend educational course or program at the Practitioner's expense;
        e. Requirement to participate in a fitness for duty evaluation or other health or psychiatric assessment at the Practitioner's expense;
        f. Initiation of a formal investigation; and/or
        g. Disciplinary action, including a suspension or restriction on Medical Staff membership or clinical privileges and/or recommendation for formal corrective action, including a

recommendation to terminate Medical Staff membership or clinical privileges.

2. The Chief of Staff will reply with an initial response or action (e.g., a request for follow-up inquiry by a designee) and state whether the MIDAS report should be escalated to the Chief Executive Officer immediately in accordance with the Just Culture Physician Behavior Scoring System (Scoring System), attached as Appendix A. The other Medical Staff Officers, and/or Director of Medical Staff Services may provide additional input on the recommended initial response or action and escalation decision.
3. The Peer Review Personnel will provide a daily report to the Chief Executive Officer of the number of event reports and the details of any reports escalated by the Chief of Staff.
4. The Peer Review Personnel will perform an initial screening of the allegations in the event report and report the results to Chief of Staff.
5. The Chief of Staff or designee may dismiss or redirect reports that are determined to be unfounded or that do not constitute inappropriate, disruptive, or unethical behavior.
6. In the discretion of the Chief of Staff or designee, minor incidents (i.e., 1st and 2nd degree conduct per Scoring System) may be addressed with coaching by the Chief of Staff or Department Chair, a letter of education or warning, or tracked and trended.
7. Significant incidents (i.e., 3rd, 4th, or 5th degree conduct per Scoring System) are subject to detailed review by the Peer Review Personnel, which must include communicating with the complainant and the Practitioner who is the subject of the report. The results will be reported to the Chief of Staff. The following actions may be taken as determined by the Chief of Staff or designee:
    a. Prompt collegial intervention by the Chief of Staff or designee;
    b. Referral to the Department Chair for collegial intervention;
    c. Requesting a written response to the allegations from the Practitioner within 15 days;
    d. Referral to the Medical Staff Behavior Committee, composed of the Medical Staff Officers. Possible actions include but are not limited to
        i. Dismiss as unfounded or if unable to substantiate;
        ii. Track and trend;
        iii. In-person meeting with Practitioner and Behavior Committee or subset of members;
        iv. Request for further inquiry and follow up;
        v. Focused Professional Practice Evaluation overseen by the Department chair or other designee;
        vi. Letter of education, warning, or reprimand;
        vii. Referral to the Well Being Committee; and/or
        viii. Referral to the Medical Executive Committee.

~~e. Direct Referral to the Medical Executive Committee for consideration of further action consistent with the Medical Staff Bylaws, including but not limited to:~~

~~i. Referral to the Well Being Committee;~~
~~ii. Letter of warning or reprimand;~~
~~iii. Imposition of a Professional Conduct Agreement;~~
~~iv. Requirement to attend educational course or program at the Practitioner's expense;~~
~~v. Initiation of a formal investigation; and/or~~
~~vi. Disciplinary action, including a suspension or restriction on Medical Staff membership or clinical privileges and/or recommendation for formal corrective action.~~

~~8. If additional incidents occur or the Chief of Staff or designee determines that a pattern of inappropriate behavior has developed or is developing, the Chief of Staff, in his or her discretion, may meet in person with the Practitioner, issue a letter of warning or reprimand, and/or refer the matter to the Medical Staff Behavior Committee or to the Medical Executive Committee.~~

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

3. All events processed and actions taken will be presented to the Behavior Committee.

When trended information indicates a pattern of inappropriate behavior has developed or is developing, the matter will be presented to the Behavior Committee for further action, consistent with the options set forth in Paragraph 2 above.

~~9.~~4. Nothing in this Policy is intended to prohibit the Chief of Staff or other appropriate person or committee from imposing immediate corrective action, such as a summary suspension, if warranted by the facts, including in response to a single incident that presents a risk of imminent danger to the health or safety of any individual. In the event of corrective action that triggers mandatory reports to the licensing board and/or National Practitioner Data Bank, the Practitioner is entitled to the procedural rights set forth in the Medical Staff Bylaws.

~~10.~~5. The Chief of Staff and Chief Executive Officer will make any reports required by state or federal law arising from actions taken or recommended or other occurrences that trigger such reports in connection with implementing this policy.

~~11.~~6. In the event of inconsistencies between this policy and the Medical Staff Bylaws, the Medical Staff Bylaws will prevail.

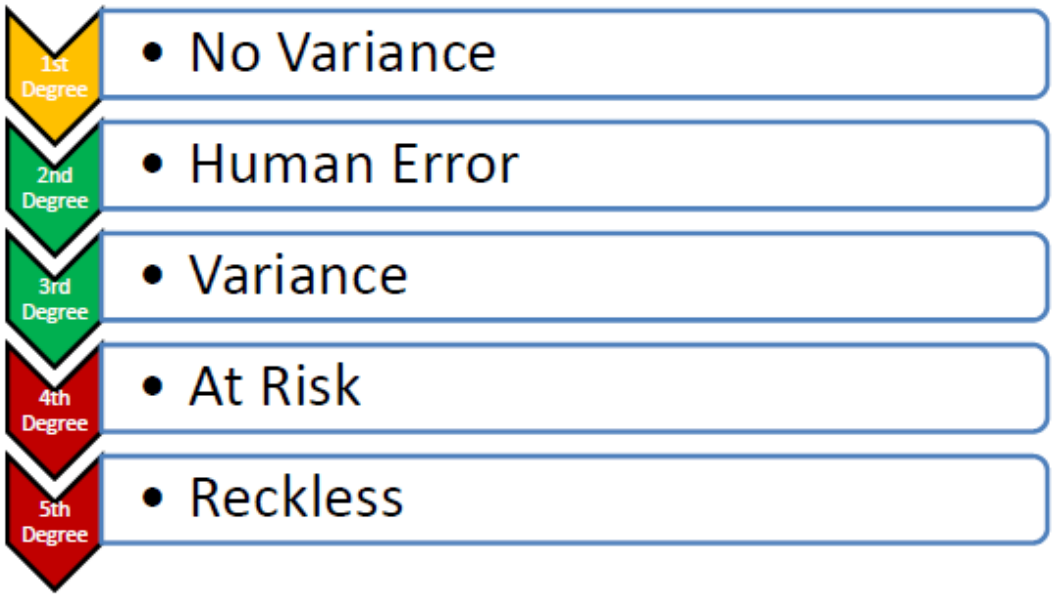
References:

Kaweah Health Medical Staff Bylaws

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

APPENDIX A

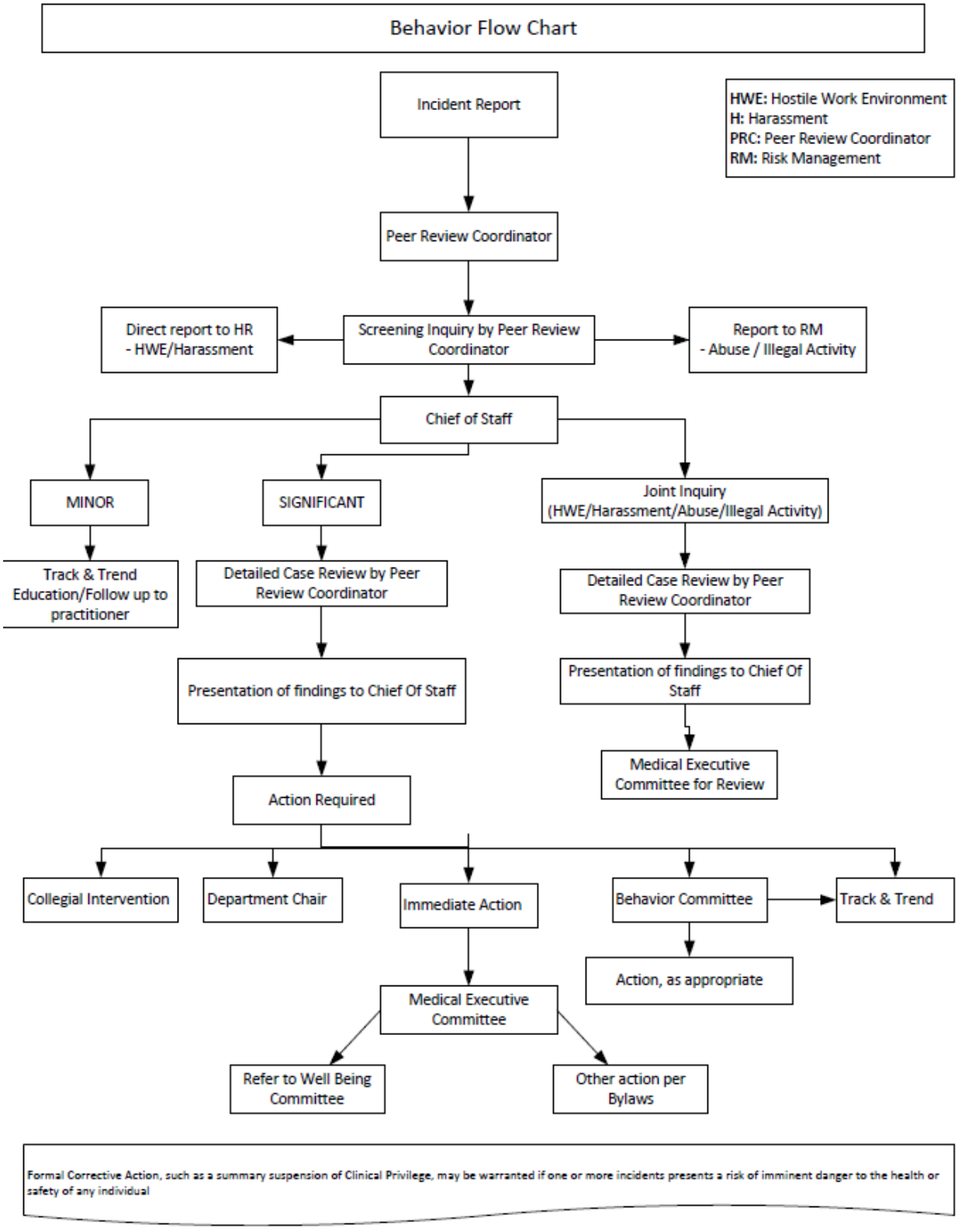
JUST CULTURE PHYSICIAN BEHAVIOR SCORING SYSTEM



1. **1st Degree No Variance –**
   Examples: Raised voice, hanging up on staff, eye-rolling at staff/peers.
   Possible Actions: Track & trend.
2. **2nd Degree Human Error –**
   Examples: Shouting outbursts, use of profanity, rude remarks to staff/peers.
   Possible Actions: Coaching by Chief of Staff or Department Chair, letter of education or warning, track & trend.
3. **3rd Degree Variances –**
   Examples: Verbal abuse, degrading/belittling Staff, throwing things, threatening behavior, retaliation, repetitive 1st and 2nd degree conduct after coaching.
   Possible Actions: Request written response; referral to Behavior Committee Meeting.
4. **4th Degree At Risk Behavior –**
   Examples: Impairment, sexual harassment, creating hostile work environment, unwarranted physical contact.
   Possible Actions: Referral to Behavior Committee or Well Being Committee, required educational course, FPPE, summary suspension or other disciplinary action.
5. **5th Degree Reckless Behavior –**
   Examples: Diversion, physical abuse, intentional violation of patient privacy, repetitive non-compliance with Medical Staff Bylaws.
   Possible Actions: Referral to Medical Executive Committee; disciplinary action.

Escalation of per Reports:

- 4th and 5th Degree: immediate escalation to Chief Executive Officer.
- 4th Degree involving sexual harassment, hostile work environment, physical abuse: report to Risk Management and Human Resources.


Behavior Flow Chart
Incident Report
HWE: Hostile Work Environment
H: Harassment
PRC: Peer Review Coordinator
RM: Risk Management
Peer Review Coordinator
Direct report to HR - HWE/Harassment
Screening Inquiry by Peer Review Coordinator
Report to RM - Abuse / Illegal Activity
Chief of Staff
MINOR
SIGNIFICANT
Joint Inquiry (HWE/Harassment/Abuse/Illegal Activity)
Track & Trend Education/Follow up to practitioner
Detailed Case Review by Peer Review Coordinator
Detailed Case Review by Peer Review Coordinator
Presentation of findings to Chief Of Staff
Presentation of findings to Chief Of Staff
Medical Executive Committee for Review
Action Required
Collegial Intervention
Department Chair
Immediate Action
Behavior Committee
Track & Trend
Action, as appropriate
Medical Executive Committee
Refer to Well Being Committee
Other action per Bylaws
Formal Corrective Action, such as a summary suspension of Clinical Privilege, may be warranted if one or more incidents presents a risk of imminent danger to the health or safety of any individual

Stroke Quality Update August 2023

Stroke Program Leadership

Dr. Sean Oldroyd
Stroke Program Medical Director

Cheryl Smit, RN-BC
Stroke Program Manager

Emma Camarena, RN
Advanced Practice Nurse

Kelsey Zapata, PharmD, BCPS, BCCCP
Emergency Department Pharmacist

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Abbreviations Used During this Presentation

TJC = The Joint Commission
AHA/ASA = American Heart Association; American Stroke Association
GWTG = Get with the Guidelines
EMS = Emergency Medical Services
ED = Emergency Department
ICU = Intensive Care Unit
TIA = Transient Ischemic Attack
Dc = Discharge
rt-PA or Tenecteplase = thrombolytic therapy “clot busting medication”
CT/CTA = Computed tomography scan/computed tomography angiography
LVO = Large vessel occlusion
CMS = Centers for Medicare and Medicaid Services
VTE = Venous thromboembolism
LDL = low-density lipoproteins
NIHSS = National Institutes of Health Stroke Scale
RRT = Rapid Response Team
STL = Stroke Team Lead
EMR = Electronic Medical Record

Primary Stroke Certification through The Joint Commission (TJC)

Full Re-Accreditation Status after Primary Stroke Survey on January 2023.

- Survey was successful, the surveyor felt that the team was very engaged in the process and commended KH on our overall stroke program

- Two findings for improvement
  - Timeliness of IV thrombolytic treatment
  - Timeliness of ED provider documentation

- Corrective action plans were submitted to TJC and approved on March 17, 2023

- 2 year certification cycle

TJC Corrective Action Plans 2023-2024

Timeliness of IV thrombolytic treatment

April 4, 2023

- **ED Stroke alert process modified to a two-tier approach, stratified by time since last known well**
  - **Tier 1:** less than 4 hours since last known well. The team will assemble immediately upon the patients return from CT to determine if IV thrombolytics are appropriate
  - **Tier 2:** 4 to 16 hours since last known well. ED stroke care as usual, and if a large vessel occlusion is found, call for possible transfer
- **Transition from alteplase to tenecteplase as the "clot busting" medication for acute ischemic stroke patients**
  - Improved times. Studies have shown improvement in door to needle times with this transition
  - Non-inferior. Multiple trials have shown tenecteplase to be non-inferior to alteplase for ischemic stroke patients
  - Easier/safer administration. Tenecteplase is given as an IV push instead of a bolus and hour long infusion
  - Cost savings. Tenecteplase is approximately $2,000 less per dose than alteplase. KH gives thrombolytics approximately 50 times a year which equates to $100,000 savings
- **KH neurologist to determine appropriateness of thrombolytic administration**
  - Education was sent to ED/RRT nursing staff along with ED providers that our neurologists will make the call regarding thrombolytics and not defer to tertiary care center if the patient has a large vessel occlusion (LVO)

TJC Corrective Action Plans 2023-2024

Timeliness of ED provider documentation

- **Education with expectations were given to providers on the necessary elements for compliance and the timeliness for completed stroke patient medical records**
- **This was completed by:**
  - **E-mail notifications**
  - **Computer Based Learning (CBL) on the ED Stroke Alert Annual Update**
  - **Presented at Emergency Medicine resident conference**
  - **Emergency Medicine partner meeting**

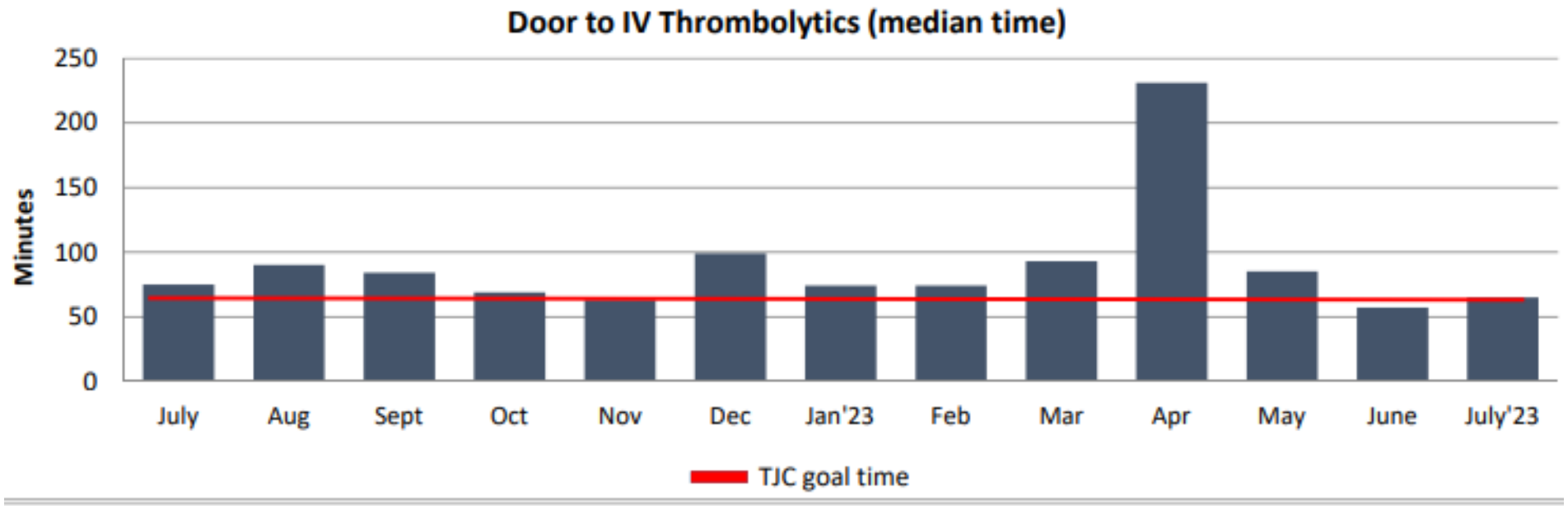
- **Ongoing compliance monitoring is being conducted and reported to the Stroke Quality Committee meeting**

Stroke Program Initiatives 2023-2024

ED Stroke Alert Process

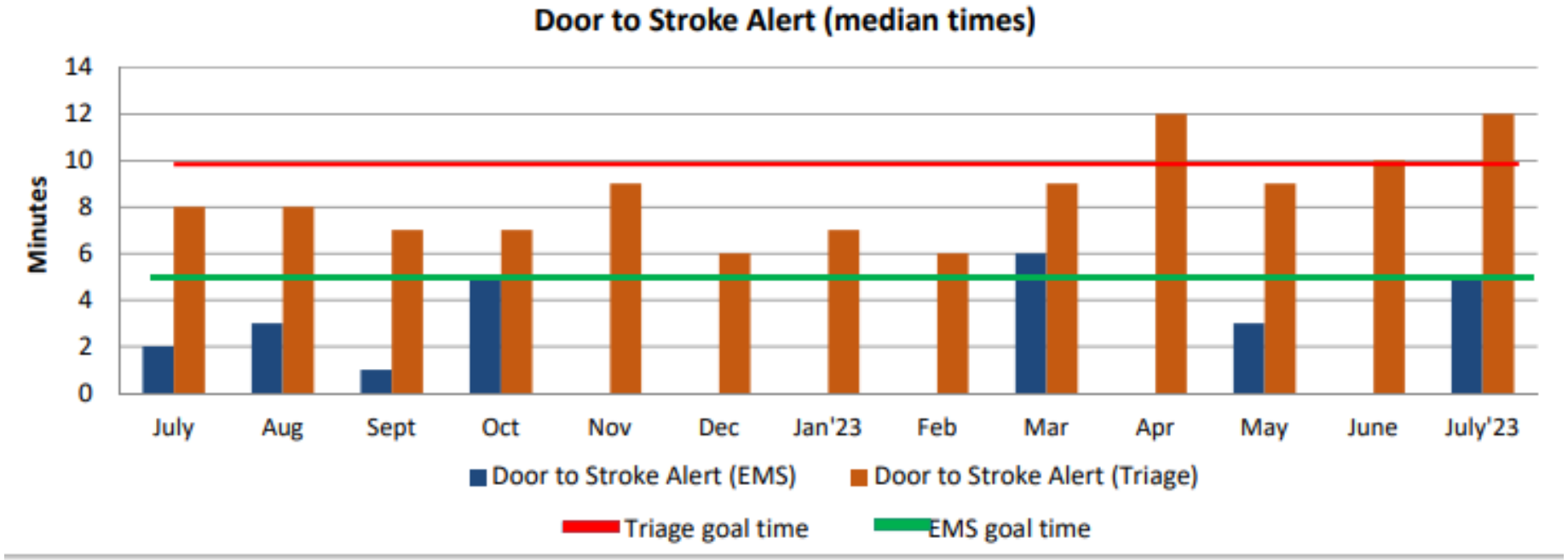
- RAPID software is available which will enhance imaging to evaluate patients who may be candidates for endovascular treatment. This requires a transfer to a tertiary care center
- Repeated stroke alerts may be called if the patient exhibits worsening stroke symptoms
- PowerPlan developed to address management of symptomatic intracranial bleeding occurring within 24 hours after administration of alteplase for treatment of ischemic strokes
- 2022: Changed stroke screening criteria from FAST to BE FAST
- 2022: Education on Medical ID. This has been shared with EMS, Skylife and ED staff and providers
- **2023 TJC CORRECTIVE ACTION ITEM:** Modification to the ED Stroke Alert Process
- **2023 TJC CORRECTIVE ACTION ITEM:** Transitioned from alteplase to tenecteplase as the “clot busting” medication for acute ischemic stroke patients
- **2023 TJC CORRECTIVE ACTION ITEM**: Education on the various corrective action items shared with ED staff and providers
- **2023 ACTION ITEM:** Modification to CT/CTA orders to prioritize stroke alert patients and expedite CT read times
- **2023 ACTION ITEM**: Planned mock stroke alert training for ED staff and Stroke Team Leads (STLs)

2022-2023 ED Stroke Alert Dashboard



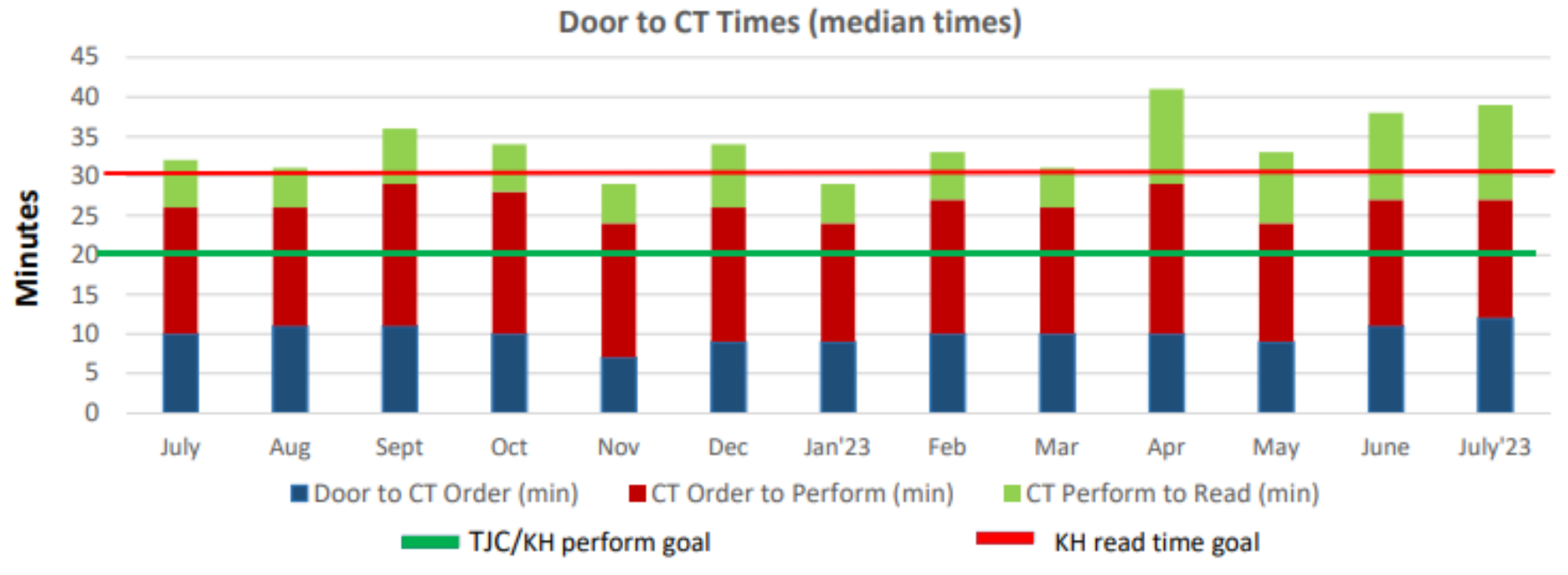
The data in this graph includes all thrombolytic patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new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

2022-2023 ED Stroke Alert Dashboard



Per KH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. Since the opening of the new Triage/zone 5 areas (summer of 2021), significant improvements have been noted in the Triage process.

2022-2023 ED Stroke Alert Dashboard



CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KH's CT read time goal is 30 minutes

Stroke Program Initiatives
2023-2024

ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

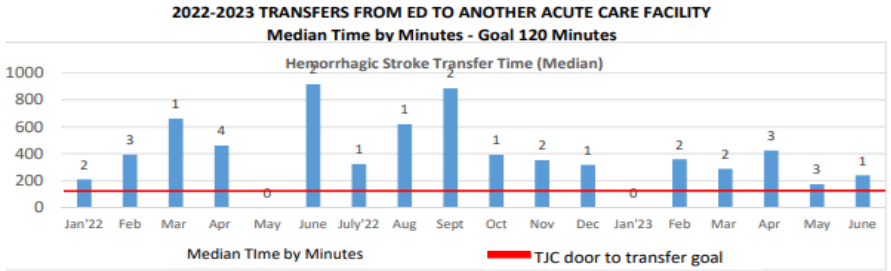
TJC Metric: Door to transfer goal <120 minutes.

Hemorrhage, IV Alteplase and Transfer “drip and ship”, Large Vessel Occlusion and Endovascular Eligible
Large Vessel Occlusion, and Not Endovascular Eligible
No Large Vessel Occlusion and Not Endovascular Eligible

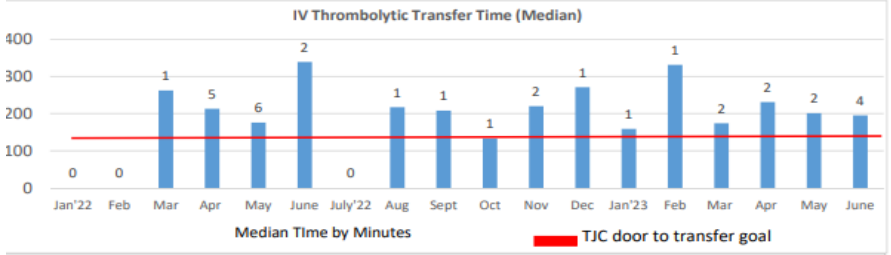
- Key stakeholders are involved in the transfer process; Skylife, EMS/American ambulance, ED and Case Management
- Ischemic/hemorrhagic stroke transfer guidelines established
- Transfer agreements signed with San Jose RMC and USC/Keck
- Education to physicians and staff regarding transfer goal time of <120 minutes
- RAPID software is available which has enhance imaging to evaluate if patients are candidates for endovascular treatment
- Immediate notification to EMS agencies of possible transfer. This helps to expedite transfer if helicopter transport is not possible. EMS transport the patient to the airport if fixed wing is required or ground transport is needed
- “Ready to Fly” checklist instituted to help improve transfer times
- Collaborative effort between key stakeholders (USC/Keck, Skylife, EMS, KH) to improve processes when a combination of air/ground transport is needed.
- Case Management notifies Skylife dispatch center that this is a “stroke alert” patient requiring expedited transfer
- Follow up communication with key stakeholders after transfer. Cover what went well and what challenges we can improve

Stroke Program Initiatives 2023-2024

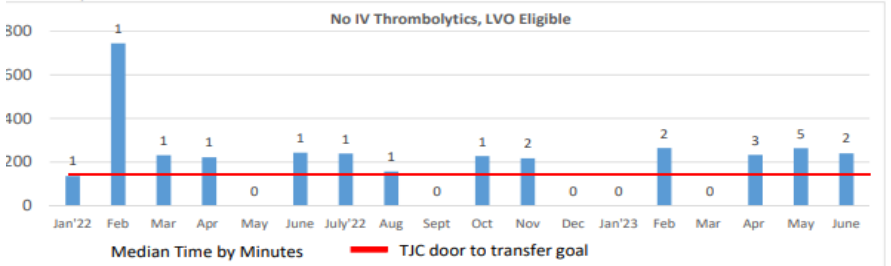
ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients



Hemorrhagic patients are transferred out for other procedures not done at KH, specifically coiling/clipping of aneurysms or bleeds. The ED Stroke Alert Committee reviews the process on an ongoing basis to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.



Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee door to transfer times have improved; however Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.



This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for thrombolytic administration. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

READY TO FLY
CHECKLIST FOR ACUTE STROKE TRANSFER

-goal is to reduce time to transfer to less than 120 minutes from 1st arrival-
KEEP THIS FORM WITH PATIENT until transfer

PATIENT NAME_____ **DOB**_____ **FIN**_____

RESIDENT PHYSICIAN

- ☐ Receiving Destination (may be preliminary) _____
- ☐ COVID TEST ORDERED
- ☐ 1st Call to ED Case Manager "Heads up" for potential emergent Stroke transfer for transport weather checks.
- ☐ Patient weight and height obtained
  Wt (kgs) _____
  Ht (cm) _____
- ☐ Call to ED Pharmacist to notify of potential stroke transfer and tPA status.
- ☐ Non-essential infusions discontinued
- ☐ Essential infusions_____
- ☐ 2nd Call to ED Case Manager to Confirm Transfer Request- Relay remainder of info to AirComm
- ☐ Patient and family informed of need for rapid transfer upon flight crew arrival. Arrange for family visit/updates/well wishes prior to flight crew arrival

Name / Ext:

PATIENT NURSE

- ☐ Team Lead/Charge RN made aware to facilitate 1:1 staffing/expedition of tasks
- ☐ COVID TEST COLLECTED
- ☐ Patient on CPAP/BiPAP or intubated?
  Yes_ No_
- ☐ Additional med supply for transport obtained from Pharmacy
- ☐ Certified Interpreter notified to be present on flight crew arrival (if applicable) x2501
- ☐ Package patient/belongings
- ☐ IMMEDIATELY "DISCHARGE PATIENT" in Cerner upon leaving unit

ED CASE MANAGER X2411

- ☐ Confirm acceptance of transfer, ETA, and needs to complete process with staff
- ☐ Attending Physician alerted to sign transfer forms

- ☐ TRANSFER FORMS signed and complete
- ☐ Time of transfer _____

*****THIS IS NOT PART OF THE PATIENT'S PERMANENT MEDICAL RECORD*****

Kaweah Health

Stroke Program Dashboard 2022-2023

	Bench-marks	2021	Jan'22	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan'23	Feb	Mar	Apr
Grouping of Stroke Patients																		
Ischemic		409	36	25	33	43	33	24	23	45	26	29	24	42	33	38	34	31
Hemorrhagic		93	4	6	7	14	7	10	8	4	11	5	9	6	7	8	10	4
TIA (in-patient and observation)		221	13	15	26	20	25	16	12	24	21	7	19	13	16	11	12	10
Transfers to Higher Level of Care (Ischemic)		26	1	1	2	1	5	3	2	1	1	2	4	1	0	3	2	5
Transfers to Higher Level of Care (Hemorrhagic)		14	2	3	1	4	0	2	1	1	2	1	2	1	1	2	2	3
TOTAL NUMBER OF PATIENTS		763	56	50	69	82	70	55	46	75	61	44	58	63	57	62	60	53
Total # of Pts who rec'd thrombolytic (Admitted/Transferred)		40	4	0	4	3	7	4	4	5	5	2	6	4	3	2	2	2
% of thrombolytics - Inpatient & Transfers		9%	11%	0%	11%	9%	18%	15%	16%	11%	19%	6%	7%	9%	9%	5%	6%	6%
% Appropriate vital sign monitoring post thrombolytics	90%	83%	100%	100%	25%	100%	86%	50%	50%	100%	80%	100%	50%	100%	100%	100%	100%	100%
Rate of hemorrhagic complications for thrombolytics pts	0%	7%	0%	NA	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	78%	100%	NA	67%	100%	100%	67%	0%	100%	33%	100%	60%	100%	100%	100%	75%	33%
% Appropriate stroke order set used (In-Patient)	90%	92%	96%	97%	96%	94%	96%	91%	96%	97%	96%	94%	95%	92%	96%	92%	88%	95%
% Appropriate stroke order set used (ED)	90%	87%	90%	80%	83%	91%	95%	92%	82%	88%	88%	93%	91%	87%	82%	76%	78%	89%
STK-1 VTE (GWTG, TJC)	85%	88%	79%	88%	100%	89%	96%	89%	79%	83%	88%	83%	100%	94%	90%	79%	73%	73%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Thrombolytics Given within 60 min (GWTG, TJC)	75%	92%	100%	0%	NA	NA	NA	NA	100%	NA	50%	100%	100%	NA	100%	100%	NA	NA
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	97%	100%
STK-6 Discharged on Intensive Statin (GWTG, TJC)	85%	98%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	94%	97%	94%	96%	94%	97%
STK-8 Stroke Education (GWTG, TJC)	75%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	91%	94%	91%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	86%	84%	83%	88%	87%	79%	85%	74%	77%	83%	71%	83%	75%	80%	71%	71%	87%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%
% LDL Documented (GWTG)	75%	99%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	97%	97%	97%	100%	97%	93%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% NIHSS Reported (GWTG)	75%	97%	97%	96%	97%	97%	100%	96%	100%	98%	96%	100%	94%	90%	90%	100%	97%	100%
Ischemic ALOS/GMLOS excess	<1.0	2.09	3.43	8.74	2.49	4.69	5.04	1.32	4.31	3.55	1.54	1.2	1.38	2.66	4.45	4.6	1.7	1
Hemorrhagic ALOS/GMLOS excess	<1.0	3.72	3.43	23.45	8.39	5.61	2.99	6.83	2.42	7.68	10.93	14.18	8.22	18.8	0.9	15.4	-1.25	4.35
Ischemic Mortality ACA O/E Ratio (Midas)	<1.0	1.18	1.3	0	0.8	0.5	0	1.3	0	0	1.3	1.1	1.2	0.6	1.1	0.6	0	1.4

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2023-2024

- ED: Door to IV thrombolytics within 60 minutes
- ED/ICU: Post IV Thrombolytic monitoring
- ED: Rapid Identification of hemorrhagic stroke patients
- ED: ED Provider documentation compliance
- ED: Stroke alert/tenecteplase process review
- ED/EMS: EMS patient contact business card
- ED/RRT: Tenecteplase consent process
- IN_HOUSE: TIA length of stay
- STROKE PROGRAM: Follow up calls/patient perception
- STROKE PROGRAM: VTE prophylaxis compliance

Stroke Program Initiatives 2023-2024

- Review of possible change as a result of the 2023 AHA/ASA Guidelines for Management of Patients with Aneurysmal Subarachnoid Hemorrhage
- VTE Prophylaxis compliance on the admitted stroke patient population
- Length of Stay (LOS) on our TIA observation patient population
- Nursing dysphagia screening and Speech Therapy process improvement project
- National Institute of Health Stroke Scale (NIHSS) certification process
- Education provided to all District staff, EMS agencies and throughout the community on BE FAST and smartphone Medical ID app information

Key Initiatives to Improve Stroke Recognition and Treatment

FAST emergency treatment may reduce disability and save your life

MORE THAN MEDICINE. LIFE.

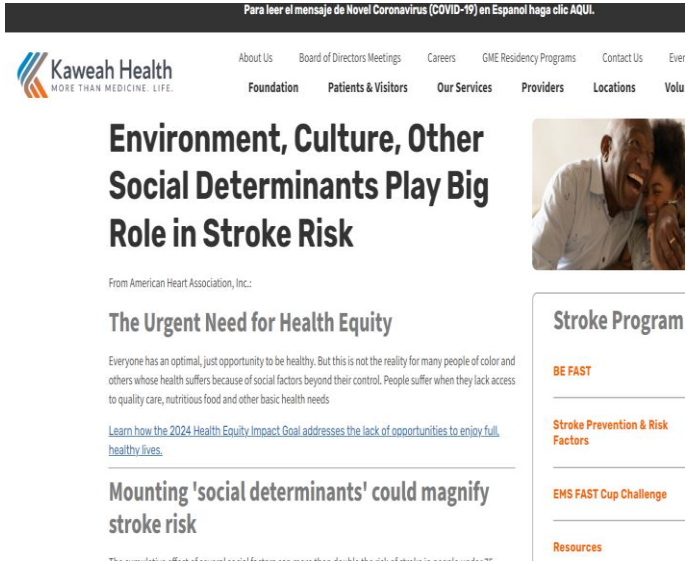
Key Initiatives to Improve Stroke Recognition and Treatment: Medical ID

Action Steps Taken:

- Kaweah Health spearheaded this valley wide initiative to increase awareness and use of the smartphone Medical ID app
- Central valley stroke coordinator group agreed to share this information with their hospital and provider staff, patients and community
- Education provided to all KH staff at the hospital BBQ in May 2022
- Highlighted in Kaweah Compass in May 2022
- Available on Kaweah Health's website: https://www.kaweahhealth.org/our-services/stroke-program/
- Proposal to add Medical ID information in the patient discharge summary/instructions

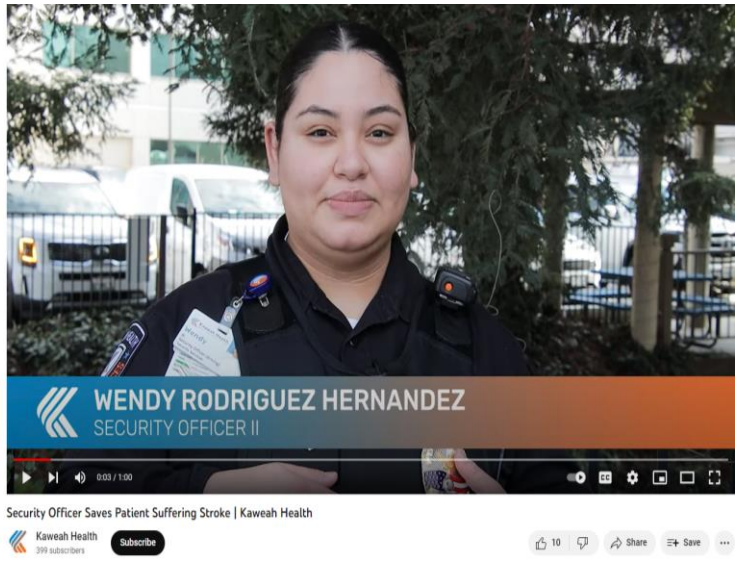
Kaweah Health
MORE THAN MEDICINE. LIFE.

Key Initiatives to Improve Stroke Awareness: Community Education



falconefamily2018 Dr.Oldroyd is amazing! My kids still have their daddy and I still have my husband because of you! You're speedy actions saved my husband! He was only 49 years old and had a basilar artery stroke, residual brainstem stroke, and cerebellar stroke. He emergently was transferred down south for an emergent thrombectomy. You will forever hold a special spot in our hearts. Thank you

2d 5 likes Reply



kaweahhealth.org

Kaweah Health
Primary Stroke Certification through The Joint Commission (TJC)

The Joint Commission

American Heart Association

American Stroke Association

CERTIFICATION

Meets standards for

Primary Stroke Center

kaweahhealth.org

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The pursuit of healthiness

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FY 2024 Strategic Plan

Organizational Efficiency & Effectiveness

August 23, 2023

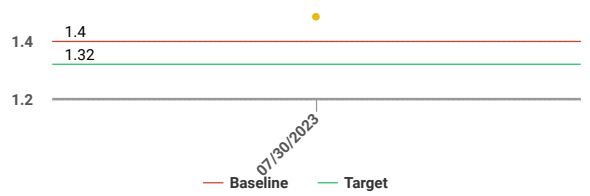
Patient Throughput and Length of Stay Champions: Rebekah Foster and Jag Batth

Objective: Improve Patient Throughput and Length of Stay.

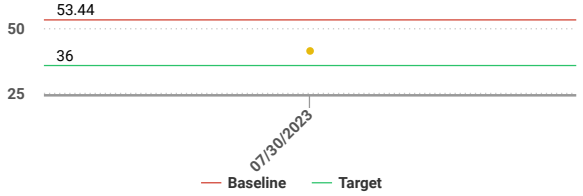
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.1.1	Objective	Using the Structure of the Throughput Steering Committee, Identify Opportunities and Implement Changes to Reduce Length of Stay	07/01/2023	06/30/2024	Rebekah Foster	Off Track	Report issues up through pt throughput and steering committee.
4.1.1.1	Outcome	Decrease Inpatient Observed to Expected Length of Stay	07/01/2023	06/30/2024	Rebekah Foster	Off Track	Slight uptick in number this month, but also had a few long stay complex patients we were able to successfully discharge.
4.1.1.2	Outcome	Decrease Observation Patient Average Length of Stay	07/01/2023	06/30/2024	Rebekah Foster	Off Track	We had 2 very long stay observation patients that we discharged out last month.
4.1.1.3	Outcome	Decrease Emergency Department (IP) Average Length of Stay	07/01/2023	06/30/2024	Rebekah Foster	On Track	Continue to see our numbers holding steady with admit holds in the ED.

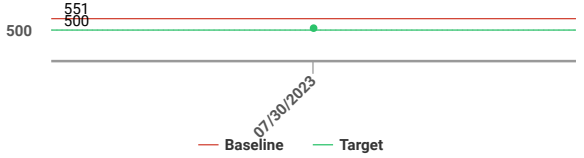
Decrease Inpatient Observed to Expected Length of Stay to 1.32 or Lower



Decrease Observation Patient Average Length of Stay to 36 Hours or Less



Decrease Emergency Department (IP) Average Length of Stay to 500 Minutes or Less



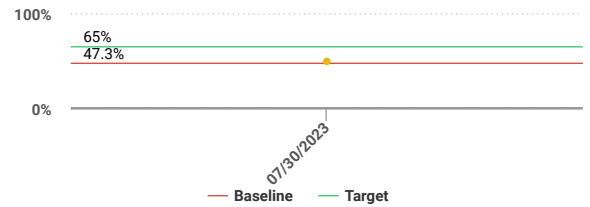
Main and Cardiac Operating Room Efficiency Champions: Jag Batth and Christine Aleman

Objective: Improve Efficiency and Capacity in the Main and Cardiac Operating Rooms.

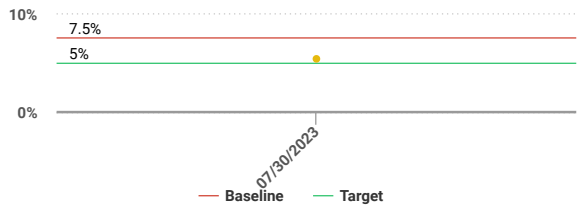
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.2.1	Objective	Monitor Key Performance Metrics in the Main and Cardiac ORs	07/01/2023	06/30/2024	Lori Mulliniks	Off Track	
4.2.1.1	Outcome	Improve Elective Case Main Operating Room Utilization	07/01/2023	06/30/2024	Lori Mulliniks	Off Track	Elective Main OR Utilization was 49% in July. We had a holiday which impacted OR utilization due to several block releases.
4.2.1.2	Outcome	Improve Elective Case Cardiac Operating Room Utilization	07/01/2023	06/30/2024	Lori Mulliniks	Off Track	Elective Case Cardiac OR Utilization for July was 16.2%. The loss of 2 surgeons in Jan 22 has dropped utilization.
4.2.1.3	Outcome	Decrease Case Cancellation Rate-Main Operating Room	07/01/2023	06/30/2024	Lori Mulliniks	Off Track	The Case Cancellation Rate for the Main OR improved from last month to 5.4% in July. 12 of the cancellations were identified as "other" and six were duplicates.
4.2.1.4	Outcome	Decrease Case Cancellation Rate-Cardiac Operating Room	07/01/2023	06/30/2024	Lori Mulliniks	On Track	We had zero weekday cardiac cancellations w/i 48 hours of surgery.
4.2.1.5	Outcome	Improve On Time Starts-First case of the Day in the Main OR	07/01/2023	06/30/2024	Lori Mulliniks	Off Track	54% of the first cases of the day started on time. Delays for the 63 cases were attributed as follows: 58% Surgeon, 16% Anesthesia, 18% staff/operations and 8% patient related.

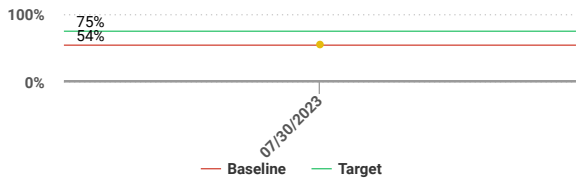
Improve Elective Case Main Operating Room Utilization



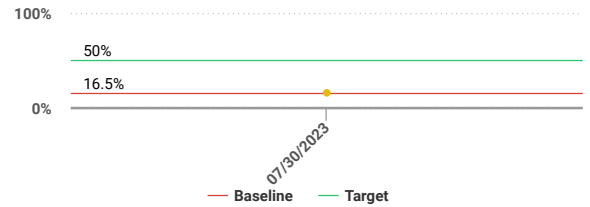
Decrease Case Cancellation Rate-Main Operating Room



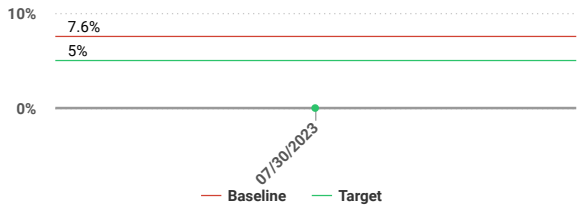
Improve On Time Starts-First Case of the Day in the Main Operating Room (Wheels in at Scheduled Start Time)



Improve Elective Case Cardiac Operating Room Utilization



Reduce Case Cancellation Rate-Cardiac Operating Room



Use of Tests and Treatments Champions: Jag Batth, Randy Kokka, and Renee Lauck

Objective: Create a Workgroup to Explore and Identify Benchmarks Related to the Use of Lab, Radiology and Therapy Tests and Treatments.

Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.3.1	Objective	Create and Initiate a Workgroup to Identify Areas of Focus and Establish Benchmarks Related to the Use of Tests and Treatments	07/01/2023	06/30/2024	Jag Batth	On Track	Initial workgroup meetings have commenced and the team is working to develop baselines and metrics for review.

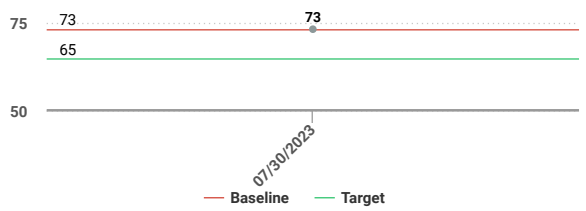
Front End Collections and Denials Processes Champion: Frances Carrera

Objective: Increase Front End Collections and Reduce Denials.

Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.4.1	Objective	Focus Efforts on Key Revenue Cycle Metrics to Increase Collections and Reduce Denials	07/01/2023	06/30/2024	Frances Carrera	Not Started	
4.4.1.1	Outcome	Reduce Days in Accounts Receivable	07/01/2023	06/30/2024	Frances Carrera	Not Started	With the implementation of Workday, we are working to finalize data reporting for this metric on a monthly basis.
4.4.1.2	Outcome	Increase Point of Care Collections	07/01/2023	06/30/2024	Frances Carrera	Not Started	We are finalizing the manner in which this will be reported on a monthly basis.

Reduce Days in Accounts Receivable



Point of Care Collections Goal

This plan item was deleted.

Throughput Steering Committee

Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Metric	Patient Type	Definition	Goal	Baseline**	Discharge Date 3/1/2023 – 7/31/2023				
Observation Average Length of Stay (Obs ALOS) *(Lower is better)**	**Overall**	Average length of stay (hours) for observation patients	36	47.97	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
					53.44	41.60	62.34	39.89	41.17
Inpatient Average Length of Stay (IP ALOS) *(Lower is better)**	**Overall**	Average length of stay (days) for inpatient discharges	5.64	5.65	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
					5.54	5.45	5.28	5.47	5.53
Inpatient Observed-to-Expected Length of Stay *(Lower is better)***	**Overall**	Observed LOS / geometric mean length of stay for inpatient discharges	1.32	1.46	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
					1.40	1.40	1.39	1.41	1.48
Discharges*	Inpatient	Count of inpateint discharges	N/A	1,247	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
					1,350	1,189	1,263	1,279	1,263
	Observation	Count of observation discharges	N/A	418	422	392	467	450	454
	Overall	Count of inpatient and observation discharges	N/A	1,665	1,772	1,581	1,730	1,729	1,717

***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

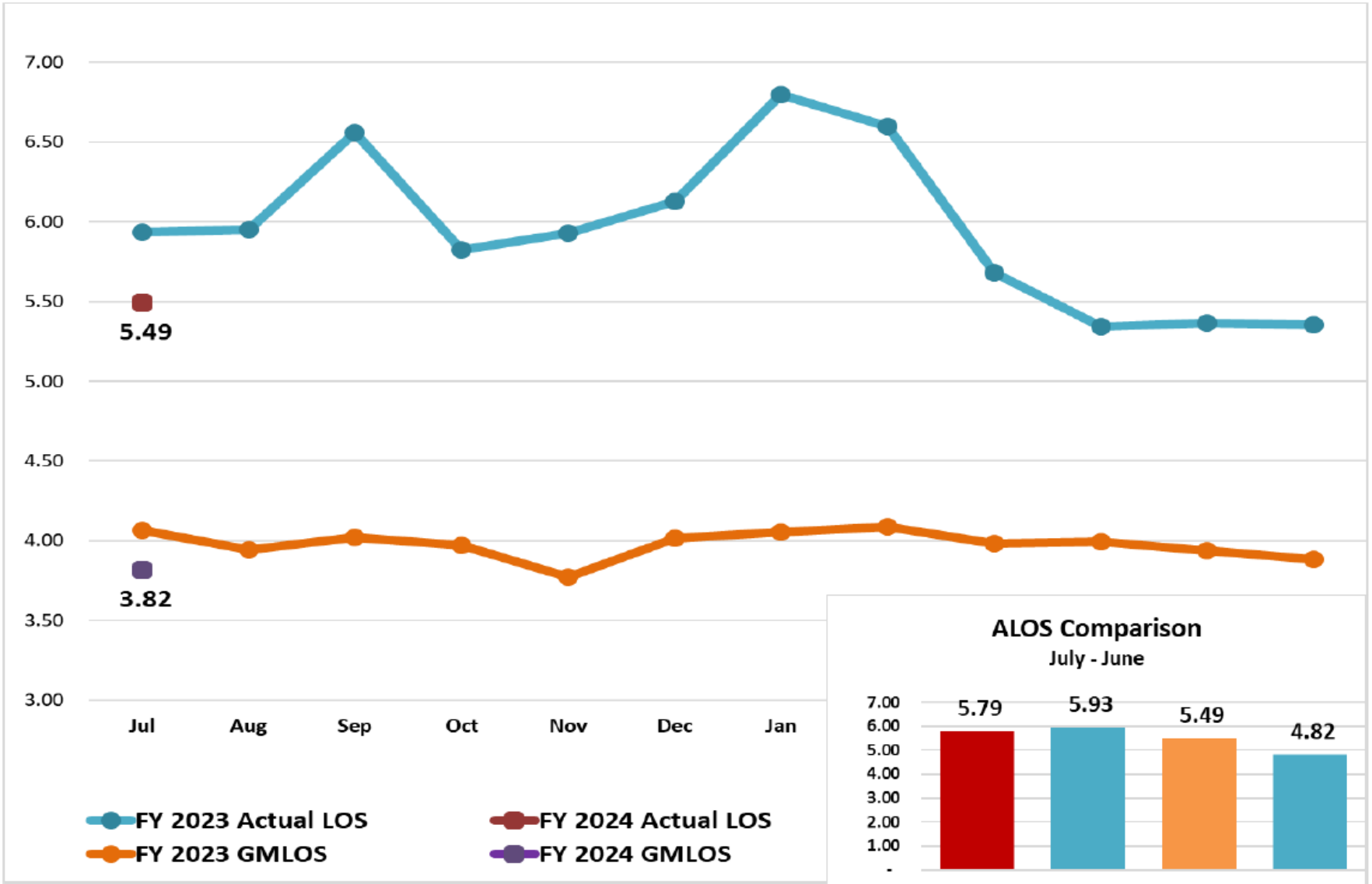
Check In Date and Time: 3/1/2023 12:00:00 AM – 7/31/2023 11:59:59 PM

Metric	Patient Type	Definition	Goal	Baseline**	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
ED Boarding Time *(Lower is better)**	Inpatient	Median time (minutes) for admission order written to check out for admitted patients	259	153	224	124	138	125	141
	Observation	Median time (minutes) for admission order written to check out for observation patients	287	158	199	124	138	119	144
	Overall	Median time (minutes) for admission order written to check out for inpatient and observation patients	286	153	223	124	138	124	142
ED Admit Hold Volume *(Lower is better)**	**Overall >4 Hours**	Count of patients (volume) with ED boarding time ≥ 4 hours	N/A	315	532	136	234	160	237
ED Length of Stay (ED LOS) *(Lower is better)**	Discharged	Median ED length of stay (minutes) for discharged patients	214	279	266	265	281	287	294
	Inpatient	Median ED length of stay (minutes) for admitted patients	612	542	628	492	491	499	506
	Observation	Median ED length of stay (minutes) for observation patients	577	530	625	488	479	477	527
	Overall	Median ED length of stay (minutes) for admitted and discharged patients	N/A	331	331	312	326	332	338
ED Visits*	Discharged	Count of ED visits for discharged patients	N/A	4,815	4,639	4,941	5,075	4,880	5,142
	Inpatient	Count of ED Visits for admitted patients	N/A	1,110	1,181	1,054	1,126	1,122	1,145
	Observation	Count of ED Visits for observation patients	N/A	417	399	420	448	472	444
	Overall	Count of ED visits	N/A	6,341	6,219	6,415	6,649	6,474	6,731

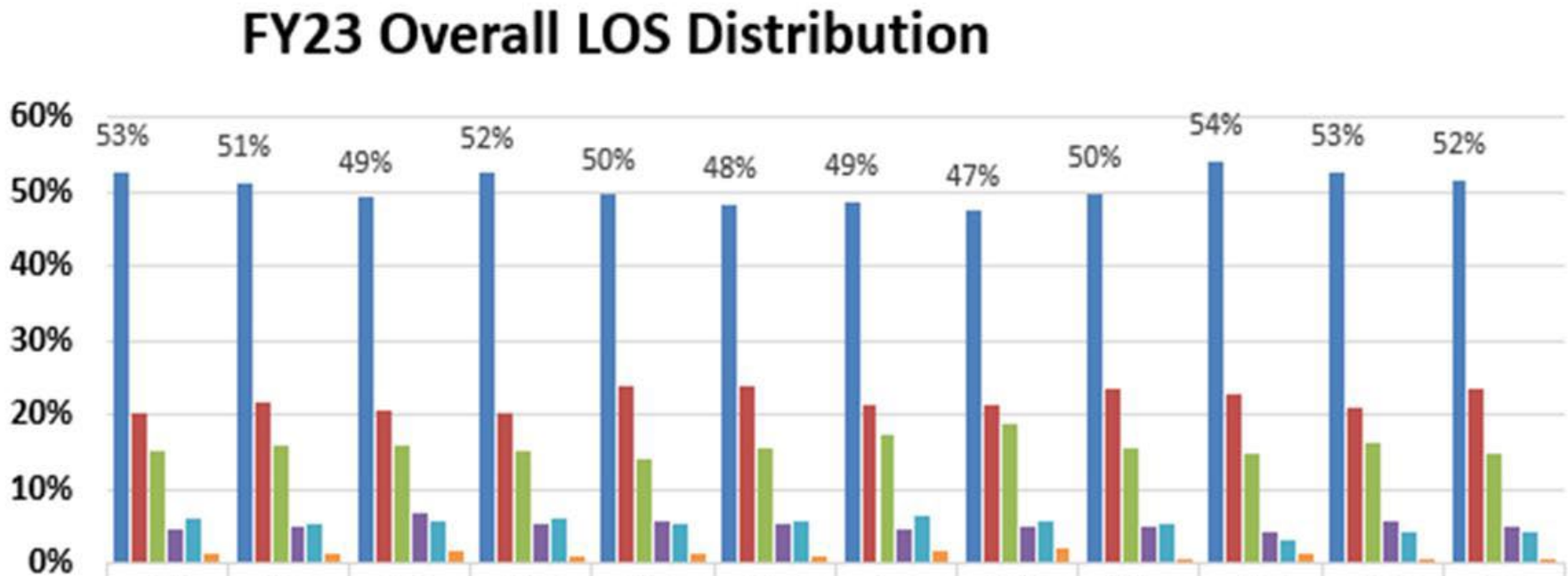
***All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data.**

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

Average Length of Stay versus National Average (GMLOS)

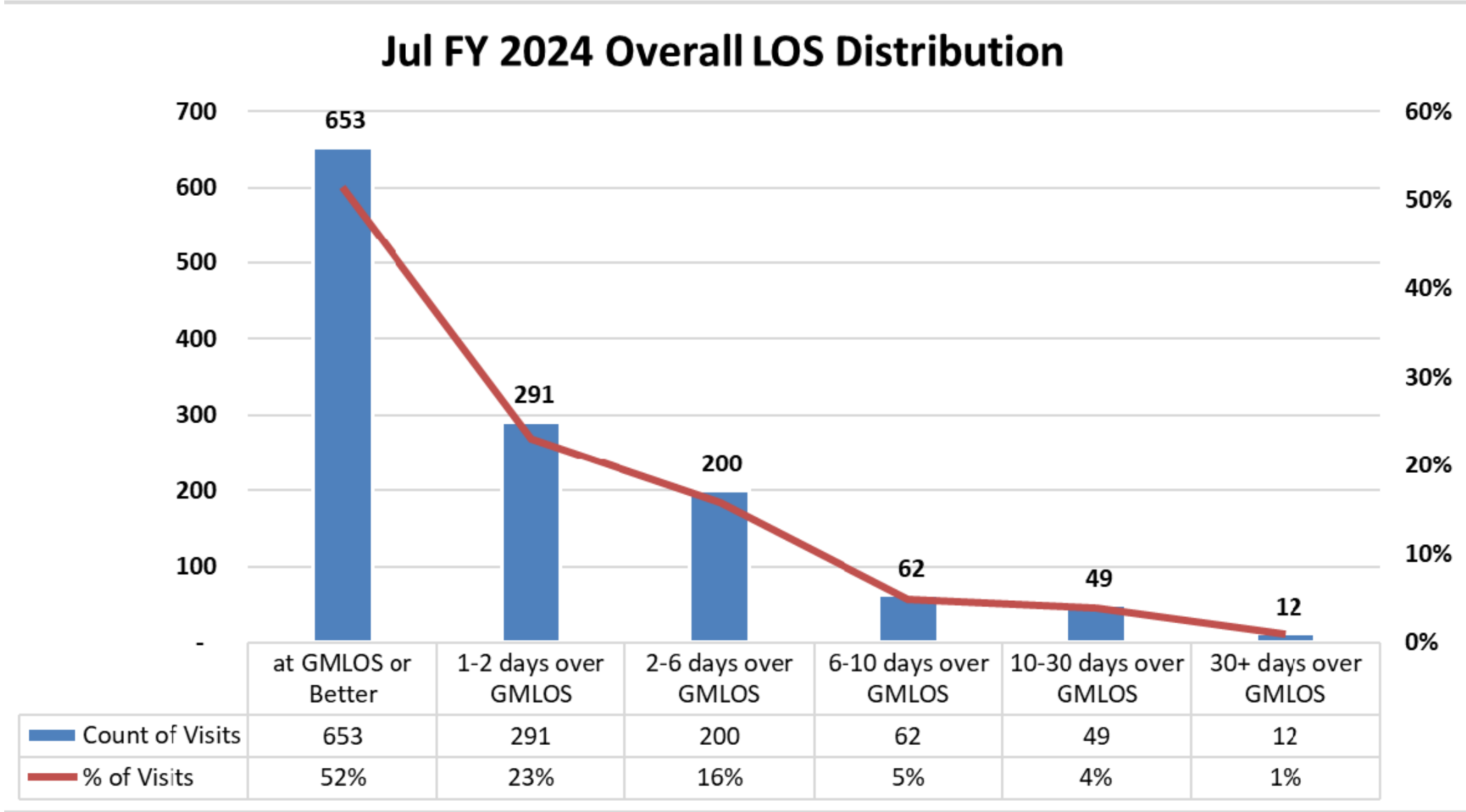


Average Length of Stay Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
at GMLOS or Better	53%	51%	49%	52%	50%	48%	49%	47%	50%	54%	53%	52%
1-2 days over GMLOS	20%	22%	21%	20%	24%	24%	21%	21%	24%	23%	21%	24%
2-6 days over GMLOS	15%	16%	16%	15%	14%	16%	17%	19%	16%	15%	16%	15%
6-10 days over GMLOS	5%	5%	7%	5%	6%	5%	5%	5%	5%	4%	6%	5%
10-30 days over GMLOS	6%	5%	6%	6%	5%	6%	7%	6%	5%	3%	4%	4%
30+ days over GMLOS	1%	1%	2%	1%	1%	1%	2%	2%	0%	1%	1%	1%

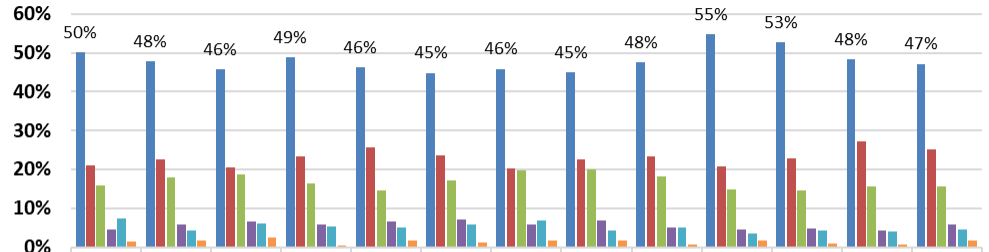
Average Length of Stay Distribution



	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	653	291	200	62	49	12
% of Visits	52%	23%	16%	5%	4%	1%

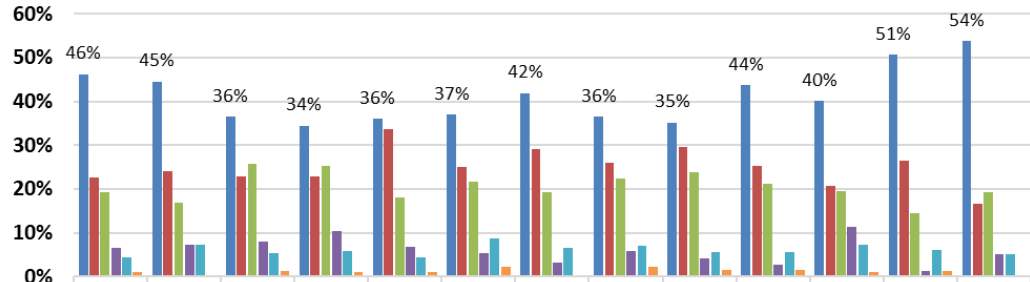
LOS Distribution

FY24 Hospitalist LOS Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	2023												2024
at GMLOS or Better	50%	48%	46%	49%	46%	45%	46%	45%	48%	55%	53%	48%	47%
1-2 days over GMLOS	21%	23%	21%	23%	26%	24%	20%	23%	23%	21%	23%	27%	25%
2-6 days over GMLOS	16%	18%	19%	16%	15%	17%	20%	20%	18%	15%	15%	16%	15%
6-10 days over GMLOS	5%	6%	7%	6%	7%	7%	6%	7%	5%	4%	5%	4%	6%
10-30 days over GMLOS	7%	4%	6%	5%	5%	6%	7%	4%	5%	3%	4%	4%	5%
30+ days over GMLOS	1%	2%	2%	0%	2%	1%	2%	2%	1%	2%	1%	1%	2%

FY24 FHCN LOS Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	2023												2024
at GMLOS or Better	46%	45%	36%	34%	36%	37%	42%	36%	35%	44%	40%	51%	54%
1-2 days over GMLOS	23%	24%	23%	23%	34%	25%	29%	26%	30%	25%	21%	27%	17%
2-6 days over GMLOS	19%	17%	26%	25%	18%	22%	19%	22%	24%	21%	20%	14%	19%
6-10 days over GMLOS	6%	7%	8%	10%	7%	5%	3%	6%	4%	3%	11%	1%	5%
10-30 days over GMLOS	4%	7%	5%	6%	4%	9%	6%	7%	6%	6%	7%	6%	5%
30+ days over GMLOS	1%	0%	1%	1%	1%	2%	0%	2%	1%	1%	1%	1%	0%

Patient Throughput Updates – July 2023

Update	Next Steps
Patient Progression: Discharge lounge – start date 10/1/23. Workflows and processes developed. Discharge nurse hired, start date 9/17/23. Established routine meetings and collaborations with community SNFs to improve discharge availability.	Patient Progression: Discharge lounge – onboard Case Management Assistants, set up metrics to measure success of initiative – due in September 2023. Developing preferred provider network for skilled nursing facilities.
ED to Inpatient Admission Process: HealtheAnalytics data availability – Cerner developed access to the data, will be available in September.	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 September 2023.
Transfer Center Operations: Repatriation of patients improved, moving patients back into hospital from higher level of care. Improved process to ensure transfers are brought in within EMTALA guidelines and to increase volume of transfers to avoid declinations.	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: 149 long stay patients discharged month of July. Longest stay was 188 days. 11 patients in house over 30 days LOS. Throughput huddle on Wednesday on ALL patients over their GMLOS. Hold with all CM and PFS teams for each unit.	Long Stay Committee: Monitor and maintain operations.
Patient Placement: Finalized placement matrix, will place by service and diagnosis. Will not place by provider group d/t variations in provider and beds.	Patient Placement: Hardwire placement of patients per the matrix. Support movement of patients to the right placement area, monitor use of matrix. Review data of patient types, update matrix as appropriate.
Observation Program: Order set changes are pending. Go live date to be determined by Informatics after review. Observation patients primarily placed in 2S. PCP scheduling for follow-up finalized, occurring before discharge.	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) Dashboard for observation patients in HealtheAnalytics developed, will make available to steering committee as finalized to share data. Patient placement focused on moving patients in observation status to 2S.

Throughput Steering Committee Monthly Update

- Update dashboard with FY24 goals (due September 2023)
- New provider education (due October 2023) clinical documentation specialists and throughput supervisor coordinate with medical staff to offer orientation to new medical staff related to:
  - documentation of patient condition
  - awareness of patient length of stay
  - participation in discharge rounds
- Evaluate current project, update or move to monitoring and implement new projects (due October 2023)

August 17, 2023

Note to Board Packet:

The Financial report for the August Board of Directors meeting is being finalized and will be uploaded by the end of the day on Monday August 21st.