BOARD OF TRUSTEES MEETING

WEDNESDAY, APRIL 8, 2026
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session, In Person: HCP Conference Center, see above address

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=85178715169
Meeting ID: 936 145 7125
Meeting Password: 20200513

One tap mobile
+14086380968,,9361457125# or
+13462487799,,9361457125#

Dial by your location
+1 408 638 0968 US (San Jose)
+1 346 248 7799 US (Houston)
+1 646 518 9805 US (New York)

Find your local number: https://alamedahealthsystem.zoom.us/u/agoA8zDn2

MEMBERS

Alan E. Fox
Lilavati Indulkar, MD
Nicholas Moss, MD
Rachel Richman
Sblend A. Sblendorio
Greg Garrett
Donna Linton
Nely Obligacion
David Sayen

[1] Log into the meeting at www.zoom.com. You will be directed to download the meeting app (free) if you have not used ZOOM previously. ZOOM meetings may be accessed on computers and portable devices.

BOARD OF TRUSTEES MEETING AGENDA

SPECIAL NOTE: Per Brown Act requirements, Trustees of the Alameda Health System will attend board and committee meetings in person at the location(s) noticed on this agenda. Staff and members of the public may attend either in person at the location noticed on this agenda, or remotely via Zoom, using the link included on this agenda.

Public Comment Instructions
If you wish to address the Board or Committee regarding an item on the agenda or in their purview, please communicate your intent with the Clerk of the Board prior to or at the beginning of the meeting. Time limitations shall be at the discretion of the Chair. Signups for public comment will close 10 minutes after public comment begins.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. CEO REPORT
James E.T. Jackson, Chief Executive Officer

B. MEDICAL STAFF REPORTS

AHS Medical:	Berenice Perez, MD, Chief of Medical Staff
AH Medical:	Catherine Pyun, DO, Chief of Medical Staff

C. COMMITTEE AND TRUSTEE REPORTS

C1. Audit and Compliance Committee: March 18, 2026
Sblend Sblendorio, Chair

C2. Quality Professional Services Committee: March 25, 2026
Lilavati Indulkar, MD, Trustee

C3. Finance Committee: April 1, 2026
Alan Fox, Trustee

D. CONSENT AGENDA: ACTION

D1. Approval of the Minutes of the March 11 Regular Meeting, the March 18 Special Meeting, and the March 20-21 Special Meeting of the Board of Trustees.

D2. AHS and AH Medical Staff:
- Licenses + Certifications Policy
- HR Policy – Extended Sick Leave – Directors and Above
- AHS Clostridioides difficile (CDI) Prevention Policy
- Pandemic Influenza Preparedness and Response Policy
- Hand Hygiene Policy
- Scope of Hydrocollator and Hydrotherm Cleaning and Disinfection Policy

- WORKPLACE VIOLENCE PREVENTION AND RESPONSE PLAN IN THE WORKPLACE
- AHS Heat Illness Prevention Plan and Policy
- Proactive Emergency Generator Testing Notification
- FIRE PROCEDURE: HAYWARD WELLNESS CENTER
- Utility Systems Management Plan
- Fire Procedure John George Psychiatric Pavillion
- Carboard Box IPC Policy
- Provision of Care Policy – Highland
- Hemodialysis Patient Management Policy
- Suicide Prevention Policy
- Restraints and Seclusion Policy
- AHS EMTALA Policy
- Patient Rights Policy
- Patient Visitor Cell Phone Electronic Device Policy
- Electronic Health Information Secure Messaging of PHI
- Patient Privacy Protection Policy
- Food and Nutrition Food Drug Interactions Education
- INTRAVENOUS ADMIXTURE PROGRAM POLICY (34517_-1)
- CASH CONTROL AND TRANSACTIONS
- PHARMACY THERAPEUTIC DRUG MONITORING POLICY
- MEDICATION ADMINISTRATION: CHEMOTHERAPEUTIC AGENTS
- FEMA_OAKLAND_URBAN_SEARCH_AND_RESCUE_TASK_FORCE_(34522_-1)
- Medication_Error_Reduction_Plan_2026_(SB_1875)_Alameda Hospital
- SYSTEM_MEDICATIONS LOOK ALIKE, SOUND ALIKE_(34528_-1)
- MEDICATIONS: BOTULISM ANTI-TOXIN
- LIDOCAINE INFUSION FOR PAIN CLINICAL PRACTICE GUIDELINES
- LIDOCAINE INFUSION FOR PAIN POLICY
- TNK For Acute Ischemic Stroke
- Code Stroke Policy
- Elopement and Medical Incapacity Hold Policy

D3. AHS and AH Medical Staff Policies and Procedures:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Application Levels
- Medical Staff Peer Case Review

D4. ACTION / DICUSSION: Contracts

D4a. **Renewal agreement with Hyland Software, Inc. for provision of enterprise content management services. The term of this agreement is effective May 1, 2026 through April 30, 2029. The estimated impact of this agreement is $2,599,491.**
Christine Yang, Chief Information Officer

D4b. **Renewal agreement with Mission Linen Supply for provision of linen rental and cleaning services. The term of this agreement is effective May 1, 2026 through April 30, 2029. The estimated impact of this agreement is $13,325,000.**
Mark Fratzke, Chief Operating Officer

END OF CONSENT AGENDA

E. ACTION/DISCUSSION

E1. **ACTION/DISCUSSION: Approve a First Amendment to the Agreement on the Repayment of Alameda Health System Debt to the Consolidated Treasury (the March 2016 Permanent Agreement) to increase the fiscal year end Net Negative Balance (NNB) limit to $100 million for FY 2026 and FY 2027 and increase the intra year maximum from $50 million to $100 million for FY 2026 and FY 2027**
James E.T. Jackson, Chief Executive Officer

E2. **ACTION/DISCUSSION: FY 27 Preliminary Budget Update**
Kim Miranda, Chief Financial Officer

E3. **ACTION/DISCUSSION: Adoption of Resolution of Commitment to Trauma Care**

F. DISCUSSION: Board Calendar and Tracking

CLOSED SESSION

1. **CONFERENCE WITH LABOR NEGOTIATORS**
[Government Code Section 54957.6]
AHS Designated Representatives: Jet Chapman, CHRO
Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA, SEIU-CIR

2. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name: **Service Employees International Union, Local 1021 v. County of Alameda and Alameda Health System, Superior Court of California, County of Alameda, Case No. 26CV168243**

3. **Regulatory Affairs, Risk Management, Patient Safety**
[Health and Safety Code 101850(ai)(1)]

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission

Caring, Healing, Teaching, Serving All

Strategic Vision
AHS will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities.

Values
Compassion, Commitment, Teamwork, Excellence, Integrity, and Respect.

Meeting Procedures
All items appearing on the agenda are subject to action by the Board of Trustees. Staff recommendations are subject to action and change by the Board of Trustees.

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/**. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.**

Disability Access
To request accommodation or assistance to participate in the meeting please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to perfumes and various other chemical-based scented products. Please help us to accommodate these individuals.

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.

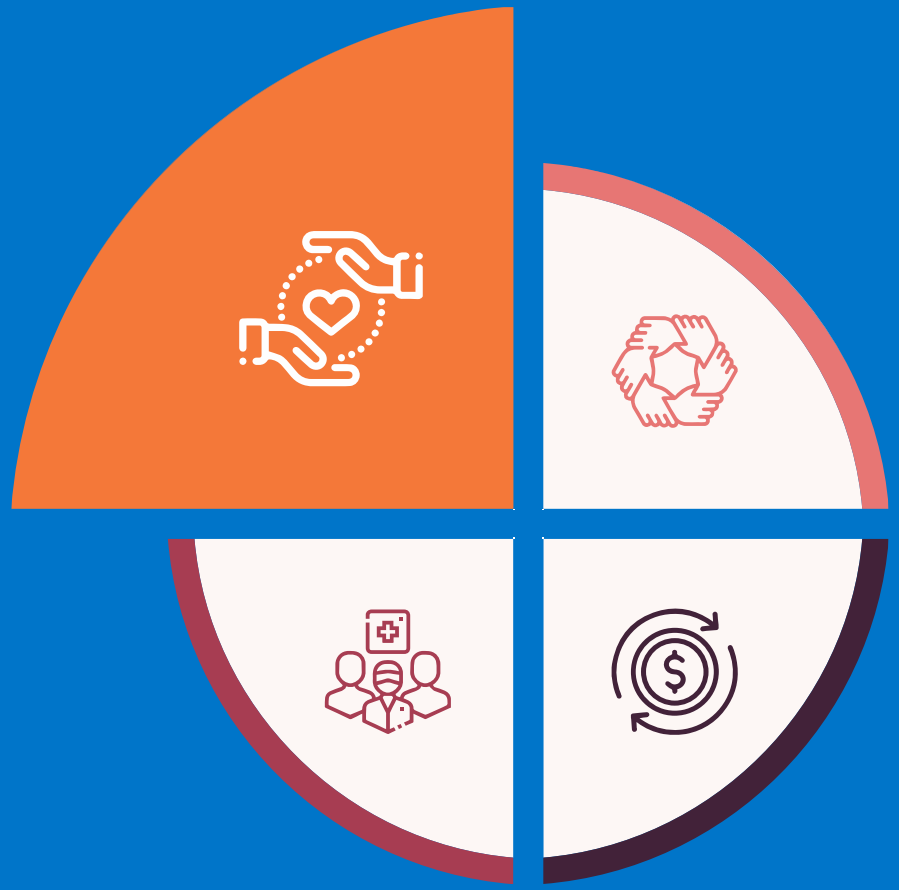
AHS CEO Board Report

James Jackson
4/8/2026
Board of Trustee Meeting

AHS Pillars

Quality Care

AHS provides Safe, Timely, Effective, Efficient, Equitable and Patient-Centered care that is accessible
to all.



CMS Star Rating and Leapfrog Projections

Both CMS and Leapfrog will soon be releasing updated public reporting data for both our star rating and our leapfrog health care grades.

Attached is our analysis of our performance and comparison of our more recent performance to determine if we are improving.

Facility	CMS Star April 2026	Leapfrog Health Grade Spring 2026	Leapfrog Health Grade Fall 2026 (prediction)
Highland	1 Star (no change)	C	B
San Leandro		B (up from C)	A or B
Alameda	4 Star (up from 3)	A (up from B)	A

Clinical Nutrition Care Manual

TO: All AHS Associates
FROM: Beth-Elle Schussler RD, System Clinical Nutrition
Rosylan Rojas, MS. RD, System Director of Food and Nutrition Services
DATE: April 7, 2026
SUBJECT: Clinical Nutrition Care Manual

This memorandum provides care providers with information needed to access and use the Clinical Nutrition Care Manual (MyDietManual).
The Clinical Nutrition Care Manual is an internet-based diet manual that provides current evidence-based nutrition care information, diet education materials standardized for Alameda Health System, and facility specific diet addendums tailored for the demographics of each campus. The manual should be utilized when any questions arise regarding available diet orders or nutrition care. Additionally, Registered Dietitians are available at all campuses to answer any questions regarding a patient or resident's diet or nutrition care.

The Clinical Nutrition Care Manual can be accessed via the AHS Connects Intranet using the following steps.

1. From the Intranet homepage locate the "**Divisions**" tab
2. From Divisions, select "**Food & Nutrition Services**"
3. On the Food and Nutrition Services division page, select "**Nutrition Care Manual & Facility Diet Addendums (MyDietManual)**".
4. Here you will find the link and login instructions to access the Clinical Nutrition Care Manual. Links are also available in the bullets below.
    - Existing users: Log in to MyDiet Manual | MyDiet Manual)
    - New users: My Diet Manual UI
        - Acute Facility Code: 26865
        - Post-Acute Facility Code: 28200

In the event of an emergency resulting in downtime, a hard copy of the Clinical Nutrition Care Manual is available in the Food and Nutrition Department of each facility.

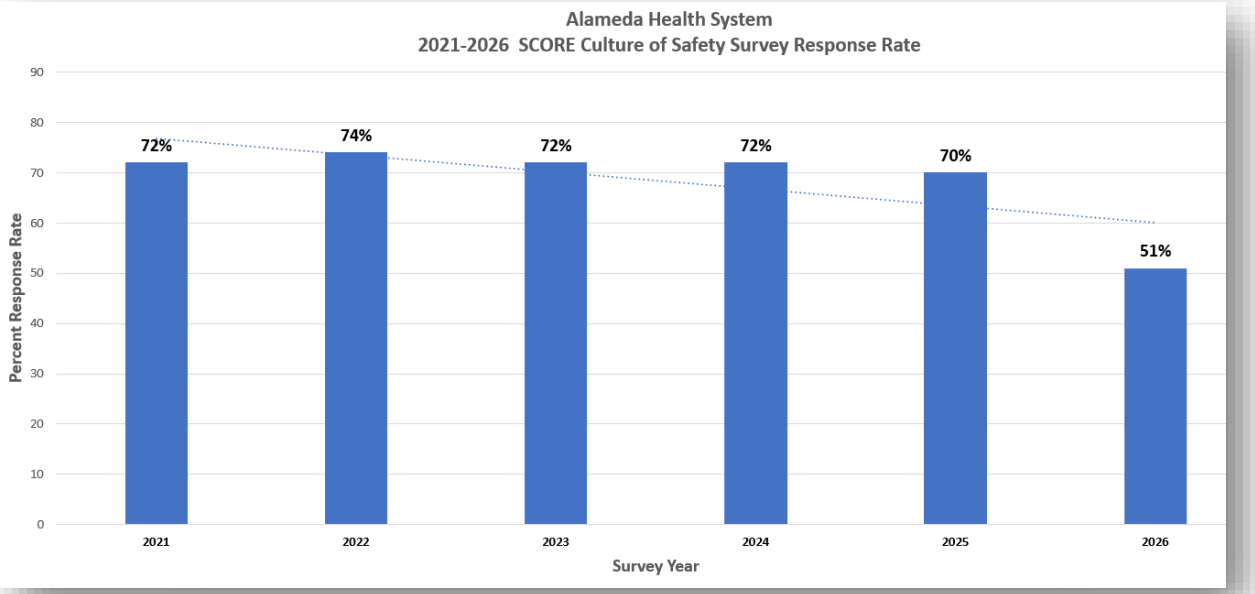
If there are any questions or you have difficulty logging into the Clinical Nutrition Care Manual please reach out to your local Food and Nutrition Services Leadership team.

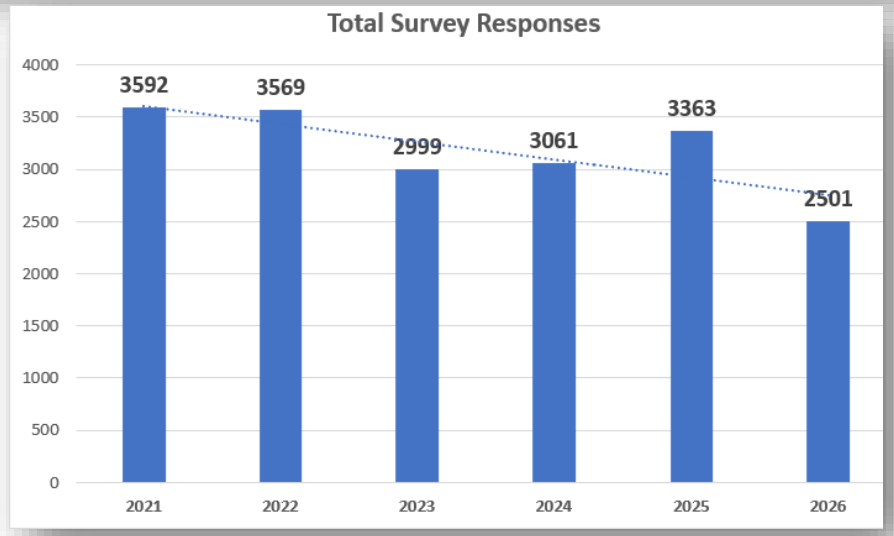
AHS Pillars

Staff & Physician Experience

AHS values its physicians, clinicians, and staff and seeks to grow, engage, retain, and empower them to serve all.

2026 SCORE Pulse Survey Results





Pulse Survey focused on key areas that drive culture:

- Safety Climate
- Teamwork
- Burnout
- Leadership

Building on past successes, AHS will make Culture of Safety a top priority in 2026, driving measurable outcomes through visible leadership and clear, consistent messaging.

SUCCESSES: 2022-2025 Performance

Safety Climate – **15% Improvement***

Teamwork – **11% Improvement***

Burnout – **13% Reduction**

Leadership – **10% Improvement***

Work-Life Balance – **11% Improvement***

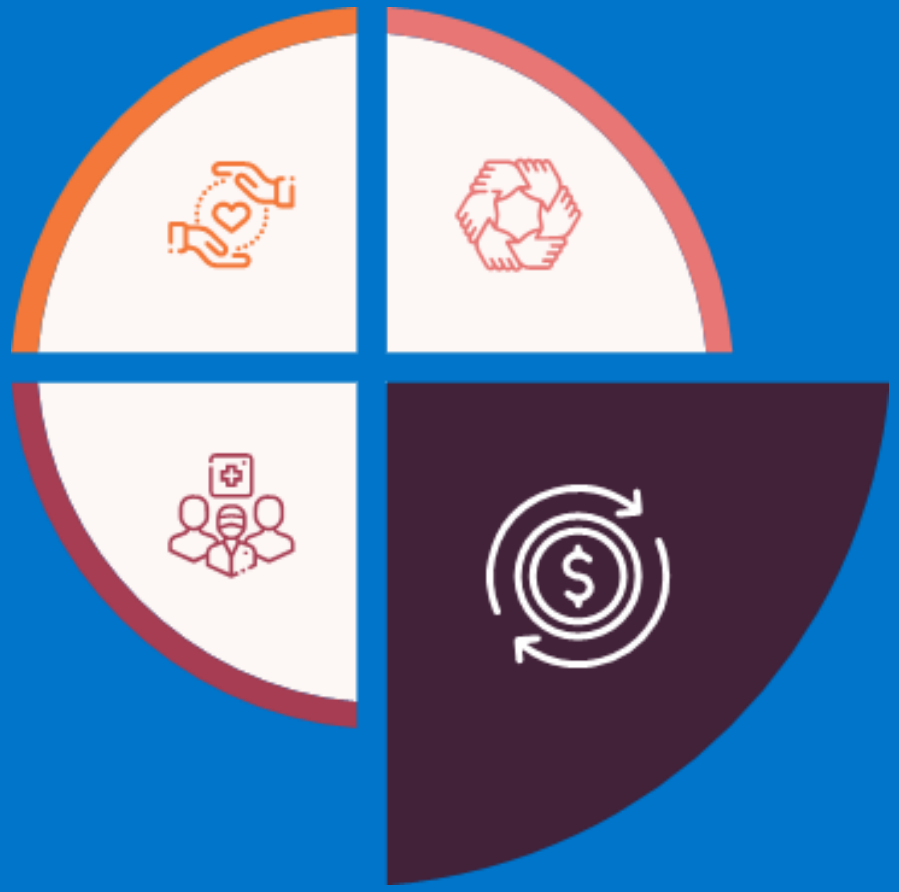
**Statistically Significant Improvements in Cultural Transformation*

Le Jung Retirement Celebration

On Wednesday April 1st The Fairmont Leadership team hosted a celebration of the retirement of Ie Jun, R. N. after 37 years of service to Fairmont Hospital and the Alameda Health System.

AHS Pillars

Sustainability



AHS will pursue innovative approaches to invest in new programs while managing targeted investments in infrastructure to support the delivery of high-quality care.

Inaugural Meeting: Trauma Center Certification Task Force

Dear Colleagues,

As we approach our impending Level I Trauma Center certification survey, and as a follow-up to the QPSC meeting last evening, it is imperative that we immediately mobilize a dedicated, cross-functional task force to accelerate our preparedness efforts and ensure full alignment with the rigorous standards set forth by the American College of Surgeons. The urgency of this work cannot be overstated.

To position our organization for success—both in this survey cycle and throughout our long-term trauma program development—I am requesting the formal establishment of a **Level I Trauma Center Preparedness Task Force**. The objective of this group will be threefold:

1. **Certification Readiness:**
   Conduct a comprehensive review of all requirements and verify that clinical care, processes, data integrity, performance improvement, and documentation meet or exceed Level I expectations. This includes rapid identification of any gaps and the execution of time-sensitive mitigation plans.
2. **Sustainable Staffing and Workforce Strategy:**
   Evaluate the staffing models, workforce capacity, and clinical competencies essential to sustaining Level I trauma designation. This includes provider coverage, trauma nursing readiness, ancillary support, recruitment needs, onboarding pathways, and ongoing education to ensure continuous high-quality, patient-centered care.
3. **Resource Allocation and Operational Readiness:**
   Assess current resources—equipment, operating room availability, specialty services, on-call coverage, diagnostic capabilities, and support services—to ensure they are adequate, reliable, and aligned with Level I standards. The task force will also recommend long-term resource strategies that support system growth and operational resilience.

Given the gravity and immediacy of the upcoming survey, I am requesting that we initiate this task force **as soon as possible**, with representation from trauma leadership, emergency services, surgical services, critical care, nursing, imaging, ancillary departments (Lab, Pharmacy), quality and performance improvement, data registry, and medical staff leadership.

I recommend convening the inaugural meeting within the next week to finalize the work plan, timelines, and accountability structure. I am available to assist in shaping the charter and ensuring appropriate clinical oversight.

I appreciate all you do each and every day: Your strong leadership, your passion for providing world-class care, and your mission-driven dedication to the patients and communities we are privileged to serve are unparalleled.

Thank you in advance for prioritizing this essential work. Your commitment to readiness and excellence is foundational to maintaining a trauma system that is both highly reliable and unwaveringly patient-centered.

Please let me know how you wish to proceed with formalizing the task force membership and next steps.

Warm regards,

Lisa

Ad Hoc Committee Meeting April 1, 2026

Board of Supervisors Ad Hoc Committee Alameda Health System Budget Members:
Supervisor Nate Miley Supervisor Nikki Fortunato Bas

Agenda
April 1, 2026
1:00 - 3:00 PM

1221 Oak Street, Room 255, Oakland, CA 94612

Welcome and Purpose - 10 min
Supervisors Miley and Fortunato Bas

Expected Outcomes - 30 min
- County
- AHS
- Labor
- Discussion

America's Essential Hospitals - 30 min
- Presentation
- Q&A

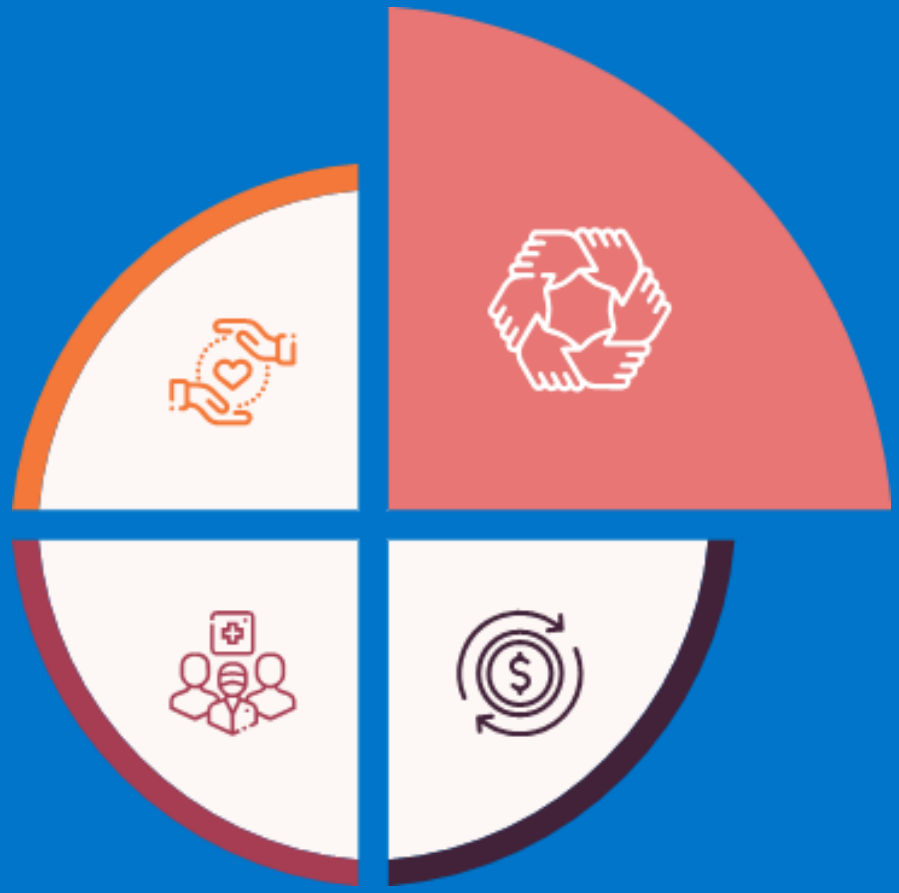
Financial Proposals - 45 min
- Labor
- AHS
- County
- Discussion (if time permits)

Next Steps - 5 min

Future Meetings
- Wednesday, May 6 at 1:00 - 3:00 PM
- Wednesday, June 3 at 1:00 - 3:00 PM

Community Connection

AHS is an anchor in its community and aligns its services to deliver a comprehensive continuum of care by providing needed services and being a trusted partner in its community at large.



ALAMEDA
HEALTH SYSTEM FOUNDATION
CELEBRATE
5 YEARS OF SOUL
APRIL 25TH, 2026
HENRY J. KAISER CENTER FOR THE ARTS
OAKLAND, CA
SOUL of SPRING

CELEBRATING THE
ST. ROSE HOSPITAL &
STANFORD HEALTH CARE
COLLABORATION
Join us as we celebrate an exciting new collaboration between St. Rose Hospital, an Alameda Health System affiliate and Stanford Health Care.
Be part of this special moment as we highlight our collaboration and shared commitment to delivering high-quality care.
April 9, 2026 | 10:30 a.m. - Noon
St. Rose Hospital
27200 Calaroga Avenue
Hayward, CA 94545
Please RSVP by April 2, 2026:
PACE@alamedahealthsystem.org
Refreshments will be served.
St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate
Stanford MEDICINE
Health Care

ALAMEDA HEALTH SYSTEM

Questions

James Jackson
4/8/2026
Board of Trustee Meeting

Alameda Hospital
and
Alameda Health System
Medical Executive Committee
Report to
Quality Professional Services Committee of the Board

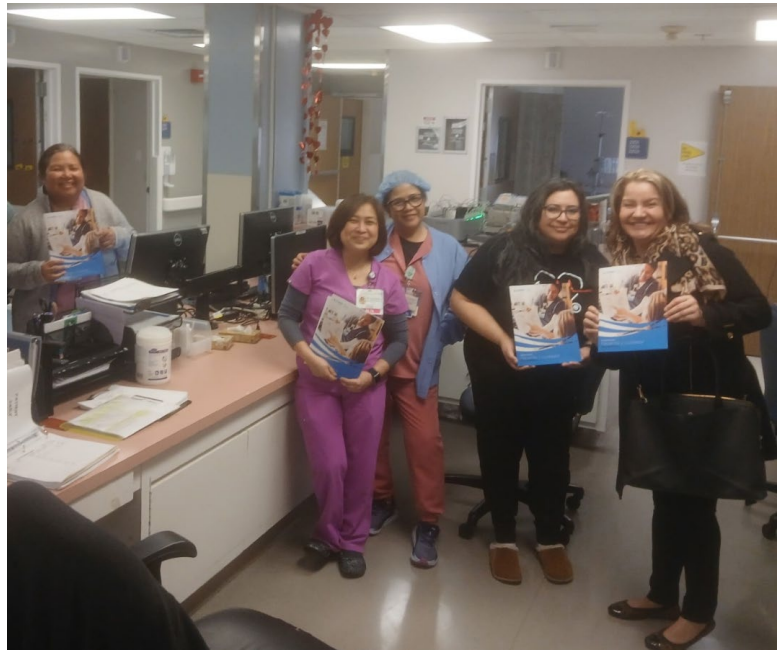
April 8, 2026

Manasa Kalluri, MD, AH Chief of Staff

Berenice Perez, MD, AHS Chief of Staff

Alameda Hospital
Medical Executive Committee Report

- **Quality of Care & Patient Safety**
  - Stroke Program met Joint Commission goal of 85%
  - On track for the Get with the Guidelines Awards for the following metrics:
    - ✓ Honor Roll and Honor Role Elite for Door to Needle (within 60 minutes).
    - ✓ Honor Roll Elite Plus for Door to Needle (within 45minutes)
    - ✓ Honor Roll Elite Plus for Door to Needle (within 30 minutes)
  - CMS 5-Star Reporting Overview
    - ✓ AHS overall 3-Star Rating in fall of 2025
- **Patient Care Experience**
  - Inpatient Patient Admission Guide
  - Service Recovery
- **AH & AHS Combined Medical Staff Committees**
  - Credentials Committee
  - Clinical Practice Council



Medical Staff Committees

Combined committees provide unified systemwide clinical governance to ensure consistent quality, aligned clinical standards and cohesive medical staffs.

AHS & AH Credentials Committee (March 2026)

- Routine credentialing and privileging
- Telemedicine Credentialing by Proxy
- Ongoing Professional Practice Evaluation (OPPE) is factored into reappointment decisions.
- Medical Staff Credentialing and Privileging of Providers Policy
- Medical Staff Application Levels

Clinical Practice Council (March 2026)

- Reviews and approves all protocols, policies and plans that affect the delivery of patient care across the system (HGH, SL, AH)
- MEC approved several systemwide policies/protocols and medication order sets
- Ensures system wide clinical alignment to support safe, consistent patient care

Quality Steering Committee: QAPI Plan, OKR dashboards and CMS 5-star rating

AHS Patient Safety Committee: Root Cause Analysis, Operational opportunities to improve patient care

Medical Staff Peer / Case Review Redesign

Purpose

Strengthen medical staff oversight of quality, safety, and professional practice through a more consistent, transparent, and improvement-focused peer review process.

Key Enhancements

- Physician cases will be selected based on predetermined quality indicators
- Multidisciplinary peer review committee replaces individual department QRC
- *More robust integration FPPE and OPPE in physician practice evaluation*
- Department M&M Conference focuses on clinical learning and advancement

Chairs

- Sunita Mistry MD, Department of Internal Medicine
- Bob Savio MD, Department of Pediatrics

Quality Department

- Ana Torres
- Christian Rieta
- Quality RNs
- Annette Johnson

ALAMEDA HEALTH SYSTEM

AHS Medical Executive Committee Report

New Medical Staff Newsletter

ALAMEDA HEALTH SYSTEM

April 2026

AHS MEDICAL STAFF NEWS

Doctors' Day Message from the AHS Medical Staff Officers

On March 30, we pause to reflect on the central role providers play in health care everywhere. Providers across the country and around the world bring knowledge, judgment, and compassion to each patient encounter. Whether responding to urgent needs or building trusted relationships over time, they share a commitment to listening, healing, and placing patients at the fore front of every decision. Their dedication strengthens communities and improves lives each day.

This year, we want to recognize and thank all providers across Alameda Health System. We are especially grateful for the providers serving our patients at the Highland Hospital campus, Alameda Hospital, and throughout our wellness clinics. Your dedication, collaboration, and perseverance help ensure high quality, compassionate care across every setting. Thank you for the time, expertise, and heart you bring to your work, and for the meaningful impact you have on our health system and the patients we serve.

Recognition of Chief Medical Informatics Officer

We congratulate Dr. David English as he retires after 37 years of service to Alameda Health System. A dedicated member of the AHS Medical Staff for nearly four decades, Dr. English served as Chief Medical Informatics Officer and led the successful implementation of Epic into the health system, which improved system performance and advanced clinical informatics across AHS.

Dr. English is leaving a lasting impact through his commitment to patient care, mentorship, and systemwide collaboration. We are grateful for his many contributions and wish him a wonderful next chapter.

Transition of Chief Physician Executive

We want to recognize Dr. Chitra Akileswaran as she embarks on new adventures. Dr. Akileswaran has been a member of the Alameda Health System Medical Staff and the Alameda Hospital Medical Staff for the last decade. She has provided strong leadership during her time within the Department of Obstetrics, Midwifery and Gynecology where she served as Vice Chair of the department for 5 years. As Chief Physician Executive, she partnered with Department Chairs to strengthen clinical strategy and staffing initiatives.

We are grateful for her service and leadership and wish her all the best in her future endeavors.

David English, MD
Emergency Medicine

Chitra Akileswaran, MD
Obstetrics, Midwifery and Gynecology

WELCOMING NEW PROVIDERS

Lakshminarayan Srinivasan, MD
Radiology/Imaging

Garima Gupta, DO
Medicine
Pulmonary and Critical Care Medicine

Samira Molaei, MD
Medicine
Internal Medicine

Nicholas Trakul, MD
Radiology/Imaging
Radiation Oncology

Alexander Beradei, MD
Psychiatry
Inpatient Psychiatry

Monthly reports of Initial Appointment and Resignation approvals by the Board of Trustees can be accessed via Medical Staff Services Page.

- Alameda Health System
- Alameda Hospital

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ALAMEDA HEALTH SYSTEM

April 2026

AHS MEDICAL STAFF NEWS

Medical Staff Peer Review Redesign Update

The Alameda Health System Medical Staff has established a single, multi-disciplinary Peer Review Committee as part of a comprehensive redesign of the Medical Staff peer review process. This redesign strengthens patient safety, quality of care, and professional accountability by creating a standardized and transparent approach to peer case review across all departments. Consistent indicators, data, and benchmarks are used to identify trends and support focused professional practice evaluations.

The Medical Staff Peer Review Committee (MS PRC) will provide system wide oversight of peer review activities. The next steps of the committee will focus on the implementation, education, and development of other policies for peer review assessment. The MS PRC will strive to support our providers through a fair and consistent peer review process while advancing quality, safe patient care across Alameda Health System.

Bylaws, Policies and Procedures

Click here to access the full Medical Staff Services division page

- AHS Medical Staff Bylaws
- AH Medical Staff Bylaws
- Medical Staff Immunization and Vaccinations
- Medical Staff Ongoing Professional Practice Evaluation (OPPE)
- Medical Staff Professionalism and Conduct Policy
- AHS Medical Staff Committees
- AH Medical Staff Committee

Patient and Quality Safety Committee

Patient Safety Committee reviewed root cause analyses and operational issues impacting quality and safety February 2026 while the Quality Steering Committee reported on the monitoring of OKRs/KPIs and on performance improvement teams for February 2026.

Medical Staff Leaders If you would like to submit a concern regarding clinical impacts resulting from recent reductions in force, please email the Patient Safety Committee email inbox: PSCRIFimpacts@alamedahealthsystem.org

Resignations

- Emily Au, MD – Emergency Medicine – effective 2/17/2026
- Julienne Aulwes, MD – Psychiatry – effective 3/1/2026
- Pascale Look, PA-C – Emergency Medicine – 3/13/2026
- Wilson Ly, MD - Anesthesiology, Perioperative and Pain Medicine – effective 3/5/2026
- Sara Obeid, MD – Medicine – effective 2/22/2026
- Alec Peniche, MD - Anesthesiology, Perioperative and Pain Medicine – effective 2/23/2026
- Geetika Sengupta, MD – Pediatrics – effective 3/1/2026
- Natasha Thrower, MD – Psychiatry – effective 2/22/2026
- Jasper Werby, MD – Psychiatry – effective 2/16/2026
- Steven Zourabian, DO – Orthopaedic Surgery – effective 3/10/2026

We extend our heartfelt thanks to our physicians for their unwavering dedication and leadership in caring for our patients.

Your commitment makes a meaningful difference every day!

Alameda Health System Medical Staff Leadership

Berenice Peres, MD
Chief of Staff

Bhrett Lash, MD
Vice Chief of Staff

Shahram Aarabi, MD
Secretary

Charlotte Wills, MD
Treasurer

Lan Na Lee, MD
Immediate Past Chief of Staff

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Department of Radiology

Equipment Update

Since last month...

- 1/25/2026: HGH ED CT contrast injector down
- 1/30/2026: SLH CT contrast injector down
- 2/9/2026: ALH CT contrast injector down
  - **3/13/2026: Replacement contrast injectors received by AHS**
- 2/28/2026: All 4 HGH portable X-ray units went down
  - **3/31/2026: Replaced with new fleet**
- 3/2/2026: HGH 1.5T MRI down (**ongoing as of last meeting**)
  - **3/16/2026: Fixed and back up after 14 days**
- 3/5/2026: HGH ED X-ray down (**ongoing as of last meeting**)
  - **3/19/2026: Fixed and back up after 14 days**

The plan

FY2026 New Requests

Approved (Y or N	Requestor Name	Campus	Brief Description of capital request	Total Amount
YES	Fredrick Lee	HGH	GE Mini Carm	69,539
YES	Fredrick Lee	HGH	GE Portable X-ray Units	683,194
YES	Fredrick Lee	SLH	GE Mini Carm	69,539
YES	Fredrick Lee	SLH & ALH	GE Mammo upgrade to 3D (FDN cover)	483,499
NO	Fredrick Lee	HGH	GE c-arm replacement	558,450
NO	Fredrick Lee	SLH	GE R&F Room replacement w/room construction	830,625
Grand Total				4,405,933

Table 1 FY2027–FY2030 Stabilization Phase

Fiscal Year	Focus	Estimated Investment
FY2027	High-Risk Stabilization	~$9.4M
FY2028	Construction-Dependent Modernization	~$11.4M
FY2029	Planned Lifecycle Refresh	~$5.4M
FY2030	Long-Range Transformation	~$9.5M

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Department of Laboratory Medicine & Pathology

Equipment Update

HGH Equipment: 10 years or older (Installed in 2015, In use in 2016)

Lifespan is 10-12 years

Control Number	Serial Number	Original Manufacturer	Current Manufacturer	Asset Model Number	Asset Type
404461347	F4MA0412A	Millipore	Millipore	ELIX	Water, Purification, RO
404461348	F4MA04102B	Millipore	Millipore	ELIX	Water, Purification, RO
404461349	1557	Gen-Probe	Gen-Probe	Panther	Analyzer, Immunochemistry
404461351	FB2989	Becton Dickinson (BD)	Becton Dickinson (BD)	BACTEC FX BOTTOM	Blood Culture Analyzer, Automatic
404461352	FT5124	Becton Dickinson (BD)	Becton Dickinson (BD)	BACTEC FX TOP	Blood Culture Analyzer, Automatic
404461350	39620282	Siemens	Siemens	MICROSCAN	System, Sedimentation Rate
404461334	5071527	Diagnostica Stago	Diagnostica Stago	STA Compact Max	Analyzer, Coagulation, Automated
404461337	C803788	Abbott Laboratories	Abbott Laboratories	Architect C8000	Analyzer, Chemistry, Automated
404461338	c803778	Abbott Laboratories	Abbott Laboratories	Architect C8000	Analyzer, Chemistry, Automated
404461353	60313A09D1	Adeza Biomedical	Hologic	TLI IQ	Analyzer, Fetal Fibronectin
404461335	iSR54398	Abbott Laboratories	Abbott Laboratories	ARCHITECT I2000	Analyzer, Immunoassay
404461336	iSR54400	Abbott Laboratories	Abbott Laboratories	ARCHITECT I2000	Analyzer, Immunoassay
404461354	ACP0710315	Abbott Laboratories	Abbott Laboratories	a3600	Sampler Handler, Automated

San Leandro Hospital:

Stago Compact Coagulation Analyzer - **19 years old; priority.**
Aerospray (Slide stainer/cytocentrifuge) -**15 years old; priority.**
Platelet Agitator by Helmer - 15+ years old
Blood Bank freezer - 15 + years old
Clinitek Advantus (urinalysis analyzer) - 15+ years old
Blood Bank centrifuge and Chemistry centrifuge - 15+ years old
Leica microscope (Hematology) - 15+ years old

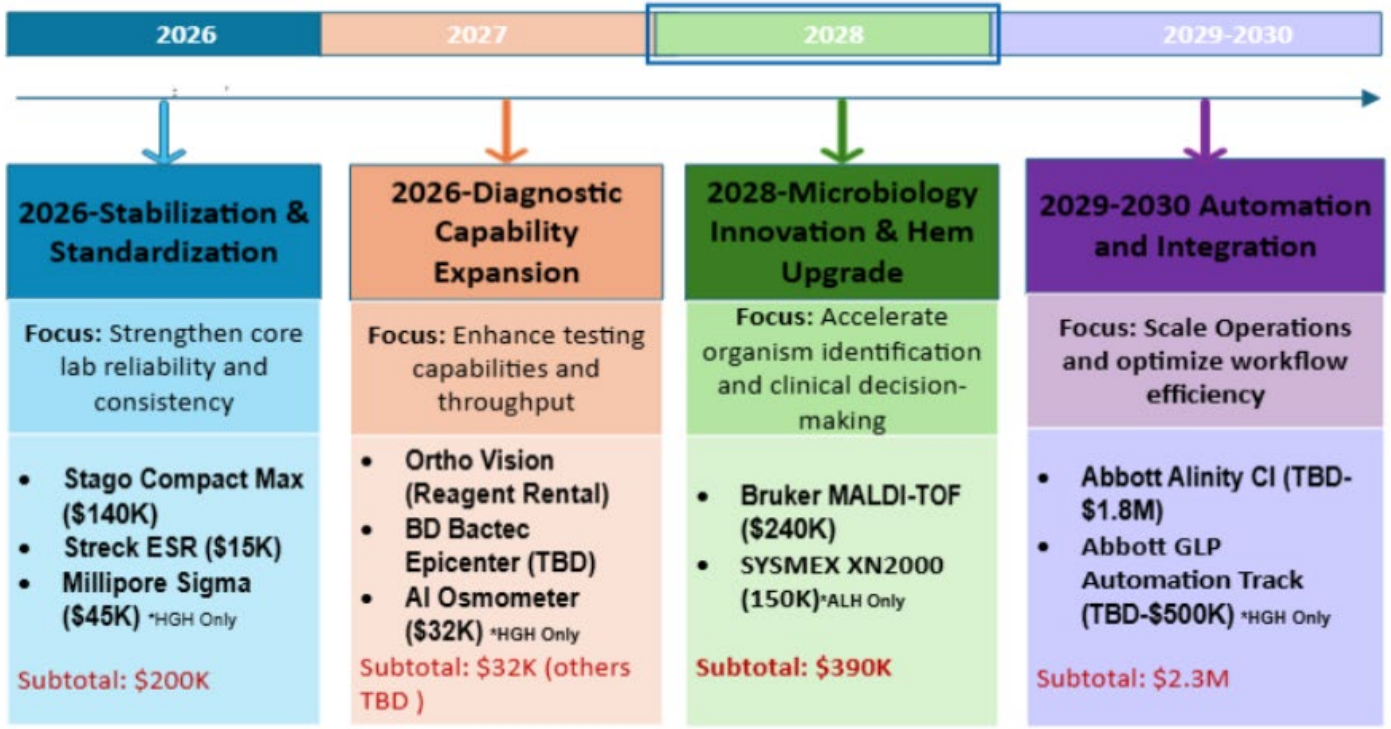
ALH Equipment: 10 years or older

Lifespan is 10-12 years

Control Number	Serial Number	Original Manufacturer	Current Manufacturer	Asset Model Number	Asset Type
70147BG		Abbott	Ruby	Hematology	
70124BG		Abbott	Ruby	Hematology	

AHS Clinical Laboratory Equipment Replacements Roadmap (2026-2030)

Stategic capital investments aligned to operational efficiency, diagnostic capability, and automation



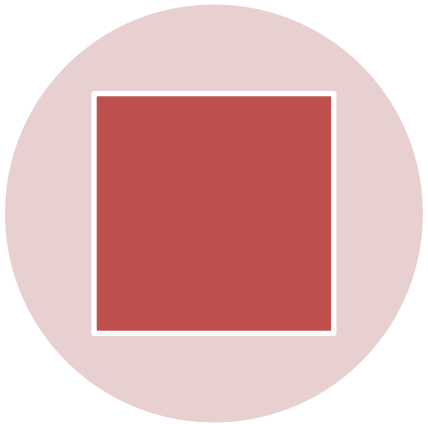
STRATEGIC OUTCOMES

2026: Standardized Platforms + Improved Reliability
2027: Transfusion Medicine Automation and Expanded Diagnostic Capacity
2028: Faster and more precise microbiology and hematology results
2029-2030: Upgraded integrated, Automated Laboratory
Total Known Cost of capital at completion:~$2.92M which excludes BD Bactec Epicenter (TBD); Ortho Vision (Reagent rental model), and Required Facility Considerations (Construction, and HCAI)**

Operating Room Committee Report

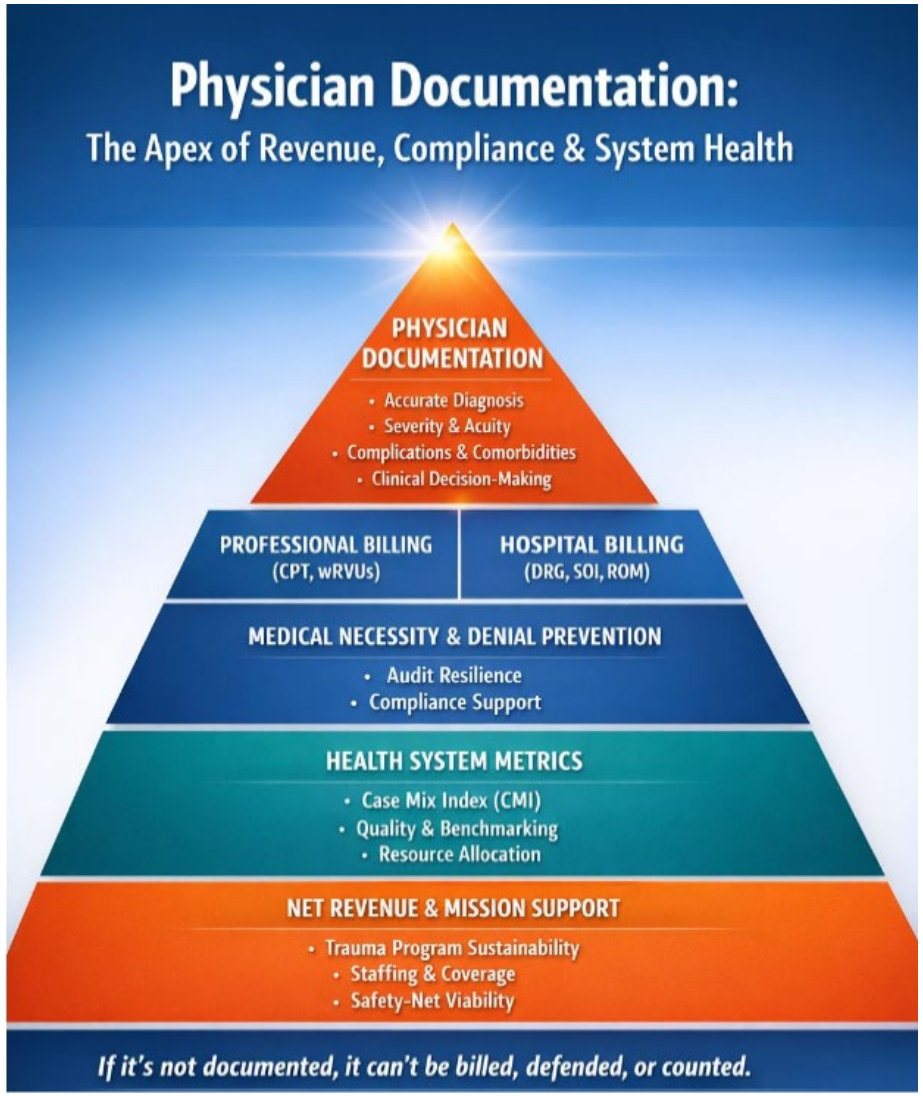
OPERATING ROOM EQUIPMENT

OPERATING ROOM BLOCK TIME



OPERATING ROOM COMMITTEE GOVERNANCE

Utilization Management Committee



ALAMEDA HEALTH SYSTEM

Clinical Impact Taskforce

Physician Hiring Workflow

Prioritization of Level 1 Trauma Recertification

Level 1 Trauma Taskforce

Staff, Space Equipment

Operating Room Availabilityintegration in Operations

MEC Integration in Operations

Capital Committee Core Membership

ALAMEDA HEALTH SYSTEM

CONSENT AGENDA: ACTION

BOARD OF TRUSTEES MEETING

WEDNESDAY, MARCH 11, 2026
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session, In Person: HCP Conference Center, see above address
55 S. Market Street, 9th Floor, San Jose, CA 95113

MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen
Sblend A. Sblendorio	

THE MEETING WAS CALLED TO ORDER AT 5:04 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox (arrived at 5:15), Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion, David Sayen and Sblend Sblendorio (arrived 5:20)

ABSENT: Rachel Richman

PUBLIC COMMENT:

Tony Fuentes spoke regarding the Supervisors' vote to defer program closures and RIFs through June 30, 2026. He urged the Board to follow that course.

Iman Khalil spoke regarding the team of caregivers that saved her life after an accident. Everyone in the community deserved that level of care.

Rex C Dizon spoke regarding the union members keeping Alameda Hospital running. They were asking for a larger increase to cover the high cost of living.

Nicole Giovando spoke to the offer on the table for SEIU UHW. The 12% offered was not enough. She asked that they hear their request. They needed more than 15%.

Ashley Mar and Christy Theis spoke regarding the support she received following the earthquake and tsunami in Japan. They encouraged the Board to engage and find a path forward to protect this community . They needed to figure a way out of these issues.

Angela Thomas said she paid taxes. They were good at taking her money and at taking services. People used to want to work at Highland because it was a trauma center.

Neil Leibert reminded them that the threat of the program closure at Highland was a betrayal to their patients. The clinic was the one place they felt safe.

Nathan Hansford spoke regarding the offer to work with the Board. They wanted them to honor the Supervisors solution. He hoped they would vote to rescind the layoffs.

Gabrielle Wimer spoke regarding how important the care of the physical and occupational therapists was. EVS was critical to clean up after emergencies.

Therese Becker said she chose to work at Highland because social justice was at the core of her being. Serving those with mental illness is one element of serving all.

Michael Martinez spoke regarding the importance of community health. He said the family health advocate department was critical. Future doctors often worked there.

Chelsea Demarte asked them to take the suggestion from the County to rescind the lay offs until June 30. They said they will help with any financial needs.

Parisa Farrohi spoke regarding a client with a long history of trauma. It was hard to work with a client when you didn't even know if you were going to have a job going forward.

Peter Masiak spoke regarding the Beilenson hearing and how the Trustees weren't all there and they had the decision making authority.

Jo Fox said the CEO told the Supervisors that it was his decision not the Supervisors decision. She spoke regarding the bylaws and the powers and duties of the CEO.

Stevon Schwartz noticed the Trustees that they were hurting people like him. It was traumatic to have the sessions on then off then on again.

Chantal Garcia read a statement on behalf of a patient whose life was changed by the treatment at Highland. He was in recovery and working on his masters degree.

Nettie Washington said she was glad she did not depend on the system. They were fighting for their jobs again. These were people and lives, not just numbers.

Benjamin Fisher said what he heard did not match his experience. They wanted respect and they wanted AHS to find solutions.

A. CEO REPORT

James E.T. Jackson, Chief Executive Officer

Trustee Indulkar asked for an outline of what the strategic plan for cancer care or a cancer institute would look like. Dr. Laurent said the Clinical Institute is a standardized, nationally

recognized, best practice-holistic approach to a disease entity or a service line along the entire continuum of care, with the understanding that everything involved was supported from a financial perspective. It was the whole compendium of a quality and safety scorecard in terms of a business development perspective.

Trustee Indulkar said everyone would agree that investing in cancer care within the community was a clinical priority. She said she would appreciate hearing about how they could strategically provide input from their personal experiences to inform and direct how some of this needed to be projected.

B. MEDICAL STAFF REPORTS

AHS Medical: Berenice Perez, MD, Chief of Medical Staff
AH Medical: Catherine Pyun, DO, Chief of Medical Staff

Trustee Garrett asked if the root cause analysis would be in the contract next time it was renewed to avoid the issues Dr. Pyun spoke about regarding the CAT scanner. Ms. Yang said the current contract included the correct certification, their hours, the SLAs, and how they were to respond, as well as the up time. The one thing that was not in the contract was the parts availability. The standard process was to source from GE, which was in the mid-west and caused multiple delays getting the parts to our location. They have received confirmation from Agility that they would purchase and store the parts in Bakersfield and San Diego.

Trustee Garrett said if the engineers were contracted to be there they should have been there. Ms. Yang said they were on site. They negotiated to elevate off hours to have a15 minute response and 2 hour on site response. Trustee Garrett said the real problem then was that the parts were not local and thus not available. Ms. Yang said there were three parts involved. They were ordered sequentially and two of them had a major delay because of weather.

Trustee Indulkar said that she was there when Agility presented to AHS with both state and national leaders on the call. She asked Agility if they had ever seen a system go down for a whole nine days for a CT. They had never seen that before. AHS was an outlier. The question needed to be about why AHS was an outlier. The reasons could be generalized. But they needed to hear why this system was so different that those things fell apart.

Trustee Linton said it seemed the staff and the vendor was on top of the problem. And they knew the Trustees were concerned. They needed to see improvements, and it seemed that conversations were taking place to ensure patient care does not suffer as it had previously.

Truste Garrett spoke about the Joint Conference Committee's request for an outside council to meet with them with the goal to learn more about labor laws. They have heard that the MEC felt like they were not involved in labor conversations. Leadership says they cannot involve them. The Board was unclear as to when that engagement could happen. He wanted to see administration speak as openly and as early as contractually as possible with the MEC. They were not confident about their understanding of when and where that could happen.

Trustee Sayen said he was puzzled by the 3 legged stool analogy. The bylaws indicated that the Trustees have the responsibility to manage, administer, and control AHS including but not limited to all matters pertaining to quality of care. That meant the Board governed the institution

with input from the physician community, the clinical community, and the administrative community, but the three legs were not quite the same because the Board was the final say. Dr. Perez agreed. But she said that the three legged stool was a nice way to consider how they must work together.

Trustee Linton said it would be useful to have an update in terms of the capital expenditures that were in last year's budget and where they were in using that allocation. There have been concerns that they had not been spending that allocation down.

Trustee Fox said the board needed to see a 3-5 year schedule of how they will plan to approve and implement replacements of all key equipment in facilities that were keeping them from providing standard of care for patients. Mr. Fratzke said 5 years ago the equipment was bad. It's cost millions to update it since. It'll be another three years to get through it all.

Trustee Fox said philanthropy was also a part of it. Mr. Jackson said he heard this Board wanted to know the plan. They had that and they could share it.

Trustee Garrett said that was promised at the beginning of the fiscal year. And it still wasn't done. Ms. Miranda said they provided that information on June 11 as part of the budget presentation.

Trustee Obligacion asked for a quarterly progress report on capital expenditures.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Human Resources Committee: February 18, 2026

Donna Linton, Chair

Trustee Linton requested they move the closed session, so the labor partners did not have to wait so long. It was challenging listening to the public testimony. The Board did not take their roles lightly, and the testimony had extreme impact on them. They had been asked to make cuts no one wanted to make. They had fiscal responsibilities and programmatic responsibilities, and it was difficult to find the balance.

Trustee Obligacion recused herself as an employee of SEIU.

Mr. Azizi announced the Board would go into Closed Session and discuss the items as listed on the agenda.

The Board moved into closed at 6:31pm

The Board returned to open session at 7:49pm

Mr. Azizi announced that in closed session the Board of Trustees moved, in accordance with the Board of Supervisors action on March 10, 2026, to defer, through June 30, 2026, all program closures and all reductions in force — including patient-facing and non-patient-facing positions — that were approved on November 19, 2025, in recognition of the Alameda County Board of Supervisors commitment at its March 17, 2026 to provide the necessary level of funding to

Alameda Health System to enable AHS to support such a deferral. The Board is informed that the necessary level of funding is approximately $14 million. The vote was unanimous, with Trustee Obligacion recused.

C2. Quality Professional Services Committee: February 27, 2026
Lilavati Indulkar, MD, Trustee

C3. Finance Committee: March 4, 2026
Alan Fox, Trustee

D. CONSENT AGENDA: ACTION

Trustee Sayen asked if there was any public comment on the consent agenda. Ms. Jojola Gonsalves said there was not.

D1. Approval of the Minutes of the January 7 Special Meeting, January 14 Regular Meeting, and February 4 Special meetings of the Board of Trustees.

D2. Recommendation from the Medical Executive Committee to approve the policies listed below:

- Surge Policy
- Diabetic Ketoacidosis (DKA) Policy

D3. Recommendation from the Quality Professional Services Committee to approve the AHS and AH Medical Staff Policies and Procedures listed below:

- AHS & AH Medical Staff Credentialing and Privileging of Providers
- AHS & AH Medical Staff Immunization and Vaccination
- AHS & AH Medical Staff Ongoing Monitoring of Expiring Items

Trustee Fox said the minuets stated that staff were to provide the percent funded for the ACERA plan and the final audit to the Board.

Moved by Trustee Moss and seconded by Trustee Indulkar to approve the consent agenda.

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.
AYES: Trustees Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion, David Sayen, and Sblend Sblendorio
NAYS: None
ABSTENTION: None

E. ACTION / DICUSSION: Contracts

E1. New agreement with Fisher Scientific Company LLC dba Fisher Healthcare for provision of laboratory supplies. The term of this agreement is effective April 1, 2026 through March 31, 2029. The estimated impact of this agreement is $6,600,000.

Mark Fratzke, Chief Operating Officer

E2. New agreement with Hill-Rom Company, Inc. for provision of a new nurse call system at our skilled nursing facilities. The term of this agreement is effective March 12, 2026 through March 11, 2027. The estimated impact of this agreement is $1,430,000.
Mark Fratzke, Chief Operating Officer

Moved by Trustee Indulkar and seconded by Trustee Moss to approve the contracts.

ACTION: A motion was made and seconded to approve the contracts. A roll call was taken, and the motion passed.
AYES: Trustees Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion, David Sayen, and Sblend Sblendorio
NAYS: None
ABSTENTION: None

F. ACTION/DISCUSSION

F1. ACTION/DISCUSSION: Diagnostic Imaging Equipment Replacement Plan
Albert Roh, MD, Chair Radiology

Trustee Garrett asked about the impact to the patients from the equipment failures discussed in the presentation. Dr. Roh said that probably the biggest impact would be the CT in Alameda being down for nine days. Alameda Hospital was a certified stroke center. For those nine days they were not able to receive stroke patients.

Trustee Sayen asked if it was customary for a CT scanner to be down that long. Dr. Roh said the root cause analysis provided by Agility indicated that it was absolutely out of the ordinary. Trustee Sayen asked if that was because the machine was old. Dr. Roh said there were multiple factors including old age..

Trustee Fox asked if all the failures were due to the fact that the equipment was past its life time. Dr. Lee said that was the case at times. Part of the agreement with Agility was to increase the amount of appointments for the machines, to help with maintenance.

Trustee Fox asked at what point the imaging equipment to be generally at the community standard of care. Dr. Lee said they would start to feel better about it at the four year mark. But it would take time.

Trustee Sayen asked where the $36m fits into the capital budget. Mr. Fratzke said they were collecting all the ideas. This would be prioritized. The $9.4M for the upcoming year could take up the entire new equipment budget so they would need to talk and prioritize.

Trustee Obligacion asked if they were asking for support if not approval. She hoped they would have top notch equipment. She's heard from workers who would rather drive all the way to Standford to use good equipment. Mr. Fratzke said it all fit together. How they did in the operating budget impacted the capital budget.

Trustee Fox said he hoped they were explaining to all physicians what they were buying and why and what they were not getting and why not. It was important to have their support.

Trustee Garrett said it was the Board's role to approve the full budget. Staff has committed to providing a list of capital purchases and getting the Board's feedback. He hoped that that would be communicated.

Trustee Indulkar asked what the timeline was for getting new equipment . Dr. Lee said it would vary based on the equipment. As an example, the four portables took a little while to get here. Some equipment required construction and took a lot longer.

F2. ACTION/DISCUSSION: New Adult Patient Access Assignments from Alameda Alliance
Porshia Mack, MD, Associate Chief Medical Officer, Ambulatory Services

Trustee Indulkar asked if there were learnings from the Newark center wait times that could be used. Dr. Mack said it was difficult to say. Their patient population was a little different though the medical risks were similar. Trustee Indulkar asked about the templates. Dr. Mack said they were a little lower.

Trustee Linton asked if it was a bad thing for them to pause sending us new patients. She asked if it might give us the opportunity to test the impact of all of the changes. Dr. Mack said she did think it gave us an opportunity to further see the impact of some of the changes. She did worry that once they were open again how they would keep up with that. Ms. Miranda said there was a supplemental funding impact as well.

Trustee Garrett asked if there would be a financial impact from a visit count. Dr. Mack said there was a slight underutilization as they rebuilt the patient count. If this continued they would have to look at the templates.

Trustee Fox asked where the Alliance would send the patients. Dr. Mack said they did note that there may not be any clinics that can meet the 10-day requirement. They also did acknowledge the grievances were a problem. Mr. Jackson said proximity would be their first priority.

Trustee Indulkar asked what the qualitative data behind the grievances said. Mr. Jackson said the Alliance realized that the raw grievance numbers were challenging. Dr. Mack said they'd asked them to tease out the grievances to help them make it more actionable.

G. DISCUSSION: Board Calendar and Tracking

Trustee Garrett said he'd like to hear an update on the patient access assignments.

Trustee Sayen said they had a retreat coming up that they were working on the agenda for.

CLOSED SESSION

1. CONFERENCE WITH LABOR NEGOTIATORS

[Government Code Section 54957.6]
AHS Designated Representatives: Jet Chapman, CHRO
Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA, SEIU-CIR

2. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name unspecified: Disclosure would jeopardize settlement negotiations
Ahmad Azizi, General Counsel

3. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name: **Service Employees International Union, Local 1021 v. County of Alameda and Alameda Health System, Superior Court of California, County of Alameda, Case No. 26CV168243**

4. **Regulatory Affairs, Risk Management, Patient Safety**
[Health and Safety Code 101850(ai)(1)]

ADJOURNMENT 9:00pm

.

BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, MARCH 18, 2026
5:00pm to 6:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session, In Person: HCP Conference Center, see above address

MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen
Sblend A. Sblendorio	

BOARD OF TRUSTEES SPECIAL MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 6:00 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion

ABSENT: David Sayen, Sblend Sblendorio

PUBLIC COMMENT:

Tony Fuentes spoke regarding the work the Board has done over the last few weeks. He applauded them for taking this courageous stand. ACMEA was looking forward to collaborating with AHS.

Mr. Azizi announced the Board would go into closed session to discuss the items as set forth on the agenda.

Trustee Obligacion recused herself from Closed Session as an employee of SEIU.

CLOSED SESSION

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Jet Chapman, CHRO
   Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA

2. CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name: **Service Employees International Union, Local 1021 v. County of Alameda and Alameda Health System, Superior Court of California, County of Alameda, Case No. 26CV168243**

Mr. Azizi said the Board met in closed session and took no reportable action.

TRUSTEE COMMENTS

ADJOURNMENT: 7:10pm

BOARD OF TRUSTEES SPECIAL MEETING

Friday, March 20, 2026
9:00am – 3:00pm

Saturday, March 21, 2026
9:00am – 1:30pm

Alameda Health System
55 Harrison Street, Oakland, CA 94607
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session, In Person:
55 Harrison Street, Oakland

MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen
Sblend A. Sblendorio	

Board of Trustees Special Meeting Minutes

DAY ONE, MARCH 20, 2026

THE MEETING WAS CALLED TO ORDER AT 9:17am

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion (arrived at 10:24am), Rachel Richman, David Sayen and Sblend Sblendorio (arrived at 11:00am)

ABSENT: None

PUBLIC COMMENT: None

DAY ONE, MARCH 20, 2026

A. Welcome
David Sayen, Board President
James E.T. Jackson, Chief Executive Officer
Kara Witalis, Witalis, LLC

B. Strategy and Board Roles

The Board of Trustees discussed the role of the Trustees as it relates to organizational strategy.

Trustee Obligacion arrived at 10:24am

Break 10:55am – 11:08am

Trustee Sblendorio arrived at 11:00am

C. Board Strategic Alignment

The Trustees discussed how to strategically align the Board with the mission and the role of the Medical Staff, the Board of Supervisors, and leadership.

Trustee Obligacion recused herself from closed session as an employee of SEIU.

Trustee Obligacion left at 2:39pm

Mr. Azizi announced the Board would meet in closed session to discuss the items as set forth on the agenda.

CLOSED SESSION

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Jet Chapman, CHRO
   Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA

2. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
   (Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
   Case name: **Service Employees International Union, Local 1021 v. County of Alameda and Alameda Health System, Superior Court of California, County of Alameda, Case No. 26CV168243**

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

Mr. Azizi announced the Board met in closed session and took no reportable action.

DAY ONE ADJOURMENT: 4:08pm

DAY TWO, MARCH 21, 2026

THE MEETING WAS CALLED TO ORDER AT 9:23am

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion, Rachel Richman, David Sayen and Sblend Sblendorio

ABSENT: None

PUBLIC COMMENT: None

D. Board Strategic Alignment Action Planning

The Board of Trustees discussed best practices for strategic alignment between the Board of Trustee and the Board of Supervisors, the Board of Trustees/leadership and the Medical Staff. They discussed the importance of communication with a focus on outcomes.

Trustee Obligacion recused herself from closed session as an employee of SEIU.

Mr. Azizi announced the Board would meet in closed session to discuss the items as set forth on the agenda.

CLOSED SESSION

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Jet Chapman, CHRO
   Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA

2. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
   (Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
   Case name: **Service Employees International Union, Local 1021 v. County of Alameda and Alameda Health System, Superior Court of California, County of Alameda, Case No. 26CV168243**

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

Mr. Azizi announced the Board met in closed session and took no reportable action.

Adjournment: 3:00pm

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS System Wide Policies & Procedures						
Licenses + Certifications Policy	Arleen Gomez Sara McElfresh	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
HR Policy – Extended Sick Leave – Directors and Above	Arleen Gomez Sara McElfresh	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
AHS Clostridioides difficile (CDI) Prevention Policy	Matthew D. White, MPH, CIC	• Revised • Attachment A - CDI Diarrhea Decision Tree		03/2029		• IPCC 1/29/2026 • CPC 2/5/2026 • MEC 3/4/2026
Pandemic Influenza Preparedness and Response Policy	Matthew D. White, MPH, CIC	• Revised •		03/2029		• IPCC 1/29/2026 • CPC 2/5/2026 • MEC 3/4/2026
Hand Hygiene Policy	Matthew D. White, MPH, CIC	• Revised •		03/2029		• IPCC 1/29/2026 • CPC 2/5/2026 • MEC 3/4/2026
Scope of Hydrocollator and Hydrotherm Cleaning and Disinfection Policy	Teresa (Terry) Randall, PT, OCS	• Revised • Policy was reviewed by Rehab Services Management Team. Policy updated to include all Rehabilitation Services Physical Therapy and Occupational Therapy in the Outpatient settings at all Campuses. Updated to include Hydrotherm model that is used at Highland.		03/2029		• CPC 2/5/2026 • MEC 3/4/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
WORKPLACE VIOLENCE PREVENTION AND RESPONSE PLAN IN THE WORKPLACE	Nilda Perez, System Director, Regulatory Affairs and EH&S Pete Alimi EH&S Manager	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
AHS Heat Illness Prevention Plan and Policy	Nilda Perez, System Director, Regulatory Affairs and EH&S Pete Alimi EH&S Manager	• Revised •		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Proactive Emergency Generator Testing Notification	James Helena, System Director, Engineering & Facilities Services	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
FIRE PROCEDURE: HAYWARD WELLNESS CENTER	James Helena, System Director, Engineering & Facilities Services	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Utility Systems Management Plan	James Helena, System Director, Engineering & Facilities Services	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Fire Procedure John George Psychiatric Pavillion	James Helena, System Director, Engineering & Facilities Services	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Carboard Box IPC Policy	David Nino Lopez Matthew White	• Revised • Addressed the exemption questions. I created a form and attached the email address l that leaders can use to submit requests. • Removed the risk assessment section		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Provision of Care Policy - Highland	Rebecca Barbosa on Behalf of Salma Adin VP of Patient Services	• Revised • Adding CALIFORNIA CHILDREN'S SERVICES PROGRAM (CCS) verbiage to the NICU section of this policy to be in line with CCS for designation requirements.		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Hemodialysis Patient Management Policy	Berlinia E. Leonor | MSN, BSN, RN	• Revised • Only adding the WC Highland facility under the Policy Statement		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Suicide Prevention Policy	Nilda Perez, System Director, Regulatory Affairs and EH&S	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Restraints and Seclusion Policy	Nilda Perez, System Director, Regulatory Affairs and EH&S	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026

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Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS EMTALA Policy	Nilda Perez, System Director, Regulatory Affairs and EH&S	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Patient Rights Policy	Nilda Perez, System Director, Regulatory Affairs and EH&S	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Patient Visitor Cell Phone Electronic Device Policy	Akemi Renn, CHC, CHPC, CPC | System Director, Compliance	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Electronic Health Information Secure Messaging of PHI	Akemi Renn, CHC, CHPC, CPC | System Director, Compliance	• Revised		03/2029		• CPC 2/5/2026 • MEC 3/4/2026
Patient Privacy Protection Policy	Akemi Renn, CHC, CHPC, CPC | System Director, Compliance	• Revised • This policy is intended to serve as a high-level overview of our privacy framework, and the more detailed requirements around access, uses, and disclosures are already comprehensively addressed in our other privacy policies.		03/2029		• CPC 10/2025 • MEC 3/4/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Food and Nutrition Food Drug Interactions Education	Rosalyn Rojas, MS, RD	• TJC triennial review – revisions made by dietary • Consent Item – PolicyTech		03/2029		• System P&T 12/2025 • CPC 2/5/2026 • MEC 3/4/2026
INTRAVENOUS ADMIXTURE PROGRAM POLICY (34517_-1)	Priya Patel, PharmD	• Added language that NICU meds will be compounded by pharmacy unless it's an emergency • Consent Item – PolicyTech		03/2029		• System P&T 12/2025 • CPC 2/5/2026 • MEC 3/4/2026
CASH CONTROL AND TRANSACTIONS	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
PHARMACY THERAPEUTIC DRUG MONITORING POLICY	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
MEDICATION ADMINISTRATION: CHEMOTHERAPEUTIC AGENTS	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
FEMA_OAKLAND_URBAN_SEARCH_AND_RESCUE_TASK_FORCE_(34522_-1)	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
Medication_Error_Reduction_Plan_2026_(SB_1875)_Alameda Hospital	Neema Kala, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
SYSTEM_MEDICATIONS LOOK ALIKE, SOUND ALIKE_(34528_-1)	Priya Patel, PharmD	• add naloxone and naltrexone to list • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
MEDICATIONS: BOTULISM ANTI-TOXIN	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
LIDOCAINE INFUSION FOR PAIN CLINICAL PRACTICE GUIDELINES	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
LIDOCAINE INFUSION FOR PAIN POLICY	Priya Patel, PharmD	• TJC Triennial Review • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
TNK For Acute Ischemic Stroke	Dr. Gaines/Cheryl Cobb	• Revisions • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
Code Stroke Policy	Dr. Gaines/Cheryl Cobb	• Revisions • Consent Item – Policy		03/2029		• System P&T 1/2026 • CPC 2/5/2026 • MEC 3/4/2026
Elopement and Medical Incapacity Hold Policy	Andrea Wu, MD	• New		03/2029		• CPC 3/5/2026 • MEC 3/18/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
MEDICATION CARTS KITS AND TRANSPORT BOXES FOR SPECIFIC DEPTS. AND DIVISIONS (34534-1)-2.2025	Priya Patel, PharmD	• Develop and stock a phenylephrine kit in the ED Pyxis. • This approach would reduce the risk of look-alike/sound-alike errors by clearly separating the formulations while still ensuring clinicians have immediate access to the necessary components to compound a phenylephrine infusion at the bedside when emergently needed. • System P&T Approval 2/2026 • Consent Item – PolicyTech		03/2029		• System P&T 2/2026 • CPC 3/5/2026 • MEC 3/18/2026
Medical Assistant Medication Administration	Eric Mahone, PharmD	• add MA ability to remove from Pyxis but not administer • System P&T Approval 2/2026 • Consent Item – PolicyTech		03/2029		• System P&T 2/2026 • CPC 3/5/2026 • MEC 3/18/2026
INTRAVENOUS ADMIXTURE PROGRAM POLICY	Kruti Rawal, PharmD	• Revise to align with new State Board of Pharmacy requirements • System P&T Approval 2/2026 • Consent Item – PolicyTech		03/2029		• System P&T 2/2026 • CPC 3/5/2026 • MEC 3/18/2026
Chronic Use of Controlled Medication in Ambulatory Clinics	Eric Mahone, PharmD	• TJC Triennial Review • System P&T Approval 2/2026 • Consent Item – PolicyTech		03/2029		• System P&T 2/2026 • CPC 3/5/2026 • MEC 3/18/2026
LANGUAGE SERVICES POLICY	Ly Sambo	• Updated policy to be clear and concise. Removed duplicate content. Added a sentence to state that some languages may require a short waiting period or the use of on-demand, telephone or video remote interpretation (VRI) services to ensure accurate communication.		03/2029		• CPC 3/5/2026 • MEC 3/18/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - March 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
HR Section 1.00 – Policy 1.36 New Hire & Annual Employee Health Screening/Physical Examination and Drug Testing Policy	Terrie Dixon, RN, BSN, MBA	• Revised • Added details about vaccination requirements and drug screening requirement		03/2029		• CPC 3/5/2026 • MEC 3/18/2026
Out of Service – Do Not Use – Equipment Tag Policy	James Helena, System Director, Engineering & Facilities Services	• Revised		03/2029		• CPC 3/5/2026 • MEC 3/18/2026
Chemical and Biological Testing and Water Analysis - BioMed	James Helena, System Director, Engineering & Facilities Services	• Revised		03/2029		• CPC 3/5/2026 • MEC 3/18/2026

ALAMEDA HEALTH SYSTEM	Policy	
	Licenses and Certifications	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 2/2026 NEXT REVIEW DATE: 2/2029

POLICY STATEMENT

Employees are responsible for maintaining current licenses and certifications as well as meeting the requirements as defined in their respective job descriptions. It is the responsibility of the staff to ensure they keep licenses and certifications current. Staff members will not be allowed to work without an active license or certification on file. Staff will be taken off the schedule and sent home if their license or certifications are not current.

Licenses and certifications will be verified by Alameda Health System (AHS) at time of hire. Upon their expiration, AHS personnel who are required to have licenses and/or certifications will renew their documents and have a copy sent to Human Resources Compliance. Only BLS, PALS, NRP and ACLS issued by the American Heart Association will be accepted to fulfill requirements for Alameda Health System.

PURPOSE

Employees who are required by job description to be licensed and/or certified will be responsible to keep their license and/or certification current; they must provide these certifications and licenses to Human Resources Compliance prior to their expiration.

RESPONSIBILITIES

This policy applies to all Alameda Health System staff, including physicians and APPs, that have licenses and certifications listed as required on their job description.

PROCEDURES

1. Licensure and Certification Verification at Time of Hire
    a. Human Resources will obtain a copy of the verification of the required license or certification from the appropriate website. This copy of the online verification will be placed in the employee file at the time of hire. If online verification is not available for the license or certification, Human Resources will make a copy of the actual document.

2. License and Certification Renewal
    a. License and certification renewal verification will be coordinated through Human Resources Compliance.
    b. All renewal verifications will be by professional websites.
    c. Licenses and certifications will be tracked by Human Resources Compliance with official records being maintained in the employee HR file.
    d. Employees will be required to submit their renewals to Human Resources Compliance. (Note: licenses and certifications should not be submitted to the manager.)

e. Employees whose license and/or certification has expired will not be permitted to work; they will be removed from the schedule and be placed on paid administrative leave by their supervisor. Employees are not permitted to work in any capacity until the license has been verified by Human Resources Compliance.

f. If an employee fails to renew required certifications or licenses within 14 days of the expiration date, they may be disciplined up to and including termination, as AHS can no longer verify their qualification to perform their job duties. Exceptions to this process may be made with the approval of the Chief Human Resource Officer or designee.

g. Temporary Licenses: California Temporary Licenses are accepted and will be verified online as stated above.

h. Employees returning from Leave of Absence will be required to become compliant within 30 days of their return-to-work date. Human Resources Compliance will notify the employee that they will be removed from the schedule until the required license or certification has been renewed. If the employee is non-compliant on day 31, they may be disciplined up to and including termination, as AHS can no longer verify their qualification to perform their job duties.

REFERENCES

HR Section 1.00: Policy 1.26 Rehire or Reinstatement to Employment

ALAMEDA HEALTH SYSTEM	Policy	
	HR Section 2.00 – Policy 2.61 Extended Sick Leave (Directors and Above)	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 2/2026 NEXT REVIEW DATE: **2/2029**

POLICY STATEMENT

The organization recognizes that senior leaders may occasionally face serious health challenges requiring extended time away from work.

PURPOSE

To provide policy and practices for the administration of Extended Sick Leave (ESL) for employees in Director or above positions.

SCOPE

This policy applies to Alameda Health System (AHS) leaders in Director and above positions.

PROCEDURES

1. Paid Sick Leave and Extended Sick Leave Combined. All employees covered by this policy separately receive paid sick leave and extended sick leave combined at the rate of 32 hours or four regularly scheduled workdays in a calendar year, to be received in a lump sum at the start of employment and subsequent anniversary dates. Employees may begin taking paid sick leave after 90 calendar days of employment.

   Paid sick leave may be used for all paid sick leave purposes detailed in state and local laws including but not limited to: illness or injury; diagnosis, care, or treatment of an existing health condition of, or preventive care for, an employee or an employee's family member; aid or care for a family member or designated person when those persons are ill, injured or receiving medical care, treatment or diagnosis; or for an employee who is a victim of domestic violence, sexual assault, or stalking.

   For the purposes of this policy, family members include biological, adopted, or foster children, stepchildren, legal wards, or a child to whom the employee stands in loco parentis, biological, adoptive, or foster parents, stepparents, or legal guardians of the 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; spouse, registered domestic partner, grandparents, grandchildren, and siblings.

   Employees with no spouse or registered domestic partner may designate one person whom they may use paid sick leave to provide aid or care.

   If the need for sick leave is foreseeable, employees must provide advance notice. If the need for sick leave is unforeseeable, AHS should be notified as soon as possible.

   Paid sick leave must be used in minimum increments of two hours. When paid sick leave is used, it will be paid at the employee's regular rate of pay. Accrued, unused, paid sick leave will not be compensated at the end of employment.

   Per HR Policy 2.21 Paid Time Off (PTO), Extended sick leave may be used for periods of illness that exceed one (1) week. The first week of such an illness will be covered by PTO. Exceptions to this rule are below; in these cases, the leave is charged to ESL.

   i. The employee is determined eligible for FMLA; intermittent FMLA is not included; or,

ii. The employee is on an accepted worker compensation leave; or,

iii. The employee is hospitalized within that first week of being off.

2. Protected Leaves. AHS provides up to 12 weeks of paid leave taken under any federal, state, or local law which otherwise provides employees with unpaid protected job leave.

   a. Family Care and Medical Leave. AHS provides family care and medical leave for up to 12 weeks per year in accordance with the California Family Rights Act (CFRA) and the federal Family and Medical Leave Act (FMLA). AHS provides up to 12 weeks of paid leave taken under the FMLA, under the condition that employees must integrate any California State Disability Insurance (SDI) or Paid Family Leave (PFL) partial wage replacement benefits for which they are eligible. Employees are responsible for applying for these benefits. Definitions and coverage information under the FMLA are set forth in AHS policy, HR Section 2.00 - Policy 2.52 Family and Medical Leave.

   b. Pregnancy-Related Disability Leave. Pregnancy-related disability leave (PDL) refers to a period when an employee takes time off work because they are disabled by pregnancy, childbirth, or other related medical conditions. AHS provides up to 12 weeks of paid leave taken under the PDL, under the condition that employees must integrate any California State Disability Insurance (SDI) partial wage replacement benefits for which they are eligible. Employees are responsible for applying for these benefits. Definitions and coverage information under the PDL are set forth in AHS policy, HR Section 2.00 - Policy 2.53 Work-Related Disability Leave of Absence and Modified Duty.

   c. Leaves will be considered to run concurrently not consecutively and so the maximum paid leave will not exceed 12 weeks.

3. Miscellaneous.
   a. AHS employees who are members of the Alameda County Employees' Retirement System (ACERA) and who retire, shall be credited for fifty percent (50%) of their Extended Sick Leave bank of unused extended sick leave accrued as of the date of their retirement, up to a maximum credit of 62.5 days.

   b. This policy shall be applied in a manner consistent with applicable federal, state, and local law.

REFERENCES

- California Family Rights Act (CFRA)
- Family and Medical Leave Act (FMLA)
- AHS Policy – HR Section 2.00 – Policy 2.21 Paid Time Off
- AHS Policy - HR Section 2.00 - Policy 2.52 Family and Medical Leave
- AHS Policy - HR Section 2.00 - Policy 2.53 Work-Related Disability Leave of Absence and Modified Duty

	Policy	
	Clostridioides difficile (CDI) Prevention PolicyDocument Title	**Reference # Version**
	Level ☑ System ☐ Site	**Effective Date:** Effective Date February 1st, 2026 **Last Review Date**: Last Periodic Review Date January 28th, 2026
	Document Owner: System Director of Infection Prevention & Control	

POLICY STATEMENT

Alameda Health System (AHS) shall implement a comprehensive, evidence-based approach to prevent healthcare-associated *Clostridioides difficile* infection (CDI). This policy establishes system-wide expectations for diagnostic stewardship, transmission-based precautions, environmental controls, antimicrobial stewardship, and surveillance to reduce CDI transmission and harm while supporting safe, appropriate patient care.

PURPOSE

The purpose of this policy is to:

- Reduce the incidence of healthcare-onset CDI
- Prevent transmission of *C. difficile* within healthcare settings
- Promote appropriate diagnostic testing and clinical management
- Standardize infection prevention practices across the health system
- Support accurate surveillance and regulatory reporting

SCOPE

This policy applies to all Alameda Health System inpatient units and applicable outpatient settings, and to all workforce members, including employees, licensed independent practitioners, students, volunteers, contractors, and affiliated personnel.

DEFINITIONS

Clostridioides difficile Infection (CDI): The presence of clinically significant diarrhea and either a positive laboratory test for toxigenic *C. difficile* or endoscopic or histopathologic findings consistent with pseudomembranous colitis.

Colonization: The presence of *C. difficile* in the gastrointestinal tract without clinical symptoms of infection.

Diarrhea: Three (3) or more loose or watery stools within a 24-hour period, not attributable to an alternative clinical cause.

Diagnostic Testing Algorithm: A laboratory testing process utilizing a multi-step approach for *Clostridioides difficile*, including initial GDH and toxin testing, with molecular testing (e.g., PCR) performed when indicated, in accordance with laboratory protocols.

Enteric Precautions: AHS-designated transmission-based precautions implemented for patients with suspected or confirmed Clostridioides difficile infection (CDI), including gown and gloves upon room entry, use of sporicidal agents for environmental cleaning and disinfection, and hand hygiene with soap and water preferred following patient care or contact with the patient environment. Hand hygiene with soap and water is required when hands are visibly soiled and during CDI outbreaks or periods of high endemicity.

Diagnostic Stewardship: Coordinated practices that promote appropriate laboratory testing to optimize patient outcomes, reduce unnecessary testing, and minimize unintended consequences of over-diagnosis.

RESPONSIBILITIES

Infection Prevention & Control (IP&C):

- Provide system-level oversight of CDI prevention strategies
- Monitor CDI surveillance data and trends
- Provide guidance on isolation practices and diagnostic appropriateness
- Escalate concerns related to CDI incidence or transmission

Nursing:

- Identify patients with clinically significant diarrhea
- Initiate nurse-driven CDI testing when criteria are met, in accordance with approved protocols
- Ensure timely specimen collection and implementation of Enteric Precautions

Medical Staff:

- Order CDI testing only for patients with clinically significant diarrhea
- Provide appropriate clinical management for patients with confirmed CDI
- Avoid testing in asymptomatic patients or those with formed stool

Laboratory Services:

- Enforce stool acceptance criteria consistent with policy and national guidance
- Communicate CDI test results promptly to clinical teams

Environmental Services (EVS):

- Perform routine and terminal cleaning using hospital-approved sporicidal disinfectants
- Follow enhanced environmental cleaning practices for rooms occupied by patients with suspected or confirmed CDI

Pharmacy and Antimicrobial Stewardship Committee:

- Promote appropriate antibiotic selection, duration, and de-escalation
- Support reduction of unnecessary antimicrobial and acid-suppressive therapy
- Collaborate with Infection Prevention & Control to mitigate CDI risk and review trends as indicated

POLICY

Diagnostic Stewardship

Diagnostic testing for CDI shall be performed only in patients with clinically significant diarrhea and no clear alternative explanation. Testing shall align with approved clinical decision support tools, including the AHS Diarrhea / CDI Testing Decision Tree (Attachment A), and with laboratory multi-step testing algorithms utilizing GDH and toxin testing with reflex molecular testing when indicated.

Isolation and Transmission Prevention

Patients with suspected or confirmed CDI shall be placed on Enteric Precautions promptly. Isolation practices are intended to reduce transmission risk and environmental contamination in inpatient care settings. Asymptomatic colonization does not require isolation.

Hand Hygiene and Personal Protective Equipment

Hand hygiene and PPE use shall follow Enteric Precaution requirements. Gloves shall be worn for patient contact, and gown use is required upon room of entry. Handwashing with soap and water is required after caring for patients with suspected or confirmed CDI.

Environmental Cleaning

Patient care areas occupied by patients with suspected or confirmed CDI shall be cleaned using hospital-approved sporicidal disinfectants. Terminal cleaning shall be performed upon patient discharge or transfer in accordance with EVS protocols.

Antimicrobial Stewardship

Antimicrobial stewardship is a core component of CDI prevention. Clinicians should minimize unnecessary antibiotic exposure and review the continued need for acid-suppressive therapy when clinically appropriate.

Surveillance and Reporting

Infection Prevention & Control shall conduct ongoing surveillance of CDI in accordance with National Healthcare Safety Network (NHSN) Laboratory-Identified (LabID) event definitions and reporting requirements. CDI data and trends shall be reviewed internally through Infection Prevention and Quality governance structures to identify opportunities for improvement.

REFERENCES

Centers for Disease Control and Prevention. (2024). *Clostridioides difficile infection (CDI): Information for healthcare professionals.*
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https://apic.org/implementation-guides/guide-to-preventing-c-difficile-infections/

California Department of Public Health. (2024). *Healthcare-associated infections (HAI) program: Clostridioides difficile infection.* https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CDI.aspx

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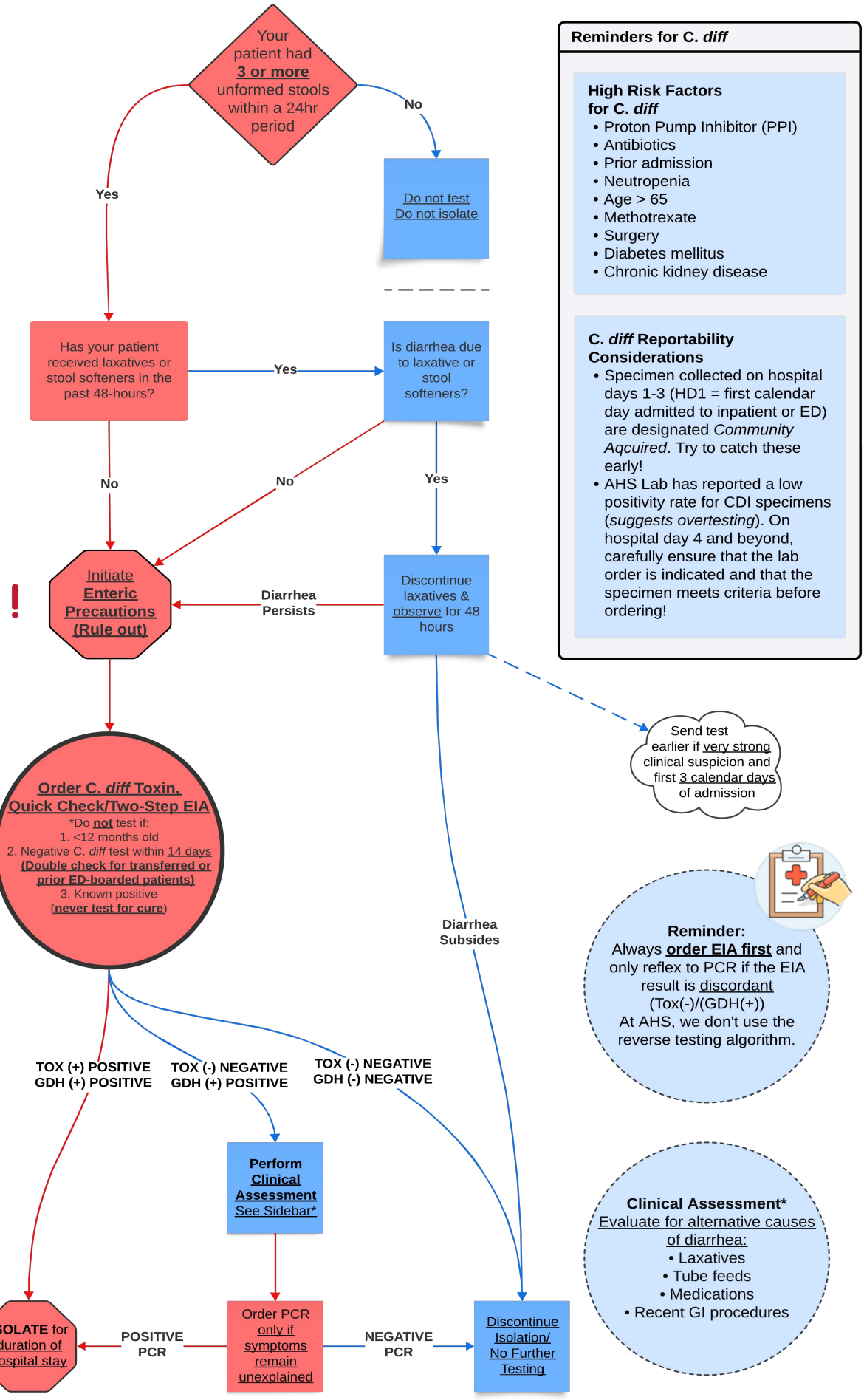
ATTACHMENTS

CDI Diarrhea Decision Tree (Attachment A)

Diarrhea Decision Tree

ALAMEDA HEALTH SYSTEM



Reminders for C. *diff*

High Risk Factors for C. *diff*
- Proton Pump Inhibitor (PPI)
- Antibiotics
- Prior admission
- Neutropenia
- Age > 65
- Methotrexate
- Surgery
- Diabetes mellitus
- Chronic kidney disease

C. *diff* Reportability Considerations
- Specimen collected on hospital days 1-3 (HD1 = first calendar day admitted to inpatient or ED) are designated *Community Aqcuired*. Try to catch these early!
- AHS Lab has reported a low positivity rate for CDI specimens (*suggests overtesting*). On hospital day 4 and beyond, carefully ensure that the lab order is indicated and that the specimen meets criteria before ordering!

	Policy	
	Pandemic Influenza Preparedness and Response Policy	**Reference # Version**
	Level ☑ System ☐ Site	**Effective Date:** Effective Date February 1, 2026 **Last Review Date**: Last Periodic Review Date January 28th, 2026
	Document Owner: System Director of Infection Prevention & Control	

POLICY STATEMENT

Alameda Health System (AHS) shall maintain a comprehensive, scalable pandemic influenza policy to protect patients, workforce members, and the community while sustaining essential healthcare operations. AHS will align pandemic preparedness and response activities with current guidance from public health authorities and applicable regulatory requirements.

PURPOSE

The purpose of this policy is to establish a standardized framework for preparedness and response to pandemic influenza events. This policy is intended to:

- Reduce morbidity and mortality associated with pandemic influenza
- Protect healthcare personnel and patients from transmission
- Ensure continuity of critical healthcare services
- Coordinated and timely decision-making through the Hospital Incident Command Center (ICC)

SCOPE

This policy applies to all Alameda Health System campuses, departments, workforce members, licensed independent practitioners, students, volunteers, contractors, and affiliated personnel in inpatient, outpatient, and ancillary care settings.

DEFINITIONS

Incident Command Center (ICC): The physical or virtual location where Alameda Health System operationalizes planning during emergencies or incidents requiring a coordinated organizational response.
Pandemic Influenza: A global outbreak of a novel influenza virus to which the population has little or no pre-existing immunity and which results in sustained human-to-human transmission.
Operational Tiers: A tiered framework (Conventional, Contingency, Crisis) used to guide healthcare operations based on local epidemiology, healthcare capacity, workforce availability, and resource constraints.
Influenza-like Illness (ILI): Fever and respiratory symptoms consistent with influenza infection, as defined by Centers for Disease Control and Prevention (CDC) guidance.
Aerosol-Generating Procedures (AGPs): Clinical procedures that may generate aerosols capable of transmitting respiratory pathogens.

RESPONSIBILITIES

Infection Prevention & Control (IP&C)

- Lead pandemic influenza preparedness and response activities
- Monitor epidemiologic trends and surveillance data
- Develop, implement, and update infection prevention guidance

Incident Command Center (ICC)

- Coordinate operational response during plan activation
- Allocate resources and approve escalation or de-escalation of operational tiers

Supply Chain / Materials Management

- Maintain oversight of personal protective equipment (PPE) inventory levels and supply chain integrity
- Monitor PPE utilization trends during pandemic response
- Coordinate procurement, conservation strategies, and distribution of PPE in collaboration with Infection Prevention & Control and Incident Command
- Activate contingency and alternate supply strategies during periods of increased demand or supply disruption

Employee Health

- Monitor workforce illness, exposures, and absenteeism
- Manage exposure assessments and return-to-work determinations

Department Leaders

- Ensure departmental compliance with this policy
- Implement tier-based operational changes within their areas

Post-Acute Services

- Post-Acute Services will monitor and respond to local public health guidance in accordance with their respective roles and responsibilities.

Workforce Members

- Comply with infection prevention measures, personal protective equipment (PPE) requirements, and reporting expectations

POLICY

AHS shall utilize an operational tier framework to guide pandemic influenza preparedness and response:

- **Tier 1 – Conventional Operations:** Routine or seasonal influenza activity managed with standard staffing models and established infection prevention practices
- **Tier 2 – Contingency Operations:** Sustained community transmission with emerging impacts to staffing, supplies, or clinical capacity, requiring adaptive operational strategies
- **Tier 3 – Crisis Operations:** Severe surge conditions resulting in significant resource constraints and implementation of crisis standards of care and resource allocation strategies

Escalation and de-escalation between operational tiers shall be based on local epidemiology, healthcare system capacity, workforce availability, and applicable public health directives.

Surveillance and Testing

AHS shall maintain ongoing surveillance for influenza activity, including ILI trends, laboratory-confirmed influenza cases, and influenza-associated hospitalizations. Diagnostic testing strategies shall be tier-based and adjusted according to laboratory capacity, reagent availability, and public health guidance.

Infection Prevention Measures

Influenza transmission may occur via droplets, short-range aerosols, and contact. Infection prevention strategies shall be risk-based and task-specific. Appropriate PPE, including respiratory protection such as N95 respirators, shall be used for aerosol-generating procedures and other high-risk clinical encounters in accordance with the Cal/OSHA Aerosol Transmissible Disease (ATD) Standard.

Workforce Management

AHS shall implement workforce contingency strategies during pandemic conditions, which may include cross-training, staff redeployment, modified staffing models, and adjusted staffing ratios as operationally necessary. Employee Health shall manage illness monitoring, exposure assessment, and return-to-work determinations in accordance with applicable regulatory and public health guidance.

Facility Access and Visitor Management

Facility access controls, visitor screening, and visitor restrictions may be implemented based on the current operational tier and public health guidance. Exceptions, including but not limited to end-of-life care and pediatric visitation, shall be managed through an established approval and documentation process.

Communication

AHS shall maintain timely, accurate, and coordinated internal and external communication throughout all phases of pandemic response activities, in collaboration with local and state public health authorities.

REFERENCES

Centers for Disease Control and Prevention. (2024). Pandemic influenza preparedness and response. https://www.cdc.gov/flu/pandemic/index.html

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	Policy	
ALAMEDA HEALTH SYSTEM	**Hand Hygiene**	**Reference 5 Version**
	Level X System ☐ Site	**Effective Date:** 1/2013, 12/2016, 5/2020, 03/11/2022 **Last Review Date**: 01/2026 Next Schedule Review: 02/2030
	Document Owner: Infection Prevention and Control	***Executive Responsible*** Vice-President, Quality

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

Purpose

1. To prevent the spread of healthcare-associated infections (HAI) through handwashing; the single most crucial strategy for preventing diseases.

2. To remove dirt, organic material, and transient microorganisms from the hands, decreasing the risk of cross-contamination.

Definitions

Healthcare workers: Employees, licensed independent practitioners, residents, volunteers, students, and contracted personnel

Natural fingernails: Natural fingernails are defined as natural nails without an artificial covering other than nail polish.

Nail polish (also known as nail varnish or nail enamel) is a lacquer that can be applied to the human fingernail or toenails to decorate and protect the nail plates. The formula has been revised repeatedly to enhance its decorative effects and to suppress cracking or peeling. Nail polish consists of a mix of an organic polymer and several other components that give it its unique color and texture.

Artificial fingernails or nail extension: Any artificial enhancements applied to the nail for the purpose of strengthening or lengthening the nail including, but not limited to:

- Wraps
- Gels
- Acrylics
- Tips
- Tapes
- Any appliqués other than those made of nail polish
- Nail-piercing jewelry of any kind

Policy

It is the policy of Alameda Health System (AHS) to promote hand-hygiene practices and reduce transmission of pathogenic microorganisms to patients and personnel in the healthcare setting through the recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC), The Society of Healthcare Epidemiology of America (SHEA), The Association for Professionals in

Infection Control and Epidemiology (APIC), Infectious Disease Society of America (IDSA) Hand Hygiene Task Force, the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO).

Background

In October 2002, the CDC published a Guideline for Hand Hygiene in Health-Care Settings. Contained within the guideline are references to studies showing:

1. handwashing results in a reduction in carriage of pathogens on the hands;
2. microorganisms proliferate on the skin within the warm moist environment of gloved hands; and,
3. handwashing results in the reduction of hospital-onset infections (HAIs).

Further evidence shows that healthcare workers who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing.

Procedure

1. Four categories of handwashing

Type	Purpose	Method
Routine Handwashing	To remove soil and transient microorganisms.	Wet hands with water, apply soap liberally, and vigorously rub hands together for at least 20 seconds, covering all surfaces of the hands and fingers. Avoid touching the sink and splashing. Rinse well with water and dry thoroughly with a disposable towel. Use a paper towel to turn off the faucet. Avoid using hot water.
Hand Antisepsis	To remove soil and remove or destroy transient microorganisms	Use the method above for routine handwashing using antimicrobial soap.
Decontaminating Hands with Alcohol-Based Waterless Antiseptic Hand Rub	To destroy transient and resident microorganisms from visibly unsoiled hands.	Apply the recommended amount of product to the palm and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
Surgical Hand Antisepsis, using either an alcohol-based hand rub with persistent activity or an antimicrobial soap before donning sterile gloves.	To remove or destroy transient microorganisms and reduce resident flora.	Antimicrobial Surgical Soap: Remove rings, wristwatch, and bracelets before beginning surgical hand preparation. Scrub hands and forearms for the length of time recommended by the manufacturer (at least 3 minutes to 5 minutes). Alcohol-based Surgical Hand-Scrub with Persistent Activity: Follow the manufacturer's instructions. Before applying alcohol solution, pre-wash hands and forearms with nonantimicrobial soap and dry thoroughly. After application of the alcohol-based surgical hand scrub, allow hands and forearms to dry thoroughly before donning sterile gloves.

2. Choose the appropriate type of handwashing required based upon the degree of hand contamination and whether there is a need to reduce minimal counts of resident flora and mechanically remove the transient flora on the hands.
   a. Handwashing with nonantimicrobial soap and water or an antimicrobial soap and water is recommended:
      i. At the start of the workday.
      ii. When hands are visibly dirty or contaminated.
      iii. Before eating, drinking, preparing food for consumption, smoking, applying contact lenses.
      iv. After handling raw meat, using the restroom, coughing, sneezing, blowing the nose.

v. After the workday has ended.
vi. When caring for a patient with C. difficile infection or Norovirus.

b. Alcohol-based waterless antiseptic hand-rub is recommended for routinely decontaminating hands in clinical situations when hands are not visibly soiled or contaminated (excluding surgery):
   i. After contact with a patient's intact skin.
   ii. After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, as long as hands are not visibly soiled.
   iii. If moving from a contaminated body site to a clean body site during patient care.
   iv. Before donning clean or sterile gloves.
   v. After removing gloves and other personal protective equipment (PPE).
   vi. Upon entering and exiting a patient's room (exam room, inpatient room, treatment room).
   vii. After contact with inanimate objects, including medical equipment, in the patient's room.
   viii. After touching equipment or surfaces that may be contaminated.

c. Surgical Hand Antisepsis:
   i. Before performing a surgical procedure.

d. Healthcare Workers' Fingernails:
   i. Artificial fingernails and extenders are prohibited for healthcare workers who prepare and handle food, prepare and handle medication, prepare and handle sterile supplies, and provide direct patient care. This includes healthcare workers and providers across the continuum of care, including but not limited to the following: Inpatient, ambulatory care, invasive/diagnostic procedures or therapies, perioperative services, ICN/NICU, perinatal services, etc.
   ii. Natural fingernail tip lengths shall not exceed .25 inch for all healthcare workers noted above except for perioperative team members.
   iii. Perioperative team members' natural fingernail tips will be no longer than 0.08 inch (2 mm).
   iv. Healthcare workers are permitted to wear fingernail polish that is freshly applied (no gaps between the cuticle and nail bed) and free of chips.
   v. Department managers are responsible for enforcing compliance.

e. Gloves will be used as an adjunct to, not a substitute for, hand hygiene.
   i. Use gloves whenever contact with blood, body fluid or other potentially infectious matter is present, for contact with patient's non intact skin or as a part of transmission-based precautions and when using chemicals during cleaning activities.
   ii. Change gloves when moving from a dirty to a clean or sterile activity involving patient care.
   iii. Remove gloves after completing care for the patient or leaving the work activity requiring the use of gloves.

f. Healthcare workers will maintain healthy fingernail and hand skin condition.
    i. Healthcare workers will only use moisturizing skin care products approved by AHS. Compatibility between lotion and antiseptic products and the effect of petroleum or other oil emollients on the integrity of gloves is considered at the time of product selection, therefore healthcare workers are not allowed to use personal lotions.
    ii. If an employee has adverse effects in using the current hospital supplied hand soap, alcohol-based hand rub, and/or lotion, discuss these issues with the Employee Health Nurse who will make recommendations for a substitute product that will meet the necessary criteria.

Appendix – Hand Hygiene Posters

ALAMEDA HEALTH SYSTEM

CLEAN HANDS

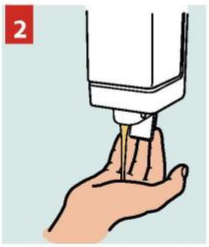
Hand Washing

If hands are dirty, wash hands with soap and water, not with hand sanitizers, for 40-60 seconds.

1

Wet hands with clean, running water.

2

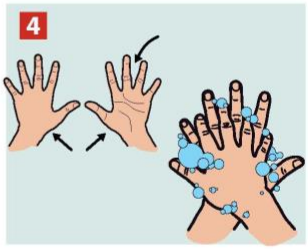


Apply enough soap to cove surfaces.

3

Rub hands together and scrub everywhere for at least 20seconds

4



Wash the front and back of your hands and in between your fingers.

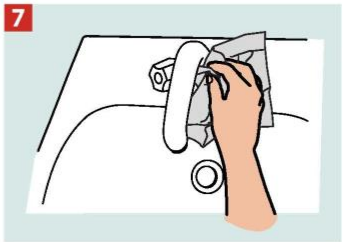
5

Rinse hands with water.

6

Dry hands completely using a single use towel.

7



Use towel to turn off faucet and throw it away.

Alcohol-based hand sanitizer

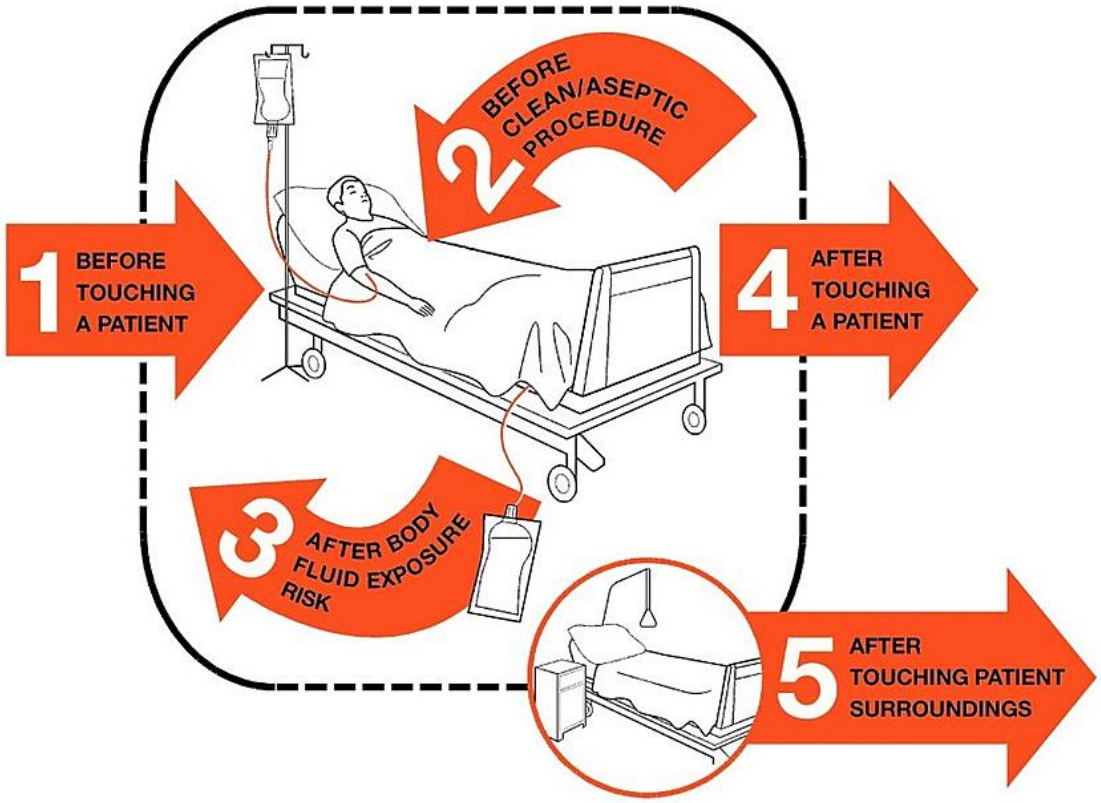
1. **Use sanitizer that contains at least 60% alcohol**
2. **Apply the gel product to the palm of one hand**
3. **Cover all surfaces of hands.**
4. **Rub your hands and fingers together until they are dry. This should take around 20 seconds**

Keep in mind

Soap and water work to remove all types of germs from hands, while sanitizer acts by killing certain germs on the skin.

Adapted from https://www.cdc.gov/clean-hands/about/index.html

October 07, 2024



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety
A World Alliance for Safer Health Care | SAVE LIVES
Clean Your Hands

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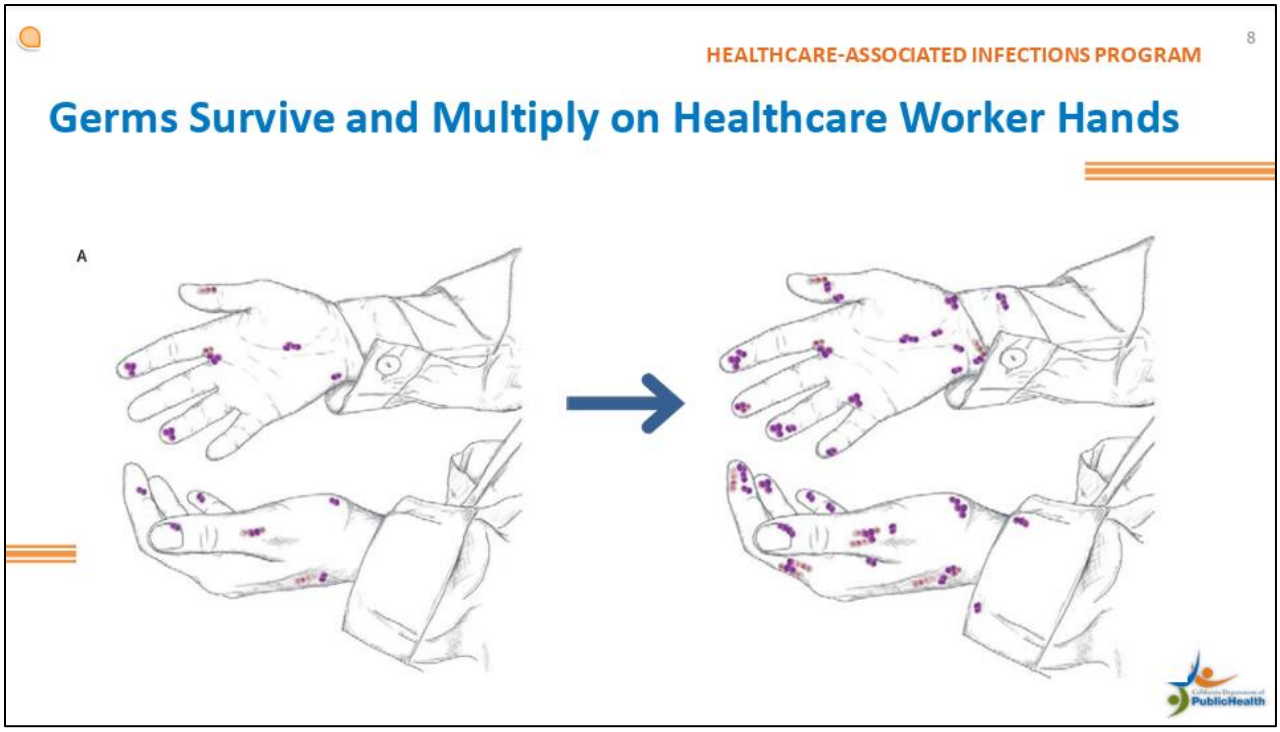
WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009



References

1. CDC, Guideline for Hand Hygiene in Health-Care Settings. The Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force are recommendations. October 25, 2002, link: RR5116-Front Cover.p65
2. Get answers to frequently asked questions about washing your hands and using hand sanitizer in community settings, link: Hand Hygiene Frequently Asked Questions | Clean Hands | CDC
3. NPSG.07.01.01 requires healthcare organizations to implement a robust hand hygiene program, link: Hand Hygiene - Key Components of a Compliant Hand Hygiene Program | Joint Commission
4. Healthcare-associated Infections Program – CDPH, Hand Hygiene Staff Training, link Front Line Staff Training: Hand Hygiene & EVS with Presenter Notes

Approvals

Departmental: Infection Control Committee	**Date: 12/2016, 12/2021**
Director, Infection Control	**Date: 1/2017, 12/2021**
CPC	**Date: 01/2022**
MEC	**Date: 01/2022**
BOT	**Date: 03/2022**

ALAMEDA HEALTH SYSTEM	Policy	
	Scope of Hydrocollator and Hydrotherm Cleaning and Disinfection Policy	**Reference # tbd**
	Level ☐ System ☐ Site	**Effective Date**: 3/2026

POLICY STATEMENT
The Rehabilitation Services Department will follow the recommendation of cleaning and disinfection per manufacturer's instructions for use for the Hydrocollator and Hydrotherm.

PURPOSE
To outline the schedule for the cleaning and disinfecting of Hydrocollator and Hydrotherm.

SCOPE
Rehabilitation Services Department, Manager, Outpatient Physical Therapists, Occupational Therapist, Physical Therapy Aide, Rehab Aide

DEFINITIONS
Hydrocollator/Hydrotherm – a thermostatically controlled unit that heats special packs (hot packs) in water.

Hot Packs – packs filled with a substance that holds heat and moisture, often heated in a special unit or water.

PROCEDURES

Hydrocollator Procedure

The Rehabilitation Services Department will follow the recommendations for cleaning and disinfecting per manufacturer's instructions for use. Current manufacturer instructions recommend cleaning the unit a minimum of every other week.

1. Place copy of most current IUF recommendations in log for ongoing maintenance and cleaning.
2. Always unplug the unit before performing any maintenance.
3. Don appropriate PPE (e.g rubber gloves)
4. Drain all water from the tank.
5. Follow routine maintenance.
6. Monthly maintenance.
7. Yearly maintenance per manufacturer's instructions for use.
8. Inspect the packs. If the filler begins to leak through the fabric or sections of the pack appear loose or empty, discard. When used daily, packs usually last about a year.
9. An electrical service check of the heating element and the power cord will be done annually by the Facility biomedical service.

10. Log cleaning and maintenance on temperature logs (Attachment A).

11. Rehabilitation Services Manager review cleaning and disinfection logs monthly.

Hydrotherm Procedure

The Rehabilitation Services Department will follow the recommendations for cleaning and disinfecting per manufacturer's instructions for use. Current manufacturer instructions recommend cleaning the unit a minimum of 2 times per year.

PROCEDURE

1. Place copy of the most current IUF recommendations in log for ongoing maintenance and cleaning.
2. Always unplug the unit before performing any maintenance.
3. Don appropriate PPE (gloves).
4. Drain all water from the unit.
5. Follow routine maintenance.
6. Inspect the packs, replace if they show signs of wear.
7. An electrical service check of the unit will be done annually by the facility biomedical service.
8. Log cleaning and maintenance on the temperature log.
9. Rehabilitation Services Manager review cleaning and disinfection logs monthly.

REFERENCES

Instructions for Operation and Care of Thermalator Moist Heat Therapy Unit, Mobil 12 Pack Thermalator Model T-12-M.
HydraTherm Composite Heating Unit Operation Manual, 3008.16.04.A

ATTACHMENTS

HYDROCOLLATOR TEMPERATURE AND CLEANING

Facility Location: _____

Note:Unit should be cleaned every other week and as needed Temperature Range: 150° - 170° F

MONTH: _____ **YEAR:** _____

DATE	TEMP (150° - 170° F)	CLEANED (Y/N)	CORRECTIVE ACTION (If required)	INITIALS
01				
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Signature / Initials / Date

Signature / Initials / Date

Signature / Initials / Date

Signature / Initials / Date

** Indicates clinic is closed (includes weekends, Holidays)

Log to be maintained in visible location by the hydrocollator. Completed sheet to be signed by all individuals and initialed, reviewed by the manager monthly and filed for retention.

HYDRATHERM TEMPERATURE AND CLEANING LOG

Facility Location: _____

Note: Unit should be cleaned as needed, minimum 2x/year **Temperature Range: 120-140° F**

MONTH: _____ **YEAR:** _____

DATE	TEMP (120° - 140°	CLEANED (Y/N)	CORRECTIVE ACTION (If required)	INITIALS
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ALAMEDA HEALTH SYSTEM	Policy	
	Scope of Hydrocollator and Hydrotherm Cleaning and Disinfection Policy	**Reference # tbd**
	Level ☐ System ☐ Site	**Effective Date**: 3/2026

Signature / Initials / Date **Signature / Initials / Date**

Signature / Initials / Date **Signature / Initials / Date**

Log to be maintained in visible location by the hydrocollator. Completed sheet to be signed by all individuals and initialed, reviewed by the manager monthly and filed for retention.

***** Indicates clinic closed (includes weekends and Holidays)***

Alameda Health System

WORKPLACE VIOLENCE PREVENTION AND RESPONSE PLAN IN THE WORKPLACE

Department	Environmental Health and Safety	***Effective Date***	4/2022
Campus	AHS System	***Date Revised***	4/2018, 4/2021, 2/2023, 5/2025
Unit	Security	***Next Scheduled Review***	4/2025, 5/2028
Manual	Environmental Health and Safety	***Author***	Director, Environmental Health and Safety
Replaces the following Policies:		***Responsible Person***	Vice President, Support Services

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Purpose

This policy establishes a comprehensive Workplace Violence Prevention Plan (WVPP) to protect the safety and security of all employees, patients, and visitors at Alameda Health System (AHS). It applies to all AHS-owned or leased properties, including off-site operations, and complies with Cal/OSHA Title 8, Section 3342, and Labor Code Section 6401.9.

Policy

Alameda Health System enforces a zero-tolerance policy toward workplace violence. Acts or threats of physical violence, including intimidation, harassment, coercion, or stalking, that involve or affect AHS employees, patients, visitors, or occur on AHS property are strictly prohibited. This applies to all individuals on AHS premises or engaged in its operations, including employees, contractors, temporary staff, patients, vendors, and visitors.

Definitions

The following definitions are based on Cal/OSHA Title 8, Section 3342 and Labor Code Section 6401.9:

Workplace Violence:
Any act or threat of physical violence that occurs at the worksite, including but not limited to:

- The threat or use of physical force that results in, or is likely to result in, injury, psychological trauma, or stress, regardless of whether an injury occurs.
- The threat or use of a firearm or other dangerous weapon, including common objects used as weapons.

This definition does **not** include lawful acts of self-defense or defense of others.

Types of Workplace Violence:

Type 1: Violence committed by a person who has no legitimate business at the worksite, including intruders or those intending to commit a crime.

- **Type 2:** Violence directed at employees by patients, clients, customers, visitors, or others receiving services.
- **Type 3:** Violence committed by a current or former employee, supervisor, or manager.
- **Type 4:** Violence committed by a person with a personal relationship to an employee (e.g., domestic violence), occurring in the workplace.

Program Elements

Alameda Health System (AHS) maintains a comprehensive Workplace Violence Prevention Plan (WVPP) in compliance with California Code of Regulations, Title 8, Section 3342. The WVPP includes the following core elements:

1. Workplace Violence Risk Assessment

AHS conducts an annual workplace violence hazard assessment and following any incident of workplace violence.

- The assessment identifies environmental, operational, and clinical risk factors.
- Findings are used to implement corrective measures and improve violence prevention strategies.

2. Violent Incident Log

AHS maintains a Violent Incident Log that records all workplace violence incidents, including threats, regardless of whether an injury occurred. The source of data for this log is the MIDAS safety reporting system.

- The log is reviewed quarterly via the Workplace Violence Committee to identify trends and develop targeted prevention strategies.
- Incident information is documented without personal identification, in accordance with confidentiality requirements.

3. Incident Response Procedures

AHS follows established procedures to respond to workplace violence incidents, which include:

- Immediate access to medical treatment or first aid, as needed.
- Prompt incident reporting, documentation, and investigation.

- Internal debriefings with affected staff.
- Coordination with law enforcement when appropriate.

4. Training and Education

AHS provides workplace violence prevention training as follows:

- Upon hire and before initial assignment to a job where workplace violence may be reasonably anticipated.
- Annually thereafter for all employees.
- Additional training following workplace violence incidents or significant changes to the WVPP.
  Training includes, but is not limited to:
- Recognizing and responding to potential workplace violence.
- De-escalation techniques and personal safety strategies.
- Reporting procedures and employee rights under the law.

5. Communication and Reporting Procedures

AHS maintains multiple channels for employees to report incidents or concerns related to workplace violence.

- Reports may be made anonymously via the Lighthouse Compliance hotline or formally via the MIDAS incident reporting system.
- Employees are encouraged to report all incidents, threats, or concerns without fear of retaliation.
- Supervisors and designated personnel are responsible for escalating reports in accordance with established procedures.

6. Post-Incident Support and Recovery

AHS provides post-incident support services for affected employees, which may include:

- Access to counseling, mental health services, or the Employee Assistance Program (EAP) after every WPV event.
- Return-to-work procedures that consider medical, psychological, and safety factors.
- Additional resources or accommodations as needed to support recovery and workplace safety.

Reporting Workplace Violence Incidents

All Alameda Health System (AHS) employees are required to report workplace violence incidents or threats immediately, regardless of severity. Urgent or Potentially Dangerous Situations

Urgent or Potentially Dangerous Situations

Employees must immediately notify Security or local law enforcement, depending on site protocols, by:

- Contacting the operator to dispatch Security personnel to the affected area; or
- Call 911 if the situation presents an imminent threat to safety.
  Employees must also notify their immediate supervisor as soon as it is safe to do so.
- response actions to ensure safety and document the incident.

Non-Urgent Incidents and Early Warning Signs

All non-urgent incidents—including threats, intimidation, harassment, or behavioral concerns—must be reported to the employee's supervisor, Security, or Human Resources Business Partner depending on type of WPV as defined above. Examples include:

- Threats or verbal aggression
- Intimidation or harassment
- Early warning signs or concerns about potentially violent behavior

Such reports must be made to the employee's **s**upervisor or Human Resources Business Partner.

Documentation and Investigation

- All workplace violence incidents must be documented in the MIDAS System under the "Workplace Violence" category.
- The supervisor is responsible for ensuring that the online incident report is completed promptly.

Incidents reported in MIDAS will be reviewed and investigated by the appropriate departments depending on type of event. All investigations will be conducted promptly, thoroughly, and in accordance with applicable policies and laws.

Communication and Notification

- The WPV Response and Communications Plan must be shared with affected staff immediately.
- Department Leaders must:
  - Communicate the plan to their teams.
  - Share the plan during shift handoffs and across departments/facilities as needed.
- A Safety Message must be developed for internal and external communication, including language for outside providers.
- Staff will be provided:
  - The Employee Assistance Program (EAP) contact number
  - Notification if an on-site counselor will be available for debriefing.

Threat Assessment and Risk Identification

AHS Security conducts Threat Assessments to evaluate and respond to potential workplace violence (WPV) risks. When Security is informed of threats, irrespective of severity, individual threatening, or employment status, AHS Security conducts a comprehensive threat assessment with a multi-disciplinary team including representatives from:

- Site leader (Chief Administrative Officer, Practice Manager, etc.)
- Director of Nursing (DON), House Supervisor, or VP of Nursing
- Director of Environmental Health and Safety
- Security Director
- Victim
- Leader of department involved

Additional personnel (e.g., department managers or supervisors) may be included as needed to expedite resolution and ensure a comprehensive response.

Post-Incident Response Supervisor and Staff Expectations

Immediate Actions for Supervisors:

- Provide emergency medical care to injured staff.
- Implement safety measures to prevent further harm.
- Notify the Workers' Compensation Third-Party Administrator
- Communicate known risks to staff via written notices.
- Ensure de-escalation strategies are in place.
- Support staff in requesting a Threat Assessment when needed.
- Complete and submit:
    - Safety Alert in Midas (by injured staff and manager)
    - Internal WPV Incident Report via designated WPVP Response Team email

Post-Incident Debriefing

- A Post-Incident Debrief must be conducted by the local leader or supervisor after every WPV incident. Debriefs should be conducted as soon as possible.
- The debrief will evaluate:
    - Administrative controls
    - Engineering controls
    - Staff practices and response
- If a debrief is not conducted, the unit leader must escalate to their leadership team so a debrief could be scheduled.

Contacting Law Enforcement

Employees may contact law enforcement directly for any workplace violence incident they believe warrants immediate intervention. Alameda Health System (AHS) strictly prohibits retaliation against any employee who, in good faith, reports threats or acts of violence to law enforcement or other appropriate authorities.

If law enforcement is contacted, the employee must notify their immediate supervisor and Security Services as soon as it is safe to do so.

Confidentiality and Non-retaliation

AHS maintains the confidentiality of reports to the extent possible and prohibits retaliation against any employee who reports workplace violence in good faith. This is in accordance with AHS policy and California Labor Code §6401.9.

Cal/OSHA Reporting Requirements

The following AHS representatives are authorized to report to Cal/OSHA by completing State Form 5020:

- Chief Administrative Officer
- Environmental Health and Safety Department
- Workers' Compensation Manager
- Regulatory Affairs

Reporting Timeframes:

- Within 24 hours: Any serious injury or incident involving a weapon.
- Within 72 hours: All other WPV-related injuries

Enforcement

Violations of this policy may result in disciplinary action, up to and including termination, and may be reported to law enforcement when appropriate.

Alameda Health System
Workplace Violence Prevention Post Incident Communication Template

ALAMEDA HEALTH SYSTEM

1411 East 31 st Street
Oakland, CA 94602

SUBMIT FORM

CONFIDENTIAL

WPV Communication Tool - Incident Report

Click on the **SUBMIT** button to automatically send it to EH&S after completing this form

Hospital/Campus: Highland Hospital

To:

From:

Incident Date:

Incident Location:

Brief description of the Incident:

What you should know:

Describe Safety Measures Implemented for Unit Staff, visitors or Staff not assigned to the Unit/ Department:

What are the known behavior triggers?

Employee Assistance Program (EAP) Contact Number

We're here to help

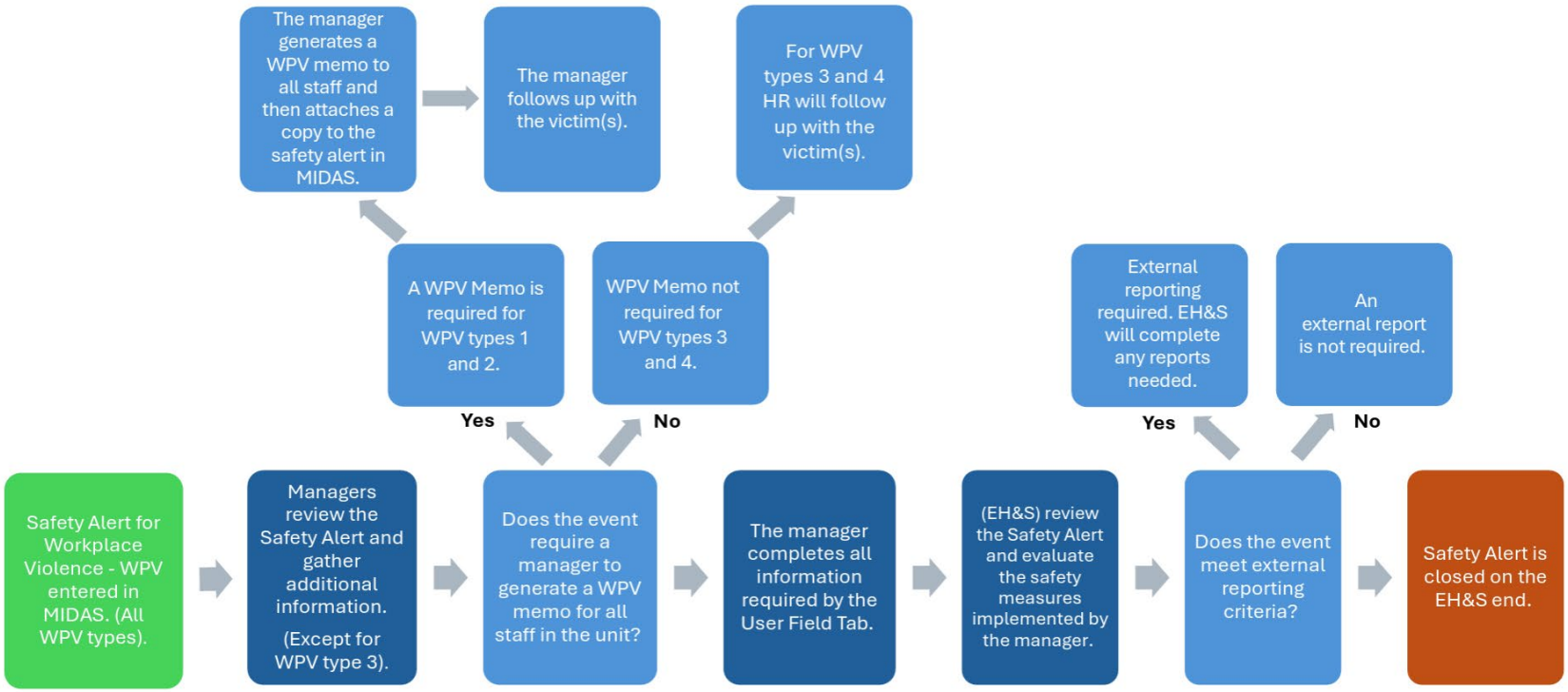
Visit www.anthemeap.com/alameda-health-system or call **844-451-1579**. Scan the QR code with your phone's camera.

Anthem | ALAMEDA HEALTH SYSTEM

Alameda Health System
Workplace Violence Prevention Algorithm

ALAMEDA HEALTH SYSTEM

Workplace Violence - MIDAS Reporting (Safety Alert) Flowchart



Environmental Health and Safety (EH&S) – October 2024

ALAMEDA HEALTH SYSTEM	Policy	
	Heat Illness Prevention Plan (Indoor and Outdoor Work Environments) **LEVEL** ☐ System	**Reference # Version 1** EFFECTIVE DATE: TBD LAST REVIEW DATE: N/A

POLICY

It is the policy of Alameda Health System (AHS) to provide and maintain a work environment that protects the health and safety of all employees from the risk of heat-related illness, in compliance with California Code of Regulations, Title 8, Sections 3395 (Outdoor Places of Employment) and 3396 (Indoor Places of Employment).

All entities within the system shall implement and maintain an effective Heat Illness Prevention Plan (HIPP) that is consistent with this system-wide policy and applicable local procedures. This includes providing access to water, cool-down areas, environmental monitoring, acclimatization support, emergency response protocols, and employee training.

PURPOSE

The purpose of this policy is to ensure consistent, system-wide compliance with California heat illness prevention standards by establishing a framework under which each site can:

- Identify and control indoor and outdoor heat hazards
- Implement procedures to reduce the risk of heat illness
- Respond effectively to incidents of heat-related illness
- Comply with Cal/OSHA regulations and occupational health best practices

SCOPE

This policy applies to all AHS employees and contractors working in indoor or outdoor environments where the ambient temperature, heat index, or other contributing factors create a risk of heat-related illness. This includes, but is not limited to:

- Clinical and non-clinical hospital operations
- Behavioral health facilities
- Maintenance and plant operations
- Construction, custodial, transportation, and groundskeeping
- Emergency response operations
- Any outdoor event, service, or field activity

DEFINITIONS

Per California Code of Regulations, Title 8, CCR T8 §§3395(b) and 3396(b)

- **Heat Illness**: A serious medical condition resulting from the body's inability to cope with a heat load, including heat cramps, heat exhaustion, heat syncope, and heat stroke.

- **Environmental Risk Factors for Heat Illness**: Air temperature, humidity, radiant heat, lack of air movement, workload severity, clothing or PPE, and duration of exposure.

- **Cool-Down Area**: A shaded or temperature-controlled area accessible to workers for recovery and rest.

- **Acclimatization:** The temporary physiological adaptation to working in a hot environment.

- **Feasible Controls:** Engineering or administrative controls that reduce heat exposure through physical changes or work practices.

RESPONSIBILITIES

Facility Administrators / Site Leadership

- Implement a local HIPP aligned with this policy and applicable regulations.
- Designate responsibility for heat hazard identification, control measures, and plan maintenance.
- Ensure availability of water, cool-down areas, and temperature monitoring equipment.
- Maintain records of environmental assessments and training.
- Respond to any report or incident of heat illness per emergency protocols.

Supervisors / Managers

- Enforce compliance with site-specific HIPP procedures.
- Monitor workplace conditions and adjust work practices based on heat risk.
- Encourage hydration and rest periods during high heat conditions.
- Respond promptly to reports of symptoms or concerns.
- Support acclimatization of new and returning employees.

Employees

- Participate in training and follow all site-specific heat illness procedures.
- Stay hydrated and take breaks as needed in designated areas.
- Immediately report symptoms of heat illness in themselves or others.
- Ask for assistance or relief when experiencing heat-related symptoms.

REQUIRED PROGRAM ELEMENTS

A. Drinking Water Access

- Provide access to suitably cool, potable drinking water sufficient to enable employees to consume at least 1 quart per hour.
- Locate water as close as practicable to work areas.

B. Cool-Down Areas

- Outdoor areas: Provide shaded areas at all times when temperature is **≥80°F**.
- Indoor areas: Provide ventilated or air-conditioned areas maintained **below 82°F**, with sufficient space for all employees on break.

C. Environmental Monitoring

- Monitor temperature and/or heat index at all worksites daily when temperature reaches to the maximum limit.
- Document environmental conditions and retain records for at least 1 year.
- Apply thresholds per regulation for implementing controls:
  - Indoor: ≥87°F, or ≥82°F with clothing or radiant heat
  - Outdoor: ≥80°F or ≥95°F (high heat)

D. Engineering and Administrative Controls

- Use ventilation, A/C, fans, and radiant heat shields where feasible.
- Modify work schedules, require rest breaks, and rotate job duties to limit exposure.
- Implement **high-heat procedures** for outdoor work ≥95°F, including buddy systems and pre-shift meetings.

E. Acclimatization

- Implement acclimatization procedures for new or returning employees, particularly during heat waves or high-heat periods.
- Closely monitor unacclimatized workers for signs of heat illness.

F. Emergency Response

- Train all employees and supervisors in recognizing and responding to heat illness symptoms.
- Ensure availability of functional communication devices to contact emergency services.
- Never leave a symptomatic employee unattended.
- Provide immediate first aid and cooling while awaiting emergency responders.

- Contact Beta at 855-648-3279 (see attachment A)

G. Training

Training must be provided for all affected employees and supervisors:

- At time of hire or prior to heat exposure
- Annually thereafter
- When HIPP procedures are updated

Training must cover:

- Risk factors for heat illness
- Prevention techniques (hydration, rest, shade)
- Recognizing signs and symptoms
- Emergency response procedures
- Employee rights under CCR T8 §§3395 and 3396

Compliance and Auditing

Facilities must retain documentation of HIPP implementation, including:

  - Temperature logs
  - Training records
  - Incident reports
  - Environmental assessments
- The system's Environmental Health & Safety department shall conduct:
  - Annual audits of local HIPPs
  - Corrective action reviews following heat illness incidents

References

- CCR Title 8 3395 – Heat Illness Prevention (Outdoor)
- CCR Title 8 3396 – Heat Illness Prevention (Indoor)
- Cal/OSHA Enforcement Policy & Procedures Manual
- Alameda Health System Emergency Operations Plan
- Cal/OSHA Title 8, Section 3362 (General Workplace Safety)

Approvals

Environment of Care Committee **August 2025**

Attachment A

IN THE EVENT OF A WORKPLACE INJURY

EN CASO DE UNA LESIÓN EN EL LUGAR DE TRABAJO

BETA HEALTHCARE GROUP NURSE TRIAGE

Step 1) Injured Employee Notifies Supervisor of Incident.
Empleado lesionado notifica a su Supervisor del incidente.

If this is a life or limb threatening injury immediately call 911.
Si se trata de una lesión que amenaza la vida o una extremidad, llame inmediatamente al 911.

Step 2) Injured Employee Immediately Call BETA Nurse Triage.
Empleado lesionado llamen inmediatamente a BETA Nurse Triage.

855-648-3279

Step 3) BETA Nurse Triage gathers pertinent information and guides the Injured Employee to appropriate care.
BETA Nurse Triage recopila información pertinente y guía al empleado lesionado a atención adecuada.

Step 4) BETA Nurse Triage immediately notifies Medical Facility if injured employee is arriving and sends Incident Reports to employer.
BETA Nurse Triage inmediatamente notifica al centro médico si el empleado lesionado está por llegar y envía informes del incidente al empleador.

IMPORTANT
Please call BETA Nurse Triage prior to seeking any treatment for non-life threatening emergencies and before leaving the job site when possible.

IMPORTANTE
Por favor llame a BETA Nurse Triage ante de procurar tratamiento para emergencias que no constituyan una amenaza a la vida y antes de abandonar el lugar de trabajo cuando sea posible.

Call 24-hours Llame las 24 horas

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM	Policy	
	Proactive Emergency Generator Testing Notification	**29974 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 3/2026 NEXT REVIEW DATE: **3/2029**

POLICY STATEMENT
The organization will provide timely, standardized communication for all scheduled emergency generator tests to ensure patient safety, regulatory compliance, and operational continuity.

PURPOSE
To ensure continuity of patient care and staff safety by providing proactive, comprehensive, and timely communication regarding all scheduled emergency power system tests.

SCOPE
This policy applies to all hospital campuses, buildings, and departments served by emergency generators, and to all Facility Management staff responsible for planning, scheduling, and notifying stakeholders of generator testing activities.

RESPONSIBILITIES

I. Regulatory Mandate (The "Why")

Emergency generator testing is **mandatory** for all California healthcare facilities to ensure **uninterrupted power for life support and critical equipment**. This requirement is enforced by:

- **NFPA 110:** Defines the technical standard for Emergency and Standby Power Systems, including monthly and annual testing intervals.
- **The Joint Commission (TJC):** Requires hospitals to test and maintain all systems used to support the environment of care (EC.02.05.07). Testing failures compromise patient safety accreditation.

II. Notification Content (The "What")

All communications must clearly include the following five data points:

1. **Annual Schedule:** The date, precise time, and duration (e.g., 30 minutes, 2 hours) for *all* scheduled monthly and annual tests for the upcoming year.
2. **Date & Time:** Specific calendar date and start/end times.
3. **Affected Buildings:** All buildings or zones served by the generator being tested.
4. **Affected Systems:** Any non-critical system (e.g., specific IT hardware, specialized lighting) that may temporarily be impacted or reset.
5. **Contact:** Name and phone number of the engineer on duty during the test.

III. Proactive Procedure (The "How")

The following schedule ensures sufficient notice for all stakeholders:

Schedule	Action	Responsibility	Recipients
Annual	Distribute the full 12-month testing schedule.	Facility Manager or Designee (Chief Engineer/Supervisor)	Hospital Leadership, Department Heads, All Staff (via intranet/email)

Monthly	Send a reminder email **one week (7 days) prior** to the scheduled test date.	Facility Manager or Designee	Hospital Leadership, Department Heads, All Staff (via email)
Weekly	**Verbal Check:** Communicate directly with affected department managers the **week leading up** to the test.	Facility Manager or Designee	Affected Department Managers
Day Of	**Final Notice:** Send an email confirmation 1 hour prior to the test starting.	Facility Manager or Designee	Affected Department Heads Only

IV. Responsibility (The "Who")

The **Facility Manager (or Designee)** is solely responsible for the timely creation, distribution, and verification of all communications outlined in this policy.

ALAMEDA HEALTH SYSTEM

FIRE PROCEDURE: HAYWARD WELLNESS CENTER

Effective Date	No Date Set	***Date Revised***	Not Approved Yet
Document Owner	DIR, FACILITIES SERVICES	***Next Scheduled Review***	No Review Date
Executive Responsible	PROJECT MANAGER II, VP, SUPPORT SERVICES		

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

Procedure

I. IF YOU DISCOVER A FIRE:

R. **R**escue anyone in the room while calling out *"Code Red, location..."* for assistance. Close the door to the fire room.

A. **A**lert others by calling out *"Code Red, location..."* and activating the alarm. Call Fire Dept. (9-911) and provide the facility address and the nature and location of fire.

C. **C**onfine (Close Doors) the fire to the smallest area by closing doors.

E. **E**xtinguish/Evacuate the building using the nearest safe exit. All staff will assemble with patients outside the building on the sidewalk adjacent to Macy's.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. In rare situations, it may be appropriate to attempt to extinguish a fire while the room is occupied if the room cannot be immediately evacuated. The inability to quickly evacuate a bariatric or resistive patient from the fire room serves as one such example.

4. As rooms are evacuated, mark the fire room door with an orange tag. Additionally, mark doors with a yellow tag to indicate rooms have been evacuated. Tags for this purpose are stored in the corridor fire extinguisher cabinet.

II. RESPONSE TO THE ALARM OR HEARING "*Code Red, Location*…" BEING CALLED OUT

A. Staff in the Immediate Area:

- Activate the fire alarm and ensure a call has been placed to the Fire Department **(9-911)** advising of the facility address along with the nature and location of the fire.
- Page/announce location of fire. Repeat announcement at least three (3) times.
- Assist in the evacuation of the fire room and close the door to the fire room.
- Evacuate the building using the nearest safe exit.
- Assemble with patients outside the building on the sidewalk adjacent to Macy's.
- Department Coordinators take a head count of staff/patients from their respective areas. Remain outside until further instructions are received from the Clinic Manager or Fire Department Officials.

B. Eligibility Clerks:

- Page/announce location of alarm based on location indicated on fire alarm panel located on lobby post in front of check in desks or phone call received if possible. Repeat the page at least three (3) times.
- Search and evacuate the following areas:
  - Lab
  - Conference Rooms
  - Bathrooms
- Assemble with patients outside the building on the sidewalk adjacent to Macy's.

C. Clinic Manager or Senior Staff Member:

- Ensure the alarm has been activated and a call has been placed to the Fire Department **(9-911)** advising of the facility address along with the nature and location of the fire.
- Ensure page announcement has been made.
- Ensure Department Coordinators evacuate their respective areas, including restrooms.
- Oversee the evacuation of the facility.
- Ensure that Department Coordinators take a headcount at the designated assembly area, and report findings to the Clinic Manager or designee.
- Ensure Security is monitoring the main entrance to prevent anyone from entering the facility.
- Meet the Fire Department and inform them of the entry door that will bring them as close as possible to the fire area. Also, inform firefighters of the situation, including headcount status.
- Inform Alameda Health Systems V.P Ambulatory Care Services (510- 895-7302 or C: 510-290-6990) as soon as safety allows.

  NOTE: If notified of a Code Red by telephone but no fire alarm has sounded, instruct the caller to activate the fire alarm.
- Inform Alameda County Medical Center, V.P. Ambulatory Care Services (510-895-7302 or C: 510-290-6990) as soon as safety allows.

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NOTE: If notified of a Code Red by telephone but no fire alarm has sounded instruct the caller to activate the fire alarm.

- Ensure assigned staff members check the following areas:

Areas to Check	Staff Responsible
Storage and Waste areas near Pod D	Pod D Staff
Conference rooms and Restrooms	Eligibility Clerks
Lab	Eligibility Clerks

NOTE: Upon exiting the building, be alert for traffic in the Parking Lot, especially incoming fire equipment.

D. Security:

- Check and evacuate lobby area, informing people to assemble outside the building on the sidewalk adjacent to Macy's.
- Monitor the main entrance to prevent anyone from entering the facility.

E. All Other Staff:

- Evacuate the building using the nearest safe exit.
- Assemble with patients outside the building on the sidewalk adjacent to Macy's.
- Department Coordinators take a head count or staff/patients from their respective areas. Remain there until further instructions are received from the Clinic Manager or Fire Department Officials.

NOTES RELATING TO VISITORS

Visitors in Waiting or other open areas will be asked to assemble outside the building on the sidewalk adjacent to Macy's and asked to remain there until and "All Clear: has been declared or they are further directed by staff or firefighters.

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ALAMEDA HEALTH SYSTEM	Plan	
	UTILITY SYSTEMS MANAGEMENT PLAN (AHS)	**29326 3**
	LEVEL ☐ System ☐ Site	**EFFECTIVE DATE**: 3/2026 No Review Date

PURPOSE

The objectives of the Utility Systems Management plan is to establish, maintain, and continually provide a reliable utility systems to promote a safe, controlled and comfortable environment of care for patients, visitors, and personnel of the facility by the assessment and minimization of risks of utility failures and to ensure the operational reliability of the utility systems.

GOALS

- Ensures operational reliability of utility systems.
- Reduces the potential for organization-acquired illness to be transmitted through the utility systems.
- Addresses the reliability and minimizes potential risks of utility system failures.

OBJECTIVE

The objective of the Alameda Health System Utility Systems Management Plan includes:

- Comply with all relevant safety standards and regulations.
- Provide a safe, controlled, and comfortable environment for patients, staff and visitors.
- Ensure the operational reliability of the utility systems:
    - Direct high-risk systems.
    - Infection Control systems.
    - Non-high risk utility support systems.
    - Reduce the potential for hospital-acquired illness.
    - Assess special risks of the utility systems.
    - Provide a plan for response to utility systems failures.
    - Coordination for scheduled utility systems interruptions.
    - Establish and maintain a program of policies and procedures consistent with the organization's mission, vision, and values.
    - Enhance of maintenance of the utility systems to reduce and minimize system failures and/or interruptions.

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SCOPE

The Utility Systems Management Plan applies to all facilities, as listed below, and to all processes, activities and departments, as well as to patients, staff and visitors at Alameda Health System. All critical elements of the utility systems used for life support, infection control, environmental support, equipment support, and communications will be included in the program. The Utility Systems Management Plan addresses the safe operation, maintenance and emergency response procedures for these critical operating systems. Utilities include systems for boiler and steam, medical gas, medical/surgical vacuum, and communication systems.

Alameda Health System facilities covered by this management plan are as follow:

- Highland Hospital
- Fairmont Hospital
- John George Hospital
- San Leandro Hospital
- Alameda Hospital
- Eastmont Wellness Center
- Hayward Wellness Center
- Newark Wellness Center
- Park Bridge Rehabilitation
- South Shore Rehabilitation
- Creedon Wound Center

RESPONSIBILITY:

The program implementation is the responsibility of the Director of Engineering and day-to-day operational management of the program is delegated to the facility manager assigned to each site.

ASSESS AND MINIMIZE RISKS OF UTILITY FAILURES, REDUCE THE POTENTIAL FOR ORGANIZATIONAL-ACQUIRED ILLNESS AND ENSURE OPERATIONAL RELIABILITY OF SYSTEMS:

Hazardous physical conditions, potentially hazardous situations, unsafe behaviors and relative risks are identified and assessed through ongoing facility-wide processes. These processes are designed to proactively evaluate the impact of building, grounds, equipment, materials, operations, and internal physical systems on patient, employee and public safety. The elements of the Utility Systems Management Plan performance are share with the Environment of Care Committee, Risk Management Department and the Infection Prevention Department to identify, analyze and control environmental risks to patient, visitor and employee safety that may contribute to undesirable outcomes. These elements of performance include:

- Annual evaluation of the Utility Systems Management Plan

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- Airborne Monitoring and Management
- Waterborne Monitoring and Management
- Routine building inspections and PM's
- Utility Failure and User error/Service interruption reporting and analysis
- Contracted assessment of individual systems with follow-up programs

PERFORMANCE ELEMENTS

Standard EC.02.05.01 – The hospital manages risks associated with its utility systems.

EC.02.05.01 (1)
The hospital designs and installs utility systems that meet the patient care and operational needs.

The hospital references appropriate NFPA standards and FGI Guidelines when designing and installing utility systems to assure the hospital meets the patient care and operational needs of the services in the hospital's buildings.

EC.02.05.01 (2)
New building systems and modifications to existing building systems are designed to meet the National Fire Protection Association's Categories 1–4 requirements. (For full text, refer to NFPA 99-2012: Chapter 4 for descriptions of the four categories related to gas, vacuum, electrical, and electrical equipment.)

The Engineering Department is responsible for ensuring any new construction and modification proceeds in a accordance to the Healthcare Facilities Code (NFPA99). The Engineering Department is responsible for evaluating new types of utility components before initial use to determine whether they should be included in the inventory.

EC.02.05.01 (3)
The hospital maintains a written inventory of all operating components of the utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to patient care (including all life support systems). The hospital evaluates new types of utility components before initial use to determine whether they should be included in the inventory.

The Utility Systems Management Plan includes equipment that meets the following criteria:

- Equipment that maintains the climatic environment in patient care areas
- Equipment that constitutes a risk to patient life support upon failure
- Equipment that is used for infection control purposes
- Equipment that is used for non-life support functions (all other)

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- Equipment that is part of the communication system, which may affect the patient or the patient care environment

The Utility Systems Management Plan includes provisions for the inspection, testing, maintenance and repair for the following systems:

A. High-risk (Life Support) Systems – are used to support life or are critical in the care and treatment of patients:
   1. Oxygen
   2. Medical Air
   3. Medical Surgical Vacuum Systems
   4. Emergency Power Distribution Systems

B. Infection Control Systems – are used to prevent the spread of infection, either directly or indirectly:
   1. HVAC Air Flow
   2. Boilers and steam delivery systems
   3. Domestic Cold and Hot water
   4. Natural Gas system

C. Environmental Support Systems - control the environment or provide for the daily needs of patients and staff:
   1. HVAC (Heating, Ventilation, and Air Conditioning)
   2. Building Automation System
   3. Elevators
   4. Domestic Water System
   5. Sanitary Sewer

D. Equipment Support Systems – deliver operational functions
   1. Clinical Pneumatic tube system
   2. Cart lift system

E. Communications Systems - provide means for patients, visitors, and staff to communicate
   1. Nurse Call system
   2. P.A. system

The hospital evaluates new and upgraded types of utility components before initial use to determine whether they should be included in the inventory.

EC.02.05.01 (4)

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For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems.

The engineering department keeps an inventory of the utility systems for Alameda Health System in the Computerized Maintenance Management System (CMMS). Maintenance activities are tracked and archived in the CMMS.

EC.02.05.01 (5)
The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components of utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program.

Maintenance policies are identified for all components included in the utility systems management program. Different strategies may be utilized as appropriate for different systems including:

- Reliability-centered maintenance
- Interval-based maintenance
- Corrective maintenance
- Metered maintenance may be selected to ensure dependable performance

There is a comprehensive preventative maintenance program, which includes a written testing and maintenance program for all utility components included in the program. It is the responsibility of the Director of the Engineering Department to keep the preventative maintenance program accurate and ongoing.

EC.02.05.01 (6)
The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations.

The utility system components that are included in the inventory that would benefit from scheduled maintenance activities to minimize clinical and physical risks are based on at least one or more the following criteria:

- Manufacturer's recommendations
- Regulatory requirements
- Risk levels
- Current hospital experience (for equipment 10 years or older)

Equipment maintenance records are documented and maintained in the Engineering Department.

A maintenance strategy will be developed for all utility systems components on the inventory. Maintenance procedures will be developed and maintained by the Director of Engineering Department, using the manufacturer's maintenance recommendations, risk levels, and current experiential knowledge with consideration of all applicable regulatory codes and standards.

Through a program of preventative and corrective maintenance, the incidence of unplanned outages of utility systems is reduced or eliminated. By reducing unplanned outages and increasing reliability, patient safety is increased. In order to respond to unplanned outages, Facilities shall work in conjunction with impacted departments to reduce the impact, provide temporary support, and correct the problem as soon as possible. All outages are documented and investigated to determine what measures need to be taken to prevent further outages of the same nature. The status of these measures will be reported at the Environment of Care Committee meetings.

EC.02.05.01 (7)
For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination of whether it is safe to permit operating components of utility systems to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use
- Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
- Availability of alternative or backup equipment in the event the equipment fails or malfunctions
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment

The Director of engineering is responsible for the oversight of the maintenance activities for all equipment in the Utilities Management Plan. The Engineering Department follows Manufacture's guidelines, regulatory requirements and risk assessment results of the new utility or equipment in order to set the maintenance strategy for new and existing equipment.

EC.02.05.01 (8)
For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital identifies operating components of utility systems on its inventory that are included in an alternative equipment maintenance program.

The Engineering Department uses a CMMS to maintain an inventory of all utility systems for AHS. Equipment maintained using an AEM strategy are identified in the CMMS.

EC.02.05.01 (9)
The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Utility controls and valves are clearly identified label in accordance with NFPA 101, NFPA 99, NFPA 72, regulatory requirements and industry best practices.

EC.02.05.01 (10)
The hospital has written procedures for responding to utility system disruptions.

The Director of Engineering Department is responsible for coordinating activities and ensuring procedures are developed that specify the action to be taken during utility system disruptions. Emergency procedures include: procedures to follow when a utility system malfunctions; alternate sources of essential utilities; shutoff procedures and controls of malfunctioning systems; procedures for notifying personnel in the affected areas; procedures to perform emergency clinical interventions; information on how to obtain repair services; procedures regarding re-certification of required systems prior to restoration of services. The written procedures include a call system for summoning essential personnel and outside assistance when required.

EC.02.05.01 (11)
The hospital's procedures address shutting off the malfunctioning system and notifying staff in affected areas.

Facility Management utility failure policy identifies the appropriate process for shutting off malfunctioning systems in collaboration with clinical staff, emergency responders and hospital administration.

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EC.02.05.01 (12)
The hospital's procedures address performing emergency clinical interventions during utility system disruptions.

All clinical department leaders are responsible for developing and maintaining emergency procedures of the utility systems as it relates to their use and application in patient care or treatment areas where a failure interruption or malfunction could result in a negative patient outcome including serious injury or death. The departmental emergency procedures will provide personnel with the essential information needed to perform during an emergency. The emergency procedures will include alternate sources of utilities or back-up protection provided. When alternate sources are not available, emergency procedures will include actions to follow until the utility system can be restored to normal function. Information in the emergency procedures includes:

- Location of emergency shutoff controls
- Conditions in which the utility may be shutoff
- Assigned authority to use the shutoff controls
- How to report a failure or interruption
- Obtaining emergency repair services
- Specific information on emergency clinical interventions

EC.02.05.01 (13)
The hospital responds to utility system disruptions as described in its procedures.

Engineering Department maintains written plans addressing appropriate response levels for utility system disruptions.

EC.02.05.01 (14)
The hospital minimizes pathogenic biological agents in cooling towers, domestic hot/cold water systems, and other aerosolizing water systems.

The Director of Engineering Department is responsible for developing policies and procedures for the inspection, testing and maintenance of all aerosolizing water systems to prevent pathogenic biological agents. Cooling towers and domestic Water Systems are tested in accordance to the Water Management Plan. These results are shared with the Infection Prevention Department.

EC.02.05.01 (15) (16)
In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange

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rates, filtration efficiencies, temperature, and humidity. For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent.

The Director of Engineering Department is responsible for developing policies and procedures for the inspection, testing and maintenance of all ventilation systems serving areas specifically designed to control airborne contaminants such as biological agents, gases, fumes and dust. These areas include, but may not be limited to:

- Operating rooms
- Special procedure rooms
- Clinical Laboratory areas. (hoods provided by Clinical Labs and Nutrition)
- Central Sterile Supply
- Pharmacies (hoods provided by Pharmacy Department)
- Airborne communicable disease rooms (i.e., "TB" rooms), and isolation rooms
- Critical Care areas
- Soiled and Clean utility rooms

The Director of Engineering Department will follow FGI guidelines, NFPA 99 guidelines, ASHRE 170 guidelines or regulatory requirements specific to the space for filter efficiencies, air pressure relationships etc.

EC.02.05.01 (17)
The hospital maps the distribution of utility systems.

Engineering Department maintains drawings showing the distribution of utility systems. These drawings are in Engineering Department Office in the respective site.

EC.02.05.01 (18)
Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7.

Medical gas storage areas are maintained in accordance to NFPA 99 guidelines.

EC.02.05.01 (20)
Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection.

The Engineering Department performs monthly inspection of GFI outlets in wet areas.

EC.02.05.01 (21)
Electrical distribution in the hospital is based on the following categories:

- Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required.
- Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients.
- Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours.

The Engineering Department is responsible for ensuring that the electrical distribution for every hospital follows NFPA guidelines.

EC.02.05.01 (22)
Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.

- Electrical outlets connected to the critical branch are color coded “RED”.
- Electrical outlets in pediatric areas have tamper-resistant covers.

EC.02.05.01 (23)(24)
Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363.

The engineering department has created policies to manage the use and maintenance of power strips in AHS.

EC.02.05.01 (25 - 27)
Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows:

- Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others.
- Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV (mercury vacuum).
- Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone valve box assemblies.

Medical gases are managed and maintained in accordance to NFPA 99 guidelines.

approval

Standard EC.02.05.03 – The hospital has a reliable electrical power source.

EC.02.05.03 (1-16)
The hospital provides emergency power for the following:

Alameda Health System. provides emergency power to at least the following:

- Alarm Systems as required by Life Safety Code
- Exit route and exit sign illumination, as required by the Life Safety Code
- Emergency communication systems, as required by the Life Safety Code
- Elevators
- Equipment that cause harm when it fails, including life support systems, blood, bone, and tissue storage systems, medical air compressors, and medical and surgical vacuum systems.
- Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms, nurseries, critical care, emergency department, urgent care areas, patient rooms and critical data systems.

Standard EC.02.05.05 – The hospital inspects, tests, and maintains utility systems.

EC.02.05.05 (1-8)

- The engineering department works closely with the clinical staff and infection prevention department to mitigate the risk associated with air-quality, infection prevention, noise and other factors that can affect the environment of care for patients and staff during maintenance activities.
- The Engineering Department tests all utility system components before initial use and documents the date of initial testing.
- All documentation of high-risk utility system components is maintained in the CMMS. High-risk equipment is identified in the CMMS and filed in the Engineering Department.
- All documentation of infection control utility system components is maintained in the CMMS and filed in Engineering Department.
- All documentation of non-high-risk support utility system components is maintained in the CMMS, and filed in Engineering Department.
- The Engineering Department performs monthly testing for line isolation monitors.
- The engineering department aligns their maintenance strategies and process to meet NFPA99, regulatory requirements and industry best practices.

Standard EC.02.05.07 – The hospital inspects, tests, and maintains emergency power systems.

EC.02.05.07 (1)

At least monthly, the hospital performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented.

Egress battery lights on campus are tested monthly. Functional testing and replacement of batteries for battery powered egress lights will be conducted per NFPA 110.

EC.02.05.07 (2)
Every 12 months, the hospital performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. The test results and completion dates are documented.

Egress battery lights on campus are tested Annually. Functional testing and replacement of batteries for battery powered task lighting will be conducted per NFPA 110 and NFPA 101.

EC.02.05.07 (3)
Every quarter, the hospital performs a functional test of stored emergency power supply systems (SEPSS) for 5 minutes or as specified for its class (whichever is less). The hospital performs an annual test at full load for 60%of the full duration of its class. The completion dates of the tests are documented.

This standard is not applicable. Alameda Health System does not have any stored emergency power supply systems.

EC.02.05.07 (4)
At least monthly, the hospital tests each generator for at least 30 continuous minutes. The completion dates of the tests are documented.

The hospital conducts and documents weekly inspections run tests, monthly building load tests, and a tri-annual four-hour building load tests for each generator.

EC.02.05.07 (5)
The monthly tests for diesel-powered emergency generators 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. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 4, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 25% of nameplate rating for 30 minutes, followed by

50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 2 continuous hours.

The hospital tests each generator in accordance with NFPA 110 and provides supplemental loads as required on an annual basis.

EC.02.05.07 (6)
At least monthly, the hospital tests all automatic transfer switches. The completion date of these test are documented.

The hospital tests all automatic transfer switches in accordance with NFPA 110. Tests are conducted and documented during the monthly generator load tests.

EC.02.05.07 (7)
Facilities that have a generator providing emergency power for the services listed in Standard EC.02.05.03 EPs 5 & 6 tests each emergency generator at least once every 36 months for a minimum of four continuous hours. This test shall be conducted under a load (dynamic or static) that is at least 30% of the nameplate rating of the generator. The completion date of the test is documented.

The hospital conducts a generator test every 36 months for 4 hours testing above 30% of the nameplate rating for each generator and document findings and date.

EC.02.05.07 (8)
At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented.

Annual fuel testing is performed by the engineering department. Records are filed in the engineering office.

EC.02.05.07 (9)
If a required emergency power system fails, the hospital implements measures to protect patients, visitors, and staff until necessary repairs or corrections are completed.

If any required emergency power system tests fail the hospital will implement appropriate measures to effect repairs and restoration of system.

EC.02.05.07 (10)
If a required emergency power system test fails, the organization performs a retest after making the necessary repairs or corrections.

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If any required emergency power system test fails the hospital performs retests after making the necessary repairs or corrections. This test is documented.

Standard EC.02.05.09 – The hospital inspects, tests, and maintains medical gas and vacuum systems.

EC.02.05.09 (1 -14)

- Engineering department maintains documentation of medical gas certification with all testing. The medical gas system is inspected/tested every 12 months.
- Documentation of medical gas repairs, with all testing and modifications are maintained in Facility Management.
- Engineering department works with hospital departments to keep supply valves for piped medical gas systems accessible and clearly identifies which valve controls which area/rooms.

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Standard EC.02.06.01 – The hospital establishes and maintains a safe, functional environment.

EC.02.06.01 (1)
Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Alameda Health System spaces are designed and constructed in accordance with current FGI Guidelines. Needs and parameters are reviewed by clinicians, Engineering Department, Infection Prevention, and Environmental Health and Safety during design. Engineering Department maintains equipment providing ventilation, temperature, and humidity levels according to established preventive maintenance procedures and monitors temperature and humidity levels in accordance with the parameters established in ASHRAE 170.

Standard EC.04.01.01 – The hospital collects information to monitor conditions in the environment.

EC.04.01.01 (1)
The hospital establishes processes for continually monitoring, internally reporting, and investigating utility systems management problems, failures, or user errors.

Processes are in place to continuously monitor, internally report, and investigate utility systems management problems, failures, and user errors.

EC.04.01.01 (11)
Based on its processes, the hospital reports and investigates utility systems management problems, failures, or user errors.

The Director of Engineering Department and Engineering Managers are notified of all utility system problems, failures, and user errors. Notification of problems and failures can come from calls from supervisors or stationary engineers or from calls in to the engineering department, which are logged and reported.

EC.04.01.01 (15)
Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

The Director of Engineering reviews the annual evaluation of the Utility Systems Management Plan submitted by the facilities managers. The objectives, scope, performance, and effectiveness of the program for each site are presented to the EOC.

PROGRAM EFFECTIVENESS

The annual evaluation of the Utility Systems Management Program will include a review of the scope according to the current Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.

The performance and effectiveness of the Utility Systems Management Program will be reviewed by the Environment of Care Committee.

approval

ALAMEDA HEALTH SYSTEM

FIRE PROCEDURE: JOHN GEORGE PSYCHIATRIC PAVILION

Effective Date	No Date Set	***Date Revised***	Not Approved Yet
Document Owner	DIR, FACILITIES SERVICES	***Next Scheduled Review***	
Executive Responsible	PROJECT MANAGER II, VP, SUPPORT SERVICES		

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

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Procedure

I. IF YOU DISCOVER A FIRE:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors. **Close** all remaining doors and windows in the fire zone, placing patients into smoke free rooms.

E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. In rare situations, it may be appropriate to attempt to extinguish a fire while the room is occupied if the room cannot be immediately evacuated. The inability to quickly evacuate a bariatric patient from the fire room serves as one such example.

4. Mark the door to the fire room with an “X” using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with “/” to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

How to operate a Fire Extinguisher:

1. P - Pull the pin
2. A - Aim at the base of the fire
3. S - Squeeze Trigger
4. S – Sweep side to side at the base of the fire

II. RESPONSE TO THE ALARM OR HEARING "CODE RED…." BEING CALLED OUT

A. Staff in the Immediate Area:

- Activate the fire alarm and call (911). Then call the Switchboard at (x 5-5555).
- Assist in evacuation of the fire room and close the door to the fire room.
- Close doors and windows to remaining rooms in the fire zone, placing patients into rooms.
- Manually close all double door in the hallway.
- Clear corridor of equipment. **Do not** place equipment into occupied patient rooms.

B. Switchboard Operator (at the Highland Campus):

- Page location of alarm based on location indicated on fire alarm panel or phone call received if possible. Repeat the page at least 3 times.
- Place back-up phone call to the Fire Department (911).
- Notify Engineering, Security and other personnel as needed via their cellphone
    - . Duty Engineer: (510) 867-8392
    - Security Supervisor: (510) 277-5646

NOTE: If you are notified by telephone (and no alarm was sounded) – notify/send someone to the area to pull the alarm.

C. Administrator on Call (AOC), Nursing Supervisor, First Security Officer, Engineering Supervisor, Duty Engineer, Engineering Staff, and the Nurse Manager of the fire area:

- Respond to the fire area.
    - Assist in closing doors, clearing corridors, etc.
    - Chief / Duty Engineer review the information on the alarm panel.

D. Nursing Supervisor:

- Set up Control Station. The Control Station will be responsible for directing additional staff to the fire area or to other areas within the building, as necessary. The Control Station will be located as follows:
    - Patient Care Area: Nurses Station of affected area
    - Non-patient Care Area: To be determined by the Nursing Supervisor (preferably on the opposite side of the fire/smoke barrier doors nearest the

area).

- Verify headcount of patients and staff evacuated from the fire area. Be prepared to report results to the Command Post (Administrator on Call (AOC)/Fire Chief).
- Communications between the Control Station and Command Post will take place by means of portable/cell phones or the Deputy Sheriff's 2-way radios.

E. Administrator on Call (AOC):

- Report to the Fire Department Incident Command Post location if evacuation of rooms other than the fire room is taking place.
  - Coordinate initial activities with the Fire Department Incident Commander
  - If situation warrants establish a facility Incident Command Center and implement the facility Incident Command System
- Verify with the Control Station that a headcount of patients and staff has taken place from the fire area. Inform the Fire Department Incident Commander of the results.
- Communication between the Control Station and the Command Post will take place by means of a cell phones.

F. Second Security Officer:

- **Meet the Fire Department** and inform them of the entry door that will bring them directly into the fire area without going against the patient evacuation flow, per evacuation floor plan (See Department Specific Procedures or all floor plans located at the back of Document).

G. All Other Staff:

- Follow department-specific procedures.

III. EXTENDED EVACUATION:

GENERAL CONCEPT:

Evacuation of the remaining rooms in the fire area would done at the decision of the person in charge of the fire area. All patients must have been removed from the corridor, and all doors in the area must have been closed. Evacuation should only take place if:

- The fire has **not** been extinguished

AND

- There is **little** or **no** smoke in the corridor

If the decision is made to evacuate:

- Staff members will begin evacuating the rooms on both sides of the fire room first, followed by the room across from the fire room. This will be followed by all rooms on the **fire side** of the hall, and then all remaining rooms on the **non-fire side** of the hall.

- Patients will be moved to the adjacent side of the smoke barrier doors, per the attached floor plan.

- The person in charge of the area will mark the door to the fire room with an "X" using

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blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

In the event of a fire in a non-patient area of the building the actions outlined in Section I of this plan will be taken. Staff from the affected area will then report to the designated assembly area for the specific department.

NOTE: Report location and nature of fire to Switchboard upon evacuating the fire area.

If evacuation of the floor or building is necessary, this will take place from the non-fire side of the building, using the stairwell / exit farthest from the fire. Floor or building evacuation will be a Fire Department / Administrative decision.

- First stage of patient evacuation will be horizontally to the adjacent smoke compartment.
  - Exception: The Administration/Registration/Therapy Building are instructed to evacuate directly to the outside, as indicated in the department-specific plan.
- Non-patient departments will evacuate to the department's designated evacuation site, as indicated in the department-specific plan.
- See Department-Specific Procedures for additional details.

- **NOTES RELATING TO VISITORS**
- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors in public areas will be asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an "All Clear" has been heard or they are further directed by staff or firefighters.

DEPARTMENTAL FIRE PROCEDURES

ADMINISTRATION BUILDING
(Administration & Registration)

I. <u>IF YOU DISCOVER A FIRE</u>:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors.

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E. **Extinguish / Evacuate** the building using the nearest safe exit. All staff to assemble with patients, as detailed in Section II below.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. **<u>EVACUATION SITE</u>: Nearest safe exit to the green triangular wall on the 150th Avenue side of the parking lot.**

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for and be prepared to report results to the Control Station.

No one should leave the assembly point until further instructions are received from Administration or Fire Department Officials.

III. **<u>AT THE SOUND OF ALARM</u>**

Staff in the Immediate Area:

- Activate the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555).
- Assist in the evacuation of the fire room and close the door to the fire room.

NOTES RELATING TO VISITORS

- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an "All Clear" has been heard or they are further directed by staff or firefighters.

DEPARTMENTAL FIRE PROCEDURES

BUILDING SERVICES / ENGINEERING

I. **<u>IF YOU DISCOVER A FIRE</u>:**

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

approval

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors. **Close** all remaining doors and windows in the fire zone, placing patients into smoke free rooms.

E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Oxygen shut-down will be the responsibility of the Respiratory Therapist or Charge Nurse of the area.

4. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. EVACUATION SITE FOR BUILDING SERVICES OFFICE STAFF:

Front Parking Lot

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for and be prepared to report results to the Control Station.

No one should leave the assembly point until further instructions are received from Administration or Fire Department Officials.

III. AT THE SOUND OF ALARM (DOES NOT APPLY TO OFFICE STAFF)

- Report to the fire location
- Assist in closing doors and clearing corridors.
- Assist in evacuating patients, if directed to do so by the person in charge of the area.
- Shut down utilities, as directed by the Fire Department.
  - NOTE: Do not shut off oxygen and other medical gases until conferring with Charge Nurse/Respiratory Therapist.

IV. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING (Applies to Engineering Office Staff Only):

- Account for all staff from the office. Be prepared to report the results to the Control Station.
- Close doors and windows in the area.

NOTES RELATING TO VISITORS

- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors in public areas will be asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an "All Clear" has been heard or they are further directed by staff or firefighters

DEPARTMENTAL FIRE PROCEDURES

ENVIRONMENTAL SERVICES & MATERIALS MANAGEMENT (Service Building)

I. IF YOU DISCOVER A FIRE:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors. **Close** all remaining doors and windows in the fire zone, placing patients into smoke free rooms.

E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. EVACUATION SITE:

If fire in Services Building evacuate to: Front Parking Lot

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If you are in another building where the fire is, follow instructions of person in charge of area.

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for and be prepared to report results to the Control Station.

III. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Close doors and windows in the area.
- Person in charge is to account for all staff and be prepared to report the results to the Control Station.
- Remain in your assigned area and await further instructions. If not in your area, report back.

NOTES RELATING TO VISITORS

- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors in public areas will be asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an "All Clear" has been heard or they are further directed by staff or firefighter

DEPARTMENTAL FIRE PROCEDURES

HEALTH INFORMATION SERVICES

I. IF YOU DISCOVER A FIRE:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors.

E. **Extinguish / Evacuate** as directed by the person in charge.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

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3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. EVACUATION SITES:

- If in a non-clinical area, evacuate the building and report to the outside through the Courtyard and return patients to their assigned units.
- If in a clinical area, remain and follow the directions of the person in charge of the fire area.

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for and be prepared to report results to the Control Station.

No one should leave the assembly point until further instructions are received from Administration or Fire Department Officials.

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DEPARTMENTAL FIRE PROCEDURES

OCCUPATIONAL THERAPY

I. IF YOU DISCOVER A FIRE:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors.

E. **Extinguish / Evacuate** the building using the nearest safe exit. All staff to assemble with patients, as detailed in Section II below.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. <u>EVACUATION SITE</u>: Evacuate to the outside through the Courtyard and return patients to their assigned units.

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for and be prepared to report results to the Control Station.

No one should leave the assembly point until further instructions are received from Administration or Fire Department Officials.

III. <u>AT THE SOUND OF ALARM</u>

Staff in the Immediate Area:

- Activate the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555).
- Assist in the evacuation of the fire room and close the door to the fire room.

NOTES RELATING TO VISITORS

- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an "All Clear" has been heard or they are further directed by staff or firefighters.

DEPARTMENTAL FIRE PROCEDURES

PATIENT UNITS
(PES UNIT / BIRCH UNIT / CEDAR UNIT / DOGWOOD UNIT)

I. <u>IF YOU DISCOVER A FIRE</u>:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors. **Close** all remaining doors and windows in the fire zone, placing patients into smoke free rooms.

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E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. IF EVACUATION OF THE AREA IS ORDERED

This is to be done under the direction of the nurse in charge of the area.

EVACUATION SITES: **PES Unit evacuates to the Birch Unit**
Birch Unit evacuates to the Cedar Unit
Cedar Unit evacuates to the Birch Unit
Dogwood Unit evacuates to the Cedar Unit

- The rooms adjacent to the fire room shall be evacuated first, followed by the room opposite the fire room. The remaining rooms in the compartment shall then be evacuated.

- If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinet.

- Following the evacuation, the nurse in charge of the area is to verify that all patients/staff are accounted for and be prepared to report results to the Control Station.

III. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

Staff remaining on unit:

- Remain in your assigned area and await further instructions. If not in your area, report back.
- Place patients in rooms, closing doors and windows.
- Clear equipment from corridors. Do not place equipment into occupied patient rooms.
- Prepare to receive patients if alarm activation as follows:
  PES Unit evacuates to the Birch Unit
  Birch Unit evacuates to the Cedar Unit
  Cedar Unit evacuates to the Birch Unit
  Dogwood Unit evacuates to the Cedar Unit
- Await further instructions.

NOTES RELATING TO VISITORS

- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an “All Clear” has been heard or they are further directed by staff or firefighters.

- Visitors in public areas will be asked to remain there until an “All Clear” has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an “All Clear” has been heard or they are further directed by staff or firefighters

approval

ORIGINAL DATE: MARCH 8 , 2021
REVISION DATE: JULY 2026
SURVEYED BY: PRM
DRAWN BY: DMZ
TITLE:
ALAMEDA HEALTH SYSTEM
JOHN GEORGE PSYCHIATRIC HOSPITAL
FIRE PROCEDURE
LEVEL ONE
JENSEN HUGHES
LEGEND
0.5HR SMOKE BARRIER
EVACUATION DIRECTION
FIRE DEPARTMENT ENTRY
ASSEMBLY AREA
ASSEMBLY AREA FOR ADMINISTRATION BUILDING (FRONT PARKING AREA)
FIRE DEPT ENTRY
MAIN ENTRANCE
REGISTRATION
FIRE DEPT ENTRY
PES UNIT
AMBULANCE ENTRANCE
FIRE DEPT ENTRY
PES UNIT
UNIT 'A'
PES UNIT
BLDG. 9981 9982
SUPERIOR COURT OF CALIFORNIA, COUNTY OF ALAMEDA
REGISTRATION DESK
COURTYARD
FIRE DEPT ENTRY
ADMINISTRATION
ADMINISTRATION
THERAPY
ACTIVITIES
FIRE DEPT ENTRY
BIRCH UNIT
UNIT 'B'
BIRCH UNIT
FIRE DEPT ENTRY
CEDAR UNIT
UNIT 'C'
CEDAR UNIT
FIRE DEPT ENTRY
DOGWOOD UNIT
UNIT 'D'
DOGWOOD UNIT
FIRE DEPT ENTRY

CHARGE NURSES

I. IF THE FIRE IS ON YOUR UNIT

- Ensure that:
  - Fire room and adjoining room have been evacuated.
  - Door(s) to fire room have been closed and marked.
  - Fire alarm has been activated and page announcement of the fire location made.
  - All patients have been removed from the corridor with doors and windows closed.
    NOTE: Closing windows does not apply to the fire room.
  - All equipment has been removed from the hall (not placed in occupied rooms).

- Make decision regarding further evacuation, using the following guidelines:
  - If fire **has** been extinguished, no further evacuation is necessary.
    - Have staff reassure patients while awaiting arrival of the Fire Department.
  - If corridor smoke conditions would **not** be tolerable for patients, do not evacuate.
    - Inform Fire Department of smoke concerns upon their arrival.
  - If fire has **not** been extinguished and corridor conditions **are** tolerable, begin evacuation as follows:
    - Patients from the fire compartment are to be moved to the adjacent side of the fire/smoke doors, per evacuation diagram.
    - Have staff evacuate the rooms adjacent to the fire room first, followed by the room opposite the fire room. The remaining rooms in the compartment shall then be evacuated.
  - Mark the door to evacuated rooms with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.
  - Account for patients and staff once all are relocated. Be prepared to report results to the Control Station.

NOTE: Charge Nurse to direct removal of patient charts to the evacuation site.

II. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Direct appropriate staff to respond to fire area.

- Direct remaining staff in securing unit by moving patients into rooms, closing windows/doors, clearing corridors, etc.

- Once unit is secured, direct staff to make rapid rounds, checking on and reassuring patients.

- Upon hearing page indicating that alarm has originated from an area that evacuates to your unit, direct staff in preparing to receive patients by clearing space for arriving patients. Position one staff member at the entrance to the unit to direct staff arriving

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with evacuated patients to appropriate areas of receiving unit.

- Ensure initial care of patients who have been evacuated to your area, if applicable.

- Account for all staff and patients in your area. Be prepared to report the results to the Control Station.

NURSING SUPERVISOR

- Upon activation of the fire alarm, report immediately to the fire scene and ensure that nurse in charge of the fire area is carrying out his/her responsibilities. If the fire/alarm area is in a non-patient care area, direct another staff member to respond with you and investigate the area together.

- If the fire has not been extinguished, establish a Control Station at the nearest nurse's station. If the fire is in a non-patient area, establish Control Station on the opposite side of the fire/smoke barrier doors.

- Send additional staff to the fire area, as necessary.

- Ensure adequate staffing of other areas of the building, especially the area to which the patients are being evacuated.

- Verify that each unit/department has accounted for all patients and staff. Report results to the Command Center, along with any changes in conditions.

- Keep the non-fire areas including those above and below the fire floor informed of the situation, as applicable.

- Notify off duty staff (Administration, Engineering, etc.) as appropriate.

- Ensure patient charts have been moved to the evacuation site.

DEPARTMENTAL FIRE PROCEDURES

PHYSICIANS / RESIDENTS / INTERNS

I. <u>IF YOU DISCOVER A FIRE IN YOUR AREA</u>

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors.

E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

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NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. **EVACUATION SITES:** As directed to do so by person in charge of the area.

III. **IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING**

- Remain in your assigned area and await further instructions.
- Person in charge of the area to account for all staff in the area and be prepared to report the results to the Control Station.

DEPARTMENTAL FIRE PROCEDURES

SECURITY

I. **IF YOU DISCOVER A FIRE:**

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors. **Close** all remaining doors and windows in the fire zone, placing patients into smoke free rooms.

E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the door to the fire room with an "X" using blue tape to identify the fire room and

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that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. AT SOUND OF THE ALARM

FIRST OFFICER

- Report to the fire location.
- Assign one officer (or Engineering) to meet the Fire Department and inform them of the entry door that will bring them directly into the fire area without going against the patient evacuation flow, per evacuation floor plans located on the last pages of this plan.
- Assist in closing doors and clearing halls.
- Assist in evacuating patients, as directed by the person in charge of the area.
- Restrict entry into the area of "unauthorized" individuals.
- Report any missing patients/staff to either the Control Station or the Command Post.

SECOND OFFICER

- Meet the Fire Department and inform them of the entry door that will bring them directly into the fire area without going against the patient evacuation flow, per evacuation floor plan (see Department Specific Procedures or all floor plans located at the back of fire procedures).

NOTES RELATING TO VISITORS

- Visitors in Waiting or other open areas will be escorted to a safe area by the staff of the particular department and asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors in public areas will be asked to remain there until an "All Clear" has been heard or they are further directed by staff or firefighters.

- Visitors with patients will be asked to remain with them until an "All Clear" has been heard or they are further directed by staff or firefighters.

DEPARTMENTAL FIRE PROCEDURES

STUDENTS / VISITING STAFF

I. IF YOU DISCOVER A FIRE:

R. **Rescue** anyone in the room while calling out *"Code Red, & location..."* for assistance. Close the door to the fire room and any room connecting doors.

A. **Alert** others by activating the fire alarm and call (9-911). Then call the Switchboard at (x 5-5555). Provide them with the facility you are calling from, the location and nature of fire.

C. **Confine** the fire to the smallest area by closing doors. **Close** all remaining doors and windows in the fire zone, placing patients into smoke free rooms.

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E. **Extinguish / Evacuate** if directed to do so by person in charge of the area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available resources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Oxygen shut-down will be the responsibility of the Respiratory Therapist or Charge Nurse of the area.

4. Mark the door to the fire room with an "X" using blue tape to identify the fire room and that it should not be re-entered. If the room has been evacuated, additionally mark the door with "/" to indicate an evacuated room. Blue tape for these purposes is stored in all extinguisher cabinets.

II. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Go to the person in charge of the area where you are and await further instructions.
- Person in charge of the area to account for all staff in the area and be prepared to report the results to the Control Station.

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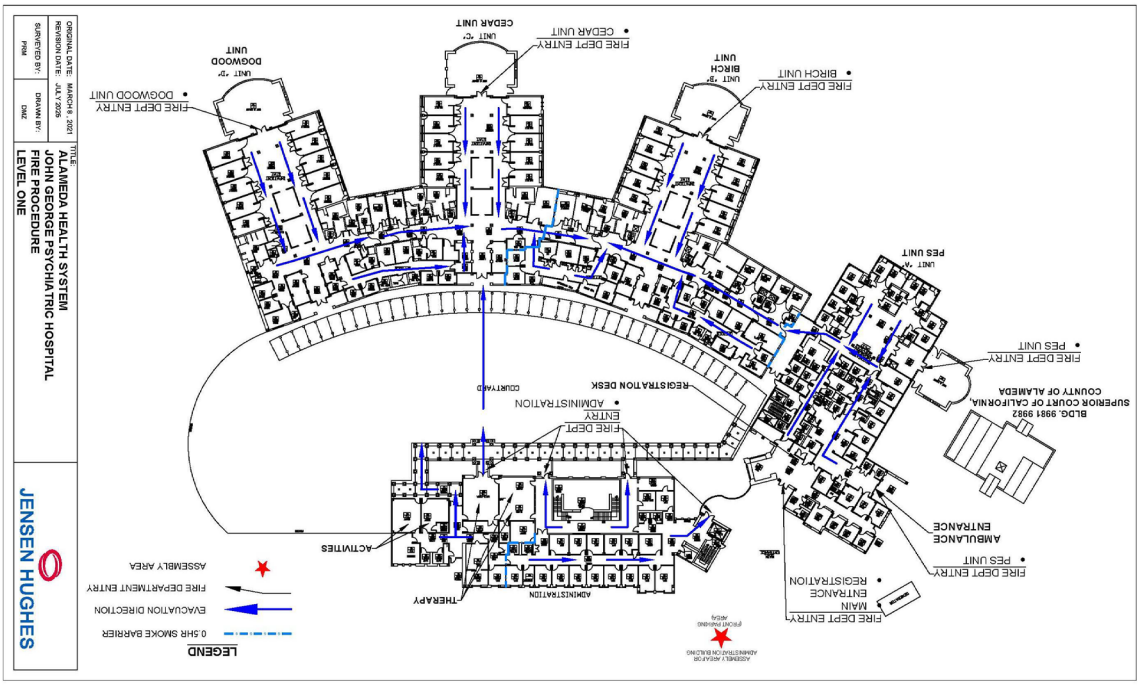

Approvals

Departmental	**Date: 8/2011, 11/2014,5/2020,03/2022, 12/2025**
Environment of Care Committee	**Date: 11/2014**
Director, Engineering/Facilities	**Date: 12/2014, 12/2025**
CPC	**Date: 2/2026**

approved

	CORRUGATED CARDBOARD MANAGEMENT	
	Document Title	**Reference # Version**
	Level ☑ System ☐ Site	**Effective Date:** 6/2025 **Last Review Date**: 5/2025 ***Next Scheduled Review 7/2030***
	Document Owner: Infection Prevention and Control	***Executive Responsible*** Vice-President, Quality

THE USAGE AND MANAGEMENT OF CORRUGATED BOXES POLICY

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

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Cardboard boxes, especially those used for external shipping, are a known vector for pathogens, dust, and pests due to their porous, moisture-absorbing, and non-cleanable nature. Their presence in clinical and sterile environments increases infection risk. To mitigate this risk: 4
1. External corrugated boxes must not enter clinical, semi-restricted, or restricted areas beyond designated receiving or breakdown areas. 4
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1. Background

Cardboard boxes, especially those made of corrugated material, are frequently used for shipping and storage in healthcare environments. However, studies and infection control guidelines have shown that these boxes can harbor microorganisms and pests due to their porous nature and inability to be cleaned or disinfected. During shipping and warehousing, boxes may be exposed to moisture, vermin, and unsanitary conditions. Once introduced into healthcare facilities, they can contribute to contamination and dust accumulation, allowing microorganisms on different facility areas. Recognizing these risks, hospitals are implementing the guidance and protocols to restrict the use of corrugated cardboard in patient care and sterile areas.

2. Purpose

To maintain a safe, clean, and infection-controlled healthcare environment by minimizing the introduction and retention of potentially contaminated cardboard (corrugated) boxes within patient care areas.

3. Scope

This policy applies to all healthcare personnel, including clinical, non-clinical, environmental services (EVS), supply chain, and vendor staff across all departments where patient care, sterile supply storage, or clean environments are maintained.

4. Definitions

4.1 Corrugated Cardboard

Material consisting of a fluted corrugated sheet and one or two flat linerboards, commonly used in shipping containers.

4.2 External Shipping Container

Corrugated containers used for shipping, typically bearing tape, labels, or markings. These containers are exposed to environmental contaminants during transport.

4.3 Internal Packaging

Product-specific packaging located inside the external shipping container, sometimes also made of corrugated material.

4.4 Patient Care Area

Any location where direct patient care is provided or where clean/sterile supplies are stored or utilized (e.g., inpatient units, procedure rooms, operating rooms, ICUs).

4.5 Clean Storage Area

An area used to store medical supplies that have been disinfected, sterilized, or otherwise designated for

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patient use.

5. Policy Statement

Cardboard boxes, especially those used for external shipping, are a known vector for pathogens, dust, and pests due to their porous, moisture-absorbing, and non-cleanable nature. Their presence in clinical and sterile environments increases infection risk. To mitigate this risk:

1. External corrugated boxes must not enter clinical, semi-restricted, or restricted areas beyond designated receiving or breakdown areas.

2. Items must be unpacked immediately upon receipt and transferred to clean, non-porous containers for further distribution.

3. Cardboard boxes will not be used for storage in patient care or sterile areas unless exempted by documented risk assessment.

6. Procedures

6.1 Receiving Area Practices

- All incoming shipments will be opened in the designated receiving or Materials Management Breakdown Area.
- Items must be removed from external cardboard boxes before being brought into patient care or clean storage areas.
- Only clean, dry, and intact internal packaging (e.g., shrink-wrapped trays, sterile peel packs) may enter patient care areas.

6.2 Storage Guidelines

- Corrugated cardboard is prohibited in sterile storage areas, medication rooms, clean supply rooms, and anywhere sterile or clean patient care supplies are handled.
- Non cardboard boxes are not to be stored on the floor or on counters in patient care areas.
- Boxes temporarily retained (e.g., < 4 hours) must be placed on shelving at least 10 inches from the floor and 18 inches below sprinkler heads.

6.3 Disposal

- Cardboard must be broken down and disposed of in designated recycling or waste containers outside of patient care areas.
- Environmental Services must ensure timely removal of cardboard waste during routine rounds.

7. Special Considerations

- Units with limited storage infrastructure may apply for a temporary exemption through Infection Prevention and Supply Chain leadership.

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8. Risk Assessment

- A quarterly checklist will be completed by Infection Prevention for any areas where corrugated boxes are permitted for short-term storage.
- Assessments include integrity, presence of pests, moisture damage, and storage duration.

9. Education & Training

- All staff involved in materials management, supply chain, or patient care will be trained annually on proper handling and disposal of corrugated cardboard.
- Infection Prevention will provide ongoing education and updates as needed.

10. Compliance Monitoring

- Routine audits will be conducted by Infection Prevention or Environment of Care and Safety teams.
- Non-compliance will be documented and addressed through departmental performance improvement plans.

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11. Appendix

11.1 Temporary Exemptions Form

Infection Control - Cardboard Storage Policy
Exemption Request Form
Email this form to infectioncontrolstaff@alamedahealthsystem.org

Purpose:
This form is used by departments/unis to formally request an exemption from the Cardboard Storage Policy. All requests will be reviewed by Infection Control and if applicable, Engineering, EVS and EH&S.

Department Information

Department Name: _____

Unit / Area Location (Building, Floor, Room): _____

Department Manager / Supervisor: _____

Contact Email: _____ Contact Phone: _____

Exemption Request Details

Requested Start Date: _____

Reason for the exemptions *(Space limitations, supply chain constraints, Operational necessity, etc.).*

_____

Specific Cardboard Use or Storage Requested: _____

_____

(Describe what cardboard items are involved, quantities, and how they will be stored)

Specific Area Where Cardboard Storage Is Requested: (Room number, storage area, hallway, etc.)

_____

Description of Cardboard Materials: _____

(e.g., medical supply packaging, equipment, food, chemicals, detergents)

Estimated Volume / Quantity: _____

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Risk Mitigation Measures

Exemption from cardboard storage is not allowed in patient care or food preparation areas:

Proposed controls to reduce infection, fire, or pest risk:

Cardboard stored off the floor: _____ _____

Storage limited to a designated area only: _____

Increased housekeeping / cleaning frequency: _____

Pest prevention measures in place: _____

Other (specify): _____

IMPACT

Infection Control Risk:	☐ Low ☐ Moderate ☐ High
Environmental Health & Safety:	☐ Low ☐ Moderate ☐ High
Environmental Services:	☐ Low ☐ Moderate ☐ High
Engineering/Facilities:	☐ Low ☐ Moderate ☐ High

INFECTION CONTROL & SAFETY REVIEW

(To be completed by reviewing departments)

Infection Control Review: ☐ Approved ☐ Approved with conditions ☐ Not approved
Comments:
_____

Facilities / Engineering Review (Fire/Life Safety Risk):
☐ Approved ☐ Approved with conditions ☐ Not approved
Comments: _____

Environmental Health and Safety:
☐ Approved ☐ Approved with conditions ☐ Not approved
Comments: _____

Reviewed by:

Infection Control Risk: _____ Date: _____
Environmental Health & Safety: _____ Date: _____
Environmental Services: _____ Date: _____
Engineering/Facilities: _____ Date: _____

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11.2 Cardboard Infographic

1. Corrugated cardboard boxes are not appropriate as storage units in medical or clean supply rooms. A corrugated box has more than one layer and channels of paper to give it added strength as pictured below:

2. Corrugated cardboard boxes are not appropriate because they are an excellent harbor for insects and pests as pictured below (courtesy University of Nebraska):

Mature Indian Wheat moth larvae pupating in corrugated cardboard:

12. References

1. "Q&A: Corrugated Cardboard Boxes." Healthcare Facilities Today, 2016, https://www.healthcarefacilitiestoday.com/posts/QA-Corrugated-cardboard-boxes--13520. Accessed 15 May 2025.

2. Cardboard Box Policy. Richland Hospital, PolicyStat, https://richlandhospital.policystat.com/policy/14655272/. Accessed 15 May 2025.

3. IC-05 Corrugated Box Policy. Kiowa District Healthcare, 21 Nov. 2018.

4. Sterilization in Health Care Facilities: Sterilization, Part 1. Association for the Advancement of Medical Instrumentation, 2006–2007 ed.

5. Conner, R., et al. AORN Standards, Recommended Practices, and Guidelines. 2005 ed., Association of periOperative Registered Nurses.

6. Joint Commission. 2017. Hospital and Hospital Clinics Manual. https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/infection-prevention-and-control-ic/000002145/

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APPROVALS

		System
Department:	Date:	
Pharmacy and Therapeutics (P&T)	Date:	N/A
Clinical Practice Council (CPC)	Date:	
Medical Executive Committee	Date:	
Board of Trustees	Date:	

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	Policy	
	PLAN FOR PROVISION OF CARE-HIGHLAND	**Reference # tbd**
	Level ☐ System ☐ Site	**Effective Date:** 04/2023Effective Date **Last Review Date: 01/2026** Next Review Date: 01/2029
	Document Owner: VP of Patient Care Services System	

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

POLICY STATEMENT

The organizational Plan for the Provision of Patient Care is an overview of patient care services. It is the foundation for the care and services the organization provides. Each department is expected to follow a general plan contained herein and departmental policies and procedures are an extension of this plan. Highland views the process of providing patient care holistically through:

1. Functional interdepartmental collaboration.
2. Leadership and staff involvement in decision making.
3. A commitment to the continuum of care.
4. The integration of delivery systems across the organization and into the community.
5. A culture that is focused on organizational-wide patient safety.
6. Involvement of employees and physicians in continuous quality improvement teams to improve patient care processes and patient outcomes.
7. Use of Press Ganey Patient Satisfaction survey results from patients and physicians to design and refine services.
8. Use of the Leapfrog Hospital Survey.

The Plan for the Provision of Patient Care is linked to the organization's strategic plan, performance improvement plan, and budgetary process. It considers the following:

1. The changing needs of the Patients, Staff, Physicians, Facility, and the Community.
2. Patient care requirements and implications for staffing.
3. Information from performance improvement activities.
4. The provision of a uniform level of care throughout the organization.
5. Opportunities to improve processes in the design and delivery of safe patient care.
6. Effective and appropriate utilization of resources.
7. Demographics and market share key findings
8. Identification of the hospital's critical issues
9. Disaster Preparedness Plan integrated with Alameda County, California, and Federal Plans.

PURPOSE

The purpose of the Highland Hospitals Plan for the Provision of Patient Care is to describe the framework by which the hospital leadership will plan, direct, coordinate, and improve the

healthcare services provided to the community(s), which it serves. This plan is based on the needs and rights of the patients served, the mission and vision of the hospital, and are applicable to all areas where patient care is delivered.

MISSION/VISION/PROMISE

Our Mission

Caring, Healing,

Teaching, Serving All.

Our Vision

Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities, and optimizes the health of our diverse communities.

Our Promise

Other health systems commit to care – We live the promise of community health. Other health systems serve some – We serve all.
Other health systems heal – We train, teach and lead.
Other health systems provide health care – We educate and enable people to better care for themselves. Other health systems support the community – We are the community.

Demographics/Patient Population

Highland Hospital is an acute care facility licensed for a total of 236 beds.

Highland Hospital inpatients ages range from newborns to geriatrics. The payer mix reflects a substantial number of Medicare, Med-Cal and uninsured patients. Our inpatients are primarily admitted through our Emergency Department. Our Emergency Department meets the needs of the community by caring for or being prepared to stabilize and discharge or transfer for admission all ranges of patients, ages from newborn to geriatric.

Community Input and Assessment of Needs

The leadership of Highland Hospital takes responsibility for providing the foundation and support for planning, directing, coordinating, providing, and improving health care services. These services are based on assessed and identified needs designed to improve patient care outcomes. Sources and tools used to accomplish needs identification include, but are not limited to, community needs assessment, collaboration with Public Health, patient and satisfaction survey results, publicly report quality data, physician input, risk management and performance improvement activities.

This Plan for the Provision of Patient Care is based upon the needs of the patient population served and is consistent with the mission and values of Highland Hospital. Patient care needs are identified through direct feedback received from patients and/or their families and through formal surveys of patient's employees and/or the community. In order to ensure that Highland Hospital 's mission, values and goals are congruent with the best interests and needs of the community, the patient population and other internal and external customers, Highland Hospital utilizes the following methodology to assess their needs:

1. A community needs assessment in collaboration with other community hospitals and the Hospital Council of Northern California.
2. A patient satisfaction questionnaire, performed by the Press Ganey Organization on a monthly basis.
3. An annual employee satisfaction survey.
4. An annual employee safety survey.
5. During operational and capital budget preparation, an extensive review of the annualized actual budget for patient care services is conducted. Budgets utilizing actual data, as well as projected data, are used in designing a budget that is consistent with historical and projected patient needs.
6. Results from quality improvement teams that target either process improvement or patient safety issues.
7. Use of risk management events to identify process improvement opportunities that improve patient care.

STRATEGIC PLAN

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

Alameda Health System is committed to provide the highest quality care to communities it serves. No matter the challenges, AHS' commitment to Caring, Healing, Teaching, Serving All remains unwavering…

Integrating the wisdom of our employees, patients, staff, executive leaders, trustees, and external constituents, the Alameda Health System 2022-2027 strategic plan galvanizes us towards foundational excellence. Our goal is to transition towards a system-wide adoption of population-based approaches for integrated health and wellness care delivery. This transformation must be in alignment with the aspirations of our communities, caregivers, and strategic partners.

Beginning in November 2021, the AHS Executive Leadership Team (ELT) partnered with Huron Consulting Group to collaborate on the development of an updated, system-wide, 5-year strategic plan. The process included input from a wide range of constituents via more than 50 interviews with internal and external constituents, Board Members, executive leadership, community, and County; a system-wide survey of all AHS employees; and a voice of the customer survey that gathered feedback on services, experience, and access within AHS from a diverse sample of patients conducted in multiple languages. This input culminated in the creation of the following strategic pillars, supporting goals, and actions that represent key priorities for AHS.

Patient and Family Centered Care is the heartbeat of the Alameda Health System care philosophy.

Key Strategic Values and Enablers

- **Health Equity, Diversity, and Inclusion:** AHS commits to reducing and ultimately eliminating health disparities and addressing social determinants that adversely impact the health of all patients.
- **Staff and Clinician Contributions:** AHS recognizes the critical contributions made by our staff and clinicians in serving our patients and community.
- **Accountability:** AHS leaders, physicians, and staff are accountable to each other, and to the community, for delivering care
- **Trust:** AHS fosters an environment of trust within its organization and outwardly with the community and its constituents
- **Data:** AHS develops and utilizes trusted sources of data in support of the delivery of care and reporting of performance results

PROCEDURE

Services are broadly organized as:

1. Nursing units.
2. Direct patient service departments.
3. Patient Support departments.
4. Physical environment support departments.
5. Management Support Departments.

Scope of Service

Highland Hospital serves the community as an acute care hospital. The following patient care services are provided:

1. Ambulatory Services
2. Anesthesia
3. Behavioral Health
4. Cardiovascular Services
5. Care Management
6. Critical Care
7. Diagnostic Imaging including CT, Angiography, Mammography, MRI Interventional and Ultrasound
8. Emergency Services
9. Endoscopy Services
10. Family Birthing Center (Labor & Delivery, Postpartum, NICU)
11. Food and Nutritional Services
12. Inpatient Acute Rehabilitation Services
13. Interventional Radiology Services
14. Laboratory/Pathology
15. Medical/Surgical/Oncology/Telemetry Acute Care
16. Neurodiagnostic, including EEG
17. Pharmacy
18. Respiratory Care, including PFT
19. Surgical Services (Inpatient and Outpatient)
20. Trauma Services

Leadership and Organizational Structure

The organizational chart describes the relationships that have been established to ensure that

the primary function of Highland Hospital can be implemented throughout the organization. These processes include developing a vision at the local level that addresses the community needs, transforming the vision into strategic plans and actions, communicating these throughout the organization, and assuring that implementation on the local level will be achieved.

Executive Leadership Team

At the Hospital level, the Executive Leadership team determines the feasibility of the various desired plans and sets priorities with input from the Vice Presidents, Department Directors/Managers, the Medical Staff leaders, and the Board of Trustees. Strategic plans, operational plans, budgetary considerations and commitments, and policies are developed throughput the Hospital in collaboration with the VP's, Department Directors, Managers and Hospital Leadership.

Board of Trustees

The Alameda Health System Board of Trustees governs Highland Hospital. There are 11 members who are approved by the Alameda County Board of Supervisors who represent the interest of the community we serve.

Orientation, Training, and Education of Staff

Highland Hospital promotes and maintains an environment conducive to continuous learning. General information is provided in a basic Hospital Orientation for all new employees through Human Resources. This is followed by department-specific orientation of varying length and intensity based on specialty. The nursing clinical component of the specialty specific orientation is individualized to each nurse/clinician based on competency data and other information.

Highland Hospital is committed to the education and development of its employees for the creation of a culture of lifelong learning and the promotion of clinical excellence throughout the organization. The Education Department provides learning opportunities that are based on patient care needs for every age group served, and the input of staff, in order to build evolving pathways for employee professional development and to support and resource best practice at all levels. Ongoing assessment of organizational priorities, identification of educational needs, and regional benchmarking ensure that all employees maintain the current knowledge and skills necessary to deliver competent, high quality patient care. Educational plans are developed from review of annual educational needs assessments, the Joint Commission on Accreditation of Healthcare

Organizations standards, identified performance improvement issues, risk management reports, and the determination of low volume and high-risk procedures within our patient population(s).

The Educational programs are provided to maintain staff competency and enrich staff knowledge and skill to enhance patient care quality. Participation in educational activities is documented in personnel files and is required for employment. Each department defines additional required competencies and/or in-services. Self-development is encouraged and supported through tuition reimbursement, audio-visuals and resource materials, self-instructional programs, and informal departmental education.

Recruitment and Retention Activities

An effective recruitment and retention plan is essential to the consistent delivery of high-quality patient care in order to attract and retain the numbers and types of personnel to meet the needs of the patient population.
While recruitment activities are important in supplying the necessary staff to fill identified staffing needs, retention activities provide the greatest long-term benefit for Highland Hospital. The Human Resources Department works with administration and department leaders to recruit and retain staff

Ethics, Rights and Responsibilities

Highland Hospital supports patient rights as is reflected in the patient rights section of the Administrative Policy and Procedure Manual. These rights are protected and exercised. Examples of these policies and procedures include:

1. Advance Directives
2. Withholding or Withdrawing of Life Sustaining Treatment
3. Organ and Tissue Donation
4. Do Not Resuscitate
5. Organizational Ethics
6. Abuse
7. Ethical Issues in Patient Care
8. Patient Safety
9. HIPPA
10. End of Life Care

The goal is to improve care, treatment, services, and outcomes by recognizing and respecting the rights of each patient and by conducting business in an ethical manner. Care, treatment, and services are provided in a way that respects and fosters dignity, autonomy, positive self-regard, civil rights and involvement of patients. Care, treatment, and services consider the patient's abilities and resources; the relevant demands of his or her environment; and the requirements and expectations of the providers and those they serve. The family is involved in care, treatment, and services decisions with the patient's approval.

Patients deserve care, treatment and services that safeguard their personal dignity and respect their cultural, psychosocial and spiritual values. These values often influence the patient's perceptions and needs.

Provision of Care, Treatment and Services

Qualified professionals assess all patients admitted for care or treatment at Highland Hospital. Each patient's assessment includes physical, spiritual, psychological, and social status. During the assessment process, data is collected to assess the needs of the patient. A plan for meeting the patient's care/treatment needs is developed based on the analysis of the data collected

The initial assessment performed by the physician is defined in the Medical Staff Bylaws and/or Rules & Regulations. The initial assessment performed by the Registered Nurse and other healthcare professionals is completed as described in the Documentation Policy. The scope of assessment of each discipline is defined in writing and approved by the organization. Staff members integrate the information from various assessments of the patient to identify and assign care priorities. A registered nurse assesses the patient's need for care in all settings where nursing care is provided. Reassessment continues throughout the patient's stay. The intervals for reassessment are described in the Medical Staff Bylaws and/or rules and regulations, and in the Documentation Policy.

All care and treatment is provided by the direction of a licensed physician with medical staff membership and appropriate clinical privileges.

Planning and Providing Care

A Care Plan is developed based upon the initial and reassessments of the patient. This plan is developed collaboratively by the clinical disciplines and is documented in the patient record.

The plan of care is updated as needed through ongoing review of assessment data. Care treatment and rehabilitation are planned to ensure that they are appropriate to the patient's needs and severity of disease, condition, impairment, or disability.

Sedation and Anesthesia Care

Highland Hospital policies and procedures guiding sedation and anesthesia care apply when patients receive in any setting, for any purpose, by any route, moderate or deep sedation as well as general, spinal, or other major regional anesthesia. This is found in the Procedural Sedation Policy.

Operative and Other Invasive Procedures

Invasive procedures are defined as those procedures involving puncture or incision of the skin and/or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspiration and biopsies, endoscopies, and implantation. Invasive procedures exclude venipuncture, PICC lines, intravenous therapy and the injection of radiographic contrast medias. Preparation for operative and other invasive procedures will include pre-and post- operative education, informed consent, a pre-anesthesia assessment, and development of plan of care assessment.

Special Interventions

At Highland Hospital we continually explore ways to prevent, reduce, and strive to eliminate the use of restraint use through effective performance improvement initiatives. The leaders' role is to create an environment that minimizes circumstances that gives rise to restraint use and maximizes safety when they are used.

Education Patient/Family

Throughout the patient's stay the patient, family and significant others, as appropriate, receive education specific to the patient's health care needs. Such education includes instruction related to specific knowledge and/or skills needed by the patient, family and significant others to meet the patient's ongoing health care needs, including information about resistant organisms and ways to prevent infection.

Continuum of Care

The patient's access to the appropriate level of care is determined by the physician in collaboration with care managers and clinical nurse leaders. As a part of the admission process, patients, families, and significant others are provided sufficient information about the nature and goals of the care to be provided and the availability of such care.

Coordination of care occurs through several mechanisms including interdisciplinary collaboration and care planning, collaborative care rounds and the use of interdisciplinary documentation in the medical record. The discharge process begins prior to or upon admission to the hospital setting. The discharge process provides for continuing care based upon the patient's assessed needs at the time of discharge.

Emergency Operations Plan

The Emergency Preparedness Committee is responsible for coordinating all emergency response plans. The emergency operations plan is an all-hazard plan intended to provide systems and guidance to staff in responding to a wide variety of emergencies that may affect patient care and hospital operations. A hazard vulnerability assessment is performed every year to determine the top threats and risks to the hospital so that planning and training may be developed to minimize the risk and prepare staff to respond to that situation. The hospital performs a minimum of two exercises per year to help train and prepare for emergencies. These exercises are evaluated to identify areas of improvement. The hospital actively participates with the county and state agencies as well as other local health care parities to plan for a wide variety of emergencies.

Safety Program

The Environment of Care Committee is responsible for managing the Environment of Care program and its six basic functions of: Safety, Security, Hazardous Materials and Waste, Fire Safety, Medical Equipment and Utility Systems. The overall goal is to provide processes to identify and manage the risks that are inherent to healthcare operations and minimize those risks through proactive actions. Routine reports are made to the Environment of Care committee to ensure operations are continuing according to standards. In addition, the committee identifies new risks and develops plans to mitigate or manage the risk. Members of the committee represent all critical functions of the hospital.

Management of Information

Highland Hospital continues to evaluate and expand information management processes to meet internal and external information needs. Confidentiality, security and integrity of data and information are maintained as described in HIPPA guidelines.

Management of Human Resources

Employees receive a formalized orientation consistent with the scope of responsibilities defined by their job description, and the patient population for whom they will provide care. Continuing education of all departmental personnel is the responsibility of the manager and other hospital staff as appropriate.
Programs for development and continuing education of all staff members are provided to retain qualified staff and to improve patient care.

Medical Staff

The Alameda Health System and Alameda Hospital Medical Staffs are governed by established Bylaws. Medical staff is actively involved in the assessment, planning, implementation and evaluation of patient care services. Medical Staff meetings provide a forum for discussion and valuable input relative to patient care services within Alameda Health System. The Medical staff is an integral component of performance improvement activities. Medical staff members are consulted as part of the strategic planning and budgetary process.

The Division of Nursing Services

Scope of Service
The Division of Nursing of Highland Hospital will provide patients with the quality of care that is commensurate with acceptable standards and meets the goals of the Vison of Nursing.

The major administrative positions of the Division of Nursing are as follows: Chief Nursing Officer (CNO), VP of Patient Care Services, Nursing Directors/Managers, Educators/Clinical Nurse Specialists, and Nursing Administration.

Authority and Responsibility

The Chief Nursing Officer possesses the authority and responsibility to influence all nursing care and all nursing practice throughout the organization via both general and specific responsibilities.

Responsibilities are carried about by working collaboratively with hospital leaders, medical staff and with and through members of the Nursing Leadership Team. Responsibilities include the following:

- Maintains the authority and responsibility for establishing and approving nursing standards of patient care and standards of nursing practice.
- Preserves the authority and responsibility to participate in the hospital admission system for the purpose of coordinating patient requirements for nursing care with available nursing resources. The daily responsibility for coordinating resources is delegated to the Department Directors/Managers.
- Approves criteria for employment, deployment, and assignment of nursing staff members.
- Develops a program of staff development and continuing education to create and maintain nursing staff competency.
- Promotes innovation in the practice of nursing.

Definition of Nursing Care

Nursing care shall be defined as the blending of technical expertise with human caring to assist patients as individuals and as a group in the performance of those activities which promote health and wellbeing, recovery or a peaceful death. These are activities that patients would perform unaided if they had the necessary strength, will, resources and/or knowledge. It is the goal of all nursing care to help the individual to be independent of such assistance as soon as possible.

The practice of Nursing at Highland Hospital is defined as:

Registered Nurse

The practice of nursing by a registered nurse shall mean assuming responsibility and accountability for those nursing actions which include but are not limited to:

- Providing the nursing leadership in planning for and provision of nursing care to patients.
- Giving direct nursing care to each patient according to needs or assigning this function to assistants in accordance with the preparation and competency of the available staff.
- The direction and continuous evaluation of nursing practice-applying nursing knowledge administrative techniques and teaching principles

toward the ultimate goal of excellence in patient care and promotion of good health practices.

- Continuous effort to recognize the abilities and potentialities of all nursing personnel and to assist each individual in an attempt to attain optimum performance.
- Assessing the patent's needs, planning for implementing and evaluating the nursing care of each patient.
- Organizing, administering, and supervising the implementation of a written nursing care plan for each patient.

Licensed Vocational Nurse

The practice of nursing by a licensed vocational nurse shall mean the assumption of the responsibilities and the performing acts, within the educational background of the vocational nurse under the direction of a licensed physician or registered nurse. These acts include the participation with registered nurses in the planning, implementation, and evaluation of nursing care by:

- Providing for the emotional and physical comfort of patient.
- Observing, recording, and reporting the condition of the patients, signs and symptoms which may be indicative of change in the patient's condition to the Registered Nurse.

Performing nursing procedures for which the preparation of the licensed vocational nurse has provided the necessary degree of skill and judgement.

Unlicensed Personnel

The practice of nursing by unlicensed personnel shall mean the assumption of responsibilities and performing acts, within the educational background of the unlicensed personnel under the direction of a registered nurse or licensed vocational nurse. Unlicensed personnel will only perform tasks in which they have been oriented to and/or have demonstrated competence.

Unlicensed personnel may not reassign an assigned task unless directed to do so by a Registered Nurse.

Nursing Services Hours of Operation

Nursing services are available twenty-four (24) hours per day, seven days per week, and

365 days per year in the inpatient units Family Birthing Center, and the Emergency Department. Other departments providing nursing care may have limited hours of operation with "on call" coverage after hours and weekends.

Clinical Supervisory Coverage

The Department Managers/Directors are responsible for 24-hour management of the delivery of patient care in an assigned unit or service area. The House Supervisor is available after hours, weekends and holidays in the absence of the Department Managers/Directors. The House Supervisor functions as an extension of the Department Managers to provide direct clinical assistance to staff with patient care activities, and managerial support for coordination of resources.

Nursing Staff Allocation for Patient Requirements (Staffing Plan)

It is the responsibility of the CNO in collaboration with the VP's of Patient Care Services to develop, approve, and implement criteria or employment, deployment, and assignment of nursing staff members.

The Nursing Department of Highland Hospital shall provide staffing by licensed nurses within the scope of their licensure in accordance with the nurse-to-patient ratios as indicated Title 22. The staffing ratios shall constitute the minimum number of licensed nurses that shall be assigned to direct patient care. Under California law, the term "licensed nurse" includes both registered nurses and licensed vocational nurses.

Consideration is given in the staffing plan to the utilization of registered nurses, licensed vocational nurses and certified nursing assistant (CNA) according to identified requirements for nursing care and the scope of practice permitted by applicable law and regulation. The care of all patients will be prescribed, delegated, and coordinated by an RN, even though the care itself may be provided by a non-RN.

Staffing, both in numbers and competency, will be sufficient at all times to ensure that a Registered Nurse prescribes, delegates and coordinates care of all patients to assure the following mechanisms are in place:

1. Assessment of patient care needs occurs in admission, during stay, on transfer and at

discharge.

2. Assessment of patient needs takes place prior to assignment of staff.
3. An RN retains responsibility for all patients co-assigned to students and agency staff.
4. Infection control measures are strictly adhered to in staff assignments.
5. Staff competency is matched to age specific patient needs.
6. Emergency and safety patient requirements are met.

Staffing will be adequate to ensure that nursing staff members are able to participate, as assigned ncommittees, staff meetings, performance improvement and education events and activities.
Adequate resources in the form of support services will be available to allow nursing staff to meet the nursing care needs of patients and their significant others.

It is the responsibility of the Department Directors/Manager or the Charge Nurse to make the nurse/patient shift assignments. These staff members possess the clinical and leadership knowledge and expertise to competently make assignments. Consideration is given to the complexity of nursing care required by the patient for whom the staff member is being evaluated or assigned to provide care. Each of these staff members has documented competency in the same patient care activities that the staff are being asked to do by performance appraisals, department specific skill check lists and/or demonstrated competency. This includes clinical knowledge, skills, and technology, ordinarily employed in the care of patients in the department where assignments are being made.
Patient care responsibilities are assigned to nursing staff based on four general considerations including the patient acuity, environment in which nursing care is provided, staff competency, and supervision required by and available to each nursing staff member assigned responsibility. These four variables translate into specific considerations for assignment, which collectively revolve around a central theme; ensuring that staff care only for patients they are competent to care for. The following variables influence assignments:

- Complexity of nursing care required by the patients for whom the staff member is being evaluated and assigned to provide care.
- Dynamics of the patient's status and frequency of nursing care activities.
- Complexity of the assessment required by the patient, including the knowledge and skills required of a nursing staff member to effectively complete the required assessment.

- Type of technology required.
- Competency of assigned personnel in relationship to knowledge and skills required to effectively provide care and utilize current technology.
- Competency of delegating RN to carry out clinical and supervisory responsibilities.
- Age of the population served.

Staffing grids based on normal and customary unit acuity and historical data (patient admits and discharges) on a day-to-day shift-by-shift basis have been developed to assist in determining minimum staffing requirements and skill mix. Variances for staffing patterns, while having budgetary impact, are expected, given the nature of fluctuation in patient needs. Reasons for variances may include higher acuity than usual, lower acuity, unavailability of skill level as called for by patterns, completion of job tasks, unexpected discharges, transfers or admissions.

Supplemental staff is utilized to provide adjustments to master staffing plans. Additional needs may be managed with the use of contract nursing staff upon appropriate authorization. If staffing variances cannot be met with the use of supplemental staffing, the Nursing Leader and Department Manager is notified and a decision is made regarding the need to close beds and/or direct patients, as appropriate.

Department Plans for Care and Service

Each department leader develops a written departmental plan that fulfills the expectations of the organization, and which are compatible with the organization's mission, vision, and values.

Department plans include the following:

1. Goals
2. Scope of Services/competencies
3. Types and Ages of Patients Served
4. Staffing
5. Hours of Operation

Emergency Department (ED)

The Emergency Room is located on the 4th Floor of the Koret Building. The ED has 54

beds and treats approximately 59,000 patients per year. Care is distributed between trauma and multiple medical conditions.

Goals

The goal of Highland Hospital Emergency Department is to deliver high quality emergent and urgent care in a safe, respectful, non-discriminating environment to all individuals who present for care. The Emergency Department is committed to working collaboratively with all ancillary departments and nursing units to provide optimal care to each patient. The goal if the ED is to triage, diagnose, and monitor all patents until they are stabilized.

Scope of Services

The Emergency Department is licensed to provide Level 1 Trauma emergency services, as part of the Alameda County Emergency Services System.

The doctors, nurses, and ancillary staff in the Emergency Department provide care for all types of urgent and emergent conditions within the department. All patients are triaged by an RN according to written guidelines based on the severity of the patient symptoms. The ED then completes a medical screening exam for each patient. Consultants are obtained as needed from a broad range of specialties. The provision of emergency health care and service is continually monitored and evaluated by varying interdisciplinary teams.

Patient education is an integral component of the medical and nursing care provided at Highland Hospital Emergency Department. Teaching is focused on the immediate needs of each individual patient. Appropriate referrals to primary care physicians, clinics, or other health care facilities will also be done at the time of discharge.

Types and Ages of Patients Served

The Emergency Department delivers care to a full spectrum of patients, including newborn/infants, pediatrics, young adults, adults, and geriatrics.

Staffing

Patient care in the Emergency Department is provided by registered nurses,

emergency department technicians, certified nursing assistants, and unit clerks. The licensed nurse to patient ratios that apply to the Emergency Department is 1:4 and 1:2 for critical care patients. A registered nurse is assigned to the Triage at all times. All registered nurses are required to have ACLS/BLS/PALS. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership.

At least one Attending physician is present 24 hours a day.

Hours of Operation

The Emergency Department is in operation 24 hours a day, 7 days a week.

Intensive Care Unit (ICU)

The Intensive Care Unit (ICU) is located on the 5th floor of the Acute Care Tower. The ICU has 24 beds.

Goals

The goal of Intensive Care Unit (ICU) is to provide a safe place for healing and to implement the nursing process in order to deliver safe, prompt, and efficient patient care in meeting patient and family needs. The ICU team delivers high quality care in a safe, respectful, non-discriminating environment to all individuals who are admitted for care. The ICU is committed to working collaboratively with ancillary departments and nursing units to provide optimal care to each patient.

Scope of Services

Comprehensive care is provided to young adult, adult, and geriatric patients in the acute phase of their illness. Services provided include diagnosis, treatment, and coordination of care to patients with multiple complex medical problems in the patient care setting. Ancillary departments complementing the nursing staff include Dieticians, Dietary aides, Laboratory Technologists, Physical Therapists, Physical Therapy Aides, Radiology technicians, Respiratory Therapists, Case Managers, Speech Therapists, Occupational Therapists, Social Workers and Enterostomal Nurses. Hemodialysis,

Peritoneal Dialysis and Plasmapheresis are provided by a contracted agency.

Types and Ages of Patients Served
The ICU provides care to young adult, adult and geriatric populations

Staffing

Staff utilized on the ICU include Registered Nurses (RN), Certified Nursing Assistant (CNA), and Medical Clerks. Highland Hospital shall provide staffing by licensed nurses within the scope of their licensure in accordance with the nurse-to-patient ratios as indicated by Title 22 regulations. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership

Hours of Operation

Services are provided 24 hours a day, 7 days a week.

Rapid Response Team

Goals

The Rapid Response Team (RRT) at Highland Hospital provides coverage by an experienced critical care RN throughout the facility 24 hours a day, seven days a week. This role is designed to provide clinical expertise to patients whenever a change in the patient's condition is assessed by the primary nurse or family

Scope of Services

The Rapid Response Nurse's (RRN) primary role is to participate in potentially emergent patient care situations in all patient care areas with the exception of the Neonatal Intensive Care Unit.
The RRN remains with the patient until their condition is stabilized or until the patient has been transferred to a higher level of care. In addition to responding to calls regarding concerns for changes in patients' conditions, the RRN, when available, responds to all emergency codes excluding code grays and codes called in the Emergency Department.

Step Down Unit (SDU)

The Step-Down Unit (SDU) is located on the 6th floor of the Acute Care Tower. The SDU has 28 beds.

Goals

The goal of Step-Down Unit (SDU) is to provide a safe place for healing and to implement the nursing process in order to deliver safe, prompt, and efficient patient care in meeting patient and family needs. The SDU team delivers high quality care in a safe, respectful, non-discriminating environment to all individuals who are admitted for care. The SDU is committed to working collaboratively with all ancillary departments and nursing units to provide optimal care to each patient.

Scope of Services

Comprehensive care is provided to young adult, adult, and geriatric patients in the acute, and phase of their illness. Services provided include diagnosis, treatment, and coordination of care to patients with multiple complex medical problems in the patient care setting. Ancillary departments complementing the nursing staff include Dieticians, Dietary aides, Laboratory Technologists, Physical Therapists, Physical Therapy Aides, Radiology technicians, Respiratory Therapists, Case Managers, Speech Therapists, Occupational Therapists, Social Workers and Enterostomal Nurses. Hemodialysis, Peritoneal Dialysis and Plasmapheresis are provided by contracted agency.

Types and Ages of Patients Served

The SDU provides care to young adult, adult, and geriatric

populations.

Staffing

Staff utilized on the SDU include Registered Nurses (RN), Certified Nursing Assistant (CNA), Monitor Technicians, and Medical Clerks. Highland Hospital shall provide staffing by licensed nurses within the scope of their licensure in accordance with the nurse-to-patient ratios as indicated my Title 22 regulations. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership.

Hours of Operation

SDU services are provided 24 hours a day, 7 days a week.

Telemetry/Oncology Unit

The Telemetry Unit is located on the 7th floor of the Acute Care Tower. The Telemetry Unit has 28 beds.

Goals

The goal of the Telemetry Unit is to provide a safe place for healing and to implement the nursing process in order to deliver prompt and efficient patient care while meeting patient and family needs. The Telemetry team delivers high quality care in a respectful, non-discriminating environment to all individuals who are admitted for care. The Telemetry unit is committed to working collaboratively with all ancillary departments and nursing units to provide optimal care to each patient.

Scope of Services

Comprehensive care is provided to young adult, adult, and geriatric patients. Patients who are admitted to the Telemetry Unit are experiencing acute medical surgical problems as well as patients who require hospitalization for acute medical oncology care and/or chemotherapy. The goal of the Telemetry Unit is to provide care for patients to achieve the optimum state of wellness/comfort that is attainable given the patients underlying disease process.

Types and Ages of Patients Served

The Telemetry Unit provides care to young adult, adult and geriatric populations.

Staffing

Staff utilized on the Telemetry Unit include Registered Nurses (RN), Certified Nursing Assistant (CNA), Monitor Technicians, and Medical Clerks. Highland

Hospital shall provide staffing by licensed nurses within the scope of their licensure in accordance with the nurse-to-patient ratios as indicated my Title 22 regulations. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership

Hours of Operation

Telemetry Unit Services are provided 24 hours a day, 7 days a week.

Medical Surgical Units

The Medical Surgical Units are located on the 8th and 9th Floor of the Acute Care Tower. Each unit has 28 beds.

Goals

Patients admitted to the Medical Surgical (MS) Units are experiencing acute, but stable medical/surgical problems. The goal of the MS units is to provide care for patients to achieve the optimum state of wellness/comfort that is attainable given the patient's underlying disease process.

Types and Ages of Patients Served

The Medical Surgical units provide care to young adult, adult and geriatric populations.

Staffing

Staff utilized on the MS units include Registered Nurses (RN), Certified Nursing Assistant, and Medical Clerks. Highland Hospital shall provide staffing by licensed nurses within the scope of their licensure in accordance with the nurse-to-patient ratios as indicated my Title 22 regulations. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership

Hours of Operation

Medical Surgical services are provided 24 hours a day, 7 days a week.

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

Labor & Delivery/Antepartum/Postpartum

The Labor & Delivery (L&D) and Postpartum (PP) Units are located on the 4th Floor of the Acute Care Tower. L&D has 8 private delivery rooms, 4 triage beds, 2 Operating Suites and 3 Post Recovery bays. Postpartum has 17 private rooms. All rooms provide rooming mothers and their newborn. Highland does not have a well-baby nursery.

Goals

To provide comprehensive services to assist patients/families in achieving and maintaining their highest level of physical, emotional, social and spiritual health. To attain optimal patient/family outcomes through collaboration of members of the multidisciplinary health care team. To promote patient/family satisfaction across the continuum of childbearing care and gynecological care in an atmosphere conducive to birthing options, adaptations to parenting, and support in coping with health outcomes to women and infants. To provide excellent patient- and family-centered medical, midwifery, and nursing care for obstetrical and postpartum patients, their infants, and gynecological patients

Scope of Services

Clinical Services

- Triage, labor and medical assessment, and evaluation of undelivered obstetrical patients; antenatal testing, and fetal diagnostic and invasive procedures.
- Medical, midwifery, and nursing care of patient experiencing vaginal or cesarean birth.
- Tubal ligation, dilation and curettage, and other obstetrical/surgical procedures.
- Evaluation, care, and assessment of the postpartum mother and couplet.
- Evaluation, care, and assessment of gynecologic patients.
- Neonatal, pediatric, and nursing care of the well or ill newborn.
- Lactation support, intervention, and education.

Types and Ages of Patients Served

The patient population includes healthy to acutely ill childbearing adolescents and women, and fetuses/neonates from low to high risk

Hours of Operation

L&D and Postpartum services are provided 24 hours a day, 7

days a week. Staffing

Staff utilized on the L&D and PP units include registered nurses (RN), Obstetric Surgical Technician. Licensed Vocational Nurse (LVN), Lactation Consultant, Certified Nursing Assistant (CNA), and Medical Clerks. Highland Hospital shall provide staffing by licensed nurses within the scope of their licensure in accordance with the nurse-to-patient ratios as indicated my Title 22 regulations. Ancillary departments complementing the nursing staff include Dieticians, Dietary aides, Laboratory Technologists, Physical Therapists, Physical Therapy Aides, Radiology technicians, Respiratory Therapists, Case Managers, Speech Therapists, Occupational Therapists and Social Workers. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership

Neonatal Intensive Care Unit Level II

The Neonatal Intensive Care Unit (NICU) is located in the 4th Floor un the Acute Care Tower. The NICU has 8 private rooms with the capability for rooming in by the parent/guardian.

Goals

To provide quality care for patients and families of all cultures and belief's, support and education to families so ensure readiness for discharge and to facilitate bonding and help families to play an active role in their baby's hospital stay.

Scope of Services

The NICU is an interdisciplinary unit specializing in the care of neonates requiring intensive care. Services provided include neonatal care to high-risk infant requiring level II Neonatal intensive care.
The team evaluates the initial needs of the neonate; stabilizing those infants with life-threatening conditions and providing the services immediately indicated.

- Treat neonates' medical illnesses.
- Transfers those neonates who are less than 32 completed weeks of gestation, have birth weight less than 1500g, require ongoing ventilator support, complicated abdominal or

cardiac surgeries, or require ophthalmology examination (See "NICU Admission/Observation Criteria and Discharge/Transfer Criteria").

- Provides care that is compatible with the neonates' developmental needs and status.
- Responds to emergencies in the labor and delivery area.
- Physicians, nurses, medical social worker, and clinical registered dietitian shall be available for consultation to community practitioners and facilities who refer patients to the NICU.
- Ensures ALL infants who are provided care in the NICU receive a hearing screening test prior to hospital discharge (see "Family Birthing Center Newborn Hearing Screen"); and
- Assures the availability of follow-up care after discharge.

Types and Ages of Patients Served

The patient population is comprised of medically ill neonates of all backgrounds and ethnicities in an urban community.

The NICU operates 24 hours a day; 7 days a week. Staffing

Pediatricians, CCS paneled Neonatologist (consultant), Intermediate NICU Nurse Manager, Registered Nurses, Licensed Vocational Nurses, Social Workers, Respiratory Therapists, Lactation Consultants, Medical Clerk. Ancillary departments complementing the nursing staff include Dieticians, Dietary aides, Laboratory Technologists, Physical Therapists, Physical Therapy Aides, Radiology technicians, Respiratory Therapists, Case Managers, Speech Therapists, Occupational Therapists and Social Workers.

There is one charge nurse for each shift in the NICU and be present in the NICU at all times.

Social work services shall be provided in the NICU by a CCS-paneled medical social worker (MSW) and who has expertise in psychosocial issues affecting the families of seriously ill neonate/infants. All infants admitted to the NICU will have a MSW assigned.

There is an identified Respiratory Care Therapist with expertise in neonatal respiratory care practice available at all times to the NICU.

Each staff member will have completed departmental specific orientation within the first 90

days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership.

The Intermediate NICU Nurse Manager:

1. Has 24-hour responsibility for the organization, management, supervision and quality of nursing practice and nursing care in the NICU.
2. Shall not be a nurse manager of more than one NICU other than at the same contiguous medical building complex; and
3. The responsibilities of the intermediate NICU nurse manager shall include, at a minimum, personnel, fiscal, and material management, and coordination of the quality improvement program for the NICU.
4. the Intermediate NICU Nurse Manager shall directly supervise the nurse supervisors for the NICU
5. If the intermediate NICU nurse manager is dedicated solely to the NICU and does not oversee more than 30 full-time equivalent positions or 50 NICU Staff members, the position and responsibilities of the nurse manager and the nurse supervisor may be combined under the nurse manager position.
6. The Intermediate NICU nurse manager shall report directly to the administrative director of nursing or individual holding and equivalent position.

The Intermediate NICU Supervisor / Assistant NICU Nurse Manager:

1. The intermediate NICU nurse supervisor shall directly supervise personnel and assure the quality of clinical nursing care of patients the NICU at all times.
2. The Intermediate NICU Nurse Supervisor shall have 24 Hour responsibility for the direct supervision of all clinical personnel who provide patient care; and the day-to-day coordination of and quality of clinical nursing care of patients in the NICU.
3. The Intermediate NICU Nurse supervisor shall not be assigned direct patient care responsibilities.
4. The CCS NICU Nurse Supervisor is responsible for the CCS NICU CNS responsibilities in the case the NICU does not have a CNS assigned to the NICU.
5. The CNS position can be alternatively covered by the CCS NICU Nurse Supervisor, when there is no assigned CNS to the NICU

The Intermediate NICU Medical Director and Intermediate NICU Nurse Manager:

1. Shall have joint responsibility for development and review of an ongoing quality improvement program
2. Shall have joint responsibility for the development and review of a Policies and Procedures Manual for the NICU which addresses, at a minimum, patient

admission, patient care, discharge and transfer criteria, and oversight of Policies and Procedures

NICU Charge Nurse:

1. The responsibilities of the Intermediate NICU charge nurse during each shift shall include the following:
    a. Coordinating the patient care activities of the NICU; and
    b. Ensuring the delivery of quality patient care.

NICU RN

1. There shall be a Registered Nurse (RN) assigned to each patient in the NICU.
2. There shall be no less than two R.N.s physically present in each area of care of the NICU at all times, when a patient is present.
3. A NNP assigned to the NICU may not be included in the calculation of the nurse staff to infant ratio in the NICU.

NICU Medical Social Worker

1. For every 15 patients in the NICU there shall be one full-time equivalent MSW

Registered Dietitian

1. The Registered Dietitian is CCS paneled.

NICU Neonatologist Staff

1. Professional Board certification requirements are updated as follows:
    a. Each associate neonatologist shall be certified by the American Board of Pediatrics Sub-Board of Neonatal-Perinatal Medicine. Current policies of the American Board of Pediatrics for the subspecialty of Neonatal-Perinatal Medicine determine the time limit for eligibility for initial certification, for maintenance of certification, and for board status

A CCS-paneled neonatologist or CCS-paneled pediatrician shall review, evaluate, and document the clinical management of each infant, on-site, at least on a daily basis. It shall be the responsibility of the CCS-paneled neonatologist or CCS-paneled pediatrician to ensure that information is provided, on an ongoing basis, to referring physicians regarding their patients.

There shall be a CCS-paneled neonatologist or CCS-paneled pediatrician who is on-call to the NICU on a 24-hour basis who:

- Shall be in the hospital or be no more than 30 minutes away from the NICU at any time; and

- Shall not be on-call for more than one hospital at the same time; and
- Shall be notified of new admissions and adverse changes in the status of neonates in a timely manner:

A neonatologist, pediatrician in postdoctoral training in neonatal-perinatal subspecialty medicine, a NNP, and/or a physician who has completed more than two years of a postgraduate pediatric residency training program with experience and training in neonatology shall be in-house and called:

- Whenever an unstable infant is in the NICU; and
- When there is a major change an infant's condition which requires a reevaluation.

There shall be 24-hour in-house coverage by a professional staff (physician, NNP, and/or RN):

- Who has evidence of current successful completion of Neonatal Resuscitation Program course of the AAP and AHA; and
- Who is proficient in needle aspiration for pneumothorax and intubation for resuscitation.

Perioperative Services

Perioperative Services consists of the Operating Room, Recovery Room, Ambulatory Surgery, The Pre-Op Holding Room and the Pre-Anesthesia Clinic. The Perioperative Services are located in the Koret Building on the 5th Floor. There are seven operating rooms.

Goals

To provide surgical services in a safe, prompt, and efficient manner. To deliver prompt and efficient patient care in a respectful, non-discriminatory environment to all individuals requiring surgical services.

Scope of Services

The Perioperative Services Department provides pre-operative, operative and post operative care to patients having elective, emergency, or trauma surgical, diagnostic or therapeutic procedures. The department also provides training opportunities to medical students, surgical interns and residents, RN nursing students, and surgical technician students.

The surgical specialties providing services to patients at Highland are General Surgery, Orthopedics, GYN, Ophthalmology, Dental/Oral, Neuro, Plastic, Urology, ENT, Thoracic and Vascular.

Surgeons and physicians doing procedures in the operating room must have privileges approved by the Medical Staff of Alameda Health System – Highland Hospital.

All staff receive age-based competencies yearly.

All surgical procedures may be done in the Operating Room with the exception of transplant and open-heart procedures. Emergency or trauma patients of any age may receive care in the perioperative area; however, the primary age group is the young adult, adult and geriatric population. Pediatric patients are transferred to Children's Hospital when stable after trauma or emergency surgery. Patients requiring transplant or open hearts are transferred when stable to a facility offering those services.

PACU provides post-anesthesia care to patients from Surgery, Angiography and from Interventional Radiology.

Same Day Surgery prepares and discharges patients having operative, diagnostic or therapeutic procedures in the operating room.

Types and Ages of Patients Served

Department provides care to pediatric to geriatric

populations Staffing

The **operating room** is staffed each weekday from 7:00 am to 7:00 pm, to run six rooms and have a trauma team (two staff – one surgical tech and one RN or two RN's) available. From 3:00 pm to 5:00 pm, five rooms are available as well as one trauma team. From 5:00 pm – 11:00 pm, staff for two room and a trauma team is available. From 11:00 pm to 7:00 am, a trauma team is available, and one team is "On Call" for back-up.

On weekend and holidays, one team is always in house for Trauma and one team is "On Call" for backup. If absences occur on nights, or any shift on weekends or holidays, "On Call" backup staff is utilized, and a system is in place to obtain additional backup.

Two staff, a surgical technician or RN for the scrub role and an RN to circulate will be assigned for all cases except for minor cases for which one RN will be assigned.

In the **PACU,** routine recoveries are staffed 1 RN to 2 patients. Intense/Emergent or Critical

recoveries are staffed 1 RN to 1 patient. "On Call" staff are assigned as a backup on nights during weekdays and on all shifts on the weekends to provide extra staff when needed.

Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership

Sterile Processing Department

The Sterile Processing Department is located on the 5th floor of the Koret building within the operating room area.

Scope of Service

The Sterile Processing Department is responsible for collection decontamination, and sterilization of reusable items used throughout the hospital. The department has the capability for steam, low temperature hydrogen peroxide gas plasma sterilization and high-level disinfection.

Staffing
The department is staffed with a Sterile Processing Manager, Supervisor and Sterile Processing Technicians.

Hours of Operation

The Sterile Processing Department is open 24 hours a day. 7 days a week.

Interventional Short Stay Unit
The Interventional Shirt Stay Unit is located on the 3rd floor of the Acute Care Tower.

Goals

To provide an overall view of the resources, services, and operations of the Short Stay Unit to ensure compliance with local, State and Federal operations and licensing requirements.

Scope of Service

The Short Stay Unit is a specialized unit where outpatients and observation patients are assessed and monitored according to hospital policy. Pre and Post procedural

patients (Interventional Radiology, Diagnostic and Interventional Cardiology, Electrophysiology)

Staffing

The department is staffed by Registered Nurses 24 hours a day, 7 days a week and 365 days a year. Minimum daily staff will be 2 Registered Nurses- patients will be staffed according to their status, the ratio shall not exceed 4 patients to one nurse. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership.

Cardiovascular Services

Goals

To provide an overall view of the resources, services, an operation of the Cardiovascular Services Department at Alameda Health System (AHS) to ensure compliance with local, State and Federal operations and licensing requirements.

Scope of Services

The Cardiovascular Services Department is a specialized unit caring for patients requiring specialty cardiac diagnosis and care. The department provides services for inpatients/outpatients/emergency patients throughout the Highland Campus. The services provided include but are not limited to:

a. Electrocardiography (EKG) (Outpatient)
b. Holter Monitor Placement (Inpatient/Outpatient/Emergency)
c. Adult Echocardiography (Inpatient/Outpatient/Emergency)
d. Vascular Ultrasound (Inpatient/Outpatient/Emergency)
e. Adult Cardiac Stress Testing (with or without Echocardiography) (Inpatient/Outpatient/Emergency)
f. Pacemaker/Defibrillator Interrogation (Inpatient/Outpatient/Emergency)
g. Trans-Esophageal Echocardiography (Staff and Equipment only provided to Interventional Services Department or ICU-Inpatient/Outpatient/Emergency)
h. Outpatients must be at least 18 years of age

Types and Ages of Patients Served

Department provides care to newborn (Echo) to geriatric

populations. Staffing

The department is staffed by Cardiologists, Registered Nurses, Cardiac Sonographers, Vascular Sonographers, Electrocardiograph Technicians (ECG Tech), Medical Assistants, and Clerks. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership.

Hours of Operation

Services are provided 24 hours a day, 7 days a week.

Ambulatory

Goals

The Ambulatory Care Division is a comprehensive network of primary care and specialty care with a supporting network of diagnostic services that provides patients with a full range of health services. Care is provided for patients of all ages. Ambulatory patient care is provided via a multi- disciplinary approach with collaboration among the various support services and providers. Each patient is provided the opportunity to establish an ongoing relationship with a primary care provider and multi-disciplinary team who manage care for that individual, including individual disease management, chronic disease management, preventive health education, screening and immunizations. Access to specialty care services is arranged through the patient's primary care provider, in consultation with the sub-specialist.

Scope of Service

Ambulatory Care Services offered at the Highland Campus include:

Primary Care

1. Adult Medicine
2. Adult Immunology
3. Pediatrics
4. Obstetrics

5. Gynecology Urgent Care
6. Prenatal (Centering) Classes
7. Comprehensive Perinatal Services Program
8. Obstetric Ultrasound
9. Non-Stress Test
10. Behavioral Health
11. Psychiatry
12. Health Education/Chronic Care
16. Anti-coagulation clinic
17. General Dentistry

Specialty Care

1. Cardiology
2. Dermatology
3. Ear, Nose and Throat
4. Endocrine
5. Endoscopy
6. Gastroenterology
7. Hematology/Oncology
8. Infusion
9. Neurology
10. Neurocognitive
11. Neurosurgery
12. Ophthalmology
13. Optometry
14. Oral Surgery
15. Orthopedics
16. Pain
17. Palliative Care
18. Podiatry
19. Pulmonary (Chest)
20. Renal
21. Rheumatology
22. Surgery: Acute, Elective, Trauma
23. Surgery: Breast
24. Surgery: Gynecology
25. Surgery: Minor
26. Surgery: Plastic
27. Surgery: Vascular

28. Urology
29. Wound Healing

Primary Care Procedures

Adult Medicine (including Urgent Care)

1. Arthrocentesis and joint injections
2. Peak Flow measurement
3. Incision and Drainage
4. Ear irrigation
5. Breathing treatment (nebulizer)
6. Skin biopsy
7. Post-void residual measurement
8. Fine needle aspiration
9. Foley Catheter insertion
10. INR testing via capillary blood specimen
11. Cryotherapy
12. Foreign body removal: eye, nose or ear
13. Local anesthetic techniques including trigger point injections.
14. Carpel tunnel injections
15. Trigger finger injections
16. Uncomplicated wound closure
17. Cautery of anterior nares

OB/GYN

1. Biopsy of cervix, vulva, vagina
2. Colposcopy
3. Cryosurgery
4. Endometrial Biopsy
5. Incision and Drainage of abscess
6. Leep Procedures
7. Removal of Condylomas
8. Removal and insertion of Intrauterine Device
9. OB Ultrasound
10. Dilation and Curettage
11. Essure permanent birth control
12. Fetal monitoring / Non-Stress Test
13. Elective Abortion
14. Procedural Sedation

15. Bartholin cyst marsupialization
16. Novasure endometrial ablation
17. Nexplanon/Implanon insertion and removal
18. Hysteroscopy

Pediatrics

1. Breathing Treatment (Nebulizer)
2. Suture Removal (minor lacerations)
3. Fluoride Varnish
4. Frenotomy
5. Foreign body removal
6. Wart removal
7. Heel sticks phlebotomy for bilirubin draws
8. Incision and Drainage of abscesses
9. Ear irrigation
10. Venipuncture
11. Urine catheterization
12. Umbilical granuloma chemical cautery

Dental

1. Exam
2. X-rays
3. Cleanings (Periodontics)
4. Deep cleanings (Periodontics)
5. Fillings (restorative dentistry)
6. Root canals
7. Dentures
8. Crowns/Bridges
9. Partials
10. Implant crowns
11. Extractions (routine & surgical)
12. Fluoride varnish/ Sealants
13. Special Needs operating room procedures
14. Apicoectomies (endodontics)
15. Crown Lengthening (Periodontics)

<u>Specialty Clinic Procedures</u>

Dermatology

1. Skin scraping for identification of fungi or parasites

2. Punch or excision biopsy for diagnosis
3. Excision of small basal cell or squamous cell carcinoma
4. Injection of keloids and scars with steroids
5. Cautery of benign lesions
6. Liquid Nitrogen therapy to benign and pre-malignant lesions
7. Incision and drainage of abscesses
8. Intralesional steroid injections for alopecia areata and hidradentitis supp
9. Electrodessication and curettage

ENT

1. Control of nasal hemorrhage; nasal packing (simple and complex)
2. Biopsy of lip, cavity, larynx, nose, ear
3. Reduction of nasal fracture
4. Removal of nasal polyps
5. Nasal – pharyngeal laryngoscopy, fiber optic laryngoscopy
6. Intranasal steroid injection
7. Placement of earwicks
8. Auricular hematoma drainage (simple and complex)
9. Removal of impacted cerumen
10. FNA of neck lesions
11. Esophagoscopy with dilatation
12. Laryngoscopy
13. Incision and Drainage
14. Tracheotomy tube changes
15. Voice prosthesis change
16. Foreign body removal ear/nose
17. Peritonsilar abscess drainage
18. Balloon sinoplasty maxillary, frontal, sphenoid
19. Microscopic ear debridement
20. Excision tongue lesion with and without closure
21. Aspiration of mass (cyst, hematoma, seroma or sialocele)
22. Biopsy nasopharynx
23. Biopsy oropharynx
24. Biopsy tongue
25. Ablation turbinates
26. Mass excision inside ear/nose

Hematology/Oncology

1. Bone marrow aspiration and biopsy

2. Therapeutic phlebotomy

Infusion Center

1. Chemotherapy
2. Hydration therapy
3. Blood Transfusions (Blood Products)
4. Parenteral medications including but not limited to
    - Antibiotics
    - Biologics
    - Immunoglobulin
    - Other IV infusions as indicated
    - Injections

Minor Surgery

1. Excision of masses less than 4 cm
2. Superficial foreign body removal
3. Biopsy of lesions
4. Skin and soft tissue lesions deemed safely accessible by the faculty surgeon
5. Removal of infusion and dialysis devices

Neurology

1. Lumbar puncture
2. Vagus Nerve Stimulation
3. Therapy Needle electromyography
4. Botox injections

Neurosurgery

1. Adjustment/Removal of Halo hardware
2. Dressing changes

Ophthalmology

1. Subconjunctival injections with antibiotics and steroids
2. Incision and drainage chalazion
3. YAG laser
4. Laser iridotomy
5. Laser trabeculoplasty
6. Optical Coherence Tomography
7. Laser retinal photocoagulation
8. Complete eye examinations
9. Visual fields testing
10. Refractions
11. Minor ophthalmic procedures

12. Dilation, probing of nasolacrimal system
13. Retinal photography/Fluorescein Angiography
14. Cyclocryotherapy, retinal hole photo coagulation
15. Eye ultrasound
16. Pneumatic retinopexy
17. Intravitreal injections of anti-VEGF agents, steroids and antibiotics

Oral Surgery

1. Simple and surgical extractions
2. Wisdom teeth removal with sedation
3. Apicoectomy
4. TMJ Therapy and Treatment
5. Dentoalveolar surgery
6. Oral Pathology
7. Osseo integrated implants
8. Prosthetic Surgery
9. Open and close treatment of fracture trauma
10. Sinus Procedures
11. Soft tissue surgery
12. Bone grafting to maxillofacial regions
13. Procedural Moderate Sedation for minor surgery

Orthopedics

1. Hardware removal
2. Alignment/reduction of fractures/dislocations
3. Incision and Drainage
4. Superficial wound debridement
5. Arthrocentesis
6. Minor hand procedures such as trigger finger/carpal tunnel release
7. Injections of joints, bursa, tendon sheaths
8. Cast application and removal
9. Splint application
10. Removal of foreign bodies
11. Excision of wrist ganglion, lesions, distal phalanx
12. Biopsy of lesions

Pain

1. Injections of joints, bursa, tendon sheaths
2. Peripheral nerve blocks
3. Myofascial trigger point injections

Podiatry

1. Alignment/reduction of fractures/dislocations
2. Avulsion of Nail
3. Destruction of Lesion
4. Excision of lesion
5. Foreign body removal
6. Aspiration
7. Biopsy of lesions
8. Cast application and removal
9. Matrixectomy
10. Wedge Excision of skin/nail fold
11. Debridement
12. Diabetic foot care
13. Hardware removal
14. Incision and Drainage
15. Injections of joints, bursa, tendon sheaths
16. Splint application
17. Destruction of lesions
18. Nail care, including nail procedures (total or partial)

Surgery (breast, general, trauma, vascular, plastic)

1. Needle aspiration for cytology
2. Needle/excisional biopsy
3. Debridement of superficial wounds
4. I & D
5. Foreign body removal
6. Dressing changes
7. Wound Culture
8. Tissue Expansion
9. Hemorrhoid banding

Urology

1. Sounding – dilation of urethra
2. BCG Instillation
3. Bladder irrigation/installation
4. Catheterization procedures
5. Stent removal
6. Voiding trials
7. Cystoscopy

8. Prostatic biopsies
9. Hydrocele aspiration/sclerosis
10. Prostate abscess aspiration
11. Gold Seed markers
12. Vasectomy
13. Post void residual
14. Uroflometry
15. Scrotal cyst/lesion excisions
16. Penile lesion excisions
17. Complex catheter changes
18. Suprapubic catheter changes
19. Trimix injection
20. Zoladex injection

Wound Healing

1. Debridement
2. Aspiration
3. Dressing changes
4. Injections
5. Lesion Removal

Respiratory Care

Goals

To provide the highest quality respiratory care, diagnostic and therapeutic services in an efficient and timely manner to the customers, patients, and members of the community.

To establish a caring and concerned relationship with the patient and family members and to strive to fulfill their individual personal and emotional needs as well as their medical needs.

To maintain an organized, well equipped and professional environment for the employees and physicians utilizing the Respiratory Care Department services.

Scope of Services

Respiratory Therapy provides all respiratory therapeutic modalities to all areas of the hospital. These modalities include airway maintenance, volume ventilator management, non-invasive ventilation, oxygen and aerosol therapy, delivery of nebulized medication, chest

physiotherapy, arterial puncture and blood gas analysis and emergency resuscitation. Pulmonary Lab provides Pulmonary Function Tests, Pulmonary exercise studies, maintains and operates the Arterial Blood Gas Lab and assists physicians in Bronchoscopies and Thoracentesis.

Types and Ages of Patients Served

Respiratory Therapy:
The inpatient population consists of newborn to geriatric patients. Emergency room patient populations may include newborn/infant and pediatric patients.

Pulmonary Lab:
The Pulmonary Lab inpatient population consists of young adult to geriatric patients.

Staffing

Staffing in Respiratory Therapy department is evaluated four hours before the beginning of the next shift and when necessary. The existing workload is counted, and staffing adjusted up or down to accommodate the workload maintaining a core respiratory therapy staff to cover all units. The department employs a SAN's staff, which can be added to the prescheduled staff if the need arises. Traveling respiratory therapists are contracted to provide staffing for needs above the department's ability to meet. Cross training of staff members in all areas provides for flexibility for vacation, illness and holiday coverage. Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership.

Respiratory Therapy staffing is determined Iby units of service for patient and treatment volumes and includes:

1. Registered Respiratory Therapist
2. Registered Respiratory Therapist (SAN)
3. Respiratory Care Practitioner II
4. Respiratory Care Practitioner II (SAN)
5. Senior Respiratory Care Practitioner

Hours of Operation

Respiratory Therapy:

Respiratory Therapy provides service 24 hours a day/7 day a week.

Pulmonary Function Laboratory:

The Pulmonary Function Laboratory operates Monday- Friday from 8:00 AM until 5:00 PM.

Case Management

Goals

To provide social work services that enhance the social, psychological and/or environmental needs of patients and families. Coordinate discharge-planning services that facilitate a safe return home or facilitate a move to another appropriate level of care. To provide case management services which monitors all aspects of patient care to assist in the promotion and maintenance of quality care through analysis, review and evaluation of clinical practice in the hospital, outcome measurement, appropriate admission and continued stay status, and utilization of resources.

Scope of Services

Social Work Services include:

1. Psychosocial assessment.
2. Individual and/or family counseling (short term).
3. Crises intervention.
4. Discharge planning.
5. Community information and referral.
6. Collaborative consultation with other team members.
7. Employee assistance counseling (short term).
8. Patient, family, physician and employee education (includes advanced directive education).

Case Management Services include:

1. Assessment of the appropriateness of the setting in which the care is being rendered
2. Identification of overutilization and underutilization of healthcare resources
3. Identification of possible quality and/or risk management issues, including outcomes measurement.

4. Assessment of utilization of resources
5. Discharge planning
6. Community information and referrals
7. Collaborative consultation with other team members
8. Coordinate care with and provide information to third party payers
9. Patient, family, physician and employee education (includes advanced directives education)

Types of Patients Served

We serve all inpatients and observation of the hospital ages newborn to geriatric. While we maintain an open referral policy, our high-risk screening program focuses on the following types of patients or concerns:

- Substance abuse.
- Victims of abuse/neglect.
- Financial concerns.
- Emotional problems which impact treatment.
- Major change or loss.
- Combative/agitated patients.
- Newborns.
- Patients 87 years of age or older.
- Patients who have been readmitted in 30 days.
- Patients living alone who have no method to obtain transportation or housekeeping needs.
- Patients returning to a SNF or Board and Care, or currently on service with home care.
- High risk diagnoses including M.I. CHF, injury and surgery involving the hip, knee or pelvis. TIA, CVA, ALOC, Cancer (newly diagnosed, requiring surgery or comfort care), DKA or other Diabetes management problems, Pneumonia, COPD, or TB.
- Victims of violence and/or trauma.

Staffing

The Case Management department currently consists of a Manager, MSW/LCSW staff, and RN Case Managers. We cover the inpatient units, Family Birthing Center, Emergency Room, Surgery, and other outpatients that request our services or who are

referred to us.

Staffing is determined by the adjusted patient census. The Manager monitors staffing needs daily and adds or deletes staff based on the productivity standard.

Each staff member will have completed departmental specific orientation within the first 90 days of employment and will complete age specific annual competencies in appropriate areas as deemed by leadership

Hours of Operation

Care Management is staffed 24 hours a day 7 days a week.

Admitting

Goals

The Admitting Department supports and works toward the mission and vision of the Highland Hospital. All new employees receive this information at their orientation and all others are reminded of their purpose for working within this environment.

This department is able to fulfill the mission and work toward the vision through caring and compassionate customer/patient care and service, giving accurate information, and prompt response time which contributes to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost-effective service to the communities we serve. It is the goal and mission of the Admitting Department to:

- Continue to improve procedures and working relations between the Admitting Department and all departments that care for patients.
- We trust our colleagues as valuable members of our health care team and pledge to treat one another with loyalty, respect, and dignity.
- Expand cross training of employees to improve efficient operation of the department and provide better service to patients, i.e., insurance verification, cashier, outpatient, inpatient and emergency registration.
- Ensuring the correct patient identity is made during the registration process.
- Signing all regulatory Documents and assuring patients have been given their rights.
- Accurately allocating the correct insurance and collecting the appropriate copays at the time of service.

Scope of Services

The Admitting Department is responsible for the registration and/or admission of the following types of patients:

1. Emergency Department
2. Family Birthing Center
3. Ancillary departments (lab, radiology, cardiology, physical therapy, etc.)
4. Observation, Outpatient in a Bed
5. Surgery, inpatient and outpatient
6. Inpatients

The function of the department is to provide service to the patients and to the hospital by collecting accurate patient demographic and financial information and input into the computer system. The information will assist us in providing better patient care and protecting the hospital's financial condition by ensuring that all insurance information is promptly and properly verified. The registration process is conducted in a confidential, considerate, respectful way with recognition of each patient's dignity and with impartial access to treatment accommodations.

The Admitting Department assists patients and physician offices in determining if facility is a provider under the patient insurance plan. The Financial Counselor provides pre-registration and insurance pre-verification as a service to the patients and physicians in accordance with the hospital financial policies.

The Admitting Department interfaces with ancillary department of the hospital, patients, doctors, and the Finance Department. The staff is cross trained for all registration/admission functions in the facility, which allows them the capability to process all types of patients at any registration site in the hospital. This makes the admission clerk very diverse and helps to expedite all registrations/admissions.

Types and Ages of Patients Served

Ages of patient's service ranges from newborn to the geriatric population.

Hours of Operation

The Admitting Department is staffed and operates 5 days per week, Monday through Friday from 8:30am – 5:00pm. Outpatient Registration is staffed 5 days per week, Monday through Friday from 8:00am until 4:30pm. The inpatient and outpatient

registration functions are performed by the Emergency Department Admitting staff after hours, weekends and holidays. The Emergency Registration is open 7 days a week, 24 hours per day.

Engineering/Biomedical

Goals

The goals of the Engineering Department are:

1. To improve the quality of life for our community and our patients by providing a safe, clean, comfortable facility that provides for the delivery of services to our community, patients, and staff.

2. To improve the care of our patients by helping to provide a healing environment where they are cared for by staff educated and trained to provide the highest quality of care.

3. To maintain an organized and professional environment for the employees and physicians utilizing the facility.

Scope of Service

To provide building engineering services which support the facility's core function of patient care. Engineering responds to work requests submitted by staff or patients. Additionally, the Engineering Department also provides a comprehensive preventive maintenance service to provide high reliability as related to the operation of all equipment, utilities, and life safety systems within the facility.

The Engineering Department includes patient/staff education and community outreach to ensure the safety and comfort of patients and staff. Needs are determined through close interaction and communication with the department leaders, family members, physicians and regulatory agencies involved in the patient's continuum of care.

Types and Ages of Patients Served

The inpatients and outpatients served by the Engineering Department are newborn/infant, pediatric, adults, and geriatrics.

Staffing

The Engineering Department is staffed by qualified Building Engineers and Biomedical Equipment Technicians. Increases in workload are met by overtime work.

Hours of Operation

The Engineering Department is available 24 hours a day, seven days per week to respond to disruption or maintenance needs of the facility with either on site staff or on call personnel.

Environmental Services

Goals

1. To assist in maintaining and managing the Environment of Care and infection prevention throughout the facility.
2. To provide a clean, safe environment for patients, visitors and employees.
3. To increase patient satisfaction scores on cleanliness.
4. To achieve and maintain cleaning satisfaction.
5. To provide clean linen service to patient care areas.

Scope of Service

Services provided to patients and customers are varied individualized. Services may include but not limited to:

- Daily cleaning of patient rooms.
- Routine cleaning of ancillary areas.
- Cleaning and stocking restrooms daily or as needed.
- Routine corridor care, dry mopping, wet mopping, machine scrub/polish, vacuuming.
- Maintaining a project schedule for walls, ceilings, floors, windows, drapes, cubicles and upholstery.

- Maintaining proper standard cleaning procedures for isolation room cleaning.
- Transporting infectious waste, soiled linen and trash within the facility for removal by designated contractors.
- Cleaning unusual spills (blood, broken glass, etc.).
- Properly storing and maintaining departmental supplies, equipment and chemicals.
- Providing an adequate supply of linen for the facility through an outside contractor.
- Ensuring the linen contractor complies with OSHA and TJC infection control guidelines.

Staffing

The EVS Department is staffed with Department Supervisor and EVS Aides. Staffing is based on hospital square footage, needs of the facility and the daily census.

Hours of Operation

The EVS Department is open 24 hours a day 7 days per week

Food and Nutrition Services

Goals

The goals of Food and Nutrition Services Department are to improve patient satisfaction, provide quality and timely nutrition care to our patients, and to work collaboratively with the medical and hospital staff.

Scope of Services

The Food and Nutrition Services Department provides food service to inpatients, outpatients, employees, medical staff and guests. Food service is provided daily as required by current regulation and is detailed in the department policy and procedure manual. Cafeteria service is available from 10:30 AM through 1:30 PM, Monday through Friday. Nourishments via floor stock on the nursing floors are available for patients' 24 hours. The department is responsible for the following functions:

1. Providing nutritionally adequate, attractive and satisfying meals to hospital staff and visitors.

2. Maintaining a safe and sanitary food service environment according to standards of quality as established by federal, state and local agencies.
3. Providing initial and ongoing training and education of Food and Nutrition Services staff to achieve the standards of quality as established in the policy and procedure manual.
4. Evaluating activities as to the provision of quality dietary intervention in patient treatment and quality meal service to associated visitors and guests.
5. Providing timely nutrition screening, assessments, counseling, nutrition education and diet instructions to meet the needs of patient's various backgrounds which affect nutritional preferences and habits as ordered by the medical staff and/or as defined in departmental policies
6. Providing nutrition services for all patient populations of the hospital, culturally diverse, and specialty units as well as for outpatient area(s) and community programs as requested.
7. Evaluating the activities of the Food and Nutrition Services Department as to the provision of quality nutrition intervention in patient treatment and quality meal service to associates, visitors, guests and patients.

Types and Ages of Patients Served

The Food and Nutrition Services Department serves patients that are:

1. Newborn/Infant
2. Pediatric
3. Young adult
4. Adults
5. Geriatric

Staffing

The Food and Nutrition Services Department includes:

1. Manager of Food Service
2. Clinical Dietitians
3. Room Service Coordinator
4. Cooks
5. Food Service Workers

It is the policy of the Food and Nutrition Services Department to provide adequate staff

to meet the needs and mission of the department and organization. Staffing of the department is based on inpatient hospital census and volume of meals served. Many of the staff is cross trained in other areas to assure complete coverage in the event of vacation, sickness and any other variances affecting the department. The department maintains a staffing plan which details core staffing and how staffing requirements change based on fluctuations in volume. The classification of the staff used in the department includes Supervisor, Dietitian, Director, Room Service Coordinators, Cooks and Food Service Workers. In the event of a disaster, the department would remain open (if possible) and additional staffing may be needed from other departments as available.

Hours of Operation

Hours of service are from 7:00 AM to 7:00 PM. Registered Dietitians are available to provide nutrition care services daily.

Infection Control

Goals

1. To identify hospital acquired infections through surveillance activities and to report them to the appropriate agencies.
2. To communicate information regarding reportable diseases to the Health Department.
3. To advise patient care departments concerning disease transmission, precautions and procedures regarding prevention of communicable diseases.
4. To implement strategies to reduce risks for and/or prevent nosocomial infections in patients, employees, and visitors.
5. To implement strategies to control outbreaks of infection when they are identified.

Scope of Services

The infection prevention program reports through the Alameda Health Systems Patient Safety and Quality, and Medical Executive Committees. The System Director of Infection Prevention, along with the Infection Prevention and Control Committee Chair, determine the specific focus of surveillance, education, and consultation efforts on an ongoing basis, dependent on hospital epidemiology, community disease surveillance and real or perceived local, national or world threats. The Director of IPC reports through the Quality Department to the Vice President of Quality.

Hours of Operation

The Infection Prevention and Control Program has an infection preventionist available 24/7 to respond to questions and guidance.

Laboratory/Pathology

Goals

To Provide accurate and timely patient laboratory testing and test results for use in the diagnosis, treatment and monitoring of patients and to support the Hospital mission by providing quality, safe, efficient and compassionate care and services.

Scope of Services

The laboratory provides patient testing services and test results in the following areas: Pathology, Transfusion Services, Hematology, Urinalysis, Chemistry, Coagulation, Microbiology and Phlebotomy.

Types and Ages of Patients Served

The laboratory serves inpatients, outpatients, and emergency patients of all ages including newborn/infants, pediatrics, adolescents, adults, and geriatrics.

Hours of Operation

1. Inpatients and Emergency Department patients: 24 hours per day, 7 days per week.
2. Outpatient Phlebotomy services: 8:00 AM – 4:30PM, Monday through Friday.
3. Pathology services: 9:00 AM – 5:00 PM, Monday through Friday.
   Other times by prior arrangement.
4. Pathologist: Available 24 hours per day/7 days per week for call or consult to support emergency needs.

Materials Management

Goals

The goals of Materials Management is to provide patients, physicians and hospital departments with supplies and services in the most efficient courteous and cost – effective manner. The Materials Management strives to fulfill the needs of its customers by working toward the following goals:

1. Ordering, receiving and distributing supplies, equipment and instrumentation to all departments

2. Provide for distribution and sorting of all incoming and outgoing U.S. Mail

3. Assist departments with expense control and ensure proper supplies and equipment are delivered and available on a daily basis

4. Ensure that all trays and instruments are cleaned, disinfected, sterilized and packaged and ready to use

Scope of Services

Materials Management is a customer-oriented department that provide services to nursing, ancillary, and no-clinical departments. These departments have no direct contact with patient care; however, act as an intermediary through a number of facets:

1. Replenishment of chargeable and non-chargeable supplies based on daily inspections, inventory levels, requisitions, and verbal requests.

2. Decontamination, processing, and sterilization of patient – use equipment, surgical instruments and trays

3. Purchasing stock and non-stock supplies

4. Receiving items brought into the hospital, stocking the shelves, and delivery of supplies.

5. Distribution of patient equipment

6. Processing orders for departments when requested.

7. Assist in product, equipment and capital selection in accordance with system purchasing contracts.

8. Provide research service for invoices and accounting discrepancies to the Accounts Payable Department
9. Provide statistical and financial reports to departments when necessary.

10. Oversees the inventory process including education

and training for the hospital.

Staffing

Materials Management is based upon projected volumes (i.e., patient census, adjusted patient days and workload volume.) Materials Management staffing consists of the Manager, Purchasing Agent, Materials Specialist, Receiving Specialist,

Hours of Operation

Purchasing and Receiving hours of operation are Monday through Friday, 8:00 AM to 4:00PM. After-hours access to either area can be obtained by designated personnel.

Medical Records (Health Information Management)

Goals

Maintain quality medical record documentation which is used to assist in providing:

1. Quality patient care during hospitalization and in the event of future illness.
2. Education for the medical staff and paramedical personnel.
3. A basis for comparative studies and research Legal protection for the patient, physician and hospital.
4. Resource Management.
5. Quality improvement and outcomes information (CHOIS and Core Measures).
6. Documentation as justification for reimbursement.
7. The basis for California Patient Discharge Data reporting and other statutory reporting
8. Documentation needed by

regulatory and accrediting agencies.

Scope of Service

The Medical Records Department maintains confidential, secure, current, authenticated, legible, and complete medical records on a permanent basis utilizing a unit record system for the following:

1. Inpatient
2. Observation
3. Surgical Day Care
4. Emergency Department
5. Ancillary Departments
    a. Radiology
    b. Laboratory
    c. Cardiopulmonary
    d. Physical, Speech and Occupational Therapies

Statistical reports are kept for classifying, collecting, and recording data in the medical record, which include indexes by disease, operation, and physician. The paper record is considered to be the legal medical record. Patient information is also available in the Clinical Patient Care System (CPCS) beginning with records on 1/28/97. This is a computer-based record that permanently maintains laboratory, pathology, and radiology data, reports transcribed by the Transcription Department, demographic information, medical orders, vital signs, etc. This information is available 24 hours a day to authorized users.

Types and Ages of Patients Served

The Medical Records Department serves patients, physicians, hospital staff, third party payers, and review organizations as needed. Hospital services include surgical, medical, diagnostic, emergency, ambulatory care, observation, transitional care, outpatient, rehabilitation, and diabetes clinic. The types of patients served are neonates, pediatric, young adult, adult or geriatric.

Staffing

Medical Records Department staffing is determined on patient days, outpatients, Emergency Department, and outpatient surgery registrations, observation visits. The Managers' hours are included in the hours used. Full-time staff may be asked to work overtime or not to work as needed to meet the staffing goals and operate the department efficiently. The department is always staffed during our scheduled hours of operation. Staff are cross-trained to optimize efficiency during staffing vacancies due to vacation, sickness, adjusted average daily census earned hours, and any other variances affecting the department and it's staffing. Managers continually look at staffing and scheduling, making adjustments as necessary to meet the needs of the department and the hospital.

Hours of Operation

The Medical Records Department is staffed Monday through Friday. HIM Technician personnel are available Monday through Friday, 6:00 AM through 5:00 PM, and open for business hours from 8:00 am through 4:30 pm. Copy hours are Monday through Friday, 10:00 AM to 4:00 PM. The department is kept locked when Medical Records personnel are not working. If a record needs to be retrieved, the only access is through the Nursing Supervisor.

Pharmacy

Goals

1. Provide patient care in a professional, accurate and timely manner.
2. Continually improve our skills and competencies above and beyond our peers.
3. Provide cost effective pharmaceutical care.
4. Design effective pharmaceutical services by ensuring that all current and new processes are planned based on the strategic goals of the Pharmacy, the needs and expectations of the customers and current sources of information about the service.
5. Continually improve our service in order to provide quality and affordable pharmaceutical care in accordance with the hospital's strategic goals and the needs of the community.

Scopes of Services

Pharmaceutical care is provided to all patients through compounding and dispensing

medication, monitoring of patient medication therapy, provision of medication information to professional staffs, and patient medication education. Specific services may include:

- Establishing policies and practices concerning selection, storage, ordering, dispensing, administering, monitoring, waste and evaluation of effectiveness of medications.
- Identifying high-risk medications and establishing methods to reduce harm.
- Reviewing medication orders for appropriateness and efficacy.
- Evaluating potential medication interactions.
- Packaging, labeling, and dispensing medications and other pharmaceutical preparations to patient care areas consistent with current recommended practices.
- Use of a bar-coded unit-dose automated medication distribution system whenever possible Compounding sterile preparations that meet USP 797/USP 800, federal, and state requirements. Scan barcoded medications during compounding whenever possible.
- Assessing patient medication therapy for potential problems such as adverse drug reactions, drug interactions, inappropriate dose or dosing interval, administration routes, duration and allergy.
- Ensuring rational and appropriate antibiotic therapy based on labs, culture and sensitivity results along with any adjustments to hepatic and renal dysfunction.
- Monitoring, reporting, and assessing adverse drug events.
- Monitor medication use and identify opportunities for improvement in cooperation with the Pharmacy and Therapeutics Committee
- Provide medication therapy management and laboratory ordering/monitoring per protocol under physician collaborative practice agreements.
- Participate in education programs for the staff of the health system.
- Drug accountability for all drugs
- Participation in drug usage evaluations in conjunction with the nursing and medical staff.
- Identification and communication to the appropriate prescriber on patient specific significant drug/drug, drug/laboratory test, drug/food or diet, or drug/disease interactions.
- Provide age-specific and "off-label" drug information to health care providers and patients.
- Evaluation and inspection of emergency drug supplies.
- Participation on multidisciplinary institutional committees to improve overall performance of the hospital.

- Pharmaceutical services will be available by pharmacy staff on a 24-hour basis (on-site or remote)
- For Adult patients, Pharmacy staff shall provide adult unit doses, individual adult intravenous and parenteral nutrition solutions; and shall also provide continuous drug surveillance per Pharmacy Therapeutic Drug Monitoring Policy.
- For NICU/Ped's patients, Pharmacy staff shall provide neonatal unit doses, individual neonatal intravenous and parenteral nutrition solutions, neonatal nutritional products in clearly marked containers and shall also provide continuous drug surveillance per Pharmacy Therapeutic Drug Monitoring Policy.

Types and Ages of Patients Served

The types of patients served are newborn/infant pediatric, young adult, adult, and

geriatric.

Hours of Operation

Pharmacy services are provided twenty-four (24) hours per day, seven days a week, either on-site or via remote services

Staffing

Pharmacy staff may include but not limited to:

- Director of Pharmacy
- Pharmacy Managers and Supervisors
- Clinical Pharmacist Specialists
- Informatics Pharmacist/Pharmacy technician
- Staff Pharmacists
- Certified Pharmacy Technicians
- Pharmacy Technicians
- Pharmacy Clinical Coordinator
- Pharmacy Buyer

The Director of pharmacy services will identify the core staffing requirements of the department and the method used to modify staffing when needed. Workload is monitored and evaluated on an ongoing basis and staffing adjusted.

Staff Development

Educational and training programs are available to pharmacy staff by AHS, area experts and are also provided by the clinical pharmacy staff. Annual competencies and competency exam upon hiring are assigned and assessed. These include topics such as but not limited to:

1. Adult Enteral Nutrition (ASHP)
2. Adult Patients for RPh (ASHP)
3. Adult Patients for Technicians (ASHP)
4. Adverse Drug Reaction Reporting (ASHP)
5. Aminoglycoside Dosing (ASHP)
6. Antibiotic Streamlining (ASHP)
7. Compounding Hazardous Drugs(ASHP)
8. Compounding Nonsterile Preparations (ASHP)
9. Compounding Sterile Preparations (ASHP)
10. Controlled Substances (ASHP)
11. Geriatric Patient for Technicians (ASHP)
12. Geriatric Patient for RPh (ASHP)
13. IV to Oral Therapy Conversion (ASHP)
14. Med Area Inspection (ASHP)
15. Med Dosing Hepatic Dysfunction (ASHP)
16. Med Dosing Renal Dysfunction (ASHP)
17. Medication Safety (ASHP)
18. Neonatal and Infant patients for RPh (ASHP)
19. Neonatal and Infant patients for Technicians (ASHP)
20. Obstetric Patients (ASHP)
21. Oncology Patients (ASHP)
22. Oral Anticoagulant Therapy (ASHP)
23. Pain Management (ASHP)
24. Parental Anticoagulant Therapy (ASHP)
25. Patient Counseling (ASHP)
26. Peds and Adolescent Patients for RPh (ASHP)
27. Peds and Adolescent Patients for Technician (ASHP)
28. Pharmaceutical Waste (ASHP)
29. Psychiatric Medications (ASHP)

30. Repackaging Medications (ASHP)
31. Adult Parenteral Nutrition
32. Aseptic Technique Competency
33. Chemotherapy Technician Test

34. Pharmacy Calculations
35. AHS Controlled Substance Diversion Education

Quality Management (Includes Risk Management and Patient Safety)

Goals

The Quality/Risk Management Department's goal is to continuously improve the hospital's important functions and processes relative to the delivery of safe, quality patient care. The department assures that processes are designed well and that the hospital systematically monitors, analyzes and improves its performance to improve patient outcomes. It has oversight of the Patient Safety Program, proactively fostering a safe environment for all patients, visitors and staff. Additionally, it coordinates the hospital's compliance with regulatory requirements (federal, state and TJC.) The approach to these functions is described in the following organizational documents:

1. Performance Improvement Plan
2. Risk Management Plan
3. Patient Safety Program
4. Medical Staff Peer Review Process

Scope of Services

1. Support of hospital and medical staff performance improvement (P.I.) processes and peer review functions.
2. Measurement, analysis and reporting of hospital wide indicators for benchmarking
3. Organization and leadership support of the Quality and Safety Council, P.I. teams.
4. Management of information as it pertains to P.I. and risk management including the tracking and trending data.
5. Coordination of a proactive process of patient safety that includes:
    a. Encouragement of a non-threatening environment for reporting of errors
    b. Fostering a system to identify, analyze, and implement measures to prevent the occurrence of medical errors
    c. Implementation and ongoing monitoring of TJC National Patient Safety Goals

6. Education of hospital, medical staff and the Board of Trustees in P.I. and patient safety
7. Identification, internal management and prevention of claims.
8. Coordination of all root cause analysis performed for Sentinel events or "near misses."
9. Coordination of annual Failure Mode and Effects Analysis (FMEA.).
10. Leadership of TJC, CPHS, Institute of Medical Quality (IMQ) ongoing survey readiness

Types and Ages of Patients Served

Do not deal directly with patients. Work is with hospital and medical staff, who do work directly with patients.

Hours of Operation

Monday through Friday, 8:00 AM TO 4:30 PM, on call 24/7 for escalation.

Rehabilitation Services

Goals

The Inpatient Rehabilitation Services Department includes the clinical services of Occupational, Physical and Speech therapy. These therapy services provide identification, prevention, and rehabilitation of acute or prolonged physical dysfunction.

Our primary goal is to maximize the functional potential of our patients. We accomplish this goal through:

1. Clinical observation, examination, and assessment
2. Therapeutic interventions, including functional mobility training, therapeutic exercises, neuro-muscular re-education, modalities, adaptive and compensatory.
3. Patient and family education and training to maximize independence.

Scope of Services

The Rehabilitation Department is an integral part of the interdisciplinary team at Highland Hospital. Team members possess the professional expertise and technical knowledge to provide quality, patient-focused care.

Rehabilitation therapy services include, but not limited to the following:

1. The determination and development of treatment goals and plans in accordance with the diagnosis and prognosis, with a treatment program established to aim at preventing or reducing disability or pain and restoring lost function.
2. Therapeutic interventions that focus on functional mobility, ambulation, strength, endurance, cardiopulmonary function, balance, coordination, joint mobility, flexibility, pain management in daily living skills.
3. The application of modalities including but not limited to heat, cold, light, water, sound, electricity, massage, mobilization.
4. Assessment and training in functional mobility and ambulation, including as appropriate, the use of orthotic, prosthetic or assistive devices.
5. Instruction in the use of adaptive devices and compensatory techniques.
6. Instruction in alternative communication strategies, cognitive retraining, and compensatory techniques.
7. Swallowing/feeding skills and compensatory techniques.
8. Patient and family education and training.

Rehabilitation Therapy services therapy staff monitor the extent to which services have met the therapeutic goals of the initial and all subsequent examinations, as well as the degree which improvement occurs relative to the identified physical dysfunction.
Evaluations and daily treatments are documented, and reassessments performed as appropriate. Treatment planning appropriate for each patient based on impairments found in the evaluation, and in coordination with other healthcare team members as needed.
Recommendations for discharge disposition and equipment are provided.

Types and Ages of Patients Served in the Inpatient Acute Care Setting
The Rehabilitation Department provides care to inpatients including newborn, young adult, adult, and geriatric patients.

Staffing
Inpatient Acute therapy coverage is provided seven days per week. Services-as-Needed or Registry staff are utilized as appropriate.

The Rehabilitation Services Department is staffed with the following job classifications:

Manager
Physical Therapists
Occupational
Therapists Speech
Language Pathologists
Physical
Therapy/Rehab Aide
Hours of scheduled services are 8:00 AM – 4:30 PM, 7 days/week

Effective Date		***Date Revised***	
Document Owner		***Next Scheduled Review***	
Executive Responsible			

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

	Policy	
	Hemodialysis Patient Management	**Reference # Version**
	Level ☐ System X☐ Site	**Effective Date:** **Last Review Date**:
	Document Owner: Director of System Admission & Transfer Center (SATC) – System Administrative Services	

POLICY STATEMENT

This policy establishes the framework for the provision of hemodialysis treatments at WC Highland facility, ensuring that all procedures are conducted by qualified personnel and that patient care is coordinated effectively between dialysis nurses, primary nurses, and hemodialysis technicians. It is essential that each role is clearly defined to maintain high standards of safety and quality in patient care.

PURPOSE

The purpose of this policy is to delineate the roles and responsibilities of nursing and support staff involved in the care of patients undergoing hemodialysis. This ensures that all staff are aware of their obligations, promotes teamwork, and enhances the overall quality of care provided to patients, while also addressing patient specific medical and educational needs throughout the treatment process.

SCOPE

This policy applies to all healthcare personnel involved in hemodialysis treatment, including dialysis nurses, primary registered nurses (RNs), hemodialysis technicians (PCTs), and any other staff engaged in the care of patients undergoing hemodialysis. It encompasses all treatment facilities, departments, and processes related to hemodialysis care.

DEFINITIONS

Hemodialysis: A medical procedure that uses a machine to filter waste and excess fluids from the blood when the kidneys are no longer able to perform this function.

AV Graft/Fistula: A surgically created connection between an artery and a vein, used for accessing the bloodstream during hemodialysis

SBAR Handoff: A standardized communication framework used to convey critical patient information effectively (Situation, Background, Assessment, Recommendation).

RESPONSIBILITIES

Dialysis Nurse Responsibilities:

1. The dialysis nurse is responsible for hemodialysis treatment and dialysis-related patient care activities, including but not limited to, assessing, accessing and de-accessing of AV graft, fistula, and shunt, as well as blood transfusion/blood product administration during hemodialysis treatment.
2. The dialysis nurse is responsible for carrying out the dialysis orders/ prescription.
3. The dialysis nurse is responsible for all routine dressing changes for the dialysis access site, during dialysis treatment.
    - 3.1 Dressing changes must be performed and labeled appropriately with Date/Time/RN initials post-dialysis treatment.
    - 3.2 All CVC (central venous catheters) with CHG-impregnated disks, capped ports, and occlusive dressings must be changed routinely every 7 days (or as needed per nurse assessment), provided the dressing remains clean, dry, and intact.

4. **Patient Education**

4.1 Explain the procedure and address any questions.
4.2 Explain the need for careful monitoring of patient during treatment for fluid and electrolyte imbalance.
4.3 Review the hemodialysis schedule with patient/ family/ significant other.
4.4 Review the nutritional requirements, fluid restrictions, and special diet.
4.5 Stress the importance of maintaining the vascular access site (temporary or permanent), and to notify the nurse of any new pain, swelling, and bleeding or sensation changes at the vascular access site.

5. A review of the patient's status with the primary RN or designee must occur prior to and upon completion of the dialysis treatment.
6. Notify the primary RN and physician of any changes in the patient's condition during dialysis treatment, and document the notification in the patient medical record.

Primary RN Responsibilities:

1. The primary RN assigned to the patient is responsible for all non-dialysis patient related activities.
2. A review of the patient's clinical status between the primary RN & the dialysis nurse must occur prior to, and at completion of the dialysis treatment
3. The primary RN provides a handoff report to the hemodialysis nurse using SBAR (see reference) to convey pertinent patient clinical information, including the immediate telephone number of the primary RN or Charge Nurse, or break nurse.
4. The primary RN is responsible for all PRN (as needed) changes of the dialysis access site i.e., dressing is damp, loosened, or soiled, post dialysis treatment.
5. The primary RN is responsible for obtaining daily weights in the morning, and post-dialysis weights of the patient. The primary nurse must document this information in the patient's electronic medical record.

Hemodialysis Technician (PCT) Responsibilities:

1. Receives patient into treatment area; weighs patient if ordered by physician, takes temperature and blood pressure pre- and post-dialysis; documents on all dialysis flow sheets.
2. Performs and records vital signs and all other parameters of End-Stage Renal Disease (ESRD) patients as per hospital policy and/or state regulations; obtains blood samples and culture specimens and prepares them for submission to the lab.
3. Collects patient data: monitors and documents status of vascular accesses, documents patient observations and seeks guidance when levels are out of normal range for ESRD patients.
4. Reviews dialysis prescription notes general physical and mental condition of patient through observation and interview, obtains information and/or data to determine compliance to dietary or medication regimen; documents observations in patient electronic medical record.

RESPONSIBILITIES OF MONITORING AND CARE FOR BOTH PRIMARY RN & DIALYSIS NURSE PER STANDARD OF CARE

Perform thorough baseline and ongoing head-to-toe assessments, every shift, which includes:
1. Check the patency of fistula/graft by auscultating the bruit (swishing sound) and feeling for the thrill (vibration). Notify physician if there is a decrease in access function or patency, or absence of bruit or thrill.
2. Neurovascular status of extremity with fistula or graft i.e., capillary refill, pulses distal to access, color & temperature of extremity, or alteration in sensation such as numbness or tingling.
3. Follow diet & fluid restrictions as ordered.
4. Monitor and document intake and output every shift per standard of practice.
5. Monitor electrolytes, glucose, and other pertinent labs, prior to treatment, per institution policy.
6. Notify Physician for K + (Potassium level) greater than 5.5 and less than 3.5
7. Place a sign above the patient's bed indicating which limb has the vascular access (AV fistula or graft). DO NOT use AV fistula/graft extremity for blood pressures; blood draws or IV access. Do not give intramuscular or subcutaneous medications on the extremity where the dialysis access is located. Do not place ID bands, restraints, constrictive clothing, jewelry, or watches on the extremity where the dialysis access is located.
8. Do NOT hold medication pre-dialysis, unless ordered by the physician.
9. All nursing assessments and interventions must be documented in the appropriate patient medical record.
10. An individualized nursing care plan shall be developed for each patient undergoing hemodialysis treatment.
11. Notify the medical provider of any of the following:
    - 11.1 Acute onset of pain in AV graft or fistula
    - 11.2 Coolness of AV graft/fistula to touch, or loss of bruit and/or thrill
    - 11.3 Abnormal neurovascular (color, sensation, mobility) changes in extremity with AV graft or fistula

POLICY TEXT

1. Patient-Centered Care: All actions taken by healthcare personnel must prioritize the safety, dignity, and well-being of patients undergoing hemodialysis. Care should be individualized, considering each patient's unique medical history, preferences, and psychosocial needs.

2. Collaboration and Communication: Effective communication among the healthcare team members—including dialysis nurses, primary RNs, PCTs, and physicians—is essential for coordinated patient care. Staff are expected to engage in open dialogue, share pertinent information, and collaborate to optimize treatment outcomes.

3. Competence and Professional Development: All personnel involved in hemodialysis must maintain the highest standards of professional competence. Continuous education and training are encouraged to ensure that staff are knowledgeable about the latest best practices, technologies, and guidelines pertaining to nephrology nursing and patient care.

4. Compliance with Standards and Regulations: Adherence to established healthcare standards, institutional policies, and regulatory requirements is mandatory. This includes compliance with infection control protocols, safety guidelines, and ethical considerations in patient care.

5. Respect for Diversity: Recognizing and respecting the diverse backgrounds, beliefs, and values of patients and their families is crucial. Care should be culturally sensitive and inclusive, ensuring that all patients receive equitable treatment and support.

6. Accountability and Responsibility: Each member of the healthcare team is accountable for their actions and decisions related to patient care. Staff must take responsibility for their professional conduct, adhere to established guidelines, and report any concerns or deviations from policy promptly.

8. Patient Education and Empowerment: Providing patients and their families with comprehensive education regarding hemodialysis, treatment plans, and self-care is essential. Empowering patients through knowledge enhances their engagement in their own care and promotes adherence to prescribed regimens.

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ATTACHMENT

DAVITA RN HAND OFF

S	**DATE:**	**PATIENT NAME:**			
	PRIMARY RN NUMBER:	**MD:** **CONSULTING NEPHRO:**	**FROM:**	**ISOLATION:**	**CODE STATUS:**
	DIALYSIS ACCESS: CVC AVG AVF	**WEIGHT:**	**FLUID RESTRICTION:**		
	FALL RISK: **Yes** ☐ **No** ☐ **RESTRAINT/TYPE:**		**SCHEDULED DIALYSIS:** S M T W TH F Sat	**LIST OF ON HOLD MEDICATION:**	
	CURRENT DIAGNOSIS:				
	CURRENT VITAL SIGNS:	**BLOOD PRESSURE PARAMETER:**			
	BP: HR: RR: TEMP: O2 Sat: PAIN:				
B	**MEDICAL HISTORY RELATED TO ADMISSION:**			**LATEST BLOOD GLUCOSE:** **Did Patient receive insulin?** **Y** ☐ **N** ☐ CRITICAL LAB RESULT:	
A	**NEURO: (Alert Oriented/Confused)**				
	RESPIRATORY:				
	Telemetry Order: Y ☐ **N** ☐ **Monitor Tech Notified: Y** ☐ **N** ☐ **Current Cardiac Rhythm:**				
	G/U:	**Foley/Drains:** **Output:**			
	SKIN: WOUND/LOCATION:		**MODE OF TRANSPORT:** **WHEELCHAIR: Y** ☐ **N** ☐ **GURNEY/BED: Y** ☐ **N** ☐		
	LINES/IVF:				
	HEPARIN:				
	LAB TEST/PROCEDURE:				
R	**POST PROCEDURE HAND OFF TO FLOOR RN**		**RN HANDOFF TO TRANSPORTER**		
	Dialysis Complete Date/Time:		Patient Name/Age		
	Current Vital Signs:		Room number being transported to		
	How much fluid was removed?		Primary RN name and Tel number		
	How did patient tolerate the procedure?		Fall risk		
	Any concerns?		Safety Concerns		
	DAVITA RN NAME:				

SATC- Hemodialysis 7/2/2024

ALAMEDA HEALTH SYSTEM

Suicide Risk Management and Prevention Policy

Department	AHS System Policy	**Effective Date**	12/15/25
Campus/System	System	**Date Revised**	11/13/25, 2/2026
Category	System	**Next Scheduled Review**	2/2029
Document Owner	System Director	**Executive Responsible**	Chief Administrative Officer

POLICY:

It is the policy of Alameda Health System to provide care for our patients at risk of suicide and help prevent further harm through prevention and management efforts. The policy outlines AHS expectations for screening assessment, treatment planning, and follow-up care including a safety plan.

PURPOSE:

To establish procedures for identifying and addressing the care of individuals at risk for suicide to minimize or eliminate that risk and maintain patient safety.

SCOPE

This policy applies to all patients of the hospital; applies to all hospital staff members who provide care, treatment, or services for patients at risk of suicide.

DEFINITIONS:

1:1 Observation: Designated care and observation of patient by a staff member who has been trained and determined competent to perform 1:1 observation for suicidal patients. Staff provide visual observation/ monitoring a patient's behavior and habits based on concerns for patient safety.

Suicide risk screening: Process in which a standardized instrument or tool is used to identify individuals who may be at risk of suicide.

Suicide risk assessment: Comprehensive evaluation to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment.

Suicide attempt: A non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicidal ideation (SI): Often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.

Ligature resistant: Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life.

Columbia Suicide Severity Rate Scale (CSSRS): evidence-based suicide screening and assessment tool.

After Visit Summary (AVS): discharge instructions summarizing hospital/department/program encounter; to include individualized patient references for crisis, follow-up care/ services.

"Safety Plan": A prioritized written list of individualized patient coping strategies and support sources for counseling and follow-up care completed during hospital/department/program encounter with patient identified as at risk for suicide that is provided to patient at discharge; for use before or during suicidal crisis. A standardized tool in EPIC.

RESPONSIBILITIES

Conducting the suicide risk screening and suicide risk assessment is the responsibility of qualified staff members who have completed relevant training and education, or have relevant experience, and who have demonstrated competency.

1. Patient interventions and treatment are based upon the results of their suicide assessment and level of risk; not legal hold status (i.e. 5150/5250, conservatorship) or any other factors.
2. Patient Screening and Assessment using Columbia Suicide Severity Rating Scale (C-SSRS), to determine overall suicide risk
3. Hospital Emergency Departments (ED)
   a. Patients (ages 12 and above) presenting to ED will be screened for suicidal ideation.
4. Non-ED Hospital Inpatient Units/ Departments
   c. All hospitalized inpatients will be screened for suicidal ideation.
5. John George Psychiatric Hospital
   a. All patients will be screened for suicidal ideation. See procedure below.
6. The treatment plan and suicide management interventions are carried out until the level of risk has been appropriately mitigated, until discharge or patient transfer.
7. Prior to discharge a Safety Plan is completed and reviewed by provider.

8. The Safety Plan is reviewed with the patient and provided along with the after visit summary (AVS) at discharge.

PROCEDURES

A. Suicide Risk Screening - Qualified staff members do the following:

1. Perform a suicide risk screening for individuals being evaluated or treated for a behavioral health condition as their primary reason for care using a validated tool.
2. Consider one or more of the following components as part of the suicide risk screening:
   a. Primary diagnosis
   b. Primary complaint for admission
   c. Primary symptomology
3. NOTE: collateral, objective information available regarding the patient (for example, if a family member or other support person, emergency medical personnel, documentation of past encounters and/or a practitioner has described the individual as suicidal.) This must be taken into account
4. Document the screening and its results in the individual's medical record.
5. Hospital Emergency Departments (ED)
   a. Patients (ages 12 and above) presenting to ED will be screened for suicidal ideation.
   b. A patient screening positive for suicide risk will be assessed further with the C-SSRS tool to determine severity of risk and suicide ideation focusing on plan, intent, suicidal or self-behaviors, risk factors, and protective factors.
   c. Document Suicide Risk in EPIC and plan of care for awareness.
   d. Patient suicide level of risk and mitigation plan to be documented in EPIC for all clinician's awareness and consideration regarding additional treatment plans.
6. Inpatient Units/ Non-ED Hospital Departments
   a. All hospitalized inpatients will be screened for suicidal ideation.
   b. Any hospital inpatient with a positive suicide risk screen or developing a new active suicide ideation will be further assessed with the C-SSRS tool to determine severity of risk and suicide ideation, focusing on plan, intent, suicidal or self-behaviors, risk factors, and protective factors.
   c.
   d. Immediate escalation to patient's attending physician is required for any observations of suicidal ideation. A consultation with psychiatry may be requested to develop an appropriate treatment plan or referral.
   e. Communication of risk to other providers and services must be done between hand-offs and for general awareness.

f. Patient suicide level of risk and mitigation plan to be documented in EPIC for all clinician's awareness and consideration regarding additional treatment plans.

7. John George Psychiatric Hospital
    a. All patients will be screened for suicidal ideation.
    b. If a new onset of suicidal ideation is identified during Q-shift screeners or clinical assessments, risk level is adjusted based on this new information and further assessments done based on this higher level of risk categorization. *See JGP CSSR Protocol*.
    c. Patients screening positive for suicide risk will be assessed for severity of suicide ideation focusing on plan, intent, suicidal or self-behavioral, risk factors, and protective factors per the CSSR-S protocol.
    d. Psychiatrist will conduct further assessment and develop a plan for care based on the assessment results, including psychiatric treatment and protective measures.
    e. Patient suicide level of risk and mitigation plan to be documented in EPIC for all clinician's awareness and consideration regarding additional treatment plans.

B. Suicide Risk Assessment

If a patient screens positive for suicide risk using the triage/admission screening tool and/or presents with a known or suspected suicide attempt, qualified staff members do the following:

1. Assess the individual's risk for suicide, and complete and document the suicide risk assessment in the electronic medical record, which, at a minimum, includes a suicide risk inquiry of ideation, plan, intent, and suicidal and self-harm behaviors. AHS has implemented the Columbia-Suicide Severity Rating Scale (C-SSRS) as the suicide assessment tool in EPIC.
2. Columbia-Suicide Severity Rating Scale (C-SSRS), levels of risk
    a. Low Risk: Patient presents with vague suicidal ideation, does not have a suicide plan, able to make a commitment to safety and exhibits insight into existing problems.
    b. Moderate Risk: Patient presents with suicidal ideation, verbalizes a concrete plan, ambivalence concerning commitment to safety, observed and/or history of poor impulse control, and minimal insight into existing problems.
    c. High Risk: Patient has attempted suicide and is in imminent danger of implementing suicide plan immediately or in the near future. Behavior includes verbalizing clear intent for self-harm, concrete and viable plan with rescue prevention, delusions of self-mutilation, command hallucinations, unable to commit to safety, poor impulse control, no insight into existing problems, and may include a past attempt via lethal method.

3. Identify specific risk and protective factors, as described in the suicide risk assessment.
4. Determine an overall level of suicide risk: low, moderate, or high.
5. Use the following when completing the suicide risk assessment:
    a. Interview with the individual
    b. Interview with the individual's family or significant other, if applicable and appropriate
    c. Observations of the individual
6. Ensure that the suicide risk assessment, including the level of risk, has been documented in the patient medical record.
7. Initiate suicide precautions that correspond to the patients assessed level of risk.
    a. If the suicide risk assessment indicates that the individual is at **moderate risk** for suicide, qualified staff members initiate suicide precautions per protocol and evaluate with the provider if the patient needs a 1:1 level of risk observation order.
    b. If the suicide risk assessment indicates that the individual is at **low risk** for suicide, the patient is provided a completed Safety Plan at discharge with referrals for follow-up care.
    c. If the suicide risk assessment indicates that the individual is at **high risk** for suicide, qualified staff members implement suicide interventions per protocol.
8. Immediate Precautions for patients at High Risk of suicide
    a. Ensure that the individual's immediate safety needs are met.
    b. Complete the Environmental Checklist.
    c. Notify the admitting or referring physician immediately to request orders for suicide precautions.
    d. Refer the individual for a psychiatry consult
    e. Explain to the individual and, if applicable and appropriate, their family that the individual is on suicide precautions for their safety.
    f. Place the individual immediately on continuous 1:1 observation
        i. 1:1 Observation must be conducted by a qualified staff member. The name of the staff member is documented.
        ii. Observation must be continuous, and the staff member must maintain proximity to the patient to be able to immediately intervene should behavior necessitate such.
        iii. The staff member should be the same gender as the individual whenever possible.
        iv. Family members or other non–staff members may not be used to provide this observation.

v. The staff member should be able to intervene immediately (without delay) if required.

vi. The staff member may be relieved for breaks and meals only by another trained staff member.

C, Suicide Precautions

1. Immediate Precautions for patients at **High Risk** of suicide
   a. Ensure that the individual's immediate safety needs are met.
   b. Complete the Environmental Checklist.
   c. Notify the admitting or referring physician immediately to request orders for suicide precautions.
   d. Refer the individual for a psychiatry consult
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      iii. The staff member should be the same gender as the individual whenever possible.
      iv. Family members or other non–staff members may not be used to provide this observation.
      v. The staff member should be able to intervene immediately (without delay) if required.
      vi. The staff member may be relieved for breaks and meals only by another trained staff member.

2. Environmental Checklist

a. Prior to the individual being admitted to a room, qualified staff members complete an Environmental Checklist to prepare the room by doing the following:

b. Removing all sharp objects

c. Removing unnecessary cables, cords, shoelaces, and equipment

d. Removing the telephone

e. Shortening the call bell so it is not used to cause harm but can still be used to call for assistance

f. Removing bottles or other containers of solutions

g. Removing unnecessary linen

h. Replacing plastic trash can liners with paper ones

3. Placing a sign on the door indicating that visitors must report to the nursing station prior to entering the room

    i. Collect and secure all items from visitors before allowing them to enter the room.

    ii. If the physician orders a “no visitors” policy, no visitors should be allowed to enter the room, in accordance with law and regulation.

4. The charge nurse does the following:

    a. Notifies relevant staff members that the individual is on suicide precautions. Notifies staff members when suicide precautions are no longer in effect.

    b. Suicide precautions can only be canceled by a physician’s order. Plans a room assignment that facilitates observation by unit staff as well as the care attendant.

    c. Meets with the care attendant upon arrival to the unit.

        a. Arranges break and mealtimes.

        b. Verifies that appropriate staff members are available to provide observation during break and mealtimes.

        c. Ensures that the care attendant is knowledgeable on suicide precautions and relevant safety concerns.

    d. Checks periodically to ensure that the care attendant is providing continuous observation.

    e. Notifies Security department staff if the individual’s behavior escalates, such as an increase in disputes and disturbances.

5. The primary nurse does the following during each shift:

    a. Obtains provider’s order for suicide precautions.

    b. Conducts a suicide risk reassessment, according to procedures established in this policy.

    c. Explains suicide precautions to the individual, including items prohibited in the room.

    d. Explains the individual’s plan of care for that shift.

    e. Documents the individual’s behavior, including any changes in behavior.

    f. Collaborates with the care attendant to address the individual’s safety care needs.

    g. Searches the individual’s room and belongings and removes any potentially harmful items and/or contraband.

    h. Explains to the individual that this is being done for their safety.

    i. Inventories and secures any seized items belonging to the individual.

    j. Turns over any contraband to Security department staff.

k. Documents the search, including the following details:
    i. Scope of search
    ii. Reason for search
    iii. Description of any items seized
    iv. Account of disposition of seized items
l. Prohibits visitors from entering the room of an individual with a “no visitors” order from a physician.
m. Collects and secures all items from visitors.
n. Returns collected items to visitors when they leave the individual’s room.
o. Searches packages delivered to the individual, either by visitors or by outside organizations.
    i. Obtains the individual’s consent to search the package.
    ii. If consent is not granted, the package will not be allowed into the individual’s room.
p. Removes any potentially harmful items or contraband from the package.
    i. Secures seized items with the individual’s other belongings.
    ii. Turns over any contraband to Security department staff.
q. Observes the individual as they take medications.
    i. Checks the individual’s mouth to ensure medication was swallowed.

6. The 1:1 Observer provides constant 1:1 observation of the patient for safety.
    a. Works closely with the RN and Charge Nurse to communicate patient’s current and ongoing needs and asks for assistance when needed
    b. Anticipates patient needs including placing non-harmful useful items around patient and providing companionship as well as observation
    c. Accompanies and remains with the patient for any clinical tests or procedures off the unit.
    d. Remains within line of site of the patient, including observation of patient while in the bathroom
    e. Receives direction from RN regarding when to seek RN assistance or escalation
    f. Receives handoff from the off-going staff assigned to patient
    g. Directs family/friends to patient’s primary nurse if asked for updates on patient’s condition
    h. Documents all patient activities in the EMR on the appropriate flow sheet or on applicable paper form every 15 minutes.
2. Family members may not be used to provide this observation.

Safety Plan

1. A Safety Plan is a prioritized written list of coping strategies and sources of support patients who have been deemed to be at risk for suicide can use to help decrease suicidal behavior after the patient leaves the care of the organization.
2. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient's own words, and is easy to read.
3. The Safety Plan is initiated during the treatment encounter for patients identified at risk for suicide. Reviewed on an ongoing basis during admission/encounter. Must be completed prior to discharge.
4. It is developed with the patient, through collaboration with clinicians.
5. Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.
6. The Safety Plan is documented in EPIC.
7. The Safety Plan must be reviewed by the Attending Provider prior to discharge, and this is documented by the provider in EPIC.
8. A copy of the Safety Plan is reviewed with the patient and a copy provided to the patient at discharge with the after-visit summary (AVS) which includes the National Suicide Hotline contact information.

Staff Education Suicide Prevention

1. Role-specific education will be provided upon hire and annually thereafter for all relevant staff.
2. Staff education on suicide prevention ideation to include:
   a. Initial Suicide screening
   b. Assessment using C-SSRS tool
   c. Environmental risk assessment for suicidal patients
   d. Patient monitoring (1:1) for patients who are at high risk for suicide)
   e. Instruction on how to complete a patient Safety Plan
3. All staff members who screen, assess, provide care for, monitor, transport, and/or have contact with patients at high risk for suicide do the following:
   a. Demonstrate competency in performing job-related tasks associated with screening, assessing, providing care for, and/or monitoring patients at high risk for suicide.
   b. Participate in all relevant ongoing education and training upon hire, annually thereafter, and when opportunities are identified.

Quality Assurance Monitoring

1. AHS will monitor the effectiveness of policies and procedures for screening,

assessment, and management of patients at risk for suicide and act as needed to improve compliance.

2. Monitoring data will be shared with the organization's Quality Safety committee (QSC) a minimum of twice a year.
3. Monitoring data will include:
   a. Compliance rate of Suicide screening, assessment documentation
   b. Completion of a treatment plan, Safety Plan for patients identified at risk for suicide – documented in the medical record

Attachments

- Sample 15-minute 1:1 Observation form
- Safety Planning Guide "A Quick Guide for Clinicians" (reference)
- Environmental Safety/ Risk Reduction room checklist (sample)
- 1:1 Observer Tip Sheet (reference)

References

- The Joint Commission Requirement, Rationale, reference (Suicide Prevention) NPSG **15.01.01**
  - r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf (jointcommission.org)
- VA Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (VA_Safety_planning_manual.doc (live.com)
- CDC
  - https://www.cdc.gov/suicide/facts/index.html
- Columbia-Suicide Severity Rating Scale (CSSRS) reference Columbia Lighthouse Project

  The Lighthouse Project The Columbia Lighthouse Project

Date: _____

IMMEDIATELY REPORT ALL "GREYED" OBSERVATIONS TO PATIENT'S PRIMARY NURSE

Reason for Observation: _____ Room Searched: _____ Utensils counted after meals: ☐ B ☐ L ☐ D ☐ S

	Visual Appearance									Behavior																Medical Concerns	Reporting	
	Hostile	Angry	Guarded	Tense	Fearful	Sad	Worried	Calm	Friendly	Agitated	Labile	Threatening	Self-Injuriuos	Suicidal	Anxious	Confusion	Responds to internal stimuli	Sexually Inappropriate	Composed	Appropriate for situation	Interacting W staff/visitors	Sleeping	Bathroom	Meal at Bedside	Visitor at Bedside	Note any patient medical concerns or symptoms to the nurse. (Concerns may include, but not be limited to: Vomiting, Seizure, SOB, CP, Diaphoresis, Pain, Not eating, Chest Pain)	RN (initials) RN to initial every 2 hours and PRN as per patient behavior.	Staff Initials
0000																												
0015																												
0030																												
0045																												
0100																												
0115																												
0130																												
0145																												
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0730																												
0745																												

SAMPLE

Comment if a pattern is observed with any of the behaviors (ex. noted during: staff care provision, family visitation, watching TV, etc).

Observer	Initials	Time	Comments

ALAMEDA HEALTH SYSTEM

1:1SUICIDE PRECAUTIONS OBSERVATION

02/1 R

- For methods with **low lethality**, clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a **highly lethal method**, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

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WICHE

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Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

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Western Interstate Commission for Higher Education

SPRC
SUICIDE PREVENTION RESOURCE CENTER

Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suidical again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

ALAMEDA HEALTH SYSTEM

Suicidal Precautions Environmental Checklist Date: _____

Precaution to be implemented and validated at each shift. If unable to implement, note reason in comments.	**Time: Initials:**	**Time: Initials:**	**Time: Initials:**
Maintain continual visual contact with patient, including when using the restroom.			
Bathroom door is closed locked when not in use.			
Staff educated that the patient must be monitored while using restroom, including grooming and bathing.			
Account for all linens, remove from room immediately after use – No extra linens in room.			
No fitted sheets.			
All non- essential and/ or detachable equipment / supplies not needed for on-going patient care are removed from room.			
All cords, including call lights, not needed for on-going patient care are removed or secured.			
Remove from the room all of the patient's clothing, jewelry, shoes, belongings – send them home with family if at all possible.			
Dietary department is notified to use paper, Styrofoam and plastic utensils. Utensils accounted for after each meal.			
Check for any weapons, sharp objects, or metal objects in the patient room.			
Visitors are not allowed to give ANY items to the patient, unless approved by the RN.			
For line of sight patients only – observe in room and remove immediately any sharp objects used for ADL; prohibited for 1:1 patients.			
Plastic trash and linen bags are removed.			
Sharps containers are removed and / or secured.			
Gloves and glove boxes are removed, use an isolation cart outside of door if gloves are needed.			
Windows do not open.			
Assure the room does not have extra supplies, equipment, or devices that are sharp, metal or plastic.			
Assure the 15 minute check list is completed.			

Comments:

RN Printed Name: _____ RN Signature:_____

RN Printed Name: _____ RN Signature:_____

RN Printed Name: _____ RN Signature:_____

SAMPLE

ALAMEDA HEALTH SYSTEM

TIP SHEET FOR 1:1 OBSERVATIONS

The 1:1 Observer performs the following to help manage patient risk of harm:

1. Reports to charge nurse at the beginning of each shift to get instructions and begin continuous observation.
2. Documents observation on an hourly basis.
3. Communicates with the primary and/or charge nurse at break times to ensure a qualified staff member is available to continue observation.
4. Introduces themself to the patient and explains the following:
    a. How long they will be with the individual
    b. How they will meet the individual's needs
5. Keeps the patient within continuous visual contact at all times.
    a. Continuous visual contact applies even when the patient is using the bathroom.
6. Keeps the room door and bathroom door open at all times.
7. Remains alert at all times.
    a. Notifies the primary and/or charge nurse if they become sleepy and require another staff member to relieve them **for any reason or period of time**.
8. Refrains from reading or watching television.
    a. The TV may be on only if the patient requests it.
9. Remains between the patient and the door at all times.
10. Checks the individual's meal tray before and after the patient eats.
    a. Ensures that the tray contains only paper or plastic ware.
    b. Ensures that all ware, including approved utensils, are returned to the tray and removed from the room or discarded.
    c. Immediately notifies the primary nurse if any items are missing from the tray.
11. Accompanies the patient to all tests and procedures off the unit/ outside the department.
    a. Notifies the primary and/or charge nurse before leaving the unit with patient.
    b. Remains in the room with all visitors. Refers visitors to the primary nurse for information.
12. Refrains from discussing the patient with anyone except the individual's caregivers.
13. Steps outside the room, but remains outside the room, when providers are examining the

individual, if requested to do so.

14. Notifies primary nurse and qualified staff members immediately when changes in the individual's behavior are observed.
15. Notifies the primary nurse when the patient engages in behavior that requires immediate attention, including but not limited to the following:
    a. Pulling at intravenous lines or tubes
    b. Pulling at restraints
    c. Giving verbal threats and/or yelling
    d. Refusing to comply with requests
16. Requests assistance if harm to the patient the care attendant is imminent.
17. Informs the patient of task they are going to perform before doing it.
18. Promotes a safe and caring environment. Remains calm and speaks in a quiet, soothing manner
19. Maintains confidentiality.
20. Refrains from wearing hair down and from wearing any items that could be used to harm the patient or staff members, including but not limited to the following:
    a. Dangling earrings
    b. Neckties
    c. Ink pens around the neck
    d. Lanyards?
21. Helps ensure that no potentially dangerous items are left in the room by other staff members, including but not limited to the following:
    a. Tourniquets
    b. Syringes
    c. Needles
    d. Chemical cleaners or spray cans

ALAMEDA HEALTH SYSTEM

AHS RESTRAINTS AND SECLUSION IN ACUTE CARE POLICY AND PROCEDURE

Campus	AHS System	***Effective Date***	09/2016
		Date Revised	05/2016, 05/2019, 04/2020, 3/2023, 2/2026
Document Owner	System Director, Regulatory Affairs	***Next Scheduled Review***	02/2029
Executive Responsible	Chief Nurse Officer		

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

approval

PURPOSE

1. To provide guidance for use of restraints and/or seclusion while maintaining patient safety and dignity.

2. To assure that patients are free from restraints and/or seclusion, of any form imposed as a means of coercion, discipline, convenience, or retaliation.

PHILOSOPHY

Each person's safety is important for successful treatment. It is the goal of Alameda Health System to reduce the use of restraints and/or seclusion. If a patient's behavior poses an immediate danger to others or self and all non-physical interventions have failed, brief episodes of restraint or seclusion may be necessary to maintain a safe environment for treatment. Trained staff will make efforts to limit episodes of restraint or seclusion to the least amount of time possible. Every effort is made to preserve the safety and dignity of all staff and patients.

POLICY

It is the policy of Alameda Health System to limit the use of restraints and/or seclusion to situations where less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. It is also our policy to limit the use of restraints and/or seclusion for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

GENERAL GUIDELINES

Patient and family will be provided restraint and seclusion education information, as applicable. The reason for restraint and/or seclusion use will be explained.

Restraint and seclusion are each a temporary measure. The use of restraints and/or seclusion is an exception to care, and will be based on an assessment of individual need. Attempts to discontinue restraints and/or seclusion will be considered with each observation.

Restraint and/or seclusion use initiation will be communicated to the Nurse Manager/Director, House Supervisor, and/or Charge Nurse. (**Note**: This is not required at John George Psychiatric Hospital.)

A Licensed Practitioner (LP) or qualified Registered Nurse will conduct restraint/seclusion needs assessment and reassessments to determine the justification for the restraint/seclusion and to select the appropriate restraint. Application, removal and monitoring may be delegated to other clinical staff that has had the appropriate training.

Restraint/seclusion initiation on a patient for staff convenience, to coerce or discipline a patient, or as a method of retaliation is strictly forbidden across Alameda Health System.

DEFINITIONS

1. Licensed Practitioner (LP) is an individual authorized by the state to provide health care services, including physicians (MD/DO), physician assistants (PAs), nurse practitioners (NPs), Clinical Psychologists.

2. **Physical Restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his arms, legs, body, or head freely. Unless otherwise specified, all uses of the word "restraint" in this document refer to physical restraint.

3. **Convenience** refers to any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.

4. **Discipline** refers to any action taken by the facility for the purpose of punishing or penalizing residents.

5. **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others. **NOTE: THE SAME POLICIES, PROCEDURES, AND GUIDELINES THAT GOVERN THE USE OF RESTRAINT BELOW ALSO GOVERN THE USE OF SECLUSION. SECLUSION AREA IS AVAILABLE AT JOHN GEORGE PSYCHIATRIC HOSPITAL ONLY.**

6. **Administrative Law Enforcement Restraints** are restraints applied by the law enforcement agency. Administrative law enforcement restrains will be honored, unless care is compromised. Only law enforcement staff can administer or remove these types of restraints. Their use is governed by Federal and State law and regulations. Typically these are handcuffs, manacles, shackles, or other restraint devices. (**Note:** The use of handcuffs or other restrictive devices applied by law enforcement officials is for custody, detention, and

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public safety, and is not involved in the provision of patient care. Therefore, the use of restrictive devices applied and monitored by law enforcement officials are not considered restraints for purposes of this document.)

The following devices and methods are not restraints:

1. **Adaptive/Protective Devices**, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examination or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

2. **Side Rails** are not restraints when:
   - used to protect or prevent the patient from falling out of bed, unless all four side rails are raised with the intent to restrain the patient;
   - used with gurneys to prevent patient from falling off;
   - used with a patient who is recovering from anesthesia, sedated, experiencing involuntary movements, or on therapeutic beds/mattresses;
   - used for a patient who on a bed that constantly moves to improve circulation or prevent skin breakdown; or
   - padded and raised for seizure precautions.

3. **Medically Necessary Immobilization for Procedures** is the use of any usual and customary device for medical, diagnostic, or surgical procedures. These mechanisms usually include arm boards during intravenous therapy, gurney, or exam table straps or belts, use of body restraints during circumcision or the restriction of movement post-operative/post-anesthetic care patient until they are cognizant.

4. **Immobilization Devices** in use during post-anesthesia care are considered part of the surgical procedure and are not considered a restraint. This post-anesthesia care can occur in ICU, the PACU, or on a nursing unit.

MEDICARE STANDARDS

The Medicare Conditions of Participation have delineated standards for the use of restraints. These standards are not specific to the treatment setting, but to the situation for which the restraint is being used to address. The following are definitions and examples of the two standards.

1. **Indications for Restraint of the Non-Violent, Non-Self Destructive Patient**
   Medical restraints are used to ensure the safety of the non-violent or non-self destructive patient. The decision to use a medical restraint is determined by a comprehensive individual patient assessment to identify medical problems that may be causing behavior changes in the patient. For example, fever, hypoxia, UTI, sepsis, hypoglycemia, electrolyte imbalances, drug interactions, drug side effects, and thyroid problems, may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the use of restraints. Patients are restrained only when essential and after less restrictive alternative interventions have been considered and deemed ineffective. Patients

may be restrained in the following situations:

a. To protect patients who attempt to remove therapeutic medical devices such as peripheral intravenous lines, central lines, endotracheal tubes, gastric tubes, catheters, drains, dressings, and other medical devices.
b. Patients who, due to an acute or chronic confusional state (such as traumatic brain injury or delirium) are unable to follow and thus continue to remove therapeutic devices.
c. **Examples:**
    i. A patient with Alzheimer's disease requires IV therapy but is unable to remember why the IV is in his arm and make numerous attempts to remove it. He cannot be diverted by other means and is restrained to protect the infusion.
    ii. A confused patient with a fractured hip is attempting to get out of bed and compromising his hip precautions. Other efforts to remind, and distract him have been unsuccessful. He is restrained to preserve the hip precautions.

2. **Indications for Violent Restraint Use**
   Restraint for a patient with violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or other, is necessary when an unanticipated outburst of severely aggressive or destructive behavior occurs that poses an imminent danger. For example:
    a. A patient with Alzheimer's disease has a catastrophic reaction where he/she becomes so agitated and aggressive that he/she physically attacks a staff member. He cannot be calmed by other methods. He/she is restrained to manage behavior, which is dangerous to him, staff and others.
    b. An intoxicated patient in the emergency department becomes suddenly aggressive and violent and strikes out at staff as he/she tries to elope from the unit. He will not respond to attempts to reassure and calm him. He/she is restrained to manage behavior, which is dangerous to himself, staff or others.

Note: At John George Psychiatric Hospital, a patient is only restrained if he/she is a danger to self. Patients who are a danger to others are secluded/not restrained.

ALTERNATIVES TO RESTRAINT

Alternatives and nonphysical interventions are less restrictive interventions and must be attempted and determined to be ineffective to protect the patient and/or others from harm *prior to the application of restraints*.

1. Psychological Alternatives
    a. Provide pain relief/comfort measures
    b. Schedule position changes
    c. Assess medications to determine if a medication may be contributing to or may alleviate the underlying problem
    d. Alter treatment regiments, e.g., saline or heparin lock vs. continuous IV when it is not necessary for hydration

e. Promote patient's normal patterns for eating, sleeping, toilet
f. Provide sensory aids (glasses, hearing aids) to prevent misinterpretation of cues in the environment
g. Ambulate
h. Foods/Fluids offered

2. Environmental Alternatives
   a. Move the patient closer to the nurse's station for increased supervision
   b. Increase lighting to compensate for vision loss, use night lights.
   c. Decrease extraneous noise to provide a more restful environment

3. Least Restrictive Alternatives
   a. Bed alarm
   b. Lap belt
   c. Abdominal Binder
   d. Distractions (television, music, movies, games, art work, journaling, etc.
   e. Companionship (staff or family stay with the patient)
   f. Low bed
   g. Toileting
   h. Massage/Back rub
   i. Comfortable positioning
   j. Decreased Stimuli

RESTRAINT PROCEDURE

STEP 1: Conduct initial restraint assessment of the patient for whom . Document the clinical assessment, including:

a. Specific behavior which is interfering with medical care or posing an imminent danger to patient or others.
b. Identification of underlying causes, *i.e.*, hydration, nutrition, bowel and bladder function, abnormal labs, medications, pain, etc., your intervention to correct and patient response to the intervention.
c. Which alternatives were attempted and their effectiveness. (**Note:** The use of restraints for the prevention of falls should not be considered a routine part of a fall prevention program.) The assessment should be conducted by a Licensed Practitioner (LP) or a qualified Registered Nurse.

STEP 2: Implement a written patient's plan of care for the use or restraints.

STEP 3: Notify Licensed Practitioner (LP), if not currently aware, and obtain order.

STEP 4: Notify Charge Nurse/Nurse Manager/Director and/or Nurse Supervisor.

STEP 5: Decide which type of restraint is least restrictive for the situation to be effective to ensure the patient's well-being is maintained, if alternatives have been ineffective.

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STEP 6: If restraint use is for management of violent behavior that jeopardizes the immediate physical safety of the a patient, a staff member, or others, a face-to- face evaluation of the patient must be conducted by a Licensed Practitioner (LP) trained in conducting face-to- face evaluation, within one (1) hour of the initiation of the restraint. Document the one (1) hour face-to-face in the medical record, which should include the following:

a. The patient's immediate situation/condition or symptoms that warranted the use of restraints.
b. The patient's reaction/response to the intervention
c. Alternatives or other less restrictive interventions attempted (if applicable)
d. The patient's medical and behavioral condition
e. The need to continue or terminate the restraint.

GUIDELINES

1. Use of restraint must be in accordance with the order of a Licensed Practitioner (LP) who is responsible for the care of the patient and approved per hospital policy to order restraint.

2. All orders for restraints must be time-limited. Restraint orders shall never be written as standing orders or PRN (as needed) orders. The order must include the type of restraint to be used, the reason for the restraint, and the length of time the restraint is to be utilized.

3. **The order for use of restraint must be for a specified period of time:**
   - For non-violent behavior restraint use, the provider must reassess the patient and write a new order daily.
   - For violent behavior restraint use, a physician or other authorized licensed practitioner primarily responsible for the patient's ongoing care sees and evaluates the patient every 24 hours
     - orders expire based on age and must be renewed prior to expiration
       - 4 hours patients > 18 years old
       - 2 hours patients 9-17 years old
       - 1 hour for children < 9 years old

4. For non-violent behavior restraint use, an RN should notify the provider of patient condition requiring restraints and obtain an order unless the need is emergent. In emergent cases, the RN should IMMEDATELY notify the provider and obtain a restraint order after application. A physician order for restraint must be obtained and a telephone order must be countersigned by the physician within 24 hours of restraint initiation.

5. Implementation of a time-limited order for restraint does not require application of the intervention for the entire period. If the patient demonstrates reduction in the activity/behavior that led to the restraint, restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

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Restraint Orders for Management of Violent Behavior

1. In addition to the above standards, if restraint use is for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, a face-to-face evaluation of the patient must be conducted by a Licensed Practitioner (e.g., M.D., D.O., NP, PA, Clinical Psychologist).

2. In an emergency where the patient can reasonably be expected to immediately bring harm upon him/herself or others, an RN who is qualified by experience and training is authorized to initiate the use of restraint. After restraint application, the RN IMMEDATELY (within a few minutes) notifies the Licensed Practitioner (LP) and obtains a restraint order.

3. Within one (1) hour of restraint application, a face-to-face evaluation of the patient must be conducted by a Licensed Practitioner (LP) and an order obtained.

Time Limitations for Restraint Orders for Management of Violent Behavior

1. The order for use of restraints for management of violent behavior must be limited to:
    a. Four (4) hours for adults
    b. Two (2) hours for children 9 – 17
    c. One (1) hour for children under 9

2. The original order may specify that an RN may reassess the patient at indicated intervals and request that the physician continue the original order for an additional:
    a. Four (4) hours for adults
    b. Two (2) hours for children 9 – 17
    c. One (1) hour for children under 9

Application of Restraints

1. To assure that patient rights, dignity, and well-being are protected, select and obtain the least restrictive restraint with the maximum freedom of movement, while ensuring the physical safety of the person and others, and using the least number of restraint points. Ensure that it is the appropriate size consistent with the patient's stature.

2. Some of the following types of restraining devices available at Alameda Health System include:
    a. Mittens
    b. Lap/seat belts
    c. Full use of Bedrails
    d. Limb
    e. Trays with spring release devices (geri-chair)
    f. Waist Roll Belts
    g. Freedom Elbow Splints
    h. Twice as Tough restraints

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3. Position the patient to maintain correct body alignment, prevent aspiration, and promote comfort.

4. Apply the restraint correctly and allow the maximum freedom of movement possible while maintaining effectiveness.
    a. Limb:
        i. Do not impede flow of IV infusion or arterial line
        ii. Never use restraints proximal to an AV fistula shunt
    b. Belt:
        i. Avoid tight application that could interfere with breathing

5. Secure restraints by a quick release method that provides for easy removal in the event of a fire or other emergency.

Note: Restraints designed for bed use should be secured to a non-movable or fixed portion of the bed frame. **NEVER** tie the restraint to the mattress, side rails, or moveable portion of the bed frame.

<u>Documentation, Monitoring, and Reassessment</u>

1. Document date, time, and type of restraint.

2. Re-assess the patient immediately following application to ensure restraints were properly and safely applied. Assess for injury, physical and psychological status and other needs.

3. Update the patient's Interdisciplinary Care Plan to include the use of restraints.

4. Monitor patients in restraints for violent behavior every fifteen (15) minutes. Staff monitoring the patient should consider or address the following items **every fifteen (15) minutes** :
    a. Signs of injury associated with the application of restraint.
    b. Need for Nutrition/hydration
    c. Range of motion in the extremities, position change, discoloration or other changes in
    d. appearance of skin or extremity
    e. Hygiene and elimination
    f. Behavior and signs of discomfort
    g. Readiness for discontinuation of restraint
5. Restraint Assessments should be done by the RN every two hours until discontinued

Note: Patients in restraints for violent behavior must be continually monitored face-to-face by an assigned, trained staff member.

5. Provide the patient as soon as medically reasonable with the rational for restraint and the behavior criteria for its discontinuation. (For example: Patient able to comply with safety requests, patient oriented to environment, and/or cessation of verbal threats).

6. Provide patient and family with restraint education information and explain the reason for restraint use and why alternatives are not effective. Reassure them that the restraint will be removed as soon as feasible. Document the patient/family education.

7. All patients requiring restraints should be monitored to:

    a. Assess for release of restraints
    b. Evaluate the patients physical and mental status, emotional, and physical well- being
    c. Assess circulation, skin condition
    d. Provide exercise or range of motion and allow for position changes
    e. Determine Nutritional, Hydration, Hygiene, and Elimination Needs

8. Document reassessments for continued need in the medical record and/or on the appropriate restraint documentation form.

9. Evaluate and document the use of alternatives, less restrictive methods and release of restraint with every observation. Look for changes in behavior or clinical condition which would allow the removal of restraints.

10. Order for restraint renewal for non-violent restraints is required each calendar day

11. Document the date, time, condition of the patient in the medical record when restraints are discontinued.

12. If restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to re-initiating restraints, but within one (1) hour of reapplying the violent restraints, and all the requirements met to re-start the restraints.

13. Update the electronic medical record or restraint log every shift. At John George Psychiatric Hospital this is a “denial of rights log”.

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MONITORING REQUIREMENTS DURING SIMULTANEOUS USE OF RESTRAINT AND SECLUSION

In the rare circumstance that simultaneous use of restraint and seclusion is deemed necessary, the patient must be continually monitored face-to-face by an assigned, trained staff member or by trained staff using both video and audio equipment that is in close proximity to the patient for the duration of the restraint and seclusion episode. The assessment, reassessment, and documentation requirements outlined above remain applicable.

STAFF TRAINING REQUIREMENTS FOR RESTRAINTS

1. Qualified Staff
   a. Practitioners authorized to order restraints at a minimum, will have a working knowledge of the hospital policy regarding the use of restraint.
   b. Staff members applying restraints, monitoring, assessing, and providing care for a patient in restraint, shall be trained and able to demonstrate competency prior to performing these actions.

2. Training and competency evaluation for staff with direct patient contact will occur at orientation, before participating in the use of restraint and on periodic bases thereafter. Training and demonstration will focus on the following:
   a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require restraint;
   b. The use of non-physical intervention skills;
   c. Choosing the least restrictive intervention based on an individuated assessment of the patient's medical or behavioral status or condition.
   d. The safe application and use of all types of restraints used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (e.g., positional asphyxia);
   e. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary;
   f. Monitoring the physical and psychological well-being of the patient who are restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and special requirements specified for 1 hour face-to-face evaluation;
   g. The use of first aid and current certification in the use of CPR.

      Note: Physicians and RNs and those staff under their direct supervision do not require first aid certification.

3. Documentation of training and competency will be maintained in the staff personnel record.

4. On occasions where additional help with restraint application is needed, other non-clinical staff may only assist following the specific directions of clinical staff.

5.

REPORTING REQUIREMENTS

A patient death must be reported if it occurs in one of three specific circumstances:

1. During the application of restraint or seclusion.

2. Within 24 hours of the patient being removed from restraint or seclusion.

3. Within one week of removal, if it is reasonable to assume the restraint or seclusion contributed to the death. "Reasonable to assume" includes, but is not limited to, death related to restriction of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

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a. Exception: An important exception exists. If only 2-point soft wrist restraints were used for medical purposes (and no seclusion was involved), the facility should log the event internally within 7 days instead of submitting a report to CMS.

The report must be filed by the close of the next business day after the hospital learns of the patient's death. All reports must be submitted electronically to the appropriate CMS Regional Office.

The patient care department is to IMMEDIATELY (within 2 hours following knowledge of death) notify Risk Management and Regulatory Affairs to report and for assistance with reporting.

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PERFORMANCE IMPROVEMENT MONITORING

The goal of Performance Improvement is to identify the underlying causes for restraint use and with this understanding to evaluate and reduce the use. Alameda Health System collects, analyzes, and evaluates aggregate restraint use data on all restrain episodes to define ways to establish a baseline and to reduce the risk associated with restraint use through preventive strategies, alternatives to restraint use and process/care redesign improvements.

Attachments

1. AHS Restraints Decision Tree
2. AHS Restraints Use Algorithm

REFERENCES

1. The Joint Commission: PC.03.05.01- PC .03.05.19

2. California Code of Regulations: 9 CCR § 865.4; 22, CCR §§ 70059, 70577

3. CMS Conditions of Participation: 42 CFR § 482.13 (e) - § 482.13 (g)

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	N/A	04/2020	04/2020
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	08/2020 03/2023	N/A	N/A
Medical Executive Committee	**Date:**	N/A 03/2023	08/2020	08/2020
Board of Trustees	**Date:**	09/2020 3/2023	N/A	N/A

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ALAMEDA HEALTH SYSTEM

RESTRAINTS DECISION TREE/ ALGORITHM

	Restraint for Non-Violent Behavior	Restraint for Violent Behavior
Situation	• Used to ensure the physical safety of the non-violent patient who is interfering with necessary medical and/or nursing care (pulling needed lines/tubes) or compromising safety (high fall risk), when alternative interventions are unsuccessful. ○ Patient with memory loss/ dementia and has an unsteady gait or impulsive behavior. ○ Immobilization to keep confused or sedated patient from removing Medical devices (e.g., IV, endotracheal tube, catheter, etc.) or climbing out of bed Mittens, elbow extenders, or soft limb holder ○ *Note:* indwelling catheters/tubes can cause a patient to be agitated. On a daily basis, evaluate for medical necessity and remove when possible	• Used to manage violent or destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others. ○ Patient presents with severely agitated or paranoid behavior, threatening to harm self ○ Includes physical devices, physical holds, and medication. ○ e.g. Soft limb holder, ○ Medications if not indicated by patient (Haloperidol & other antipsychotics) ***NOTE:*** *Emergency application of restraint (i.e. when need for restraint intervention occurs so quickly that provider order cannot be obtained prior to application), RN may initiate restraint use. After patient's and/or staff's safety is ensured, order for restraint must be obtained from the physician/LIP either during the emergency application of the restraint, or IMMEDIATELY (within a few minutes) after restraint is applied.*
OBS Frequency	**Patient MUST be assessed at least every 2 hours,** or more frequently as indicated by patient condition	Patient MUST be under continuous observation **and documenting of observation every 15 minutes**
Required Nursing Assessment	**Patient MUST be assessed at least every 2 hours**	Patient MUST be assessed every 2 hours or more frequently as indicated by patient condition
Required Provider (LIP) Assessment	Requires face-to-face and medical assessment within 24 hours of restraint application **with documentation of ongoing need**	Requires face-to-face and medical assessment within 1 hour of restraint application **with ongoing documentation**

Updated 03 2023

Restraint Use Algorithm (UPDATED 01/2026)

A restraint is any manual method, physical or mechanical device, material or equipment that immobilized or reduces the ability of a patient to move his/her arms, legs, body or head freely. A drug is also a restraint when used solely to manage behavior or restrict the patient's freedom of movement & is not standard treatment or dosage for the patient's condition.

Is the patient exhibiting behavior that may require restraint?

Yes

Assess & document use of alternative or less restrictive interventions that were attempted
Review Appendix C: Examples of Alternative Interventions and Less Restrictive Devices

Were less restrictive alternatives and/or interventions effective?

Yes → **Continue to Monitor**

No

Non-Violent Restraint Use: For patients who are **NOT** demonstrating violent behaviors and are demonstrating behaviors such as: confusion, impulsiveness, agitation; pulling at lines, tubes, and dressings.

(Review Appendix A&B)

MD Order / Renewals:

Restraint order will be obtained and **renewed by the end of the next calendar day** after MD assessment

1. Notify Physician of Patient's Condition
2. Obtain a Restraint Order

OR

For ***emergent situations***,

1. The RN applies restraints, assesses patient's condition,
2. **IMMEDIATELY** notifies physician of patient's condition & restraint application (SBAR documentation)
3. Order is **IMMEDIATELY** documented

Violent Restraint Use:

For patients that **ARE** demonstrating violent behaviors such as: combative, destructive; hitting, kicking.

MD: **Perform the comprehensive Face-to-Face restraint assessment within 1 hr.** of initiating restraint. **MD Order / renewals:** The RN notifies physician of patient's condition (SBAR) and obtains an initial age specific order and renewal order prior to the previous restraint order expiration, if still indicated.

4 hours patients > 18 years old
2 hours patients 9-17 years old
1 hour for children < 9 years old

MD must assess the patient q 24 hrs. if this restraint is still needed
See Assessment and Monitoring Components

Non-Violent Restraint Patient Monitoring

Patient Assessment at initiation & Monitoring at least q 2 hrs. until discontinuation

See below for Assesssment and Monitoring components.

Violent Restraint Patient Monitoring:

- **Visual checks of patient are ongoing**
- **Patient MUST be under continuous observation and documenting of observation every 15 minutes is required.**

Assessment and Monitoring components to be performed by RN:

- Level of distress and agitation, mental status, cognitive functioning
- Circulation of all restrained extremities
- Comfort and care needs (such as)
  1. nutrition,
  2. hydration
  3. elimination needs
  4. release of restraint and Range of motion of restrained limbs (q 2 hrs. for both types of restraint)
- Assessment of the readiness for discontinuing the restraint.

ALAMEDA HEALTH SYSTEM

AHS EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Department	Emergency Department, Nursing, Medical Staff, Family Birthing Center	***Effective Date***	02/2026
Campus	AHS System	***Date Revised***	10/2011, 12/2014, 12/2017, 10/2020, 01/2026
Category	Clinical	***Next Scheduled Review***	01/2029
Document Owner	Director, Critical Care Services	***Executive Responsible***	Chief Administrative Officer/Chief Nurse Executive

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

SCOPE

The scope of the EMTALA policy and procedure includes all affiliated facilities of Alameda Health System (AHS) healthcare system, including Dedicated Emergency Departments (DED's), outpatient units, and any entity operating under the hospital's license.

POLICY

It is the policy of the AHS healthcare system to provide an appropriate Medical Screening Exam (MSE) to individuals presenting to a DED and requesting examination or treatment of a medical condition. Individuals requesting such examination or treatment must be evaluated regardless of the patients' ability to pay.

It is also the policy of AHS to accept emergency patient transfers from other facilities assuming:

1. The individual being transferred requires specialized capabilities or facilities at AHS that are not offered or not immediately available at the transferring hospital (i.e. higher level of care);

2. The AHS has the capacity to treat the individual.

In the event the Emergency Operations Plan (EOC) is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency, the hospital is unable to provide proper care, treatment, or services (Section 1135(b) of the Social Security Act §489.24(a)(2)).

DEFINITIONS

Appropriate Transfer: occurs when:

1. The transferring hospital provides medical treatment within its Capacity that minimizes the risks to the individual's health and in the case of a women in labor, the health of the unborn child;
2. The receiving facility has the available space and qualified personnel for the treatment of the individual and has agreed to accept transfer;

3. The transferring hospital sends to the receiving hospital all medical records (or copies thereof) related to the emergency medical condition for which the individual has presented; and

4. The transfer is affected through qualified personnel, transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Campus: refers to the entire Hospital campus, including the physical area immediately adjacent to the main hospital, driveways, sidewalks, and other areas and structures that are not strictly contiguous to the main Hospital buildings but are owned and operated by the Hospital. The Highland Campus is considered the main Hospital campus for purposes of the EMTALA policy and procedure and also includes the "250 yard rule" to cover buildings, structures, and areas within this vicinity of the main campus. Property also includes any ambulance owned and operated by the Hospital, even if the ambulance is not on Hospital grounds.

The Fairmont and John George Psychiatric Hospital campuses are also part of the main hospital as they are identified as such on the hospital license. (Refer to page 9 for additional information).

Capabilities: of a medical facility or main hospital provider means the physical space, equipment, supplies and services (e.g., trauma care, surgery, intensive care, obstetrics, neonatal unit or psychiatry), including ancillary services on the hospital license and available at the Hospital or at an on campus or off campus Department of the Hospital.

Capacity: is the ability of the Hospital to accommodate the individual requesting examination or treatment of the Transferred individual. Capacity encompasses number and availability of qualified staff, beds, equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Central Log: is a log that a hospital is required to maintain on each individual who comes to its DED(s) or any location on AHS property or premises seeking examination or treatment of a medical condition and the disposition of each individual. (Refer to page 11 for additional information).

Comes to the Emergency Department: an individual who:
1. Presents at AHS DED or on AHS property other than a DED and requests or has a request made on their behalf for examination or treatment for a medical condition.

2. An individual in a non-Hospital owned ambulance on Hospital property or premises is considered to have come to the Hospital's emergency department.

Dedicated Emergency Department (DED): is any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus that meets **at least one** of the following requirements:

1. Is licensed by the State in which it is located under applicable State laws as an emergency room or emergency department.

2. Is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for Emergency Medical Conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or

3. During the calendar year immediately preceding the calendar year in which a determination is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment.

4. To meet one-third requirement of being a DED, the hospital must include those individuals in their case count who meet all three criteria:
    a. All outpatients
    b. All walk-in individuals without appointments
    c. All individuals with EMCs who receive stabilizing treatment

5. If one-third of the total cases being reviewed meet all three criteria above, the hospital has an EMTALA obligation in that department and it becomes a DED for EMTALA purposes. (Refer to page 10 for additional information.)

Department: is a facility that is either created by or acquired by the Hospital for the purpose of furnishing health care services of the same type as those furnished by the Hospital under the name, ownership, and financial and administrative control of the Hospital. A Department of a Hospital may not be licensed to provide health care services in its own right, may not by itself be qualified to participate in Medicare as a provider and Medicare Conditions of Participation do not apply to department as an independent entity. This facility may be located on or off the Highland Campus. For the purpose of all EMTALA policies, the term "Department of Hospital" shall include all on-campus "Hospital-based Entities" as described in this policy. On-Campus Hospital departments include all departments on the Highland Campus. Off-Campus Hospital departments include all departments on the Fairmont and John George Campuses.

Emergency Medical Treatment and Active Labor Act (EMTALA): refers to Sections 1866 and 1867 of the Social Security Act, 42 U.C. Section 1395dd, which obligates hospitals to provide medical screening, treatment and Transfer of individuals with Emergency Medical Conditions or women in Labor. It is also referred to as the "anti-dumping" statute and COBRA.

Emergency Medical Condition (EMC):

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
    a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part; or

2. With respect to a pregnant woman who is having contractions:
    a. That there is adequate time to effect a safe transfer to another hospital before delivery; or
    b. That transfer may pose a threat to the health and safety of the woman or the unborn child.

3. With respect to an individual with psychiatric symptom:
    a. That acute psychiatric or acute substance abuse symptoms are manifested; or
    b. That individuals are expressing suicidal or homicidal thoughts or gestures and are determined to be a danger to self or others.

Hospital: is Alameda Health System, a provider that has entered into a Medicare Provider Agreement. For the purpose of these policies, "Hospital" refers to the main building at the Highland Campus in which the emergency department is located and all other campuses or locations identified on the license provided to the hospital by the State.

Hospital-Affiliated: is the Hospital and all Departments of the Hospital.

Hospital-Based Entity: is a provider of health care services, or a rural health clinic (RHC), that is either created by, or acquired by, a hospital for the purpose of furnishing health care services of a different type from those of the hospital under the name, ownership, administrative and financial control of the Hospital. A Hospital-based entity may, by itself, be qualified to participate in Medicare as a provider and the Medicare Conditions of Participation (CoP) do not apply to a hospital-based entity as an independent entity. Hospital based entities may be located on or off the main hospital campus. Examples of Hospital-based entities include distinct part rehabilitation unit, inpatient psychiatric units (distinct part), and federally qualified health care centers. When using the term "Department of the Hospital," it shall include all on-campus Hospital-based entities.

Labor: is the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a Physician or Qualified Medical Personnel acting within his/her scope of practice as defined in hospital medical staff bylaws and State law certifies that, after a reasonable period of observation, the woman is in false labor.

Medical Screening Examination: is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether or not an individual who come to a DED has an Emergency Medical condition or is in Labor. Such screening must be done within

the facility's' capability and available personnel, including on-call Physicians and be applied in a non-discriminatory manner.

With respect to an individual with psychiatric symptoms, an MSE consists of both medical and psychiatric screening. The Medical Screening Examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs. This must continue until the patient is either Stabilized, Appropriately Transferred, or the Emergency medical condition is removed.

Movement from Off-Campus Department: is the movement of a patient from an off-campus department to the Highland campus. Movement of the individual from the off-Campus department to the Highland Campus is not considered a transfer.

On-Call List: is the list that the Hospital is required to maintain which defines those physicians who are "on-call" for duty after the initial Medical Screening to provide further evaluation and/or treatment necessary to stabilize an individual with an Emergency medical condition.

Physician: (i) a doctor of medicine or osteopathy; (ii) a doctor of dental surgery or dental medicine; (iii) a doctor of podiatric medicine; or (iv) a doctor of optometry, each acting within the scope of his/her respective licensure and clinical privileges.

Physician Certification: is the written certification by the treating physician ordering the transfer and prior to the patient's transfer, based on the information available at the time of transfer. The medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, in the case of a woman in labor and to the unborn child, from affecting the Transfer.

Qualified Medical Person or Personnel: is an individual other than an emergency physician who is licensed or certified in one of the following professional categories and who has demonstrated current competence in the performance of Medical Screening Examinations:

1. Obstetricians or family practice physicians with OB privileges

1. Advanced Practice Registered Nurses acting under standardized procedures
    a. Certified nurse midwives
    b. Nurse practitioners

2. Physician Assistants acting under protocols
   The above-referenced categories of professionals have been approved by the Hospital's governing board as qualified to administer one or more types of Medical Screening Examination and complete/sign a certification for Transfer in consultation with a Physician.

Signage: refers to the signs posted in places likely to be noticed by all individuals entering the DED's informing individuals of their rights under Federal law with respect to examination and treatment for medical conditions and women in labor.

Stabilized: with respect to an Emergency Medical Condition. An individual is deemed stabilized if the treating physician has determined, with reasonable clinical confidence, that the Emergency Medical Condition has been resolved.

To Stabilize: with respect to an emergency medical condition to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer from a facility or, in the case of a woman in labor, that the woman has delivered the child and the placenta.

Stable for Discharge: a patient is considered Stable for Discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the patients is given a plan for the appropriate follow-up care with discharge instructions. For the purpose of discharging a patient with psychiatric condition(s), the patient is considered to be Stable for Discharge when he/she is no longer considered a threat to him/herself or to others.

Stable for Transfer: A patient is Stable for Transfer from one hospital to another if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. In the case of a patient who is suffering from psychiatric condition(s), the patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

Transfer: is the movement (including discharge) of an individual outside of a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement or an individual who has been declared dead or who leaves the facility against medical advice or without being seen.

Triage: is the process to determine the order in which individual/s will be provided a Medical Screening Examination. ***Triage is not the equivalent of a Medical Screening Examination and does not determine the presence or absence of an emergency medical condition.***

PROCEDURE

Screening and Stabilization Requirements

Medical Screening Examination (MSE)

All individuals who come to a DED of AHS for examination or treatment, and all individuals who present on AHS property requesting examination or treatment of an EMC shall receive an appropriate MSE. The AHS shall not inquire about an individual's method of payment or insurance status until treatment has been rendered.

AHS DED's shall prominently post signage in its main entrances informing the public of their

rights to seek and receive emergency services. The posted signage and any written communications concerning patient transfers or refusals to provide emergency services and care shall indentify the California Department of Public Health as the government agency to contact if any individual wishes to complain about the hospital's conduct.

An individual must receive an MSE, within the capabilities of the hospital's DED, to determine whether or not an EMC exists, or with respect to a pregnant woman having contractions, whether the woman is in labor, and whether or not the treatment requested is explicitly for a medical condition if:

1. The individual comes to a DED of AHS and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:
    a. The individual requests medication for a medical condition
    b. The individual arrives as a transfer from another hospital or health care facility. A physician or qualified medical person must perform a screening sufficient to determine whether or not there has been any change in the individual's condition during transport.

2. The individual arrives on the hospital property other than a DED and a request is made on the individual's behalf for examination or treatment.
    a. Screening where the individual presented: If an individual is initially screened in a department or location other than a DED, the individual could be moved to another hospital department on-campus to receive further screening or stabilizing treatment without such movement being considered as a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE as the MSE must be conducted by a qualified and credentialed practitioner.

3. A patient requiring examination for the presence of an emergency medical condition may inadvertently present anywhere on campus. Should this occur staff must ensure a safe transport to the closest, most appropriate DED. All women believed to be in active labor should be assisted to the Labor and Delivery Department; all other concerns should be assisted to the ED.

4. An individual is in a ground or air ambulance for purposes of examination and treatment for a medical condition at the hospital's DED, and the ambulance is either:
    a. Owned and operated by the hospital, even if the ambulance is not on hospital grounds or
    b. Neither owned nor operated by the hospital but on hospital property.

5. Prior to the transfer of a patient to a hospital specified by a community-wide plan to treat certain emergency medical conditions (e.g. psychiatric, trauma, physical or sexual abuse).

6. A peace officer requests hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a MSE to determine whether or not an EMC exists.

7. 250-Yard Rule:
    a. If a danger or threat to hospital staff is suspected, hospital personnel should contact the on-site police officer to secure the area prior to leaving the DED to provide care.
    b. Only upon notification that the area or scene has been secured are hospital personnel allowed to go out and assist the patient into AHS.
    c. The 250-yard zone does NOT include nonmedical businesses, medical entities with separate Medicare identities and off-campus facilities, regardless of provider-based status unless independently qualifying as an emergency department. Further it does NOT include physician offices, rural health clinics, skilled nursing facilities, other entities that participate separately under Medicare, or restaurants, shops and other nonmedical activities.

8. The hospital is **NOT required** to provide an MSE if an individual presents to a DED:
    a. requested services are clearly NOT for examination or treatment for a medical condition, such as requests for preventive care services (i.e., "flu" shot, a preventive care service)
    b. requested services are NOT for a medical condition such as gathering of evidence for criminal cases (sexual assault, blood alcohol).

Scope of Examination

1. MSE is the process required to reach, within reasonable clinical confidence, the point at which it can be determined whether an EMC exists. The scope of the examination must be tailored to the presenting complaint and the medical history of the patient. The process may range from a simple examination (such as brief history and physical) to a complex examination that may include laboratory test, MRI, or diagnostic imaging, lumbar punctures, other diagnostic tests and procedures, and the use of on-call Physician specialists. A medical record documenting the history and physical examination, and any special reports such as consultations, clinical laboratory, x-ray, etc. will be created to document the screening exam.

   The examination must include all services within the capabilities of the medical center, which, in the judgment of the emergency physician or other treating physician, are necessary to screen and/or stabilize an individual with an EMC. A list of the physicians on call shall be maintained by the Medical Center and shall be posted within the main DED at all times.

2. If an individual has been admitted to the hospital as an inpatient EMTALA no longer applies. However, if an individual is retained for observation status, EMTALA does apply.

3. A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the medical screening examination or stabilizing treatment of any individual, who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation of EMTALA.

4. In the event of a national emergency or crisis, State or local governments may develop community response plans that designate specific entities (hospital, public health facilities, etc.) with responsibility of handling certain categories of individuals during these

catastrophic events. The hospital would still be required to perform a MSE on all individuals requesting such examination or treatment for a medical condition or EMC, but transfer or referral of these individuals in accordance with such a community plan would not result in sanctions against the hospital under EMTALA. These plans should only be used when the event has been officially declared as a disaster by the appropriate governmental agency.

5. A hospital psychiatric service that is a DED (is held out to the public as a department that provides emergency psychiatric services on an urgent basis without requiring a previously scheduled appointment), is required to comply with all EMTALA obligations such as signage, central log, opening of medical records and on-call coverage, as well as policies for medical screening examination, necessary stabilizing treatment and an appropriate transfer (if required) for any individual who presents to the psychiatric service seeking or in need of examination or treatment for any medical condition.

   Medical Screening Examinations are provided in the following on-campus hospital locations:
   a. Emergency Department
   b. Family Birthing Unit

   Medical Screening Examinations are provided in the following off-campus departments:
   a. Psychiatric Emergency Services – John George Campus.

WHO MAY PERFORM THE MEDICAL SCREENING EXAMINATION

1. Medical screening examinations must be performed by a physician or by a non-physician practitioner who is qualified and/or credentialed to conduct such examinations. Non-physician practitioners who are authorized to perform medical screening examinations are referred to as Qualified Medical Personnel (QMP).

2. A QMP may conduct the medical screening examination provided the individual is:
   a. Determined qualified by hospital medical staff bylaws, rules and regulations, or policy.
   b. Functioning within the scope of his or her license and in compliance with State law and applicable State nurse and medical practice acts.

CENTRAL LOG

AHS departments/facilities will maintain Central Logs to include information on individuals who present for emergency services or are seeking examination or treatment for a medical condition, including those patients presenting to Labor and Delivery, the Emergency Department and other on-or-off campus DED's that provide medical screening for patients.

1. The logs must contain:
   a. The name of the individual who comes to the hospital seeking examination and treatment for a medical condition
   b. Time of presentation
   c. Presenting complaint or condition
   d. Disposition of the patient (e.g. discharged, AMA, admit, transfer, etc)

e. Time of disposition

2. The Central Logs must be retained for EMTALA purposes for a minimum of five years from the date of disposition of the individual. The logs must be maintained in a manner that makes them readily available (generally within 30 minutes) in the event of an EMTALA survey.

STABILIZATION AND TRANSFERS

1. Once the MSE is completed and there is determination the patient does not have an EMC or the EMC has been stabilized, the patient may be:
    a. treated; or
    b. discharged, so long as the patient has clinically reached a point where further care is not needed or may be reasonably performed on an out-patient basis, and the patient is given a reasonable plan for appropriate follow-up care and discharge instructions; or
    c. transferred for continued care.

2. Transfer of Patients with an EMC
    a. If the patient has an EMC, the patient is to be treated in the DED until the condition is stabilized or the patient can be appropriately transferred.
    b. If the pts emergency condition cannot be stabilized within the capability and capacity of AHS, the patient may be transferred in compliance with state and federal law.

ACCEPTANCE AND REFUSAL OF EMERGENCY TRANSFERS FROM OTHER FACILITIES

1. AHS must accept an appropriate transfer of an individual with an unstabilized EMC if both conditions are met:
    a. The individual being transferred requires such specialized capabilities or facilities that are not offered or not immediately available at the transferring hospital; and
    b. AHS has the capacity to treat the individual.

    All calls to AHS regarding a potential patient transfer to an in-patient area will be directed to Utilization Review for approval. All ED to ED transfers are accepted through the Emergency Department Attending Physician in collaboration with the Nursing Supervisor/designee as appropriate.

2. AHS may refuse to accept a transfer of an individual with an unstabilized EMC if any one of the following conditions exists:
    a. The individual does not require the specialized capabilities and facilities of AHS at the time of transfer.
    b. AHS does not have the capacity at the time of the transfer to provide the specialized services required for the individual.
    c. The transferring facility has the present capability and capacity to provide the specialized services required for the individual.

SIGNAGE

AHS and all its facilities covered by this policy shall post signs in obvious locations likely to be noticed by all individuals entering DED's, Labor & Delivery, and other areas where individuals may receive a MSE. At a minimum the signs must specify the rights of individuals with emergency conditions and women in labor who come to a DED or to other areas of AHS for health care services.

The signage must also indicate whether the facility participates in Medicaid program. The signs shall be posted in English and Spanish.

ON-CALL PHYSICIAN COVERAGE

AHS shall maintain a list of physicians who are on-call to come to a DED to consult or provide treatment necessary to stabilize a patient with an EMC for a period of five years. The On-call physician must respond to the bedside when requested by the ED physician within a time period, based upon the patient's acuity that is determined to be reasonable by the treating physician. The ED physician's judgment should be deferred to by the specialist in situations where the ED physician requests the presence of the specialist, but the specialist does not believe that his/her presence is necessary.

REFERENCES

EMTALA – A Guide to Patient Anti-Dumping Laws, 9th edition (2018). California Hospital Association: Sacramento, CA.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	10/2020	N/A	N/A
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	11/2020, 2/2026	N/A	N/A
Medical Executive Committee	**Date:**	11/2020, 3/2026		
Board of Trustees	**Date:**	01/2021, 3/2026	N/A	N/A

ALAMEDA HEALTH SYSTEM	Policy	
	Patient Rights	**19538 5**
	LEVEL ☑System ☐ Site	EFFECTIVE DATE: 03/31/26 LAST REVIEW DATE: NEW

Purpose

To educate patients about their rights and responsibilities in relation to their health care to engage them in the process and better meet their needs.

Policy

It is the policy of Alameda Health System (AHS) that all workforce members are responsible for recognizing the rights and responsibilities of patients. Alameda Health System (AHS) provides all patients or their delegate/ legal representative, as applicable, with information about patient rights and responsibilities of the patient, consistent with applicable state/federal laws.

Scope

Applies to all patients receiving care, treatment, and services from Alameda Health System. Applies to all workforce members who provide patient care, treatment, and services on behalf of the hospital.

Definitions

Patient responsibilities – Consistent with state law, the patient (and/or legal representative, as appropriate) has the following responsibilities:

- To provide information that facilitates care, treatment, and services
- To ask questions or acknowledge when the patient does not understand the treatment course or care decisions
- To follow instructions, policies, rules, and regulations that support quality care and a safe environment
- To be considerate and respectful when interacting with staff members
- To maintain civil language and conduct
- To meet financial commitments to the hospital
- To provide accurate and complete information about health-related matters
- To take an active role in making decisions about care, treatment, and services by doing the following:
    - Discussing condition and treatment with the practitioner
    - Reporting any changes to condition
    - Providing advance directive and/or expressing wishes regarding use of life support
- To cooperate with hospital staff who provide care
- To ask questions if plans or direction of care are not clearly understood
- To follow and respect the hospital's rules and regulations about patient care and conduct

- To be considerate of the rights of other patients and staff members
- To follow guidelines about use of cameras
- To accept responsibility for actions if treatment is refused or practitioner instructions are not followed
- To provide the hospital with complete information to process insurance claims
- To arrange to pay bills within an acceptable time period
- To be responsible for belongings and not bring unnecessary items or valuables to the hospital
- To inform staff members of all information that may affect care and safety

Patient rights – Consistent with state law, the patient (and/or legal representative, as appropriate) has the following rights:

- To be informed of visitation rights, including:
  - Right to receive visitors, according to the patient's wishes and consent
  - Right to withdraw or deny consent for visitors
- To be treated with dignity and respect
- To effective communication
- To have cultural and personal values, beliefs, and preferences respected
- To personal privacy and privacy of heath information
- To pain management
- To religious or other spiritual services
- To access, request amendments to, and obtain information on disclosures of health information
- To have a family member, a friend, or another individual present for emotional support during the patient's stay
- To be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression
- To receive information in a manner that is understandable and tailored to the patient's age, language, and ability to understand
- To receive information in a manner that meets the patient's needs when they are impaired by vision, speech, hearing, or cognitive impairments
- To be involved in making decisions about care, treatment, and services
- To have the patient's physician promptly notified of the patient's hospital admission
- To refuse care, treatment, and services and to receive information about this in writing
- To have a surrogate decision maker if the patient is unable to make decisions on their own. The surrogate decision maker has the right to refuse care, treatment, and services on the patient's behalf
- To have family involved in decision making about care, treatment, and services
- To receive information about the outcomes of the patient's care, treatment, and services that is needed to participate in current and future health care decisions
- To be informed about anticipated outcomes of care, treatment, and services that relate

to sentinel events
- To give or withhold informed consent
- To give or withhold informed consent to produce or use recordings, films, or other images for purposes other than the patient's care
- To receive relevant information when deciding whether to participate in research, investigation, or trials, including the following:
    - Explanation of the purpose of the research
    - Expected duration of participation
    - Clear description of the procedures involved in the research
    - Statement of the potential benefits, risks, discomforts, and side effects
    - Alternative care, treatment, and services available to the patient that might prove advantageous
- To receive information about the individual(s) responsible for and providing the patient's care, treatment, and services
- To be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse
- To have an environment that preserves dignity and contributes to positive self-image
- To have complaints reviewed by the hospital without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care
- To access protective and advocacy services
- To discuss with a physician any ethical issues that arise during the course of care
- To request access to the hospital's Ethics Committee
- To receive information about advance directives
- To have advance directives respected and followed
- To have issues addressing autopsy and organ donation conducted in a sensitive manner
- To request and receive pastoral counseling
- To request and expect the hospital to arrange for the prompt and orderly transfer of the patient's care to others when the hospital cannot meet the patient's request or needs for care, treatment, and services

Responsibilities

Compliance with this policy and its related procedures is the responsibility of all AHS members who provide patient care, treatment, and services.

Procedures

1. Display signage explaining patient rights and responsibilities in all-access areas of the facility.
2. Provide copy of the Patient Rights information/ form to all inpatients on admission and to all outpatients on admission or registration.
3. Answer any questions about patient rights and responsibilities or provide

information/referrals upon request.

4. Include information regarding patient's rights and responsibilities in the Patient and Family Handbook.
5. Encourage the patient and/or legal representative, as appropriate, to read the patient rights and responsibilities section of the Patient and Family Handbook. See AHS webpage for electronic copy at the following link: http://www.alamedahealthsystem.org/wp-content/uploads/2021/03/AHS-Patient-Family-Handbook-2022.pdf
6. There are individual AHS policies/protocols on the following patient rights, including but not limited to:

    a. Withholding/Withdrawing Life Sustaining Treatments
    b. Ethical Issues
    c. End of Life
    d. Advance Directives
    e. Emotional, Spiritual, and Attitudinal Support
    f. Restraints/ Seclusion
    g. Pain Management
    h. Patient Education
    i. Patient Complaints/Patient Affairs
    j. Patient Informed Consent
    k. Interpreter/ Language Service
    l. Visitors

Reference

Joint Commission Standard RI.01.01.01, EP 1. "The [hospital] has written policies on patient rights."

Attachment

Patient Rights Form
Patient and Family Handbook

Approvals

Clinical Practice Committee	**Date:**
Medical Executive Committee	**Date:**
Board of Trustees	**Date:**

draft

ALAMEDA HEALTH SYSTEM

PATIENT/VISITOR CELL PHONE/ELECTRONIC DEVICE USAGE POLICY

Department	All	***Effective Date***	9/2019
Campus	All	***Date Revised***	7/2019
Category	Administrative	***Next Scheduled Review***	9/2022, 11/2025, 11/2028
Document Owner	Director, Privacy and Regulatory Compliance	***Executive Responsible***	Chief Compliance Officer & Audit Executive

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

PURPOSE

Alameda Health System (AHS) recognizes that cellular phones and electronic devices usage may be a potential security, safety and privacy risk. This policy provides the following guidelines for usage of cell phones and other electronic devices by patients/visitors in patient care areas so that electronic device usage does not interfere with patient care or violate the privacy or jeopardize the safety of anyone.

DEFINITIONS

Electronic devices: Any device that is capable of photography, videography or audio recordings. Such devices are any cellular/smartphone phone, tablet, camera, mobile device, audio and video equipment, web cam, etc. This includes any outdated or vintage devices that have been retired or discontinued because of changes in technology but still used by an individual.

Photography: Film and digital photographs, video images or audio recordings created using a camera or other electronic device.

AHS Workforce Member: Employees, contractors, medical staff, trainees, students, and volunteers.

Consent: Verbal or written agreement to the Photography/recording process.

POLICY

Cell phone and any other electronic device usage including, but not limited to, photography, videotaping, audio recording, imaging and other recordings by patients/visitors in patient care areas is strictly prohibited without consent. AHS has restricted electronic device usage capacity within these areas for the following reasons:

- To prevent disruptions between physicians and patients
- To prevent delays in total visit time
- To ensure privacy and security of patient information
- To ensure privacy and security of information within the organization

Use of electronic devices by AHS workforce members is addressed in the *Consent: Photography Policy.*

California law prohibits recording of "confidential communication" without the consent of the person being recorded (CA Penal Code 632). In addition, HIPAA precludes the disclosure of patient health information without patient consent. A "confidential communication" or video recording in violation of HIPAA includes a physician, nurse or staff providing care to a patient.

Consequently, it is against our policy for an individual to video or audio record a caregiver when providing care to a patient without the consent of the patient **and** the consent of the caregiver.

1. Patients/visitors may use their cell phone or other electronic device for non-photography reasons such as voice calls, using search engines, etc. in AHS facilities.
2. Patients/visitors who use their cell phone shall do so in a manner respectful of everyone's privacy and to not disturb those around them.

PROCEDURE

1. Patient/visitor must request permission from clinical staff and other patients/visitors in vicinity for permission prior to any photography/recording.
2. Photography of a patient by a patient's family member or friend is allowed if the patient agrees to the photography. However, staff must inform the family member or friend performing the photography that such photography must be limited to the patient only and cannot capture staff, other patients or activities in the room. Photography taken under these circumstances causing concern to staff for any reason should be reported to the nursing supervisor.
3. Consent may be verbal or documented in the patient progress notes.
4. All AHS workforce members will aid with enforcement of this policy by informing patients/visitors of the above referenced restrictions and guiding them to locations appropriate for cell phone or other electronic device usage.
5. Patients/visitors who violate this policy will be asked to turn off their cell phone/electronic device. If the patient/visitor does not comply, please notify the department supervisor.

REFERENCES

CA Penal Code 632
The Joint Commission Comprehensive Accreditation Manual for Hospitals – 2018 – RI.01.03.03
California Code of Regulations Title § 70763
California Hospital Association – Consent Manual 2018
Consent: Photography Policy

APPROVALS

		System	Alameda Hospital
Departmental	**Date:**	**1/2019**	
Clinical Practice Council	**Date:**	**7/2019**	
Medical Executive Committee	**Date:**	**8/2019**	**8/2019**
Board of Trustees	**Date:**	**9/2019**	

ALAMEDA HEALTH SYSTEM

ELECTRONIC HEALTH INFORMATION (EHR) SECURE MESSAGING OF PHI

Department	All	***Effective Date***	8/2019
Campus	All	***Date Revised***	6/2019
Category	All	***Next Scheduled Review***	6/2022, 11/2025, 11/2028
Document Owner	Director, Privacy and Regulatory Compliance	***Responsible Person***	Chief Compliance Officer & Audit Executive

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

PURPOSE

This policy establishes standards for the appropriate and reasonable safeguards for the use of secure messaging in protecting Protected Health Information (PHI), Personally Identifiable Information (PII) and any other confidential information to comply with HIPAA and HITECH regulations.

POLICY

Alameda Health System (AHS) will electronically transmit brief, non-emergent messages with patient PHI and PII using text messaging, only through the EHR Secure Chat function.

DEFINITIONS

AHS Workforce Member – consists of employees, contractors, medical staff, residents, volunteers or any other individual who is working at AHS.

Personally Identifiable Information (PII) - is information that is a subset of health information, including demographic information collected from an individual, and: (1) is created or received by a health care provider, health plan, employer, or healthcare clearing house; and (2) relates to the past, present, or future physical or mental health or condition of an individual; including payment of health care to an individual. This applies to identity of the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information (PHI) - means individually identifiable health information, including demographic data, held or transmitted by AHS or its business associates or agents, in any form or media, whether electronic, paper, or oral.

***Secure Messaging* -** is any electronic communication that ensures only the intended parties can access the communication.

A. General Information About Secure Messaging

1. While smartphone companies have implemented strong security features--and may allow data sharing with healthcare providers through specific device functions or third-party apps--the devices themselves, and the data they collect, are not protected by HIPAA. This is because they are not provided by, or acting on behalf of, a covered entity, and therefore do not create, receive, transmit, or maintain ePHI on the entity's behalf. As a result, using these other messaging applications to send PHI, PII, or any sensitive information is strictly prohibited..
2. Secure messaging is a tool used to facilitate patient care and enable care team communication.
3. Secure messaging is meant to convey brief, non-emergent messages. It must not be used for time sensitive or critical information or results.
4. Secure messaging is not a substitute for clinical decision making, official documentation, or orders in the electronic health record.

B. Reasonable and appropriate security measures for Secure Messaging containing PHI or PII

AHS Workforce Members must comply with the following security measures whenever PHI or PII is included in Secure Messaging:

1. Using secure messaging to transmit orders is prohibited, regardless of the application utilized. Computerized Provider Order Entry (CPOE) is the approved method of order entry by a provider.
2. AHS prohibits users from taking screen shots or any replications of texts or images sent via Epic Secure Chat on the individual's device (e.g., cannot take photographs of the secure message transmissions with another device).
3. AHS prohibits forwarding, or otherwise sharing in any form, any transmissions to parties not directly involved in the care of the patient.
4. AHS prohibits taking photographs of paper documents using secure chat with the intention of uploading these documents to the patient medical record. Documents that need to be included in the patient medical record should be scanned following scanning protocol to ensure they are filed in the appropriate folder in the EHR.

C. Legal Medical Record of Secure Messages

1. Secure messages **are not** part of the legal medical record; however, they may be discoverable.
2. Secure messages will be deleted 30 days after the date the message was received.
3. When clinical images are intended to become part of the legal medical record, then the EHR applications such as Haiku, Canto, or Rover are the approved mechanisms for photo capture.

D. Reporting Concerns

1. Any devices lost or stolen with a Secure Messaging application installed must be immediately reported to a supervisor and the IT HelpDesk (510) 437-4503 (x44503).

2. Report all unencrypted messages that are sent that contain any PHI immediately to the AHS Compliance Department and to IT HelpDesk.

E. Failure to Comply

1. Misuse of secure messaging tools may result in limitation of access to these tools and/or AHS electronic health record, loss of medical privileges, reporting to licensing agencies, or other disciplinary action, up to and including termination of employment, as defined by AHS policy.

REFERENCES

45 CFR § 142.308(c)(1)(ii), 45 CFR § 142.308(d)(1), 45 CFR § 142.308(a)(12), 45 CFR § 142.308(b)(4), 45 CFR § 142.308(b)(6)

APPROVALS

		System	Alameda	AHS Core	San Leandro
Departmental	**Date:**	**6/2019**			
Clinical Practice Council	**Date:**	**6/2019**			
Medical Executive Committee	**Date:**		**7/2019**	**7/2019**	**7/2019**
Board of Trustees	**Date:**	**9/2019**			

Alameda Health System

PATIENT PRIVACY PROTECTION

Department	Compliance	***Effective Date***	4/2003
Campus	AHS System	***Date Revised***	1/2012, 9/2015, 8/2017, 2/2026
Unit	All	***Next Scheduled Review***	3/2029
Manual	Administrative	***Author***	Regulatory Counsel
Replaces the following Policies:		***Responsible Person***	VP, Internal Audit & Compliance

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

Purpose

To provide guidance regarding each individual's responsibility related to identifiable patient information. This policy addresses intentional or unintentional breach of patient confidentiality, including oral, written and electronic communication. This definition will safeguard patient privacy and help minimize exposure and/or liability. Each individual is responsible for adhering to this policy by using only the minimum information necessary to perform his or her responsibilities, regardless of the extent of access provided or available.

To establish the requirements for (AHS) to protect patient's privacy rights and their individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and all Federal regulations and interpretive guidelines promulgated thereunder.

Policy

It is a policy of Alameda Health System (AHS) that only individuals with a legitimate "need to know" may access, use or disclose patient information. This includes all activities related to treatment, payment and health care operations on behalf of any entity. Each individual may only access, use or disclose the minimum information necessary to perform his/her designated role regardless of the extent of access provided to him/her.

Definition

For purposes of this policy, protected health information means any individually identifiable health information collected or stored by an entity. Individually identifiable health information includes demographic information (name, address, etc.) and any information that relates to past, present or future physical or mental condition of an individual.

Procedure

This policy is based on the following principles related to the access, use and disclosure of patient information:

1. All providers and staff must obtain the patient's consent before discussing medical information in the presence of others not involved in the care of the patient.

2. Individuals must always use only the minimum amount of information necessary to accomplish the intended purpose of the use, access and disclosure.

3. With respect to system access, patient privacy will be supported through authorization, access, and audit controls (e.g., role-based access) and should be implemented for all systems that contain identifiable patient information. Within the permitted access, an individual system user is only to access the minimum necessary information they need to perform his/her job.

4. Each individual is responsible for completing annual competency on patient privacy.

5. Each individual is responsible for compliance with these Patient Privacy Policies.

6. Enforcement will be consistent with the HIPAA Violations Sanctions Policy.

7. The Privacy Officer (PO) has the responsibility of facilitating compliance with these principles.

References

45 CFR Parts 160 and 164

Approvals

		Alameda	**AHS Core**	**San Leandro**
Departmental	**Date:**	**8/2017**	**8/2017**	**8/2017**
VP, Internal Audit and Compliance	**Date:**	**8/2017, 2/2026**		
Medical Executive Committee	**Date:**	**10/2017, 3/2026**	**9/2017**	**9/2017**
Board of Trustees	**Date:**	**10/2017, 4/2026**		

	Policy	
ALAMEDA HEALTH SYSTEM	**Food and Nutrition Services: Food-Drug Interaction Education**	**4720_1**
	LEVEL x System	EFFECTIVE DATE: 10/28/2008 LAST REVIEW DATE: **Error! No document variable supplied.**

~~**Purpose**~~

~~To~~**POLICY STATEMENT**

~~1.~~ The purpose of this policy is to develop a procedure to identify drugs used in the facility that ~~has~~have potentially significant food-drug ~~or herb-drug interactions.~~

~~To~~interactions, and to outline procedures and guidelines for the interdisciplinary team to provide food-drug ~~and/or herb-drug interaction education and to ensure patient safety~~education.

POLICY TEXT

~~2.~~ Patients will receive written instructions and verbal counseling on potential food-medication interactions during hospitalization on drugs designated by the facility to have potential food-medication interactions.

~~**Procedures**~~

Pharmacy and Therapeutic Committee

1. Identifies drugs used in the facility with potentially significant food-medication ~~herbal~~ interactions that require patient education.

~~2. Determines process for education of patients.~~

~~3. Designates interdisciplinary team member who educates patient.~~

~~4. Reviews and approves patient educational materials.~~

~~**Director of Clinical Nutrition**~~

~~1. Consults Manual of Clinical Nutrition Management during development of materials.~~

~~**Physicians**~~

~~1. Identifies patients on drugs with potentially significant food-drug and herb-drug interactions that require patient education.~~

~~2. Orders appropriate diet in the electronic or manual order entry system to accommodate for the significant food-medication-herbal interaction.~~

~~3. Generates a consult for the Registered Dietitians Nutritionist (RDN) for nutrition education as appropriate.~~

~~**Nursing**~~

~~1. Identifies patients on drugs with potentially significant food-drug and herb-drug interactions that require patient education.~~

2. ~~Generates a referral for the RDN for nutrition education.~~ Consults the organization's approved diet manual during development of materials.
3. Determines process for education of patients:
    a. Designates interdisciplinary team member who educates patient.
    ~~2.~~b. Reviews and approves patient educational materials.

Registered Dietitian Nutritionist (RDN)

1. Counsels the patient and/or ~~family on potential food-drug and/or herb-drug interactions and documents education in the medical record. Counsels the patient and~~ caregiver on potential food-~~drug-herbal~~medication interactions and documents education in the medical record.

~~2. For patients who are taking herbal supplements, notify the patient's physician of this practice. From this information, the physician may order a consult on medication-herbal interaction as appropriate.~~

~~3. For patients who bring herbal supplements into the hospital, notify the physician, nurse and pharmacist.~~

~~4.~~2. For patients receiving anticoagulant therapy, education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse medication reactions and interactions.

~~5. Notifies diet clerk or designees of the patients on anticoagulant therapy.~~

Diet Clerk/Nutrition Assistant/Designee

1. Modifies patient meal pattern or diet ~~as ordered.~~ when consulted.

~~2. Ensures that~~When the patient ~~menu follows the physician order per guidelines outlined the Manual of Clinical Nutrition Management.~~

~~3.~~2. ~~Ensures~~is taking an anticoagulant that interacts with food, ensures the patient menu follows the recommendations ~~for vitamin K intake~~ as outlined in the ~~Manual of Clinical Nutrition Management. (Reference: National Heath Institute)~~approved diet manual.

~~4. Ensures that patients receiving anticoagulant therapy receive no more than 8 oz of cranberry juice per day. (Reference: Zhaoping et al, 2006)~~

~~**References**~~

~~1. National Health Institute: Warren Grant Magnuson Clinical Center~~

~~2. Zhaoping LI, Seeram NP, Carpenter CL, Thames G, Minutti C, Bowerman S. Cranberry does not affect prothrombin time in male subjects on warfarin. J Am Diet Assoc. 2006; 106:2057-2061~~

REFERENCES

~~3.~~1. Joint Commission National Patient Safety Goal (NPSG), Improving the Safety of Using Medications: Anticoagulation Therapy.

		~~System~~
~~**Food and Nutrition Dept.**~~	~~**Date:**~~	~~3/2022~~
~~**Pharmacy Departmental**~~	~~**Date:**~~	~~3/2022~~
~~**Pharmacy and Therapeutics**~~	~~**Date:**~~	~~4/2022~~
~~**Clinical Practice Committee**~~	~~**Date:**~~	~~5/2022~~
~~**Medical Executive Committee(s)**~~	~~**Date:**~~	~~5/2022~~
~~**Board of Trustees**~~	~~**Date:**~~	~~6/2022~~

ALAMEDA HEALTH SYSTEM	Policy	
	INTRAVENOUS ADMIXTURE PROGRAM POLICY	**29764 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 12/1/2023 LAST REVIEW DATE: **1/2025**

POLICY STATEMENT

The Department of Pharmacy at all acute care sites which include Wilma Chan Highland Hospital, San Leandro Hospital and Alameda Hospital shall ensure the quality, safety, and regulatory compliance of all compounded sterile preparations administered to patients within this facility.

PURPOSE

The Department of Pharmacy shall follow policies and procedures outlined in this document to comply with the guidelines, standards, and requirements for Compounded Sterile Preparations (CSPs) established by the United States Pharmacopeia (USP) – General Chapter <797> and the American Society of Health-System Pharmacists (ASHP) in accordance with Federal and California State Board of pharmacy laws and regulations.

SCOPE

This system policy encompasses all the campuses of Alameda Health System that engage in the practice of sterile compounding in accordance with Federal and California State board of pharmacy laws and regulations.
Each individual campus is responsible for creation, implementation, execution and maintenance of their own Site Specific Standard Operating Procedure (SS-SOP) to outline the campus specific guidelines as defined by this Policy.

DEFINITIONS

1. Administration = direct application of a sterile product or preparation to a single patient by injecting, infusing or otherwise providing a sterile product or preparation in its final form.
2. BSC = Biological Safety Cabinet
3. BUD = Beyond Use Date – defined as the date, or hour and date, after which a CSP must not be used. The BUD is determined from the date and time that preparation of the CSP is initiated.
4. CAI = Compounding Aseptic Isolator
5. Category 1 = are compounded under the least controlled environmental conditions and therefore are assigned a BUD of 12 h or less at controlled room temperature or 24 h or less when refrigerated
6. Category 2 = require more environmental controls and testing than category 1 CSPs and may be assigned a BUD of greater than 12 hours at controlled room temperature or more than 24 hours if refrigerated, but not to exceed the limits established
7. Category 3 = preparations undergo sterility testing, supplemented by endotoxin testing when applicable and have more requirements than category 2 CSPs for personnel qualification, use of sterile garb, use of sporicidal disinfectants, frequency of monitoring, and stability determination
8. CSP = Compounded Sterile Preparations

9. Expiration Date = The time during which a product can be expected to meet the requirements of the USP-NF monograph, or maintain expected quality provided it is kept under the specified storage conditions
10. Designated Person: One or more individuals assigned to be responsible and accountable for the performance and operation of facility and personnel as related to the preparation of CSP's.
11. Assigned trainer = One or more individuals assigned by the designated person(s) to be responsible and accountable for directly providing the training, observation, and evaluation of personnel for the preparation of CSPs
12. GFT = gloved fingertip and thumb sampling
13. Sterile Compounding = defined as combining, admixing, diluting, pooling, reconstituting, repackaging or otherwise altering a drug product or bulk drug substance to create a sterile preparation13. CSPs include:
    a. Injections, including infusions.
    b. Irrigations for internal body cavities
    c. Ophthalmic dosage forms
    d. Aqueous preparations for pulmonary inhalation
    e. Baths and soaks for live organs
    f. Implants
    g. Hazardous Drugs
14. Immediate Use CSPs = a sterile preparation prepared outside of an air quality less than ISO class 5, the preparation involves not more than 3 different sterile products
15. LAFW = Laminar Air Flow Workbench
16. PECs = Primary Engineering Controls; includes LAFW, CAI and BSC
    SECs = Secondary Engineering Controls; a temperature and air flow-controlled environment in which PECs are placed
17. Preparation Per Approved Labeling = Compounding does not include mixing, reconstituting, or other such acts that are performed in accordance with directions in approved labeling provided by product's manufacturer. Preparing a manufactured sterile product per the manufacturer's approved labeling is outside the scope of USP chapter 797 only if the product is prepared as a single dose for an individual patient; and the approved labeling includes information for the diluent, resulting strength, container closure system, and storage time.
18. Proprietary bag and vial systems = Docking and activation of proprietary bag and vial systems in accordance with the manufacturer's labeling for *immediate* administration to an individual patient is not considered compounding and may be performed outside of an International Organization for Standardization (ISO) Class 5 environment.
19. Repackaging: Repackaging of a sterile product or preparation from its original container and into another container must be performed in accordance with the requirements in USP Chapter <797>.

PROCEDURES

A. Designated Person(s)

The compounding facility must designate one or more individuals (i.e., the designated person(s)) to be responsible and accountable for the performance and operation of the facility and personnel in the preparation of CSPs and for performing other functions determined by United States Pharmacopeia (USP) – General Chapter <797> and the American Society of Health-System Pharmacists (ASHP) in accordance with Federal and California State Board of pharmacy laws and regulations.
The Designated Person(s) must be identified in the facility's SOP's.
The Designated Person(s) must be qualified and trained to serve as the subject matter expert and be responsible for the content outlined in this policy.
The Pharmacist-in-Charge may serve as the Designated Person for a facility.

B. Pharmacist-in-Charge (PIC) Responsibility:

1. On a biennial basis, before July 1 of every odd-numbered year, the pharmacist-in-charge (PIC) shall review and complete the self-assessment form 17M-39 (Rev. 01/2022) for compounding. This may be obtained from the California Board of Pharmacy website.

2. On an annual basis, the pharmacist-in-charge (PIC) and/or the designated person(s) shall review this Intravenous Admixture Program policy and standard operating procedures for compliance with any and all changes related to the practice of compounding sterile preparations.

3. Any changes to policy, procedures, and standard operating processes will be communicated to assigned compounding staff through any/or all of the following: email, newsletter, pharmacy huddles, training and/or additional competency testing.

4. The PIC and /or designated person(s) are responsible for creating and implementing a training program for personnel and ensure that all personnel who prepare CSPs:
   - have direct oversight of compounders;
   - perform restocking or cleaning and disinfection duties;
   - are initially trained and qualified by demonstrating the knowledge and competency in maintaining a sterile compounding area before being allowed to perform their job functions independently.
   - Training may be performed by the designated person(s) or an assigned trainer.

C. Pharmacy Personnel Responsibilities:

1. Only pharmacy staff who successfully completed all required IV admixture competency training, aseptic media fill manipulation skills testing and fingertip glove sampling testing, shall be allowed to prepare compounded sterile products (CSPs).

2. Personnel allowed to perform tasks in a sterile compounding environment shall receive and complete appropriate didactic and calculation competency initially and at least every 12 months in regard to appropriate sterile compounding principles and practices.

3. Garbing and Hand Hygiene competencies are administered biannually for personnel preparing category 1 and 2 CSPs. (Please See SS-*SOP – Training of Sterile IV Compounding Staff and Support Personnel)*

4. All medications intended for neonatal patients shall be prepared, compounded, appropriately labeled, and dispensed exclusively by the Pharmacy Department. This includes all sterile IV admixtures, parenteral nutrition solutions, and any high-risk or weight-based compounded products. Nursing personnel shall not prepare or compound intravenous medications for neonatal patients except in circumstances approved by Pharmacy leadership or in emergency situations.

5. Pharmacy Technician: Each assigned technician is responsible to:
   a. Garb and perform proper hand hygiene (Refer to SS-SOP – *Garbing for Non-Hazardous and Hazardous Parenteral Compounding*)
   b. Clean the PEC prior to compounding.
   c. Work only on one drug preparation at a time.
   d. Select appropriate drugs, additives, diluents, solutions, supplies, and other devices needed and calculate quantities for compounding based on the prescription.
   e. Check the condition of the packaged items, their labels and expiration dates.
   f. Any damaged or outdated items shall be removed from the area and will be returned/credited from the manufacturer or discarded.
   g. Items used in the PEC are kept in direct airflow to minimize the chance of airborne contamination.
   h. Visually inspect for particulates, turbidity, or other unexpected changes during the compounding process.
   i. Place all necessary items in the work area before beginning admixture to prevent frequent interruptions and breach of aseptic technique. Keep all unnecessary items out of the PEC work area.
   j. Record all drugs compounded (see Record Keeping)
   k. Notify the pharmacist immediately upon completion of a STAT or NOW medication.
   l. Properly dispose of needles, syringes, and supplies used in the designated containers.
   m. Stock the IV room with sufficient quantity of medications, solutions, and supplies.
   n. All exterior packaging of items and supplies must be wiped with alcohol before introduction into the IV room (i.e. IV bags, vials, etc.)
   o. Order supplies needed to replenish stock.
   p. Complete and document the following as defined in the SS-SOP

i. PEC cleaning
ii. IV room bins, racks, shelves, carts cleaning
iii. Temperature logs

q. Abide by all compounding preparation techniques and procedures as defined by hospital policy (Please See SS-*SOP – Sterile Hazardous and Non-Hazardous Compounding Preparations*

6. Pharmacist(s) is(are) responsible to:
   a. Check all IV orders for incompatibilities (physical, chemical, and therapeutic), allergies, instabilities, contraindications, dosage, appropriate diluents, infusion time and rate using professional knowledge, appropriate references, etc. Contact the prescriber if problems are identified and communicate with the patient's nurse if any delay is expected.
      i. If physical compatibility, stability, or solubility of an admixture is dependent on solution pH, temperature, or other factors beyond the control of the pharmacy department, use of a final in-line filter may be recommended.
   b. Enter IV orders into the pharmacy computer system accurately with appropriate administration times.
   c. Ensure the proper storage and delivery of the product to the patient based on the drug's package insert or manufacturer recommendations.
   d. Verify all components prepared by the technician for the compounding process BEFORE and AFTER compounding.
      i. Inspects the expiration date and integrity of each drug, diluent, and solution used.
      ii. Inspects each vial for the appropriate amount withdrawn to ensure potency and review the appropriate calculations performed to ensure appropriate strength of the final CSP.
      iii. Inspects each vial for the absence of harmful levels of contaminants such as particulates or discoloration to ensure quality of each drug ingredient used.
      iv. Initial all completed CSPs labels prior to dispensing.
   e. Ensure all CSPs are labeled appropriately and include:
      i. Hospital pharmacy name
      ii. Minimum of 2 patient identifiers
      iii. Patient room number
      iv. Name and concentration/strength of ingredients of the CSP.
      v. Date/time drug is compounded.
      vi. Route and rate of administration
      vii. Instructions for storage and handling (i.e. Refrigerate, protect from light), if applicable.

viii. Final expiration date/time of the CSP

7. Personal Hygiene and Garbing
    a. Individuals entering a compounding area must be properly gowned and garbed.
    b. Personnel must maintain proper personal hygiene to minimize risk of contamination to the environment and CSPs.
    c. Food and drink are not permitted within the compounding areas.
    d. Personnel must remove:
        i. Outer garments (e.g., bandanas, coats, hats, jackets, sweaters, or vests)
        ii. Cosmetic products
        iii. Hand, wrist, and exposed jewelry including ear/facial piercings.
        iv. Earphones or ear buds
        v. Nail polish, artificial nails – nails must be kept clean and neatly trimmed.
    e. Wipe eyeglasses, if worn, with appropriate cleansing wipes
    f. Individuals with rashes, recent tattoos, oozing sores, conjunctivitis, or active respiratory infections must report these conditions to the designated person(s)and/or supervising pharmacist.
    g. Designated person(s) and/or supervising pharmacist are responsible for evaluating and determining whether these individuals shall be excluded from working in the compounding areas before their conditions have resolved.

D. Training, Competencies, and Evaluation in Aseptic Manipulation Skills

1. Training Program
    a. Personnel who prepare CSPs must complete and pass competencies before being assigned to sterile compounding activities.
    b. Observation: During the fingertip and media-fill tests, the personnel's garbing, hand hygiene, and sterile technique are validated by observation by another staff member trained in the compounding of sterile products.
    c. The following shall be assessed initially and at a minimum every 12 months:
        i. Cleaning and Disinfection
        ii. Didactic coursework, pharmacy calculations [examination questions shall be updated annually]
        iii. Aseptic technique
        iv. Documentation of compounding process (e.g master formulation and compounding record)
        v. Proper use of PECs

vi. Principles of high-efficiency particulate air (HEPA)-filtered unidirectional airflow within the ISO Class 5 area
vii.
viii. Principles of movement of materials and personnel within the compounding area

d. Personnel must score at least 90% on all didactic examinations to pass.
e. Results of all competency evaluations and corrective actions performed for failures must be documented and documentation maintained to provide a record and assessment of personnel competency. Documentation shall include:
   i. Name of Person Evaluated
   ii. Evaluation date/time
   iii. Media components used including manufacturer, lot/expiration dates
   iv. Temperatures for each interval of incubation
   v. Dates of incubation
   vi. Results
   vii. Name or identifier of competency observer and documenter of results.

2. Garbing and Hand Hygiene Competency
   a. Compounding personnel must successfully complete an initial garbing competency evaluation with no fewer than 3 separate garbing processes in succession - failure of any of the 3 initial garbing competency evaluations requires repeat testing until personnel completes 3 garbing evaluations successfully in a row.
      i. Each garbing competency consists of a visual observation and a gloved fingertip and thumb (GFT) sampling of both hands.
      ii. Failure is indicated by visual observation of improper hand hygiene and/or garbing procedures.
      iii. Failure of gloved fingertip/thumb testing is sampling results that exceed the action levels described below in *section d.v*:
   b. After successful initial competency demonstration, personnel shall complete the garbing competency every 6 months for compounding of category 1 and category 2 CSPs.
   c. Personnel who have direct oversight of compounding personnel, **but do not compound**, may complete garbing competency every 12 months. Personnel who have direct oversight of compounding are not allowed to compound unless they successfully complete the garbing competency at the same requirement for compounding personnel.
   d. Competency in garbing and hand hygiene shall be assessed by means of:
      i. Finger-tip glove testing for aseptic manipulative skills initially and every 6 months.

ii. A qualified evaluator will have each personnel sample the glove fingertips onto a TSA with lecithin and polysorbate 80 agar media after proper garbing and hand hygiene but prior to applying any disinfectant.
iii. Three sets of gloved fingertip samples should be performed before initial compounding is allowed.
iv. Plates are covered, inverted, and placed into an incubator at 30-35°C for no less than 48 hours and then at 20 to 25 ºC for no less than 5 days.
v. Personnel must have a result of zero (0) colony forming units (CFUs) at the end of the incubation period to pass.

3. Aseptic Manipulation Competency
   a. Pharmacy personnel shall successfully complete an aseptic manipulation competency prior to beginning the compounding of category 1 and category 2 CSPs.
   b. The aseptic manipulation competency evaluation consists of visual observation, media fill testing, followed by post compounding gloved fingertip and thumb sampling, as well as surface sampling of the direct compounding area.
   c. Personnel compounding category 1 and category 2 CSPs shall successfully complete an aseptic manipulation competency initially and every 6 months.
   d. Personnel who have direct oversight of compounding personnel, **but do not compound**, may complete aseptic manipulation competency every 12 months. Personnel who have direct oversight of compounding are not allowed to compound unless they successfully complete the aseptic manipulation competency at the same requirement as for compounding personnel.
   e. Media-fill testing for aseptic manipulative skills shall be performed initially and every 6 months.
      i. Immediately following completion of the media-fill test, GFT sampling must be performed on both hands inside of an ISO class 5 PEC.
      ii. Surface sampling of the direct compounding area must occur after compounding completion. A failure in the media fill, GFT, or surface sample constitutes an overall failure of the aseptic manipulation competency.
      iii. Bags are examined daily for turbidity. Turbidity indicates positive growth of microorganisms which fails the test.
      iv. If the minibag is clear, the test is negative, and the compounding personnel has passed the test.
      v. Successful completion of GFT post compounding is defined as less than or equal to 3 CFU as a total from both hands. Microbial

identification is not required for gloved fingertip and thumb sampling.

f. Media fill tests shall simulate the most difficult and challenging aseptic compounding procedures encountered; the components shall be replaced with the use of soybean-casein digest media. The media fill test must capture factors that may affect sterility of a CSP including but not limited to:
   i. Length of the process that can create contamination risk (e.g., operator fatigue, quality of equipment)
   ii. Number of aseptic additions or transfers
   iii. Number, type, and complexity of manipulations.
   iv. Number of personnel in the buffer room or SCA

g. If commercial sterile microbial growth media is used, a certificate of analysis must be on record from the supplier stating that the lot of growth media will support the growth of microorganisms.

h. Growth media shall be stored according to manufacturer instructions.

4. Any employee who fails any of the above competencies will be unable to work in the IV compounding room until competence is certified and will be placed on a performance improvement plan. The employee will be retrained and re-evaluated to assure correction of all aseptic practice deficiencies and will repeat the competency testing in 6 months.
5. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.

E. <u>Facilities and Equipment Controls</u>

1. Facility Design
   a. The surfaces, ceilings, walls, floors, doors, door frames, fixtures, shelving, work surfaces, counters, and cabinets in the classified clean room area must be smooth, impervious, free from cracks and crevices, and non-shedding so they may be cleaned and disinfected and to minimize spaces in which microorganisms and other contaminates can accumulate.
   b. Surfaces should be resistant to damage by cleaning agents, sporicidal and other types of disinfectants and tools used to clean.
   c. Seals and sweeps should not be installed at doors between buffer rooms and anterooms. Access doors should be hands free. Tack mats must not be placed within ISO classified areas.
   d. Junctures between the ceiling and the walls and between the walls and the floor must be sealed to eliminate cracks/crevices where dirt can accumulate.
   e. If ceilings consist of inlaid panels, panels must be caulked around each panel to seal them to the support frame.
   f. Walls must be constructed of durable material and integrity must be maintained. Panels must be joined together and sealed to each other and the support structure.

g. Floors must include coving to the sidewall, or the juncture between the floor and the wall must be caulked.
h. Ante rooms must have a line of demarcation to separate the clean side from the dirty side. The anteroom shall be entered through the dirty side, and the clean side is closest to the buffer room.
i. Classified areas should minimize dust collecting overhangs such as ledges and windowsills. If present, the overhangs, and windowsills must be easily cleanable.
j. Surfaces within an SCA should be smooth, impervious, free from cracks and crevices, and non-shedding so that they can be easily cleaned and disinfected to minimize microorganisms and other contaminant accumulation.
k. Surfaces in an SCA should be resistant to damage by cleaning agents, sporicidal and other types of disinfectants and tools used to clean.
l. SCA areas should minimize dust collecting overhangs such as ledges and windowsills. If present, the overhang and windowsills must be easily cleanable.
m. Water Sources and Sink Placement: The facility where CSP's are prepared must be designed so that activities such as hand hygiene and garbing will not adversely affect the ability of the PEC to function as designed. Sinks should enable hands-free use.
    i. If the sink is located outside of the anteroom, it must be located in a clean space to minimize the risk of bringing contaminants into the anteroom.
    ii. If the sink is located outside of the anteroom, it may be placed on either the clean or the dirty side of the anteroom.
    iii. The buffer room must not contain plumbed water sources.
    iv. The anteroom must not contain floor drain(s)
    v. In a facility with an SCA design, a hand- washing sink must be placed not closer than 1m to the PEC and may be either inside the SCA or in close proximity to the SCA.

2. Ante-area
    a. Environmental services (EVS) staff will clean floors daily when no aseptic operations are in progress and document the cleaning on the EVS cleaning log.
    b. Racks, bins, equipment, and shelving will be cleaned weekly and documented on the EVS cleaning log.
    c. Ceilings and walls will be cleaned weekly by EVS staff and documented on the EVS cleaning log.
    d. Air quality testing will be done every 6 months and surface quality testing will be done every month by a qualified certification company.
3. Buffer Area
    a. Environmental services (EVS) staff will clean floors daily when no aseptic operations are in progress and document the cleaning on the EVS cleaning log.

b. Racks, bins, equipment, and shelving will be cleaned weekly and documented on the EVS cleaning Log.
c. Ceilings and walls will be cleaned weekly by EVS staff and documented on the EVS cleaning log.
d. Air quality testing will be done every 6 months and surface quality testing will be done every month by a qualified certification company.
e. Air pressure gradients between the buffer area and the ante area will be monitored daily.

4. Equipment Controls
   a. All intravenous (IV) solutions with additives made in the pharmacy shall be prepared in a PEC, either a horizontal laminar airflow workbench (LAFW) or in a vertical LAFW which is also known as a Class II Biological Safety Cabinet type B2 (BSC) or in Compounding Aseptic Isolator (CAI) and dispensed by the pharmacy department.
   b. Compounded sterile products shall be prepared in an ISO Class 5 environment (LAFW,BSC or CAI) located within an ISO Class 7 buffer area and separated from the pharmacy proper by an ante-area.
   c. The exception to this shall be for “Immediate Use” products which may be prepared by trained registered nurses or providers in an urgent/emergent situation.
   d. The PECs shall be located in a buffer room of a clean room suite or SCA that minimizes conditions that may increase risk of microbial contamination.
   e. A PEC may be located within an unclassified area without an anteroom or buffer room; this design is referred to as a segregated compounding area (SCA). The SCA must be located away from unsealed windows, doors that connect to outdoors, and traffic flow. The area within 1 meter of the PEC should be dedicated only for sterile compounding.
   f. ISO classified anterooms and buffer rooms must be separated from surrounding unclassified areas by fixed walls and doors. Classified rooms must be equipped with a pressure-differential monitoring system.

Summary of Minimum Requirements for Placement of PECs for Compounding of Non-Hazardous CSPs

PEC Type	Device Type	Placement for Compounding Only Category 1 CSPs	Placement for Compounding Category 2 and 3 CSPs
LAFS	LAFW	Unclassified SCA	ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom

	BSC	Unclassified SCA	ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom
	CAI	Unclassified SCA	ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom

5. Air Quality, Air Exchanges, Air Pressure Differential and Monitoring
    a. Clean room suites are required to maintain adequate HEPA filtered airflow to buffer rooms and ante rooms. Air supplied to the cleanroom suite must be introduced through HEPA filters that are located in the ceiling of the buffer and anteroom. Air quality standards are listed in the table below:

    b. A minimum of 30 total HEPA filtered air changes per hour (ACPH) must be supplied to ISO class 7 rooms
        i. The total HEPA filtered air change rate must be adequate to maintain ISO class 7 during dynamic operating conditions.
        ii. At least 15 ACPH of the total air change rate must come from the HVAC through HEPA filters located in the ceiling.
        iii. The HEP filtered air from PECs when added to the HVAC-supplied HEPA filtered air must increase the total air changes to at least 30 ACPH.
    c. A minimum of 20 total HEPA filtered ACPH must be supplied to ISO Class 8 rooms
        i. The total HEPA filtered air change rate must be adequate to maintain ISO class 8 during dynamic operating conditions.
        ii. At least 15 ACPH of the total air change rate in a room must come from the HVAC through HEPA filters located in the ceiling.
    d. Air Returns in the cleanroom must be low on the wall unless a visual smoke study demonstrates absence of stagnant airflow.

Summary of ISO Classification and Particulate Matter in Room Air

ISO Class	Particle Count per Cubic Meter
3	35.2
4	352
5	3520
6	35,200
7	352,000

8	3,520,000

Summary of ACPH Requirements for Non-Hazardous Sterile Compounding Areas

Compounding Area	ACPH Requirement
Unclassified SCA	No requirement
ISO Class 7 room(s)	Greater than or equal to 30 ACPH
ISO Class 8 room (s)	Greater than or equal to 20 ACPH

6. Air Pressure Differential Monitoring:
    a. Air pressure gradients between the buffer room, ante-area, and the pharmacy proper shall be monitored continuously using a pressure differential monitoring device and documented at least daily when compounding is occurring.
    b. Continuous air pressure differentials are required to minimize airflow from an area with lower air-quality classification to an area of higher air quality classification.
    c. No pressure differential is required between an SCA and the surrounding areas.

Air Pressure Differential Range Requirements

Type of Pressure Gradient	Range	Alarm Set Point
Positive (+)	0.02 to 0.05 “WC	Less than (+) 0.02
Negative (-)	-0.01 to -0.03 “WC	More than (-) 0.01

7. Temperature and Humidity Monitoring:
    a. The cleanroom suite should be maintained at a temperature of 20 ºC (68 F) or cooler and a relative humidity of 60% or below.
    b. Temperature and humidity must be monitored and documented daily for each day that compounding activities are performed.
    c. Temperature and humidity in the cleanroom suite must be controlled through a heating, ventilation, and air conditioning (HVAC) system.
    d. Free standing air conditions, humidifiers, and dehumidifiers must not be used within the classified areas or the SCA.
8. Primary Engineering Controls (PECs) and Equipment:
    a. Horizontal Laminar Airflow Workbench (LAFW):
        i. *Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area* – for guidance on cleaning procedures and requirements.
        ii. *Refer to SOP – Quality Assurance of Compounded Sterile Products and Certification of Sterile Compounding Area* – for guidance on certification procedures and requirements.
    b. Biological Safety Cabinet (BSC):

i. *Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area* – for guidance on cleaning procedures and requirements.
ii. *Refer to SOP – Quality Assurance of Compounded Sterile Products and Certification of Sterile Compounding Area* – for guidance on certification procedures and requirements.

c. Compounding Aseptic Isolator
   i. *Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area* – for guidance on cleaning procedures and requirements.
   ii. *Refer to SOP – Quality Assurance of Compounded Sterile Products and Certification of Sterile Compounding Area* – for guidance on certification procedures and requirements.

d. Refrigerators
   i. Temperatures will be recorded and maintained in accordance with hospital policy. (Please See *AHS Medication Storage policy)*
e. Incubators
   i. Temperatures will be recorded and maintained in accordance with hospital policy. (Please See *AHS Medication Storage policy)*
f. (If applicable) Measuring equipment will be calibrated and certified annually by the California Department of Weights and Measures.

F. Sterile Compounding Area Certification and Recertification

1. Designated Person(s) Responsibilities:
   a. The designated person(s) must ensure that each area and PEC meet the classified air quality standard(s) for appropriate activities to be conducted in those areas.
   b. A corrective action plan must be implemented and documented in response to any out-of-range results.
   c. Data collected in response to corrective actions must be reviewed to confirm that the actions taken have been effective.

2. PEC, SEC Certification and Frequency:
   a. Certification of the classified areas including the PEC must be performed initially, and at least every 6 months. Testing must include:
      i. Airflow testing
      ii. HEPA Filter Integrity Test
      iii. Total Particle Count
      iv. Dynamic Airflow Smoke Patter Test

b. Classified areas must be recertified if there are changes to the areas including, redesign, construction, replacement, or relocation of any PEC
c. Classified areas must be recertified if there are alterations in the configuration of the room that may affect airflow or air quality
d. Number of persons present in PEC and SEC during total particle count testing and dynamic airflow pattern certification testing must be documented
e. All records must be reviewed by designated person(s) to ensure that the classified environments meet the minimum requirements.
    a. Documentation of review must occur. Any corrective action must also be documented.

3. Microbiological Air and Surface Monitoring
    a. The monitoring program involves collection and evaluation of samples from various air and surface locations. Results of microbiological air and surface sampling shall be reviewed in conjunction with personnel data to assess the state of control and identify potential risks of contamination.
    b. Microbiological air and surface sampling must be conducted in all classified areas during dynamic operating conditions
    c. The microbiological air and surface monitoring program must be clearly described in the facility's SOP, which must include a diagram of sampling locations, procedures for collecting samples, frequency of sampling, size, time of day of sampling in relation to activities in the compounding area, and action levels that will trigger corrective action.
    d. Air and surface sampling must be incubated in an incubator at the temperatures specified.
    e. Incubator must be placed in a location outside of the of the sterile compounding area.
    f. The incubator temperature must be monitored during incubation using either manual or continuous recording device.
    g. Results must be reviewed and documented for air and surface sampling.
    h. Sampling must include:
        i. Viable impact volumetric airborne particulate sampling
        ii. Surface sampling

    i. Viable Air Sampling must be performed at least every 6 months.
    j. Sterile Compounding Areas that compound category 1 and 2 CSPs must perform viable surface sampling at least monthly.

Compound Type	Viable Sample Type	Frequency
Category 1 & 2	Air	Every 6 months

Category 1 & 2	Surface	Every 1 month

4. Microbiological Sampling Data Evaluation and Action Levels
    a. Evaluation of the CFU counts against the action levels referenced and previous data shall occur to identify any adverse results or trends in environmental monitoring.
    b. If two sampling media devices are collected at a single location, all recovered growth on each must be documented and action levels applied to each sampling media device separately.
    c. If action levels are exceeded, the cause must be investigated, and corrective action taken
    d. Data collected as part of a corrective action plan must be reviewed to confirm effectiveness. Corrective action plan must be dependent and responsive to the CFU count and types of microorganisms recovered. The investigation should include an evaluation of trends.
    e. If measured levels exceed the action limits, an attempt must be made to identify microorganisms to the genus level.
    f. The corrective action plan must be documented.

Action Levels for Surface Sampling

ISO Class	Surface Sampling Action Levels (CFU/media device)
5	>3
7	>5
8	>50

Action Levels for Air Sampling

ISO Class	Air Sampling Action Levels [CFU/Cubic Meter (1000 liters) of air/media device]
5	>1
7	>10
8	>100

G. Cleaning of Sterile Compounding Area(s)

1. Refer to *SOP – Cleaning & Disinfecting Sterile Compounding Area for Pharmacy & Supporting Personnel*
    a. All cleaning and disinfecting activities must be performed by trained and appropriately garbed personnel using facility approved agents and procedures.
    b. Cleaning must be performed in the direction of cleanest to dirtiest areas.
    c. Floor Mops may be used to clean a non-hazardous buffer room and ante room but in that order to ensure areas are being cleaned from most clean to dirty.
    d. Cleaning equipment used in HD compounding areas may not be used to clean any other areas.
    e. All documentation logs for cleaning shall be maintained and stored in the pharmacy for three years from when it was created.
    f. Cleaning of surfaces in classified areas used to prepare category 1 and 2 CSPs must be:
        i. Cleaned
        ii. Disinfected
        iii. Sporicidal Disinfectants applied
    g. Environmental services (EVS) staff will perform the following when no aseptic operations are in progress and document in the EVS cleaning log
        i. Clean and sanitize IV room floors and empty trash daily
        ii. Clean racks, bins, equipment, exterior workbench surfaces, ceilings and walls shelving weekly with approved disinfectant solution
        iii. Non-shedding wipes and mops are dedicated for Pharmacy use only
    h. Pharmacy staff will perform and document the following in the cleaning log:
        i. Clean sink area, IV room counters, work-top surfaces, and baskets daily
        ii. Clean IV PEC(s) each shift and as needed.

H. <u>Storage and Handling of CSPs</u>

1. Compounding personnel are responsible for ensuring that CSPs are accurately identified, measured, diluted, mixed, and are packaged, sealed, labeled, stored, dispensed, and distributed appropriately.
2. Solutions, medications, supplies, and equipment used to prepare sterile products will be stored in accordance with manufacturer or USP requirements.
3. When CSPs are known to have been exposed to storage or temperatures outside of the recommended parameters, the manufacturer will be contacted for specific lot and expiration information and instructions for shortened dating or disposal.
4. Temperatures in refrigerators and/or freezers used to store medications and compounded sterile products will be monitored and documented twice daily if such monitoring is not done though the Pyxis Smart Remote System.

5. When a temperature falls out of range, engineering will be contacted, and documentation of out-of-range temperatures will be recorded.
6. Cytotoxic drugs (if any) shall be handled and safely disposed of in accordance with the *AHS policy on Medications: Hazardous Drugs Preparation and Handling*.
7. Spills of hazardous drugs shall be handled and cleaned up using chemo spill kits, material safety data sheets (MSDS) and in accordance with Occupational Safety and Health Administration (OSHA) laws and regulations.
8. Medications, supplies, and compounding equipment will be stored on shelves, cabinets, and carts to facilitate appropriate cleaning.
9. Products that have exceeded their expiration date will be removed from active storage areas and will be placed in a segregated, clearly defined area of the pharmacy.
10. Before any item is brought into the clean side of an anteroom, placed into a pass-through, or brought into the SCA, it must be wiped with a sporicidal disinfectant, EPA-registered disinfectant, or sterile 70% IPA using low-lint wipes by personnel wearing gloves.
    a. The wiping procedure should not compromise the packaging integrity or render the product label illegible.
11. Before any item is introduced into the PEC, it must be wiped using sterile 70% IPA using low-lint wipes and allowed to dry before use.
    a. The wiping procedure should not compromise the packaging integrity or render the product label illegible.
12. Before use, each medication, ingredient, and container will be visually inspected for damage, defects, and expiration date.
13. Critical sites must be wiped with sterile 70% IPA in the PEC to provide both a chemical and mechanical action to remove contaminants. The sIPA must be allowed to dry before entering the package.

I. Record Keeping of Compounded Sterile Products

1. Master Formula Records
    a. No drug product may be compounded until the pharmacy has first prepared a written master formula record that includes at least the following elements:
        i. Name and Strength of the compounded drug preparation.
        ii. Active ingredients to be used.
        iii. Equipment to be used.
        iv. Inactive ingredients to be used.
        v. Process and/or procedure used to prepare the drug.
        vi. Quality reviews required at each step-in preparation of the drug.
        vii. Post-compounding process or procedures required, if any.
        viii. Expiration dating/Beyond Use dating requirements.
        ix. Instructions for product labeling, storage, and handling.

2. Where a pharmacy does not routinely compound a particular drug product, the master formula record for that product may be recorded on the prescription document itself.
3. The pharmacy maintains formula record(s) for each compounded drug product. These records are maintained and readily retrievable for at least three years from the date the record was created. The record shall include:
    b. The master formula record
    c. Active ingredient used.
    d. Inactive ingredient used.
    e. IV solution or diluents
    f. Date the drug product is compounded
    g. Two patient identifiers and order number
    h. Drug lot number, manufacturer, expiration date and quantity or volume of each component used in preparing the drug product
    i. The quantity or amount of the final compounded drug product
        i. Pharmacy shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products and components used in compounding
        ii. Chemicals, bulk drug substances, drug products, and components used to compound drug products shall be obtained from reliable suppliers. The pharmacy shall acquire and retain any available certificates of purity or analysis for chemicals, bulk drug substances, drug products, and components used in compounding. Certificates of purity or analysis are not required for products that are approved by the Food and Drug Administration
    j. Equipment used in compounding the drug product
    k. Pharmacy assigned reference or lot number for the compounded drug product
    l. Technician initial who prepared the drug product
    m. Pharmacist initial who reviewed the final drug product
    n. Beyond Use Date (BUD) of the final compounded drug product

I. Beyond Use Date Determination

1. CSPs prepared by the pharmacy department will have appropriate beyond use dates clearly indicated on the label.
2. Beyond-use dates are assigned according to the chemical and physical stability of the medication and based on USP <797> guidelines established for category 1, 2, and 3 products for sterility. The dates shall be supported by references, literature searches, written documentation, and/or published studies from reliable sources.
3. Product labels shall be legible and accurate indicating the date and time of beyond use or expiration.
4. Beyond-Use Dating will apply to the following:

a. Compounded Intravenous Admixtures – beyond use dating is based on USP <797> guidelines and is determined by the risk level assigned to the product.
b. Category 1: must be prepared in an ISO Class 5 or better primary engineering control that may be placed in an unclassified segregated compounding area. Beyond use dating is determined by medication stability, but cannot exceed the following:
    i. 12 hours at CRT (controlled room temperature)
    ii. 24 hours in a refrigerator
c. Category 2: CSPs must be prepared in a cleanroom suite. Beyond use dating is determined by medication stability, but depending on the following factors, cannot exceed the following:
    i. If aseptically processed, no sterility testing, and only sterile starting components:
        1. 4 days at CRT
        2. 10 days in a refrigerator
        3. 45 days in a freezer
    ii. If aseptically processed, no sterility testing and one or more nonsterile starting component(s)
        1. 1 day at CRT
        2. 4 days in a refrigerator
        3. 45 days in a freezer

d. Proprietary bag and vial system -
i. Docking for immediate use is not considered compounding
ii. Docking for future activation and administration is considered compounding
    i. Cannot exceed BUD specified in manufacture's labeling.

J. Compounded Sterile Product Recall

Steps to be taken in the event of a drug recall. Based upon California Business and Professional Code Section No. 4127.9(a):
A pharmacy licensed pursuant to Section 4127.1 or 4127.2 that issues a recall notice regarding a sterile compounded drug shall, in addition to any other duties, contact the recipient pharmacy, prescriber, or patient of the recalled drug and the board as soon as possible within 12 hours of the recall notice if both of the following apply:

- (1) Use of or exposure to the recalled drug may cause serious adverse health consequences or death.
- (2) The recalled drug was dispensed, or is intended for use, in this state for more details please refer to Medication – Drug Recall policy and SS-SOP: Recall of Sterile Compounded product.

K. **Complaint Handling:** All complaints including but not limited to concerns or reports on quality, labelling or possible adverse reactions related to a specific CSP will be handled appropriately.

A designated person(s) must review all complaints to determine whether

i. The complaint indicates a potential quality problem with the CSP.

ii. If it does, a thorough investigation into the cause of the problem must be initiated and completed. The investigation must consider whether the quality problem extends to other CSPs. Corrective action, if necessary, must be implemented for all potentially affected CSPs.

iii. Consider whether to initiate a recall of potentially affected CSPs and whether to cease sterile compounding processes until all underlying problems have been identified and corrected.

- This will be handled throught the MIDAS – Safety Alert System.

L. Adverse Drug Reaction

Adverse effects reported or potentially attributable to a pharmacy's sterile drug product shall be reported to the board within 12 hours and immediately reported to the MedWatch program of the federal Food and Drug Administration

M. Packaging and Transporting of CSPs

- Packaging materials should protect CSPs from damage, leakage, contamination, degradation, and adsorption while preventing inadvertent exposure to transport personnel.
- Alternative modes of transport and/or special packaging (e.g., tamper-evident closures) may be needed to protect the quality of CSPs. If the CSP is sensitive to light, light-resistant packaging materials must be used. In some cases, the CSP must be packaged in a special container (e.g., a cooler) to protect it from temperature fluctuations.
-

N. Quality Assurance Program

1. The CSP QA Program is intended to provide a mechanism for monitoring, evaluating, correcting, and improving the activities and processes described in USP 797.

2. The following must be documented:
   a. Training and competency of compounding and checking employees
   b. Master Formula Records used for compounding
   c. Refrigerator and freezer temperature logs
   d. Certification of LAFW/BSC/CAI

e. Cleaning logs of the room and LAFW/BSC/CAI

3. The following tests will be performed to ensure sterility in compounding sterile room.
   a. Glove fingertip testing biannually for employees who compound CSPs.
   b. Media Fill Testing biannually for employees who compound CSPs.
   c. End product evaluation that includes endotoxins, sterility and potency testing will be performed on two compounded samples every six months.
   d. Results from end product evaluations will be reviewed and documented by the pharmacist-in-charge or a designated person.
   e. In the event a sample product is discovered to be outside the appropriate threshold or below the minimum standards for sterility, potency, or endotoxin, the following actions will be implemented:
      i. Designated person(s) will investigate and formalize an action plan.
      ii. A different staff member will perform the same test and a new sample product will be sent in for repeated testing.
      iii. If the new sample product meets standards, the staff who initially performed the below standards will repeat training and aseptic technique competencies with a designated pharmacist. Staff must pass competencies prior to resuming any compounding activities.
      iv. If the new sample product does not meet standards on the repeated test, the IV room will be sanitized and cleaned immediately before any patient care activities resume. A qualified certification company will be scheduled to come in for IV room and hood re-certifications.
   f. Results from end product evaluations will be reviewed and documented by the pharmacist-in-charge or a designated pharmacist.
   g. If an action plan must be implemented, it will include the following:
      i. Designated pharmacist will investigate and formalize an action plan.
      ii. Both pharmacy management and EVS management will be alerted and will immediately terminally clean the area.
      iii. Testing will be redone by a qualified company, and if the new sample does not meet testing standards, the area will be sanitized and cleaned immediately before any patient care activities resume

4. A summary report on the QA program will be presented to the Medication Safety Committee and Quality Council quarterly.

References

1. USP<797> 2022 Version May 1 2024.
2. California Pharmacy Lawbook 2023

3. ASHP Guidelines on Compounding Sterile Preparations 2014

Approvals

		System	SLH/HH/JF/FM	ALH
Departmental	**Date:**			
System Pharmacy and Therapeutics Committee (P&T)	**Date:**	**1/2025**		
Clinical Practice Committee (CPC)	**Date:**	**2/2025**		
Medical Executive Committee	**Date:**	**2/2025**		
Board of Trustees	**Date:**	**3/2025**		

ALAMEDA HEALTH SYSTEM

CASH CONTROL AND TRANSACTIONS

Site	Alameda Health System	***Previous Revision Dates***	1/2023, 1/2026
Effective Date	No Date Set	***Date Revised***	
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	1/2026, 1/2029
Executive Responsible	Please Fill In		
Approvals	Departmental		

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Policy

The cash register is used to facilitate transaction and receipts of cash (including bank charge transactions) as well as charges to the patient's hospital account (discharge invoices).

Procedure

1. The cash register is preprogrammed, and a final report is generated via EPIC at close of business.
    a. The morning pharmacist is responsible for unlocking the register at the time the pharmacy is opened and locking the register keys into C2 safe when done.
    b. The assigned pharmacy technician will verify the cash count and document on workflow for the day.
    c. The pharmacist or technician will process all *cash type transactions* through the register under the appropriate prescriptions. Receipts will be generated automatically after each transaction. Receipt will be given to the patient.
    d. Copayments for discharge prescriptions will be processed via an invoice that is presented to the patient and mailed for follow up
    e. In addition, the pharmacist or technician will:
        i. Process bank card transactions
        ii. Promptly replace receipt tape.
    f. The assigned technician will complete Epic reports daily and count each register to remove amount to be deposit next day.
    g. The closing outpatient pharmacist is responsible for locking the cash and reports into the C2 Safe by the end of the shift.
    h. The technician will take deposit and reports to the cashier window at the assigned time, every other day.
    i. The pharmacy manager/PIC/PSC or designee will record deposit and reconcile with receipts from cashier office weekly.

Approvals

Departmental	**Date: 10/14/2022; 1/1/2026**

ALAMEDA HEALTH SYSTEM

PHARMACY THERAPEUTIC DRUG MONITORING POLICY

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	No Date Set	***Date Revised***	Not Approved Yet
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	No Review Date
Executive Responsible	Please Fill In		
Approvals	BOT, QPSC		

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PURPOSE

To authorize Clinical Pharmacists to order selected drug levels and related laboratory values for the inpatients of Alameda Health System to enhance the safe and effective use of these drugs.

JUSTIFICATION

Drug related problems are known to increase morbidity, mortality and healthcare costs. Drug related problems such as non-optimal use of dose, drug interaction and need for monitoring are more frequently associated with narrow therapeutic index drugs.

DEFINITIONS

TDM – Therapeutic Drug Monitoring
Trough – 30 min before the next scheduled dose.
Peak – 1 Hour post dose (Time to peak may be used to determine alternative peak times).

POLICY

1. When indicated, Clinical Pharmacists may order drug levels and related laboratory values such as serum creatinine and albumin for narrow therapeutic index drugs:

Drug	Optimal Sampling Time	Time to Steady State
Carbamazepine	Trough	Unable to predict since autoinduction
Digoxin	Trough (If loading dose given, draw serum concentration 12-24h after the initial loading dose)	Normal renal function: ~7 days Impaired renal function: ~at least 14 days
Drug	**Optimal Sampling Time**	**Time to Steady State**
Lithium	Trough	~5 days*

Phenobarbital	Trough	~14 days
Phenytoin	Trough	6-7 days
Theophylline	Peak (After initial dose and before each dose increase)	1-3 days (depends on factors)
Valproic Acid	Trough	3-4 days (may depend on formulation)

2. Indications for drug monitoring include (but are not limited to):
    a. Newly prescribed drug
    b. New dosage change of drug
    c. Change in renal or liver function
    d. Drug interactions
    e. No or non-therapeutic drug level within the past six months

3. Pharmacy and nursing staff will work together to determine the optimum time for specimen collection. For TDM to be meaningful, the patient should be in steady-state on the present dose of the drug or for nephrotoxic medications to be checked prior to steady state to help assess with appropriate dosing. In general, samples should be taken after drug dosing has continued for at least four half-lives.

4. In cases of suspected toxicity, waiting to attain steady-state is not necessary and a random drug level may be collected to aid in clinical decision making.

5. After ordering the drug level, the Clinical Pharmacist will follow, interpret the level and contact the patient's physician for any recommendations and/or dosage adjustments if needed.

6. Clinical Pharmacists will maintain competency in this area of practice via an annual competency exam.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
System Clinical Leadership	**Date:**	10/2025		
System Pharmacy and Therapeutics (P&T)	**Date:**	10/2025		
Clinical Practice Council (CPC)	**Date:**			
Medical Executive Committee	**Date:**			
Board of Trustees	**Date:**		N/A	N/A

ALAMEDA HEALTH SYSTEM

MEDICATION ADMINISTRATION: CHEMOTHERAPEUTIC AGENTS

Effective Date	No Date Set	***Date Revised***	Not Approved Yet
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)	***Next Scheduled Review***	No Review Date
Executive Responsible	Director, Pharmacy		

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Definition

Antineoplatic therapy refers to medications primarily used to treat cancer. These agents are genotoxic, carcinogenic, teratogenic, and may cause reproductive toxicity, or organ toxicity. . Antineoplatic therapy include chemotherapies , immunotherapies, and targeted therapies (biologics).

Purpose

To ensure staff are competent to safely administer antineoplastic therapy in both inpatient and outpatient settings.

Policy

1. Antineoplastic therapy is administered to patients by licensed and approved personnel within their scope of practice.
    a. Interventional radiologists for chemoembolization
    b. Oncologists and interventional radiologists for intrathecal administration
    c. Advanced Practice Providers (APPs) under the supervision of oncologists for intrathecal administration
    d. Registered nurses (RNs) for intravenous, intramuscular, and subcutaneous administration.
        i. Chemotherapy certification is required for intramuscular (IM) and subcutaneous (SubQ) antineoplastic administration expect for IM methotrexate and IM or SubQ anti-hormonal agents (e.g. goserelin, leuprolide, fulvestrant, medroxyprogesterone, degarelix)

2. Employees who are pregnant, actively trying to conceive, or breast-feeding may elect to refrain from administering antineoplastic therapy.

3. RNs deemed competent to administer antineoplastic agents must have:
    a. Completed the Oncology Nursing Society Chemotherapy and Biotherapy course
    b. Passed a nationally standardized exam at the conclusion of the above course.
    c. Demonstrated clinical competency annually using the chemo skills checklist Clinical Practicum Evaluation for Chemotherapy Administration.

d. Registry and contract RNs must have completed a chemotherapy course and certification, the AHS chemo skills checklist, and must demonstrate clinical competency.

4. Antineoplastic medications are verified by independent checks by two pharmacists and two chemo-certified RNs prior to administration.

5. The pharmacy department will mix all antineoplastic medications and will attach and prime IV tubing on hazardous infusion bags. If further priming is necessary, return the bag to the pharmacy.

6. The specialty provider must be consulted prior to the administration of antineoplastic therapy for a sudden deterioration in the patient's condition or if the dosage is outside of the usual parameters.

7. The specialty provider must be contacted while administering antineoplastic therapy in the event of an unexpected reaction to the medication.

8. Vesicant antineoplastic agents shall not be infused with other medications unless ordered by the specialty provider for specific protocols.

9. Continuous infusion of antineoplastic medications will be administered via central venous catheters.

10. Implanted infusion catheters/devices (e.g. Portacath) or PICC lines are preferred for long-term antineoplastic administration.

11. Prior to administration of antineoplastic medications, the patency of the line is verified by aspiration of blood with a syringe, followed by normal saline flush.

12. When using implanted infusion catheters/devices:
    a. Needle placement is verified by line patency and blood return.
    b. Patency will be checked at least every shift
    c. For maintenance and care, refer to Central Venous Catheter (Central Lines/PICC/PORT-A-CATH) – Insertion, Maintenance and Removal policy

13. If IV solution (e.g. normal saline, 0.45% normal saline, or D5W) is run simultaneously through a chemotherapy line, ensure that the solution is compatible with the antineoplastic medication that is infusing
14. Protective personal equipment must be used by RN's when administering chemotherapeutic agents: non-absorbing gowns, ASTM certified chemotherapy nitrile gloves (double glove), face shield, mask and eye protector.

15. A chemotherapy spill kit shall be available for use in the event of a spill in any area that antineoplastic therapy is administered.

16. Extravasation antidotes are stored in and compounded by pharmacy (See Medication Administration: Chemotherapy Antidotes for Extravasation Management)

17. Antineoplastic medication administration and patient's tolerance to treatment are documented in the electronic health record (EHR)

18. Patients being treated with antineoplastic therapy will be monitored for side effects and symptoms continuously through the duration of the treatment.

Equipment

1. Non absorbing disposable gown and pad
2. ASTM certified chemotherapy nitrile gloves (non-sterile), gown, eye protector, face shield, masks
3. IV start kit or appropriate Central Venous Device equipment.
4. Antineoplastic medication using a closed system transfer device (CSTD)
5. Chemo Waste container
6. Yellow bag for antineoplastic-soiled linens
7. Optional: Normal Saline flushes

Procedure

Obtain an allergy history and document on the patient's record before administration of the initial dose.2. Check appropriate laboratory data comparing values to acceptable parameters. If findings are abnormal contact the provider. Labs should be drawn within 72 hours prior to administration of antineoplastic therapy unless otherwise noted by provider. If labs cannot be obtained within 72 hours due to a holiday, labs may be drawn on earliest business day prior to the holiday. Labs will only need to be drawn before day 1 of cycles consisting of consecutive days of treatment

3. Check that appropriate procedures (e.g. echocardiogram) are done prior to medication (e.g. anthracyclines, anti-HER2 medications) administration as specified on the orders
4. Verify that the height and weight is updated in the EHR. The body surface area (BSA) will be auto-calculated in the EHR.

5. Review all immediate and delayed side effects of the medications
6. Identify self to patient and reason for interaction
7. Identify patient via AHS approved dual ID method. .8. Explain procedure and any toxicities/side effects of the medications and answer patient's questions; utilize medication handouts as needed.
9. Inquire patient's response to previous therapy.10. Determine if patient has implanted infusion catheter/device.
11. Assess the patient's level of anxiety and readiness to learn; inform the patient of potential for allergic reaction and the necessity to report symptoms immediately.

13. Inform patient on procedure for reaching a nurse during treatment.
14. Ensure patient is comfortable and provide antiemetics, if ordered.
15.
16. Obtain baseline vital signs and record mental status in EHR.
17. CSTD adapter will be applied to the end of the tubing prior to hanging the infusion bag.
18. Prior to antineoplastic therapy administration, two chemo-certified nurses will verify patient's name, date of birth, medication name, dose, route, rate, bag volume, and beyond use date
18. If giving the antineoplastic agent IV push into a free flowing IV, aspirate back every few ml's to assure vein patency. If unable to obtain blood during aspiration, stop infusion immediately
19.
20. If multiple medications are to be given, flush primary tubing with compatible fluid between medications.21. Verify that the primary IV fluids is compatible with the antineplastic medication that is being administered at the same time.
22. If patient experiences a hypersensitivity reaction, initiate proper treatment (see Management of Acute Adverse Reactions (ADR) policy)
23. Documentation in EHR:
    a. Vital signs
    b. Route of administration
    c. Site of administration
    d. Appearance of central or peripheral catheter site prior to, during and at the conclusion of antineoplastic therapy administration
    e. Patient's tolerance to treatment including any hypersensitivity reactions
    f. Education with patient and family, if appropriate
    g. On Medication Administration Record (MAR):
        i. Medication name
        ii. Dosage
        iii. Route of administration
        iv. Site of administration
        v. Sequence of medication administration
        vi. amount and type of fluid administered

23. Chemotherapy contaminated needles and syringes shall be disposed of in puncture proof chemo waste containers.

24. Empty chemotherapy infusion bags, gowns, and gloves will be disposed of in chemo waste containers.
25. Face mask and shields will be disposed of in regular trash.

26. Any remaining (pourable) antineoplastic medication will be disposed of in RCRA waste containers (Black with white top).

27. Blood, vomitus and excreta from a patient who has received an antineoplastic agent is considered contaminated for 72 hours after administration has been completed.

a. Excretion precautions, consisting of gowning and gloving, will be used to handle excretions during the administration time and 72 hours following completion of the chemotherapy infusion.
b. Excretions will be disposed of in the usual and appropriate place (e.g., toilet)
c. All blood, vomitus, and/or excreta contaminated linen will be treated as though it is chemotherapeutic waste.

28. If a patient dies within 72 hours after administration, inform the coroner and morgue attendant of potential exposure risk.

Antineoplastic Therapy Verification

1. The oncologist or other qualified provider enters and signs orders in EHR

2. Prior to compounding antineoplastic therapy, one pharmacist will verify the protocol, medication name, height, weight, dose, laboratory data, necessary procedure (e.g echocardiogram), concentration, diluent type and volume, and frequency. A second pharmacist will then complete the second verification.

    a. If the pharmacist notices a 10% or more dose change from the previous cycle, the medication dose will be changed and the oncology provider will resign the order.
    b. If the dose is within 10% from the previous cycle, patients may receive the same dose

3.

4. Upon receipt of the antineoplastic medication, two chemo-certified RN's will complete the following verification process:
    a. Verify the patient with two identifiers and compare with label
    b. Compare the MAR with the label affixed to the antineoplastic medication for medication name, dose, route, rate, bag volume, and beyond use date/time
    c. Document medication administration in MAR

References

1. Siegel RD, LeFebvre KB, Temin S, et al. Antineoplastic therapy administration safety standards for adult and pediatric oncology: ASCO-ONS standards. *Oncol Nurs Forum*. 2024;1-24. doi:10.1188/24.ONF.1-24.AP
2. Neuss MN, Gilmore TR, Belderson KM, et al. 2016 updated American Society of Clinical Oncology/Oncology Nursing Society chemotherapy administration safety standards, including standards for pediatric oncology. *Oncol Nurs Forum*. 2017;44(1):31-43. doi:10.1188/17.ONF.31-43
3. The Joint Commission. MM.06.01.01
4. CMS 482.23 TAG A-0404, 0405, 0409

Approvals

		AHS Core	AH
Infusion Center	**Date:**	**9/2021**	
System Pharmacy and Therapeutics Committee	**Date:**	**9/2021**	
Clinical Practice Committee	**Date:**	**10/2021**	
Medical Executive Committee	**Date:**	**10/2021**	
Board of Trustees	**Date:**		

ALAMEDA HEALTH SYSTEM

FEMA OAKLAND URBAN SEARCH AND RESCUE TASK FORCE

Department	Pharmacy	***Effective Date***	05/1995
Campus	Highland Hospital	***Date Revised***	01/2020
Category	Clinical	***Next Scheduled Review***	07/2023
Document Owner	Director of Pharmacy	***Executive Responsible***	Chief Administrative Officer/ Chief Nurse Executive

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

POLICY

Alameda Health System (AHS), Highland Campus pharmacy will supply pharmaceuticals to the Federal Emergency Management Agency (FEMA), California Emergency Management Agency (Cal EMA), and Oakland California Task Force-4

PROCEDURE

1. The FEMA Oakland Urban Search and Rescue CATF-4 will provide to the Director of Pharmacy or designee a list of emergency medications to be immediately available for deployment by the Oakland CATF-4 when mobilized by FEMA or when conducting training exercises except as follows:
    a. Any medications or central supply items listed which could not be returned to AHS for re-issue due to refrigeration or sterility will not be issued for training exercises.
    b. Narcotics will not be issued for training exercises.

2. CATF-4 “Medical Specialist” will immediately call Highland pharmacy, (510) 437-4222, and request that the attached list of medications and central supplies be made available when the CATF-4 is being mobilized by FEMA or conducting training that will require the use of the medical cache.

3. Upon receiving a call from FEMA Oakland US&R Task Force for activation, the AHS pharmacy staff will order the FEMA cache from the wholesaler. The wholesaler will fill all the medications on the FEMA list EXCEPT for CIIs. CII medications on the list will be provided by Highland pharmacy.

4. Pharmacy staff will provide highest priority to CATF-4.

5. The Wholesaler will deliver the medications within 4-5 hours from when the order is placed.

6. CATF-4 “Medical Specialist” will pick up the medications. Pharmacy will obtain the IV fluids from central supply if necessary.

7. CATF-4 Medical Specialist below receiving the supplies must show a pictured Task Force ID (either MD or EMT-P) and sign for all items received.

NAME	POSITION
McPartland, David	Medical Team Coordinator
Ho, Jeff	Medical Specialist
Waite, Woody	Medical Specialist
Gray, Geoff	Medical Team Coordinator
Buell, Linda	Program Coordinator
Almedarez, Freddie	Medical Specialist
Meineke, Ryan	Medical Specialist
Strehl, Devin	Medical Specialist
Perez, Marc	Medical Specialist
Mahar, Paul	Medical Team Coordinator
Jarred, Neal	Medical Specialist

8. A pre-written narcotic order signed by CATF-4 physician below will be on file in the pharmacy to be filled when the CATF-4 is mobilized by FEMA or Cal EMA. Pre-signed DEA-222 by the CATF-4 physicians (minimum of two DEA 222 forms) will be kept in the outpatient CII safe. The pharmacist filling narcotics will complete the DEA-222 form. The narcotic order will be dated on the date of mobilization.

NAME	PHONE
Jayasekera, Neil	510-290-8306
Peterson, Bill	707-480-6113
Johnson, Malcolm	404-734-6252
Koo, Ralph	916-595-7856
Bains, Gurvijay	661-428-0826
Breyre, Amelia	516-835-2748
Ault-Riche, JeanMarc	650-793-0937

9. At the conclusion of any CATF-4 drill or deployment, AHS will accept the return of all emergency medications and central supply items that both parties (AHS and CATF-4) agree are reusable.

10. CATF-4 will pay for all used and non-returnable items received from AHS. Pharmacy buyer will create an invoice within three weeks and follow up on the status with Paramedic Team Manager at (510) 615-5872

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	N/A	N/A	01/2020
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	03/2020	N/A	N/A
Medical Executive Committee	**Date:**	N/A	N/A	04/2020
Board of Trustees	**Date:**	N/A	N/A	07/2020

	Plan	
	LEVEL ☐ System ☐ Site	**EFFECTIVE DATE:** **LAST REVIEW DATE:**

OVERVIEW/BACKGROUND

A. Alameda Health System (AHS) is an integrated public health care system with over 800 beds and 1000 physicians across nine major facilities throughout Alameda County. Founded in 1864 as Alameda County Infirmary, the System has a legacy of commitment to its communities that still serves as its foundation for growth.

B. Alameda Health System has the strength and responsibility to build relationships, and forge partnerships with government and community organizations to ensure better access to quality care for every resident of Alameda County.

C. The heart of its mission – caring, healing, teaching and serving all – continues to drive innovation, change and enhancement at Alameda Health System as it looks to promote wellness and eliminate disparities within the diverse communities it serves.

D. A solid body of evidence points to medication error as a significant source of preventable error in hospitals. The purpose of this plan is to describe the processes through which the organization assures the safe delivery of medications to patients. The Plan for Medication Safety will herein be referred to as "the Plan". The Plan is based on patient needs and rights, the mission and vision of the organization, and standards of professional practice. The Plan contains a description of the scope of services, oversight and management, delivery methodology, interdisciplinary collaboration, patient and family involvement, patient and family education, and plan for orientation, training and education of staff.

E. Alameda Health System (AHS) is committed to continuously improving patient safety and reducing health care errors through the establishment of a proactive processes that;

1. Encourages a non-threatening environment for reporting medical/medication events
2. Use of a system to identify, analyze, and implement measures to prevent the occurrence of medical/medication events
3. Foster awareness from historical incidents (internal and external)
4. And, spread current knowledge to improve patient safety

Improving patient safety and reducing medication events is conducted through a coordinated multidisciplinary approach. An organization-wide patient safety and error reduction program has been developed that integrates activities related to performance improvement, environmental safety, and risk management.

GOALS AND OBJECTIVES OF THE PLAN

A. Goal

1. It is the expectation of Alameda Health System Alameda Hospital that patient safety be the priority of the hospital thus our goal is to eliminate or substantially reduce medication related errors. In this plan we will address the seven objectives outlined in the California Health and Safety Code 1339.63.

B. Objectives

1. Evaluate, assess, and include a method to address each of the 11 components of medication use processes within the medication management system and to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.
    I. The 11 components of medication use processes that have been identified include:
        1. Prescribing
        2. Prescription Order Communication
        3. Product labeling
        4. Packaging and Nomenclature
        5. Compounding
        6. Dispensing
        7. Distribution
        8. Administration

9. Education
10. Monitoring
11. Use

II. Alameda Health System will annually review the effectiveness of the implementation of the 11 components of the procedures and systems.
   1. Will update P&T Committee and Quality and Safety Committee (QSC) on our progress with achieving satisfactory compliance in various procedures and systems.
   2. Progress over time will be tracked through occurrence reports and audits, allowing an overview of how the team is achieving the medication error reduction goals.

III. Modify this plan when weaknesses or deficiencies are noted to achieve the reduction of medication errors.
   1. Conduct rapid cycling of PDSA (Plan Do Study Act) to modify plan and achieve improvement.

IV. Describe the technology to be implemented and how it is expected to reduce medication-related errors.
   1. Implementation of infusion pump interoperability is planned for mid-2026. Infusion pump interoperability should help reduce manual programming and transcription errors; ensure infusion settings align with verified medication orders and provide automatic dose checks through integration with drug libraries.
   2. AHS implemented BD HealthSight Diversion Management System that will assists with opioid investigations, by creating an investigation workflow with access to analytics and anomalies. The system uses machine learning algorithms and multiple dispensing behaviors to surface clinicians whose behaviors indicates higher risk for diversion.
   3. AHS has implemented a Computerized Physician Order Entry (CPOE) system called “EPIC”. The implementation of the EPIC CPOE system and e- prescribing has helped reduce medication errors in the following areas as evident by a reduction in pharmacist interventions:
      A. illegibility problem
      B. improper drug doses
      C. potentially harmful drug-drug interactions
      D. potentially harmful drug use with a patient allergy
   4. The new integrated EHR, has allowed for the following support to help reduce medication errors:
      A. Ability to consolidate patient information multiple disparate systems into a single source.
      B. Linkage between the pharmacy and laboratory for critical values.
      C. Linkage between pharmacy and Food Nutrition Services to enhance our Page 3 of 8 processes for identification of food-drug interactions and improved TPN process.
      D. With the consolidation of the multiple disparate systems, an ability to capture past medical history and adverse drug reactions
   5. The Pharmacy System has upgraded their medication distribution system to allow for support to help reduce medication errors:
      A. Alameda installed and implemented Anesthesia Pyxis Machines in 2023. The Anesthesia Pyxis machines offers clinical workflows centering on the patient to help increase medication safety and anesthesia workflow efficiency. By controlling access to medication, it promotes compliance with regulatory requirements.
      B. The Micromedex information system and Up to Date information system is available to enhance the availability of medication information to the staff who prescribe, dispense and administer medications
      C. Epic labeling system contains headers to allow for easy identification of hazardous and antineoplastic agents.
      D. The Medication Error Reduction Team will continuously measure, analyze and evaluate the organization’s current and future technologies to ensure appropriate implementation and effectiveness.
      E. Pharmacy has implemented the Pyxis Profile System in all areas Trauma and code rooms in the ED.

V. Proactively identify actual or potential medication-related errors.
   1. The risk management database and reporting process was redesigned in 2002 to enhance our ability to track and trend medication variances. This upgrade decreased the lag time to analyze variance and develop preventive processes to reduce medication variances.
   2. In 2008, a new risk management system was installed into the organization. The system is named "3M" and will allow the submission of occurrence reports electronically.
   3. The paperless system will also notify Unit Managers and the Risk Management Department of events almost immediately after the event has been recorded into the 3M Occurrence Reporting System. This will improve follow-up time and eliminate the possibility of misplacing hardcopy occurrence reports. In addition, accurate data collection will assist in identifying the steps where mistakes most often occur and help with implementing safety systems that help prevent them.
   4. In 2015, the Midas Occurrence reporting system was purchased that allows custom data collection, more robust data reporting, promotes accountability and integrates corrective action plans and root cause analysis.
   5. In July 2016 the MIDAS AHS Safety Alert was implemented and is expected to improve both event reporting and follow up strategies that can enhance the safety culture for AHS patients and non-patients.
   6. In August 2022 the MIDAS AHS Safety Alert was revised to provide Unit Level Safety Alert Report to individual departments and revisions to the follow up to improve efficiency.

VI. Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical and administration, to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.
   1. The Medication Error Reduction Team has been delegated authority and responsibility for the Medication Error Reduction Plan by the organization's QSC. The Medication Error Reduction Team meet will meet at least quarterly and is an interdisciplinary committee with the following members:
      A. Physicians
      B. Pharmacists
      C. Nurses
      D. Administration (Quality, Regulatory, Patient Safety)
      E. Informatics/Epic Analysts
      F. Ad Hoc team members are included when necessary
   2. The chairperson of the Medication Error Reduction Team shall be the Pharmacy and Therapeutics Chairperson and/or his/her designee and the Medication Safety Officer and/or his/her designee.
   3. Medication Error Reduction Team assigned to oversee the Medication Safety Program has the following duties:
      A. Review and recommend approval of Medication Error Reduction Plan
      B. Evaluation of the Medication Safety Program
      C. Evaluation of medication safety issues and trends
      D. Review of pertinent PI data and measurements of medication and ADR events
      E. Review of procedures and policies to improve medication safety
      F. Submit a summary report to QSC at least biannually
      G. Provide annual evaluation and recommendation of the medication safety plan
      H. Recommend and initiate educational opportunities that originate from what is learned during the committees' assessment and evaluation of internal and external information and trends.
   4. The Medication Error Reduction Team will on a regular basis aggregate and assess all organizational data related to adverse medication events and provide ongoing reports to P&T.

VII. The Medication Error Reduction Team will include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate.
   1. Adopt a System-Oriented Approach to Medication Error Reduction.

2. Implement Standard Processes for Medication Doses, Dose Timing, and Dose Scales in a Given Patient Care Unit.
3. Standardize Prescription Writing and Prescribing Rules.
4. Limit the Number of Different Kinds of Common Equipment.
5. Use Pharmaceutical Software. f. Have the central pharmacy supply high-risk intravenous medications.
6. Use special procedures and written protocols for the use of high-risk medications.
7. Ensure the availability of pharmaceutical decision support.
8. Include a pharmacist during rounds of patient care units.
9. Make relevant patient information available at the point of patient care.
10. Improve patients' knowledge about their treatment

ORGANIZATION/GOVERNANCE

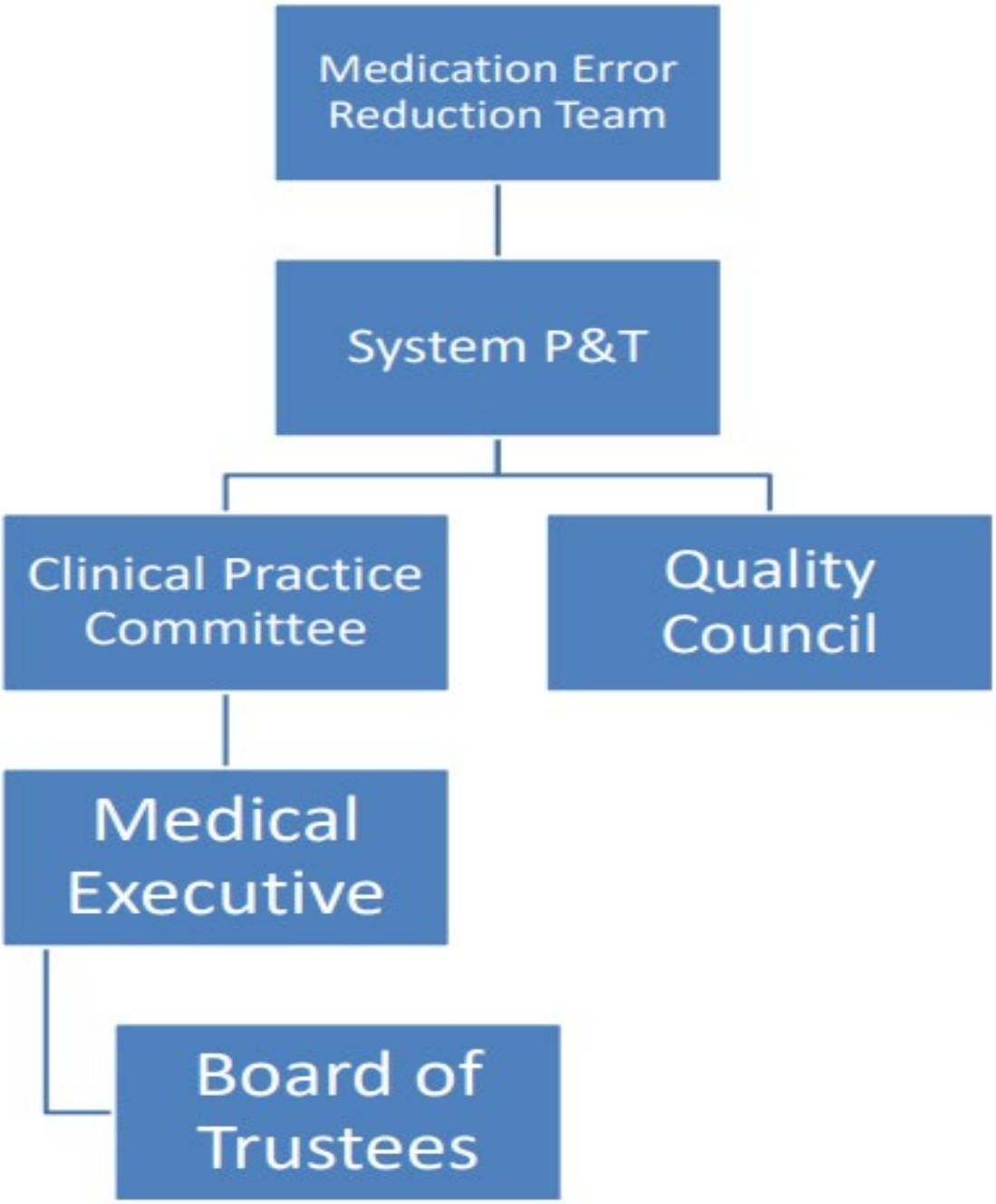
I. Authority & Responsibility

A. Board of Trustees

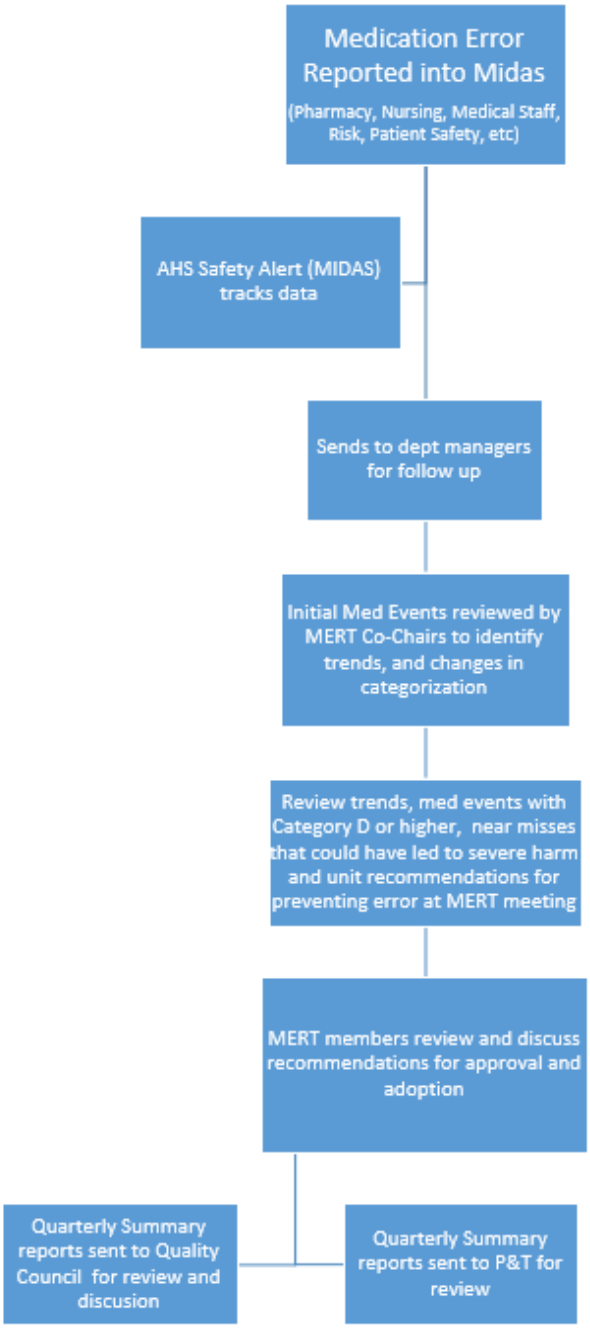
I. Medication safety begins at the AHS Board of Trustees. The Board acknowledges its accountability for medication safety and directs the establishment of a planned and systematic approach to preventing and addressing medication safety. The Board of Trustees delegates the implementation and oversight of this program to the Chief Executive Officer (CEO) of the hospital.

B. Chief Executive Officer

I. The CEO has been granted the authority and is responsible for assuring that this program is implemented, supported, and evaluated throughout the organization. As such, the CEO will establish the structures and processes necessary to accomplish this objective. The CEO delegates the day-to-day implementation and evaluation of this program to the VP of Quality.


Medication Error Reduction Team
System P&T
Clinical Practice Committee
Quality Council
Medical Executive
Board of Trustees

Medication Events Flow Chart



	Plan	
	LEVEL ☐ System ☐ Site	**EFFECTIVE DATE:** **LAST REVIEW DATE:**

11 Elements of MERP	Goal	Weaknesses or Deficiencies Identified	Methodology	Technology
Administration	Goal ≥95%	Improvement around administration of medications using appropriate guardrails with the Alaris Pump.	Obtain reports from pump on when guardrails are used. vs basic infusions.	BD CareFusion Guardrail Use Reports
Compounding	Goal =100%	Compliance to Monthly Surface Sampling Action Levels Action Levels: ISO Class 5: >3	Manual monthly surface sampling conducted by staff and third part agency using the appropriate microbiological growth plates	Manual monthly surface sampling conducted by staff and third part agency. Samples are incubated per USP 797 requirements and results are reported.
Compounding	Goal = 100%	Mismatch between Compounding logs and Compounding recipes.	# of accurate compounding logs audited quarterly / by total # of compounding	N/A – manual audits

			recipes (#10) (in alignment with BOP requirements)	
Dispensing	Goal ≥95%	Percent of Pyxis controlled-substance discrepancies resolved within 24 hours.	N - # of Pyxis discrepancies resolved within 24 hours D – Total pyxis discrepancies	BD CareFusion Knowledge Portal
Distribution	Goal = 0 events	Compliance to drugs being refilled in the pyxis in their accurate bins. Pyxis QA report for medication errors per SBOP.	Reported by staff when discovered during pyxis fills and audit	Tracking and trending through self-reported med events.
Distribution	Goal = 0 med events	Medications placed in the incorrect bins. Mixed inventory in the pharmacy.	Random bin audits for accuracy of med.	N/A – Manual Log sheet
Education	Goal <5%	Nurse education on entering the right weight based on MAR weight into the pump.	Tracking of medication events.	Midas
Education	Goal 0%	Ketamine nurse education on max dose of 30mg in med surg units.	Tracking of medication events.	Epic MAR report
Monitoring	Goal ≥ 95%	Compliance to Heparin Protocol-starting heparin drip at correct initial dose	Chart audits.	Use epic reporting to identify Heparin Patients
Packaging and Nomenclature	Goal = 0 new meds without barcode	Track compliance of new medication barcodes.	Obtain report from Epic BCMA PowerBI dashboard on "0%" scans and through self-reported Midas events.	Epic
Prescribing	Goal >95%	Compliance to obtaining medication history	Tracking through EHR chart audits.	Epic Power BI Dashboard
Prescription Order Communication	Goal <1%	% of unresolved unreconciled transactions per policy	N=# of unresolved unreconciled transactions >14 days D = total # of unreconciled transactions (BD Healthsite)	BD HealthSight Analytics
Product Labeling Goal	Goal ED: >95%	BCMA compliance in the ED	Epic data based on MAR administrations.	Epic Power BI Dashboard
Use	Goal >95%	Compliance for choosing the correct medication based on patient pain score	Retrospective Chart Audits	EPIC and BD HealthSight Analytics

	Plan	
	LEVEL ☐ System ☐ Site	**EFFECTIVE DATE:** **LAST REVIEW DATE:**

REFERENCES

California Department of Public Health Medication Error Reduction Plan | Institute For Safe Medication Practices (ismp.org)

APPROVALS

		System	AH
AH Medication Error Reduction Team Committee	Date:		1/2025
System P&T	Date:		
Clinical Practice Committee	Date:		
Medical Executive Committee	Date:		
Board of Trustees	Date:		

ALAMEDA HEALTH SYSTEM

SYSTEM MEDICATIONS: LOOK ALIKE, SOUND ALIKE

Effective Date	5/1/2024	***Date Revised***	4/2025
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	4/2028
Executive Responsible	DIRECTOR, PHARMACY		

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PURPOSE

To ensure Alameda Health System (AHS) has a system in place to eliminate medication errors caused by the procurement, storage, dispensing and administration of look alike, sound alike medications.

POLICY

- To assist with the reducing the likelihood of medication events associated with Look Alike/Sound Alike medications, AHS will make every effort to comply with the following risk reduction strategies:
  a. Pre-printed order forms or order sets will be used whenever possible.
  b. Prescribers should not give verbal or telephone orders for sound alike look alike medications and chemotherapeutics.
  c. Computer screen selection and automatic dispensing machine screens (ADM's) will use **Tallman Lettering** to display easily confused medications whenever possible.
  d. Medications labels will include both generic and trade names to make them easier to distinguish whenever possible.
  e. Separate look-alike or sound-alike medications in the pharmacy and in the automated dispensing machine in the units.

- Problematic medications and safety strategies identified will be instituted per the guidelines referenced below.

PROCEDURE

1. The Institute of Safe Medication Practices (ISMP) will be reviewed to identify those medications to add to AHS Sound Alike Look Alike List.

2. At least annually, AHS Pharmacy and Therapeutics Committee will review and update (if needed) the list of look-alike/sound alike drugs used by the organization

3. AHS will regularly provide information to professional staff on drugs that have been determined to be problematic through published reports or internal issues.

REFERENCES

1. The Joint Commission Medication Management MM.01.02.01

2. Institute for Safe Medication Practices: ISMP's List of Confused Drug Names

3. https://www.ismp.org/tools/confuseddrugnames.pdf

APPROVALS

		System
Departmental	**Date:**	1/2026
Pharmacy and Therapeutics (P&T)	**Date:**	1/2026
Clinical Practice Council (CPC)	**Date:**	
Medical Executive Committee	**Date:**	
Board of Trustees	**Date:**	

ACUTE CARE HOSPITALS

MEDICATIONS		SAFETY STRATEGY
ALPRAZolam	**LOR**azepam	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
aman**TADINE**	amio**DARONE**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
bu**PROPion**	bu**SPIR**one	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Captopril	Carvedilol	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Ce**FAZ**olin **–** Cef**TRIAX**one – Ce**FOX**itin – Cefo**TE**tan – Cef**TRIAX**one - Cef**TAZ**Idime		• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
CeleBREX	Cerebyx	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
carBAMazepine	**OX**carbazepine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
CISplatin (Platinol)	**CARBO**platin (Paraplatin **)**	• Pre-printed order forms are used to clearly identify medication being ordered. • Stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted. • Orders are double checked by two pharmacists and two nurses prior to administration.
DOPamine	**DOBUT**amine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
DOXOrubicin	**DAUNO**rubicin	• Pre-printed order forms are used to clearly identify medication being ordered. • Stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted. • Orders are double checked by two pharmacists and two nurses prior to administration.
FOSphenytoin (Cerebyx)	**PHENY**toin (Dilantin)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
glipi**ZIDE**	gly**BURIDE**	• Store separately from each other in different cubies in the ADM.

MEDICATIONS		SAFETY STRATEGY
		• Tallman lettering and Auxiliary label
Heparin	HEPARIN (pediatric strength versus adult)	• Stored in limited supply in Automated Dispensing machines. • Double checked by pharmacy before restocking Automatic Dispensing Machine (ADM) • Heparin drip requires double RN signature during medication administration and each dose titration
hydr**ALAZINE**	hydr**OXY**zine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
HYDROcodone	Oxy**CODONE** (immediate release)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
HYDROmorphone (Dilaudid)	morphine (Astramorph, Duramorph)	• Dispensing of these medications are controlled and tracked through the Automated dispensing machines. • Stored in the ADM in different cubies and/or different drawers. • Tallman lettering.
Insulin products • Lantus and Lente • Humalog and • Humulin • Novolog and • Novolin • Humalog and • Novolog • Novolin 70/30 and • Novolog Mix • 70/30	**H**umu**LIN** **H**uma**LOG** **N**ovo**LOG** **N**ovo**LIN**	• Only approved insulin products are stocked in the nursing unit to limit the variety. • The removal of insulin doses are recorded and tracked through the automated dispensing machines. • All insulin short acting medications are available as vials while insulin long acting medications are available as pens whenever possible. • All insulin medications are patient specific and clearly marked with auxiliary labels to differentiate the products and are patient specific (except for the ED). • Tallman lettering
LamoTRIgine	LevETIRAcetam	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Lev**ETIRA**cetam (Keppra)	Lev**OCARN**itine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label

MEDICATIONS		SAFETY STRATEGY
levo**FLOX**acin	lev**ETIRA**cetam	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Met**FORMIN** (GLUCOPHAGE)	metro**NIDAZOLE** (**FLAGYL)**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Dexamethasone	Dexmedetomidine	• Store separately from each other in different cubies in the ADM. • Auxiliary Label
methylene blue	**V**ision**B**lue	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
MS Contin (morphine extended release)	Oxy**CONTIN** (extended Release)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
niCARdipine	NIFEdipine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
predni**SONE**	predniso**LONE**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
PACLitaxel (Taxol)	**DOCE**taxel (Taxotere)	• Pre-printed order forms are used to clearly identify medication being ordered. • stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted. • Orders are double checked by two pharmacists and two nurses prior to administration.
PHENYLephrine (Neo-Synephrine)	**NOREPI**nephrine (Levophed)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
ri**FAM**pin	ri**FAX**imin	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
solu**CORTEF**	solu**MEDROL**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Tdap	**D**tap	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
vin**CRIS**tine (Oncovin)	vin**BLAS**tine (VELBAN)	• Pre-printed order forms are used to clearly identify medication being ordered. • stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted.

MEDICATIONS		SAFETY STRATEGY
		• Orders are double checked by two pharmacists and two nurses prior to administration.
COVID-19 Monovalent vaccine	COVID-19 BIVALENT Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) for monovalent vs. bivalent • Labeling: Each vaccine has a specific label in the fridge/freezers (color specific) and in Pyxis
COVID-19 Adult Vaccine	COVID-19 Pediatric Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) specific for adult vs. peds • Labeling: Each vaccine has a specific label in the fridges/freezers (color specific labels) and in pyxis

Ambulatory Care, Behavioral Health, and Long Term Care

MEDICATIONS		SAFETY STRATEGY
bu**PROP**ion	bus**PIR**one	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
citalopram hydrobromide (Cele**XA**)	Celecoxib **(**Cele**BREX)**	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
clo**NID**ine (Catapress)	Clonaze**PAM** (Klonopin)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
Concentrated: morphine oral liquid Roxanal, MSIR	**Conventional:** morphine oral liquid	• Concentrated oral morphine solutions are only dispensed upon receipt of an order for a specific patient (not as unit stock). • The concentrated solution is segregated from the other concentrations in the Pyxis C2 Safe. • Concentrated solutions are purchased and dispensed in dropper bottles and dispensed as unit dose for inpatients.
chlorpro**MAZINE**	chlordiaze**POXIDE**	• Store separately from each other in different cubies in the ADM.

MEDICATIONS		SAFETY STRATEGY
		• Tallman lettering and Auxiliary label
DULoxetine	**FLU**oxetine **PARoxetine**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Insulin products • Lantus and Lente • Humalog and • Humulin • Novolog and • Novolin • Humalog and • Novolog • Novolin 70/30 and • Novolog Mix • 70/30	**H**umu**LIN** **H**uma**LOG** **N**ovo**LOG** **N**ovo**LIN**	• Only approved insulin products are stocked in the nursing unit to limit the variety. • The removal of insulin doses are recorded and tracked through the automated dispensing machines. • All insulin short acting medications are available as vials while insulin long acting medications are available as pens. • All insulin medications are patient specific and clearly marked with auxiliary labels to differentiate the products and are patient specific (except for the ED). • Tallman lettering
lami**VUD**ine	lamo**TRI**gine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Terbinafine (Lam**ISIL**)	Lamotrigine (La**MIC**tal)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
Thio**THIX**ine	thio**RID**azine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
tra**ZOD**one	tra**MAD**ol	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Nefazodone (Serzone)	Quietapine (**SERO**quel)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
Olanzapine (Zy**PREXA**)	Cetirizine (Zyr**TEC**)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.

MEDICATIONS		SAFETY STRATEGY
Hep A Vaccine Adult (HAVrix)	Hep A Vaccine Pediatric (HAVrix)	• For those campuses that carry both Adult and Pediatric doses, adult dosing syringes will be labeled “Adult” • ADULT dose syringes stored on separate shelf from pediatric dose syringes • Pharmacist to double check all syringes & dosage prior to loading in Pyxis • Nurses to confirm ADULT and dosage prior to administration
Hepatitis A Vaccine (HAVrix)	Hepatitis A/B Vaccine (TWINrix)	• Stored separately from each other on different shelves when possible in refrigerated • Pharmacist to double check all syringes & dosage prior to loading in Pyxis • Nursing to confirm name and dosage prior to administration
COVID-19 Monovalent vaccine	COVID-19 BIVALENT Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) for monovalent vs. bivalent and separated by a shelf when possible • Labeling: Each vaccine has a specific label in the fridge/freezers (color specific) and in Pyxis
COVID-19 Adult Vaccine	COVID-19 Pediatric Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) specific for adult vs. peds and try to limit the vaccine available and stocked in a particular area • Labeling: Each vaccine has a specific label in the fridges/freezers (color specific labels) and in pyxis identifying Adult vs Peds and what age range

SOUND ALIKE – LOOK ALIKE MEDICATIONS

(Ambulatory, Long Term Care and Psychiatry)

buPROPion – busPIRone

citalopram (CeleXA) – celecoxib (CeleBREX)

concentrated morphine oral liquid - conventional morphine liquid

chlorproMAZINE – chlordiazePOXIDE

DULoxetine – FLUoxetine

DULoxetine – PARoxetine

Insulin Products – HumuLIN, HumaLOG, NovoLOG, NovoLIN

lamiVUDine – lamoTRIgine

Terbinafine (LamISIL) – lamoTRIgine

thioTHIXine – thioRIDazine

traZODone – tramadol

fazodone (Serzone) –quietapine (SEROquel)

olanzapine (zyPREXA) – Cetirizine (zytrTEC)

Hep A Vaccine **Adult** – Hep A Vaccine **Pediatric**

Hepatitis A Vaccine HAVrix - Hepatitis A/B Vaccine TWINrix

naLOXone - nalTREXone

SOUND ALIKE – LOOK ALIKE MEDICATIONS

ALPRAZolam – **LOR**azepam
aman**TADINE** – amio**DARONE**
bu**PROP**ion - bu**SPIR**one
captopril - carvedilol
car**BAM**azepine – **OX**carbazepine
ce**FAZ**olin **–** cef**TRIAX**one – ce**FOX**itin – cef**TAZ**idime - cefo**TE**tan
celeBREX - cerebyx
CISplatin – **CARBO**platin
Dexamethasone - Dexmedetomidine
DOPamine – **DOBUT**amine
DOXOrubicin – **DAUNO**rubicin
glipi**ZIDE** – gly**BURIDE**
FOSphenytoin – **PHENY**toin
Heparin adult strength – Heparin Pediatric strength
hydr**ALAZINE** – hydr**OXY**zine
HYDROcodone –oxycodone
HYDROmorphone – morphine
Insulin Products – Humu**LIN**, Huma**LOG**, Novo**LOG**, Novo**LIN**
lev**ETIRA**cetam - lev**OCARN**itine
lamo**TRI**gine - lev**ETIRA**cetam
levo**FLOX**acin – lev**ETIRA**cetam
methylene blue - **V**ision**B**lue
metformin – metro**NIDAZOLE**
MS Contin – oxy**CONTIN**
ni**CAR**dipine - **NIFE**dipine
PACLitaxel – **DOCE**taxel
l**ENYL**ephrine – **NOREP**Inephrine
predni**SONE** – predniso**LONE**
solu**CORTEF** - solu**MEDROL**
Tdap – **D**tap
vin**CRIS**tine – vin**BLAS**tine
na**LOX**one - nal**TREX**one

REV. 1/2026

ALAMEDA HEALTH SYSTEM

MEDICATIONS: BOTULISM ANTI-TOXIN

Department	Pharmacy	***Effective Date***	03/2007
Campus	All Acute Care	***Date Revised***	02/2020
Category	Delivery of Care	***Next Scheduled Review***	03/2023
Document Owner	Director, Pharmacy	***Executive Responsible***	Chief Administrative Officer/Chief Nurse Executives

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

PURPOSE

1. Establish a procedure for timely acquisition of botulism anti-toxin ordered for suspected cases of botulism.
2. Assure that public health reporting and submission of required paperwork/specimens by the ordering Provider(s) to public health for suspect botulism cases are completed in a timely manner. Assure an immediate phone report of suspected botulism is made as required by Title 17, California Code of Regulations, sec. 2500

POLICY

On a 24-hour basis, botulism anti-toxin is available to Alameda Health System (AHS) through the California Department of Health Services (DHS).

PROCEDURE

Accessing and administering botulism anti-toxin

1. The managing physician should refer to document "Checklist: diagnosis and management of wound botulism" prepared by California Department of Public Health (CDPH). Please refer to the paperwork provided by the Public Health Department that comes with the botulism anti-toxin for instructions and details.

2. The physician must call the Alameda County Department of Public Health (ACPHD) on a 24-hour basis to have botulism anti toxin released to AHS. M-F business hours 510- 267-3250 after hours 925-422-7595 and ask to speak to a Public Health Duty Officer. The on-call representative of ACPHD will be paged.

3. If the release of the anti-toxin is approved by both the ACPHD and the on-call CDC point of contact. Then the CDC point of contact will act as the authorizing agent to provide the physician details of where the anti-toxin can be picked up.

    - The pick-up location is usually at a large hub (like LAX or SFO), but this will be
    - specified by the CDC authorizing agent.

4. After receiving approval and details of the pick-up location, he physician must call the Inpatient

Pharmacy: Highland Hospital Inpatient Pharmacy
(510) 437-4222
San Leandro Hospital Inpatient Pharmacy (510) 667-4505
Alameda Hospital Inpatient Pharmacy (510) 814-4048
and speak with a pharmacist to arrange for pick-up of the botulism anti-toxin. If this occurs at the hospital without a 24 hour pharmacy operation, the physician will obtain the Pharmacist On-Call schedule from the House Supervisor and speak with the Pharmacist On-Call when

the pharmacy is closed.

5. The pharmacist receiving the call will arrange for an ~~taxi cab~~ AHS contracted courier service (ie. DCS) or hospital staff member to pick up the anti-toxin at the location provided by the physician.

6. Botulism antitoxin should be delivered to the Inpatient Pharmacy at the appropriate campus

6. to be admixed and dispensed to the unit where patient is housed. Pharmacy will provide

6. tracking for doses dispensed to AHS. Pharmacy will return unused vials to California DHS

6. as directed by the ACPHD Doctor of the day, or per the "Return of Unused Antitoxin"

6. Memorandum that accompanies the vials during delivery.
7. Monitor patient for sensitivity to antitoxin and administer antitoxin according to the instructions in the antitoxin package insert (PI) and follow recommendations from the PI to manage those at risk of hypersensitivity reaction. Any adverse events and medication errors must be reported to the FDA at www.fda.gov/medwatch and to the manufacturer at productsafety@ebsi.com

8. The anti-toxin will be accompanied by a letter and packet of CDC case report forms that must be completed by the treating physician. Both the CDC "Botulism Case Report Form" and the CDC "Clinical Outcome Report" must be completed and faxed to the CDC within 7 days of treatment with the anti-toxin.

9. For responsibilities of other department(s), follow the instructions given by the Public Health provided with the anti-botulism toxin is received.

PUBLIC HEALTH REPORTING

1. Physician should inform infection control department immediately of potential botulism case by voice mail:
   Highland Hospital Infection Control: 510- 437-4131.
   SLH/AH hospital Infection Control: 510-501-4523

2. Infection control will be responsible for subsequent completion of case reporting and communication with ACDPH

3. Please refer to paperwork from the Public Health for details and instructions for reporting

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	N/A	02/2020	02/2020

Pharmacy and Therapeutics (P&T)	**Date:**	03/2020	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	03/2020	N/A	N/A
Medical Executive Committee	**Date:**	03/2020	N/A	N/A
Board of Trustees	**Date:**	03/2020	N/A	N/A

Lidocaine Infusion for Pain Clinical Practice Guidelines

Background:
In general pain and specifically perioperative pain, is best managed with a combination of methods including regional anesthetic and analgesic techniques (e.g. nerve blocks, local wound infiltrations, epidural catheters) along with systemically administered analgesics such as acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), opioids and other adjuncts. A multi-modal analgesic approach often provides more effective pain relief than opioid treatment alone with a more favorable side effect profile. Studies suggest intravenous (IV) lidocaine may have benefit in multiple types of pain. IV lidocaine may be indicated as an adjunct to systemic opioids for surgical pain when other multimodal approaches such as regional analgesia are not possible.

Clinical Application:
The following guidelines offer recommended management of patients on Lidocaine Infusions. The intent of these guidelines is to direct physicians in the safe use and benefit of lidocaine infusion. May be limited to the perioperative service at some AHS campuses.

***Definitions*:**
APS – Acute Pain Service
ABW – Actual Body Weight
LAST – Local Anesthetic System Toxicity

Prescribing restrictions
Intravenous lidocaine use for pain management is restricted to the following providers: Acute Pain , Chronic Pain, Anesthesiology, Critical Care, Emergency Medicine, and Addiction Medicine, Trauma..

Level of care restriction:
Patient's being started or continued on lidocaine infusions for pain must be on cardiac monitoring, a telemetry unit or higher level of care.

Guidelines

Indication:
- Analgesia for acute and chronic moderate to severe pain
- Adjuvant analgesia peri- and post-operative
- Analgesia in the opioid tolerant patient

Contraindications:
- Second- and third-degree heart conduction block
- Accessory pathways including Wolff-Parkinson-White syndrome
- High clinical suspicion for cardiac dysrhythmias
- Allergy to corn or corn-related products
- Allergies to other amide local anesthetics (e.g bupivacaine and ropivacaine)
- Mental status not intact in order to report side effects being monitored
- Uncontrolled seizures
- Concurrent administration of other local anesthetics by another route

Relative contraindications:

- First degree heart conduction block
- Cardiovascular instability and concomitant use of alpha agonists (e.g., clonidine) or beta blockers (e.g., metoprolol, labetalol) are relative contraindications.
- Severe liver dysfunction-these patients are more prone to adverse effects
- Uncorrected electrolytes disturbances especially hypokalemia or hypomagnesemia before lidocaine therapy

General considerations:

1. Infusions will be limited to no more than 24 hours
2. Lidocaine infusion shall not be reordered within 48 hours of last Lidocaine infusion. Providers must wait at least 48 hours from last Lidocaine infusion to reorder if clinically needed.
3. Lidocaine infusion should not be reordered within 24 hours of receiving a nerve block
4. The nurse must be available to be at bedside with the patient for the first 15 min after administration of the lidocaine bolus. The nurse should be trained in the recognition and treatment of local anesthetic systemic toxicity (LAST). See (Recognition and treatment of Local Anesthetic Systemic Toxicity [LAST])
5. The physician must be available to come to bedside promptly for at least 15 min after administration of the lidocaine bolus if signs of LAST or other adverse reaction are observed.
6. Weight
    a. Use Actual Body Weight (ABW) in kg
    b. If patient's BMI is more than 30, use ideal body weight (IBW) in kg
7. Lidocaine must be administered in a clinical area where the following is available:
    a. Continuous cardiac monitoring
    b. Non-invasive BP, HR, RR
    c. Pulse oximetry
    d. Resuscitative equipment/cardiac arrest cart is available

Dosing Recommendations:

Bolus	1 mg/kg IVPB over 10 minutes (Max total bolus dose should not exceed 80mg) Bolus dose can be given only in patients with cardiac monitoring
Continuous infusion	Usual starting dose is 1mg/kg/h (max hourly dose 1.5mg/kg/h per IBW)
Titration	ED/ICU (Titrate by RN) non-ED/ICU (Titrate by MD)
Duration	Duration dependent on benefit, Max duration of 24 hour

1. Dose adjustments based on suspected toxicity
    a. Stop infusion and alert primary team or whoever ordered the lidocaine drip
    b. Lidocaine drip should be stopped until toxicity symptoms resolve
    c. Once toxic symptoms resolve, may resume lidocaine drip at a lower rate if ordered by medical provider. (e.g decrease the rate of the continuous infusion by 0.5mg/kg/h from the previous rate)
2. Discontinuation of Infusion

a. Lidocaine infusion for patients may only be discontinued if patient experiences suspected toxicity or at the discretion of medical provider

Monitoring

1. Initial Baseline
    a. BP, HR, RR, SpO2, Sedation Score, Pain Scale level, location of pain
    b. Ensure baseline 12 ECG done and read prior to initiation of lidocaine infusion
2. Ongoing
    a. BP, HR, RR, Q15min x1 hr, then Q4h until treatment completed
    b. Pain Scale level and Sedation Score Q15min x1 hr, then Q1h x4 hrs and then Q4h until treatment completed
    c. Assessment of Lidocaine toxicity signs and symptoms Q15min x1 hr, then Q4h until treatment completed
    d. Once Lidocaine infusion discontinued, then monitor the pts BP, HR, Sedation Score, RR and Pain Scale 1 hour post lidocaine infusion.

Recognition and Treatment of Local Anesthetic Systemic Toxicity (LAST)

1. The signs and symptoms of Lidocaine induced LAST have been observed to have a stepwise progression that correlates with the plasma lidocaine concentration.(**Figure 1**.)

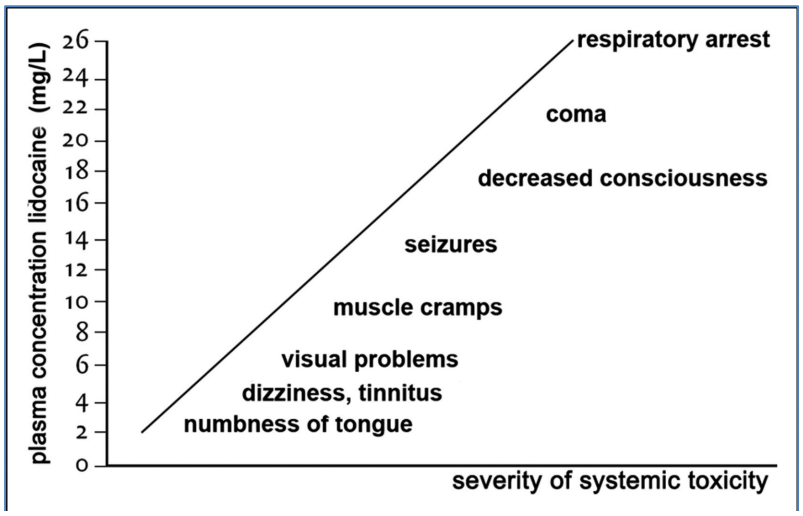

Figure 1. Correlation between toxic symptoms of lidocaine and plasma concentration of drug. Goldfrank, L. R., & Flomenbaum, N. (2006). *Goldfrank's toxicologic emergencies*. New York: McGraw-Hill.

2. Signs and symptoms
    a. **Mild LAST**. These symptoms usually disappear with cessation of the infusion for 1–2 h. The physician may decide to continue, decrease infusion rate, or pause and restart infusion based on clinical judgment.
        i. Perioral numbness
        ii. Tinnitus
        iii. Dizziness
        iv. Hypertension
        v. Drowsiness

vi. Metallic taste
vii. blurred or double vision
viii. Auditory disturbances

b. **Signs and symptoms of Moderate to Severe LAST**. These symptoms indicate a potentially more serious adverse event that may require immediate intervention and generally should preclude the patient from receiving further IV lidocaine.
   i. Muscle cramps
   ii. Twitching
   iii. Tremors
   iv. Seizures
   v. Agitation
   vi. Decreased level of consciousness and/or confusion
   vii. Bradycardia and/or hypotension
   viii. Respiratory and / or cardiac arrest

3. Treatment
   a. Page/call ordering physician stat if patient develops any signs or symptoms of toxicity and/or if there is no change in pain scores and requirements of other analgesic consumption
   b. Initial Focus
      i. Airway management: ventilate with 100% oxygen
      ii. Neurologic symptoms including: tremors, muscle cramps, or seizure should be treated immediately:
         1. Benzodiazepines are the preferred first-line agent (e.g. 1-4mg IV lorazepam)
         2. Avoid propofol in patients having signs of cardiovascular instability
   c. Management of Cardiac Arrhythmias or Shock
      i. Avoid vasopressin, calcium channel blockers, beta blockers or local anesthetic
      ii. Reduce individual epinephrine bolus doses to <1 mcg/kg if required for treating hypotension
   d. Lipid Emulsion (20%) Therapy
      i. Bolus 1.5 mL/kg (lean body mass) IV over 1 min
      ii. Continuous infusion 0.25 mL/kg/min
      iii. Repeat bolus once or twice for persistent cardiovascular collapse
      iv. Double the infusion rate to 0.5 mL/kg/min if blood pressure remains low
      v. Continuous infusion for at least 10 minutes after attaining circulatory stability
      vi. Recommend upper limit: approximately 10 mL/kg lipid emulsion over the first 20 min

Infusion Requirements:

1. A 4mg/mL (0.4% solution) of preservative free lidocaine prepared as 2000 mgs in 500mL 5% dextrose in water or
   0.9% NaCl will be supplied by pharmacy.
2. The infusion should be administered at the prescribed dosage for no longer than 24 hours.

<u>Procedures</u>

Provider responsibilities:

1. All patients must be placed on telemetry units or clinical area where the following is available:

a. Continuous cardiac monitoring
b. Non-invasive BP, HR, RR
c. Pulse oximetry
d. Resuscitative equipment/cardiac arrest cart is available

2. The physician must be available to come to bedside promptly for at least 15 min after administration of the lidocaine bolus if signs of LAST or other adverse reaction are observed and reported by the nurse.
3. Order Lidocaine Infusion for Pain using the approved Lidocaine Infusion for Pain Order Set
4. Order Serum lidocaine levels PRN, routine serum lidocaine level testing is not necessary
5. Ensure baseline 12 ECG done and read prior to initiation of lidocaine infusion
6. Lidocaine infusion shall not be reordered within 48 hours of last Lidocaine infusion. Providers must wait at least 48 hours from last Lidocaine infusion to reorder if clinically needed.

Nursing Responsibilities:

1. Obtain accurate weight for appropriate weight base dosing of Lidocaine
2. Trained in the recognition and treatment of local anesthetic systemic toxicity (LAST).
3. IV Lidocaine should be administered only through the Alaris Pump using Guardrails Safety System
4. Lidocaine IV Infusions can be given via peripheral IV or central IV lines
5. Be available to be at bedside with the patient for the first 15 min after administration of the lidocaine bolus.
6. Limit Infusions to no more than 24 hours
7. Monitoring
    a. Initial Baseline Monitoring
        i. BP, HR, RR, SpO2, Sedation Score, Pain Scale level, location of pain
    b. Ongoing Monitoring
        i. BP, HR, RR, Q15min x1 hr, then Q4h until treatment completed
        ii. Pain Scale level and Sedation Score Q15min x1 hr, then Q1h x4 hrs and then Q4h until treatment completed
        iii. Assessment of Lidocaine toxicity signs and symptoms Q15min x1 hr, then Q4h until treatment completed
    c. Once Lidocaine infusion discontinued, then monitor the pts BP, HR, Sedation Score, RR and Pain Scale 1 hour post lidocaine infusion.
8. Contact Physician for the following:
9. Stop the infusion and call the ordering physician IF:
    a. BP drops > 15 mmHg systolic or diastolic
    b. BP increases > 30 mmHg diastolic or systolic
    c. Change in HR/pulse by 20 bpm
    d. Lidocaine toxicity signs and symptoms (see 'Recognition and Treatment of Local Anesthetic Systemic Toxicity')

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APPROVALS:

		System	AHS Core	AH
System Pain and Addiction Committee	Date:	12/2025		
System P&T Committee	Date:	1/2026		
Clinical Practice Committee	Date:			
MEC	Date:			

ALAMEDA HEALTH SYSTEM

LIDOCAINE INFUSION FOR PAIN POLICY

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	No Date Set	***Date Revised***	Not Approved Yet
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	No Review Date
Executive Responsible	DIRECTOR, PHARMACY		

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POLICY

To ensure the safe and effective management of pain during intravenous lidocaine infusion for patients who are experiencing inadequate analgesia with other analgesic interventions

ABBREVIATIONS

IBW – Ideal Body Weight
ABW – Actual Body Weight
LAST—Local Anesthetic System Toxicity

PRESCRIBING RESTRICTIONS

Intravenous lidocaine use for pain management is restricted to the following providers: Pain Service Providers, Anesthesiology, Critical Care Attending Physicians and ED Providers.

LEVEL OF CARE RESTRICTION:

Patient's being started or continued on lidocaine infusions for pain must be on cardiac monitoring, a telemetry unit or higher level of care.

INDICATION

- Analgesia for acute and chronic moderate to severe pain
- Adjuvant analgesia during and following surgery
- Analgesia in the opioid tolerant patient

CONTRAINDICATIONS

- Second and third degree heart conduction block
- Accessory pathways including Wolff-Parkinson-White syndrome
- High clinical suspicion for cardiac dysrhythmias

- Allergy to corn or corn-related products
- Allergies to other amide local anesthetics (e.g bupivacaine and ropivacaine)
- Mental status not intact in order to report side effects being monitored
- Uncontrolled seizures
- Concurrent administration of other local anesthetics by another route

PROCEDURE

Provider Responsibilities:

1. All patients must be placed on telemetry units or clinical area where the following is available:
    a. Continuous cardiac monitoring
    b. Non-invasive BP, HR, RR
    c. Pulse oximetry
    d. Resuscitative equipment/cardiac arrest cart is available
2. The physician must be available to come to bedside promptly for at least 15 min after administration of the lidocaine bolus if signs of LAST or other adverse reaction are observed and reported by the nurse.
3. Order Lidocaine Infusion for Pain using the approved Lidocaine Infusion for Pain Order Set
4. Order Serum lidocaine levels PRN, routine serum lidocaine level testing is not necessary
5. Ensure baseline 12 ECG done and read prior to initiation of lidocaine infusion
6. Lidocaine infusion shall not be reordered within 48 hours of last Lidocaine infusion. Providers must wait at least 48 hours from last Lidocaine infusion to reorder if clinically needed.
7. Lidocaine infusion should not be ordered within 24 hours of receiving a nerve block.

Nurse Responsibilities:

1. Limit Infusions to no more than 24 hours
2. Be available to be at bedside with the patient for the first 15 min after administration of the lidocaine bolus.
3. Trained in the recognition and treatment of local anesthetic systemic toxicity (LAST).
4. Administer Lidocaine IV Infusions via peripheral IV or central IV lines only through the Alaris Pump using Guardrails Safety System
    a. Except for loading dose, no nursing intravenous push, bolus or patient PCA volus doses are permitted.
5. Obtain accurate weight for appropriate weight base dosing of Lidocaine
6. Initial Baseline Monitoring
    a. BP, HR, RR, SpO2, Sedation Score, Pain Scale level, location of pain
7. Ongoing Monitoring
    a. BP, HR RR, Q15min x1 hr, then Q4h until treatment completed
    b. Pain Scale level and Sedation Score Q15min x1 hr, then Q1h x4 hrs and then Q4h until treatment completed
    c. Assessment of Lidocaine toxicity signs and symptoms Q15min x1 hr, then Q4h until treatment completed
8. Once Lidocaine infusion discontinued, then monitor the pts BP, HR, Sedation Score, RR and Pain Scale 1 hour post lidocaine infusion.

9. Contact Physician for the following:
    a. **Signs and symptoms of Mild toxicity**. These symptoms usually disappear with cessation of the infusion for 1–2 h.
        i. Perioral numbness
        ii. Tinnitus
        iii. Dizziness
        iv. Hypertension
        v. Drowsiness
        vi. Metallic taste
        vii. blurred or double vision
        viii. Auditory disturbances

    b. **Signs and symptoms of Moderate to Severe toxicity**. These symptoms indicate a potentially more serious adverse event.
        i. Muscle cramps
        ii. Twitching
        iii. Tremors
        iv. Seizures
        v. Agitation
        vi. Decreased level of consciousness and/or confusion
        vii. Bradycardia and/or hypotension
        viii. Respiratory and / or cardiac arrest
    c. SBP or DBP increase > 30 mmHg
    d. SBP or DBP decrease > 15 mmHg
    e. Change in HR by 20 bpm
    f. No change in pain scores

PHARMACIST RESPONSIBILITIES

1. Validate appropriate dosing based on recorded weight
2. Compound standard concentration Lidocaine 2000mg in 500ml of D5W or NS per order.

REFERENCES

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2. Kranke P, Jokinen J, Pace N, Schnabel A, Hollmann MW, Hahnenkamp K, Eberhart LHJ, Poepping DM, Weibel S. Continuous intravenous perioperative lidocaine infusion for postoperative pain and recovery***. Cochrane Database of Systematic Reviews 2015***, Issue 7. Art. No.: CD009642. DOI: 10.1002/14651858.CD009642.pub2
3. Fitzpatrick BM, Mullins ME. Intravenous lidocaine for acute pain: an evidence-based clinical update. *Clin Exp Emerg Med.* 2016; 3(2): 105–108.
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APPROVALS

		System	Alameda Hospital
System Pain and Addiction Committee	**Date:**	**12/2025**	
System Pharmacy and Therapeutics	**Date:**	**1/2026**	
Clinical Practice Council	**Date:**		
Medical Executive Committee	**Date:**		
Board of Trustees	**Date:**		

	Policy	
ALAMEDA HEALTH SYSTEM	**Tenecteplase (TNKase) for Acute Ischemic Stroke: Nursing Administration Protocol**	**Reference # Version**
	Level ☐ System X Sites WCHGH	**Effective Date:** 12/2025 **Next Review Date**: **12/2027**
	Document Owner: Stroke Core Team	

POLICY STATEMENT

Guidelines developed by the American Heart Association/ American Stroke Association (AHA/ASA) state that Tenecteplase (TNKase) should be administered in a safe, effective and time efficient manner for adult acute ischemic stroke patients who meet eligibility criteria.

PURPOSE

To establish standardized, evidence-based protocol for the reconstitution, dosing, administration, and monitoring of TNKase to eligible stroke patients, in accordance with best practices and regulatory guidelines. TNKase treatment should be initiated in less than or equal to 4.5 hours from the time last known well for those eligible patients. Treatment beyond 4.5 hours for select patients meeting evidenced based criteria may be considered.

SCOPE

This policy applies to all patients who are eligible and receive TNKase in any clinical area in the hospital setting.

DEFINITIONS

Tenecteplase (TNKase) is indicated for use in the treatment of acute ischemic stroke. It has been demonstrated to improve neurological recovery and reduce the incidence of disability. TNKase is a medication that induces and accelerates acute blood clot lysis. It does so through activation of plasminogen into plasmin. It is approximately 80 times more resistant to inhibition by plasminogen activator inhibitor-1 (PAI-1) than alteplase (tPA).

Note: TNKase is a **HIGH-ALERT MEDICATION**; **ALL CALCULATIONS AND DOSE ADMINISTRATIONS MUST BE CO-SIGNED BY TWO REGISTERED NURSES, OR ONE RN AND A PHYSICIAN OR PHARMACIST.**

NIHSS is the National Institutes of Health Stroke Scale, a standardized 11-item tool used by healthcare professionals to quantify the severity if a stroke. A higher number means a more sever stroke, and a score of 0 means no symptoms. The NIHSS is crucial for determining appropriate treatment, monitoring changes in a patient's neurological status, and in predicting outcomes.

EHR is the Electronic Health Record, the digital system thar stores and manages a patient's medical information

Last Know Well (LKW) Time is the last confirmed time a patient was seen or known to be without signs of a stroke or at their normal baseline health.

TXA is Tranexamic Acid, a reversal agent for Bleeding associated with TNKase

RESPONSIBILITIES

This policy applies to all physicians, pharmacists, and nursing staff involved in the care of patients receiving TNKase in any clinical area in the hospital setting.
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POLICY

A. RECONSTITUTION and DOSING Of Tenecteplase

1) **Prior to Reconstitution**
   a) The physician determines that the patient is a candidate for TNKase treatment by assessing neurological symptoms which should include performing a National Institutes of Health Stroke Scale (NIHSS) assessment, past medical/surgical history, time last well known, and allergies.
   b) Check or confirm point of care glucose and blood pressure parameters and notify provider if not within limits.
   c) Persistent blood pressure elevation (SBP ≥ 185 mmHg or diastolic ≥ 110 mmHg) – treat BP prior to administration
   d) Obtain the patient's weight in kilograms. Enter weight into the electronic health record (EHR).
   e) Place patient on continuous cardiac monitoring, blood pressure, and oxygen saturation monitor.
   f) Initiate two IV lines if possible (do not delay TNKase for second IV start).
2) **Supplies**
   a) TNKase product kit includes:
      i) 10mL vial of sterile water
      ii) TNKase (tenecteplase) vial 50 mg/10mL
3) **Preparation**
   a) Aseptic technique: thorough handwashing and gloves prior to administration.
   b) Reconstitution

i) Aseptically withdraw 10 mL of sterile water from vial.
ii) Inject the entire 10mL of sterile water into the TNKase vial.
iii) Swirl the vial gently to allow contents to dissolve. DO NOT SHAKE THE VIAL.
iv) The final solution should look colorless or pale yellow and transparent. Final Concentration 5mg/mL

4) Dosing

a) The physician will order the TNKase total dose based on the patient's current weight.

b) Recommended total dose for acute ischemic stroke does not exceed 25 mg or 5mL of reconstituted solution.

B. ADMINISTRATION

Tenectaplace should only be administered by critical care RN, emergency department RN, or the provider who has received appropriate education and training and have demonstrated competency in preparation and administration.

Alameda Hospital

1) Review the inclusion and exclusion criteria for TNKase administration located in Appendix A.
2) If TNKase is being administered, a physician should document in a note the risk and benefit conversation took place prior to administration.
3) **Obtain the TNKase from the blue box in the ED and CCU pyxis room. DO NOT TAKE MEDICATION DIRECTLY OUT OF PYXIS.**
   a. A 2nd RN or pharmacist must independently double check the order, calculations, and final doses as per the MAR. Calculate the patient's weight (kilograms) x 0.25 mg
   b. Divide the previous answer by 5. Round to the nearest 10th.
      i. Example dosing: 37.7 kg x 0.25 mg= 9.4mg --> 9.4mg/5mL= 1.88 --> round to the 10th --> 1.9ml)
4) TNKase is not compatible with dextrose containing solutions. Ensure that the IV line is flushed with 10 cc of saline before and after administration.
5) Administer a single TNKase bolus over 5 to 10 seconds.
6) When TNKase has been used, the vial should be placed back in the blue kit and the kit should be brought back to pharmacy as soon as possible Monday thru Friday 0700 – 1900. If the medication has been given overnight or on the

weekend, it should be brought back to the pharmacy as soon as the pharmacy opens at 0700.

Wilma Chan HGH

1) Review the inclusion and exclusion criteria for TNKase administration located in Appendix A.
2) If TNKase is being administered, a physician should document in a note the risk and benefit conversation took place prior to administration.

3) **ED** – the TNKase kit can be retrieved from the **ED pyxis 2** machine after Epic order entry and validation. The ED nurse will use the Tenecteplase guide for acute ischemic stroke to aid in compounding and the 5mL syringe to draw up the appropriate dose per Epic order for administration. See dosing guide in Pyxis.
4) **Inpatient-** TNKase will be compounded by the central pharmacy after Epic order entry and order validation. Pharmacy will send up/bring up TNKase with appropriate labeling and dose to the unit patient is located.
    a. A 2nd RN or Physician/pharmacist must independently double check the order, calculations, and final doses as per the MAR. Calculate the patient's weight (kilograms) x 0.25 mg
    b. Divide the previous answer by 5. Round to the nearest 10th.
        Example dosing: 37.7 kg x 0.25 mg= 9.4mg --> 9.4mg/5mL= 1.88 --> round to the 10th --> 1.9ml)

San Leandro Hospital

1) Review the inclusion and exclusion criteria for TNKase administration located in Appendix A.
2) If TNKase is being administered, a physician should document in a note the risk and benefit conversation took place prior to administration.
3) TNKase kits are located outside of Pyxis (in Blue tackle boxes), retrieve from Pyxis machine after epic order entry and validation.
    a) ED – ED pyxis room
    b) ICU – med room
4) Pharmacy track of usage, so that there is always a kit available (as the pharmacy is closed from 10pm- 7am Monday – Friday and 9pm-7am on holidays and weekends)
5) Supplies for SLH TNKase kit:
    a) 2 Medication label stickers
    b) 1 bag = one 5 ml luer lock syringe + AIS dosing chart
    c) 1 bag = STEMI dosing chart

d) 1 box of TNKase 50 mg box with compounding instructions

6) RNs can mix it 24/7 and it must be cosigned by two RNs
   (1) -1st co-signed by ICU charged RN since ICU charged RN responds to code
   (2) -2nd RN check/ Physician or Pharmacist will be required and prompted by Epic before administration. 2nd co-signed is pt's primary RN

C. NURSING CARE

1) After TNKase administration, monitor vital signs and NIHSS/neuro assessments
   a) Every 15 minutes for the first 2 hours
   b) Every 30 minutes for the next 6 hours
   c) Every 1 hour for the next 16 hours
2) Maintain blood pressure less than 180/105 mmHg for at least 24 hours after TNK administration. Notify provider immediately if patient exceeds this BP limit parameter.
3) Continuously monitor cardiac rhythm, oxygen saturation, respiratory effort.
4) Monitor for signs and symptoms of intracranial hemorrhage.
   a) Neurologic deterioration, new headache, acute hypertension, nausea and vomiting
   b) If ICH is suspected
      i) Notify provider immediately
      ii) Prepare to obtain an emergency non contrast head CT scan
      iii) Anticipate orders for labs (ie. CBC, PTT, Protime-INR, Fibrinogen level, Type and screen)
         (1) *Note: PTT, PT/INR and fibrinogen may be unreliable during and for up to 24 hours after TNKase administration.*
      iv) Anticipate Cryoprecipitate transfusion
      v) Anticipate tranexamic acid 1000 mg IV infusion
5) Monitor for signs and symptoms of orolingual angioedema
   a) Notify provider if patient develops a swollen tongue, difficulty breathing, or new drooling
   b) Obtain an order from provider "ED/IP management of Orolingual Angioedema Associated with IV Thrombolytic"
   c) Keep patient NPO
   d) Verify that ACE inhibitors have been discontinued
   e) Continue post -TNK assessments.
   f) Anticipate to give:

i) Epinephrine IM
ii) Methylprednisolone IV
iii) Diphenhydramine IV
iv) Famotidine IV

6) Monitor for signs of bleeding
   i) Bleeding puncture sites, gingival oozing, stool, hematuria, hemoptysis, skin hematomas, ecchymosis/petechiae, abdominal or flank pain, shortness of breath, rales, rhonchi
   ii) Monitor hemoglobin and hematocrit as ordered
7) No antiplatelets or anticoagulants for 24 hours after TNKase administration.
8) Avoid central lines, nasogastric tube placements, or urinary catheter placement in the first 24 hours after TNKase administration.
9) No IM injections, no arterial blood gases, and no arterial lines for the first 24 hours post TNKase administration.
   a) Monitor for signs of reperfusion such as resolution of neurological deficits.
      a. Diet: Patient to remain NPO until swallow screen has been completed, passed and documented in the EMR. No oral medications should be administered until the swallow screen has been completed and documented in the EMR before the first PO medication is scanned.

REFERENCES

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2. Powers, W.J, Rabinstein, A.A., Ackerson, T. , et al (2019). *Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke ; A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association*

3. TNK(tenecteplase) instructional video, 2015 Genentech USA, inc.
4. TNK(tenecteplase) package insert, 2018 Genentech USA, inc.

ATTACHMENTS

Appendix A – Tenecteplase Inclusion and Exclusion Criteria

APPROVALS

1. November 20, 2025, Stroke Subcommittee Task Force

Appendix A

Tenecteplase Inclusion and Exclusion Criteria

INCLUSION CRITERIA:

- Clinical diagnosis of ischemic stroke causing measurable neurological deficit
- Onset of symptoms ≤ 4.5 hours before beginning treatment; if the exact time of stroke onset is not known, it is defined as the last time the patient was known to be normal or at neurologic baseline. Treatment beyond 4.5 hours for select patients meeting evidenced based criteria may be considered.
- Age ≥ 18 years

EXCLUSION CRITERIA:

- Ischemic stroke or severe head trauma in the previous 3 months
- Previous intracranial hemorrhage
- Intra-axial intracranial neoplasm
- Gastrointestinal malignancy
- Gastrointestinal hemorrhage in the previous 21 days
- Intracranial or intraspinal surgery with the prior two months
- Symptoms suggestive of subarachnoid hemorrhage
- Persistent blood pressure elevation (SBP ≥ 185 mmHg or diastolic ≥ 110 mmHg) – treat BP prior to administration
- Presence of intracranial conditions that may increase the risk of bleeding (ie. Intracranial neoplasm, arteriovenous malformation, or aneurysm.
- Active internal bleeding
- Presentation consistent with infective endocarditis
- Stroke known or suspected to be associated with aortic arch dissection
- Acute bleeding diathesis, including but not limited to conditions defined under 'Hematologic'
- Bleeding diathesis:
- Platelet count < 100k/mcL
- Currently anticoagulant use with an international normalized ratio (INR) > 1.7 or prothrombin time (PT) > 15 seconds or aPTT > 40 seconds
- Received therapeutic dose of low molecular weight heparin (LMWH) within the previous 24 hours (eg, to treat VTE and ACS); this exclusion does not apply to prophylactic doses
  (eg, to prevent VTE)
- Current use (ie, last dose within 48 hours in a patient with normal renal function) of a direct thrombin inhibitor or factor Xa inhibitor with evidence

of anticoagulant
effect by laboratory tests such as aPTT, INR, or factor anti-Xa
activity assays

- Evidence of hemorrhage or extensive regions of obvious hypodensity consistent with irreversible injury per head CT

WARNINGS:

- Only minor and isolated neurological signs or rapidly improving symptoms
- Serum glucose < 50 mg/dL
- Serious trauma in the previous 14 days
- Major surgery in the previous 14 days
- History of GI bleeding (remote) or GU bleeding

	Policy	
ALAMEDA HEALTH SYSTEM	**CODE STROKE: Acute Stroke Evaluation and Management**	**Reference # Version**
	Level ☐ System X Site WC HGH, ALH, SLH	**Effective Date:** 12/2025 **Next Review Date**: 12/2027
	Document Owner: Stroke Core Team	

POLICY STATEMENT

Alameda Health System adopts practice guidelines to delineate a consistent, evidence-based approach to treating the patient who presents with signs and symptoms consistent with acute stroke.

PURPOSE

Patients presenting with stroke symptoms and signs must be rapidly identified to differentiate the cause of the stroke (ischemic vs. hemorrhagic) and treat emergently. The stroke policy and procedure will expedite the identification, assessment, and optimal treatment of patients sustaining acute ischemic or hemorrhagic stroke.

SCOPE

1. Clinical Services
    a. Stroke patient care during the hyperacute and acute stroke care phases.
    b. Medical, nursing care of patient experiencing a stroke

2. Population Served
    a. Patient population ages 18 or greater

DEFINITIONS

Acute Ischemic Stroke occurs due to a disruption in arterial blood flow to a portion of the brain. This disruption in flow leads to neuronal ischemia and infarction, resulting in loss of central nervous system tissue (brain, spinal cord, or retinal cells) as evidenced by neuropathologic, neuroimaging, and/or clinical evidence of permanent tissue injury.

Acute Hemorrhagic Stroke occurs when a blood vessel in or around the brain ruptures, causing bleeding into the brain. It impedes the blood flow to the brain, decreasing the availability of oxygen and nutrients to brain tissue, causing dysfunction and possible brain cell death.

Transient Ischemic Attack (TIA) is a transient (<24 hour) episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia, *without* neuropathologic, neuroimaging, and/or clinical evidence of infarction.

Thrombolytic Agent: A drug that dissolves blood clots by converting plasminogen to plasmin, an enzyme that breaks down fibrin, the protein that forms the structure

of a blood clot

Tenecteplase (TNKase or TNK) is a thrombolytic agent used in the treatment of ischemic stroke.

Chemoprophylaxis Agent is a medication used to prevent the development of a disease or infection. An example is medications that are used to prevent clots in hospitalized patients.

BEFAST (Balance, Eyes, Face, Arms, Speech, Time) is an acronym for identifying the sudden signs and symptoms of stroke and when to access emergency services.

Hyper Acute Stroke Phase is the very early, time-sensitive period of a stroke, generally considered the first 24 hours after symptom onset. During this phase the primary goals are rapid assessment and immediate, life-saving treatment, such as administering thrombolytic therapy or performing an interventional procedure to restore blood flow to the brain.

POLICY

Hyper Acute Stroke Phase

1. ED Arrival:
   a. EMS: Patient with acute ischemic or hemorrhagic stroke symptoms arriving by EMS. The Report from pre-hospital personnel last known well, vital signs and blood glucose. ED Physician and ED nurse perform initial patient assessments and identify patients who meet the inclusion criteria for the Acute Stroke Management Protocol.
   b. Private Auto or "Walk-in": Patients with acute ischemic or hemorrhagic stroke symptoms who arrive by private auto or by "walk-in" to the ED. ED Physician and ED nurse perform initial patient assessments and identify patients who meet the inclusion criteria for the Acute Stroke Management Protocol.

2. In-Patient:
   a. Patients exhibiting new sudden onset of stroke signs and symptoms. (BEFAST) Nurse should initiate a "Code Stroke" by contacting the hospital operator (dialing 5-5555) and giving the operator the room number or patient location to activate the stroke response team.

3. A "Code Stroke" may be initiated by any Provider or RN for patients with stroke-like symptoms (BEFAST) with last known well (LKW) of 24 hours or less or "Unknown" time

4. The following individuals will respond to "code stroke" in the following areas:
   a. ED: ED physician; ED RN; Nursing Services Technician (NST); Respiratory Therapist; Laboratory if needed; Neurology (when available); Stroke Coordinator (when available), ED Pharmacists (when available)
   - In-Patient: Primary MD, Primary RN, Charge RN, Rapid Response or Critical Care RN, ED Code Blue resident (if available), Neurology (or Teleneurology), IM Pharmacist (when available)

Code Stroke in ED

Initial assessments and treatment

1. **ED Physician**
   a. Evaluate patient.
   b. Assess ABC's (airway, breathing, circulation)
   c. Manage and stabilize patients.
   d. Complete initial NIHSS assessment
   e. Initial Neurology Consult or Tele neurology consult. Enter "ED/IP Code stroke" order set in EPIC.
   f. Determine if patient is stable to transfer to CT.

2. ED Nurse assigned to stroke patient
   a. Assess ABC's (airway, breathing, circulation)
   b. Assess neurological status.
   c. Obtain FSBG, Vital signs.
   d. Treat abnormal Blood Glucose
   e. Confirm with ED provider patient is stable to transfer to CT.
   f. Accompany patient to CT.
   g. Obtain 2 large bore IVs (at least 20g, do not delay head CT for 2nd IV)
   h. Keep pt NPO.
   i. Keep O2 Sats greater than 94%, apply O2 via nasal canula as needed.

3. Nursing Services Technician (NST)- if available
   a. Assist ED nurse with vital signs, FSBG.
   b. Assist in setting up TeleNeurology cart (HGH after 5pm) in patient's room.
   c. Assist as directed by the ED RN
4. Laboratory Tech:
   a. Obtain blood specimen as ordered (CBC, troponin)
   b. Send blood specimens to Laboratory for expedited processing.
5. Respiratory Therapy:
   a. assists team with airway interventions.
6. Imaging Team:
   a. STAT CT head for stroke
   b. STAT CT head angiography head and neck as ordered
   c. Radiology Physician to provide closed loop direct communication of CT head to ED provider.

After CT

1. ED physician
   a. Review CT results
   b. Determine patient's stroke plan of care in discussion with neurologist.
   c. Review Plan of care with patient, family member or care giver.
2. ED RN
   a. Attach patient to cardiac monitor, non-invasive BP, and SpO2
   b. Zero bed and obtain patient weight.
   c. Assess and document vital signs, neuro status every 15 minutes if condition warrants.
   d. Continue to follow provider's orders.
   e. Continue to keep pt NPO (including medications until patient passes bedside nurse swallow screen). Request for SLP swallow eval if patient fails Bedside swallow screen.
   f. Place 2nd large bore IV (at least a 20g) if not already placed.

All patients with stroke symptoms presenting within 0 to 4.5 hours of symptom onset –

1. ED Physician:
    a. Consider IV Tenecteplase (TNKase or TNK) option in discussion with neurology -- please see TNK protocol.
    b. Review of TNK inclusion/exclusion criteria and NIHSS assessment, lab results, and CT results
    c. If patient meets criteria:
        i. Order TNKase via order set: ED/IP Tenecteplase (TNKase) for Acute Ischemic Stroke.
        ii. Review risk and benefit with patient, family, or caregiver.
        iii. Obtain consent and document consent.
        iv. Arrange for critical care admission
    d. Maintain Blood pressure:
        i. Ischemic stroke, TNK given:
            - Before TNK administration, BP must be less than 185/110 mmHg.
            - After TNK administration- SBP less than 180 mmHg and Diastolic Blood Pressure less than 105 mmHg.

        ii. Ischemic stroke or TIA *not* receiving IV TNK:
            - Permissive hypertension as ordered up to SBP of 220 mmHg and DBP of 120 mmHg. Avoid rapid drops in blood pressure. Treat hypotension if present.

        iii. Spontaneous intracerebral hemorrhage: SBP 130-150 mmHg and DBP 70-90 mmHg (or other targets specified by neurology/neurosurgery)

        iv. Aneurysmal subarachnoid hemorrhage: SBP 110-140 mmHg and DBP 70-90 mmHg. Of note, these patients should be transferred emergently to an appropriate outside facility for a higher level of care.

2. ED RN:

    Review Blood Pressure parameter orders, notify provider and obtain blood pressure medications if:

i. Prior to TNK administration (TNKase or TNK)- SBP is less than than 185 mmHg and DBP is greater than 110 mmHg.

ii. After TNK administration- Maintain SBP less than180 mmHg and Diastolic Blood Pressure less than 105 mmHg.

iii. Ischemic stroke or TIA patients not receiving IV Tenecteplase- Maintain SBP 180-220 mmHg and DBP less than 120 mmHg, or as ordered by provider

iv. Spontaneous intracerebral hemorrhage - Maintain SBP 130-150 mmHg, or as ordered by provider.

v. Aneurysmal subarachnoid hemorrhage- Maintain SBP less than 140 mmHg, or as ordered by provider; these patients should be transferred emergently to an outside facility for higher level of care.

Critical Care Phase Interventions:

a. First 24-hour Post Tenecteplase
   a. See TNK protocol and provider orders
   b. NIHSS and Vital signs are assessed at the following frequency:
      - Every 15 minutes for 2 hours
      - Every 30 minutes for 6 hours
      - Every 1 hour for 16 hours
   c. Maintain temperature between 36 degrees Celsius and 38 degrees Celsius.
   d. Continuous Cardiac Monitoring
      - Notify Provider of arrythmias
   e. FSBG for 2 occurrences. Notify provider is blood glucose is greater than 150mg/dL
   f. Assess for signs of increased intracranial pressure (ICP) notify provider if:
      - New or worsening headache
      - Decreased level of consciousness
      - Changes in motor function
      - New Visual disturbances
      - Pupillary changes

- Changes in respiratory patterns
- Changes in vital signs

g. Assess for signs of bleeding and notify provider if:
- Bleeding in gums, Urinary catheter site, IV sites
- Seizure activity
- Nausea or Vomiting
- Hypertension or Hypotension
- Hematuria
- Hemoptysis

Inpatient Providers:

a. Ischemic Stroke with TNK enter order set: "IP Acute Ischemic Stroke Following Thrombolytic (TPA/TNK/alteplase) Treatment."

b. Ischemic Stroke (If No TNKases) enter order set: "IP Transient Ischemic Attack& Acute Ischemic Stroke without Thrombolytic (TPA/TNK/alteplase/Tenecteplase)"

c. Hemorrhagic Stroke enter order set: "IP Hemorrhagic

Stroke." Standard inpatient Stroke Care for all Stroke patients:

a. NIHSS and GCS per unit protocol or as specified by neurology.
b. Keep Patient NPO until passed Bedside Swallow Screening
c. Reduce risk of DVT
- Apply sequential compression devices and initiate DVT chemoprophylaxis as early as indicated in patients with reduced mobility
  - for ischemic stroke without TNK – initiate both chemoprophylaxis medications and sequential devices
  - for ischemic stroke receiving TNK – implement sequential devices, but wait to administer chemoprophylaxis medications until 24 hours after TNK;
  - for spontaneous intracerebral hemorrhage - once ordered by provider, typically 1-4 days after bleeding has stopped).
- Assess and encourage increased mobility.

- Ensure hydration (IV or PO)

b. Reduce risk of pressure ulcers in patients with reduced mobility
   - Turn every 2 hours while in bed.
   - Monitor skin integrity especially at pressure points.

c. Prevent falls in patients with reduced mobility.
   - Initiate Fall precautions
   - Keep bed in low position.
   - Keep call light in reach.

d. Provide Stroke education (all patients)
   - Review with patient and family.
   - Individual risk factors for stroke
   - Methods to reduce risk factors Signs and symptoms of stroke (BEFAST)
   - What to do if symptoms occur (Call 911)
   - New medications prescribed, uses, schedule, precautions, side effects.
   - Smoking Cessation counseling (if appropriate)
   - Need for follow-up after discharge.
   - Diabetes education and follow up (if appropriate)
   - Other lifestyle interventions as appropriate
     - weight reduction
     - activity recommendations
     - antihypertensive diet
     - healthy diet
     - diabetes
     - blood pressure
     - cholesterol
     - atrial fibrillation

REFERENCES

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Powers, W. J.; Rabinstein, A.; Ackerson, T. Adeoye, O.M.;… Tirschwell, D. L. (2019) Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association Stroke Volume 50, Number 12 https://doi.org/10.1161/STR.000000000000021

APPROVALS

1. November 20, 2025, Stroke Subcommittee Task Force
2. December, 2025, AHS VP, Patient Care Services

	Date:			

	Elopement and Medical Incapacity Hold Policy	
	Document Title	**Reference # tbd**
	Level ☐ X System ☐ Site	**Effective Date:** 4/2026 **Next Review Date**: **4/2029**
	Document Owner: Associate Chief Medical Officer, Acute Care	

POLICY STATEMENT

This policy establishes a medical incapacity hold implementation process in the context of incapacitated patients who want to leave an acute care setting against medical advice and assists clinicians in assessing decision-making capacity. This policy does not apply to patients on involuntary psychiatric legal holds.

PURPOSE

The purpose of this policy is to establish Alameda Health System's ("AHS") commitment to preventing and appropriately responding to patient elopement. AHS is dedicated to ensuring the safety and well-being of patients who may be at risk of leaving a care setting. This policy aims to protect unrepresented patients without a surrogate decision maker who lack decision-making capacity due to non-psychiatric, medical illness or condition and are at risk of serious harm if they leave the hospital.

This policy provides a framework for identifying patients at risk for elopement, implementing preventive measures, and outlining appropriate interventions when involuntary detention with a medical incapacity hold may be necessary to protect a medically incapacitated patient. It further establishes the criteria, procedures, and oversight necessary to promote patient safety, regulatory compliance, and ethical decision-making.

SCOPE

This policy applies to all AHS general acute care hospitals and to all clinical and support staff involved in patient care in this setting, including but not limited to physicians, nursing, care management, and security. This policy specifically addresses the prevention and management of elopement among unrepresented patients who lack decision-making capacity due to a medical, non-psychiatric condition. While incapacitated, *represented* patients with an identified surrogate decision-maker may be held or discharged over their objection with the surrogate's consent, this policy only governs cases involving incapacitated, *unrepresented* patients, or while attempting to reach the surrogate decision-maker.

DEFINITIONS

Adverse Outcome: Defined as serious injury, serious harm, or serious impairment which will result in, or are likely to result in, one or more of the following: death; a significant decline in physical, mental, or psychosocial functioning (not solely due to normal progression of a disease or aging process); loss of limb, or disfigurement; avoidable pain that is excruciating and more than transient; and/or other serious harm that creates life-threatening complications/conditions.

Informed consent/informed refusal: Process of dialogue between the patient or their surrogate decision-maker and a physician or advanced practice provider (APP) that includes disclosure of information about the patient's diagnosis, prognosis, and treatment options, including the treatment's potential risks, benefits, and alternatives, and includes a demonstration of understanding on the part of the patient or surrogate, and voluntary agreement to either proceed or not proceed with the proposed treatment.

Surrogate decision-maker: Designated representative with authority to act on behalf of a person who lacks capacity to make their own medical decisions. Legally recognized surrogate decision-makers may make health care decisions on the patient's behalf in the following order of priority: 1) the patient's orally designated surrogate designated by a patient with capacity during the current hospitalization; 2) the patient's agent designated in their advance health care directive; and 3) the conservator or guardian of the patient having authority to make health care decisions for the patient. In the absence of any of the above, the patient's health care provider can select a surrogate decision-maker from any of the following: the spouse or domestic partner of the patient, an adult child of the patient, a parent of the patient, an adult sibling of the patient, an adult grandchild of the patient, and/or an adult relative or close personal friend of the patient. The patient's surrogate shall be an adult who has demonstrated special care and concern for the patient, is familiar with the patient's personal values and beliefs to the extent known and is reasonably available and willing to serve.

Leaving against medical advice (AMA): When a patient with decision-making capacity chooses to leave against the advice of a physician or APP. It is an informed decision made by a patient who understands the recommendations of the physician or APP, including the applicable risks and benefits, and makes the choice to leave despite those recommendations.

Elopement: When a patient leaves the health care facility in any scenario other than discharge, transfer, or making an informed decision to leave against medical advice.

Decision-Making Capacity: The ability of a patient to understand relevant information, appreciate the medical consequences of a decision, reason through options, and communicate a choice. A patient must have decision-making capacity to provide informed consent or informed refusal. It is the responsibility of the treating physician or APP to make a clinical determination of whether the patient has decision-making capacity. A patient who is incapacitated does not have decision-making capacity.

Unrepresented patient: A patient for whom efforts to locate a proper surrogate decision-maker have been unsuccessful.

Medical Incapacity Hold (MIH): MIH is time-limited detainment of a patient against their will and does not authorize forcible treatment. A physician or APP order that allows staff to temporarily prevent a medically incapacitated patient, who has been evaluated not to have medical decision-making capacity, and has an imminent, expected adverse outcome if treatment is discontinued, from leaving the hospital. The MIH is distinct from psychiatric holds under Welfare and Institutions Code § 5150.

Psychiatric legal holds: lnvoluntary detention under the Lanterman Petris Short (LPS) Act:

- **California 5150**: Used when a person is a danger to self, a danger to others, or gravely disabled, as a result of a mental health disorder, severe substance use disorder or chronic alcohol use disorder.

  - A California 5150 may last up to 72 hours. It does not confer permission for medical intervention (which would require consultation with a surrogate decision-maker).
- **California 5250:** Extends a California 5150 for up to 14 days if the patient still requires treatment for the above reasons. Requires a judicial hearing. One of the same three criteria must be met.
- There are other temporary and longer-term conservatorships.

RESPONSIBILITIES

Physician or APP – Evaluate decisional capacity, determine medical risk for adverse outcome, order MIH when criteria are met, collaborate with clinical team on implementing MIH, reassess the patient regularly, document the need for MIH, and lift the MIH when no longer warranted.

Nursing and Care Management – Identify patients at risk, support evaluation and monitoring, notify physician or APP, assist in engaging surrogate decision-makers, notify Patient Safety/Risk Management as needed.

Security – Support safe management of patients, especially patients without decision-making capacity attempting to leave the acute care setting.

Patient Safety/Risk Management – Provide oversight of grievances or concerns about patient/staff safety.

Legal/Office of the General Counsel – Provide legal review and support for MIH use.

POLICY

A. AMA PROCEDURE FOR PATIENTS WHO HAVE DECISION-MAKING CAPACITY:

1) If any staff member has concerns that a patient may be attempting to leave or thinking about leaving the unit contrary to medical recommendations, they should share these concerns with their supervisor, the patient's nurse, and/or the patient's physician or APP.
2) Attempt to de-escalate the patient with early intervention techniques and address potential concerns.
    a. Refer to Appendix: Early intervention techniques
3) Notify the physician or APP of the patient's intention to leave the acute care setting and request that the physician or APP see the patient to explain the risks related to leaving against medical advice.
4) If appropriate, feasible, and permissible under HIPAA, family and friends should be included in efforts to persuade the patient to stay and complete medical treatment such that a safe discharge is possible.
5) Patient will be provided any applicable discharge teaching, prescriptions, follow-up appointments, assistance with transportation and/or community resources.
6) Physician or APP should document the facts in the medical record.

7) Physician or APP should complete the AMA form and place it in the patient's chart.
8) If the patient declines to sign the form, the physician or APP should document the declination and verbal conversation with the patient.
9) If the patient chooses to leave AMA before the provider discusses risks, document in the medical record.

B. PROCEDURE FOR PATIENTS WHO REQUEST TO LEAVE AMA AND *LACK* MEDICAL DECISION-MAKING CAPACITY

1) If any staff member has concerns that a patient may be lacking in decision-making capacity and may be attempting to leave or thinking about leaving the unit, they should share their concerns with their supervisor, the patient's nurse, and/or the patient's physician or APP.
2) Attempt to de-escalate patient with early intervention techniques and address potential concerns.
    a. Refer to Appendix: Early intervention techniques
3) Physician or APP assessment to determine if the patient is still lacking decision-making capacity.
4) If available, notify the patient's surrogate decision-maker and attempt to notify them of the patient's desire to leave the hospital AMA. Seek their assistance in encouraging the patient to reconsider leaving AMA.
5) If a patient is determined to lack decision-making capacity, then the patient also lacks the capacity to leave AMA or make any other healthcare decisions.
    a. See Table 1: Criteria for Decision-Making Capacity
    b. See Figure 1: Risk-Based Evaluation of Patients Attempting to Leave the Hospital
    c. MIH is indicated if a patient's lack of decision-making capacity is due to a medical illness/condition.
    d. Psychiatric hold (5150) is required if patient meets psychiatric criteria (e.g. gravely disabled, danger to self, or danger to others due to a mental disorder or severe SUD, or chronic alcohol use disorder); MIH is not appropriate.
6) A MIH prevents unrepresented patients lacking decisional capacity due to medical illness/condition from leaving the hospital when doing so would place them at risk of serious adverse outcome.
    a. **MIH Criteria:** All the following must be met:
        i. Unrepresented, without a surrogate decision-maker, or while reaching or identifying a surrogate decision-maker.
        ii. Lacks decision-making capacity,
        iii. Attempts/threatens to leave the hospital,
        iv. Cannot understand risk of leaving due to medical illness/condition,
        v. Leaving poses risk of serious adverse outcome, such as harm/disability/death,
        vi. Less restrictive measures are ineffective.
    b. Common conditions which might affect a patient's decisional capacity: traumatic brain injury or other head injuries, stroke, seizure, significant infection with delirium, shock, cognitive deficiencies (including age-related and developmental disabilities), and being under the influence of drugs or alcohol.

7) Procedure for MIH

a. Provider performs clinical assessment of the patient's condition, determines if the patient has medical decision-making capacity, and meets criteria for MIH.
b. Clinical team will perform MIH huddle [See Appendix B: MIH Huddle for questions] with provider, nursing staff, including charge nurse and house supervisor, with notification of administrator on call (AOC), and Office of General Counsel.
c. Physician or APP: Place MIH order in electronic health record and reassess the patient regularly.
    i) If a resident physician or APP is ordering, then the attending physician needs to approve, with approval documented in the chart.
    ii) If an attending physician is not available, then the resident physician or APP will order the MIH so as not to delay care and obtain approval from an attending physician as soon as possible.
d. Physician or APP must inform the patient that they have been deemed to lack decision-making capacity, and an MIH has been instituted. Clearly document [see Appendix C: Documentation Template] the rationale in support of such a decision in the medical record.
e. Nursing/Care Management: Evaluate referral to Public Guardian when appropriate, continue efforts to find surrogate decision-makers.
f. At the discretion of the physician or APP, consult Legal/Office of General Counsel, Psychiatry or Ethics Committee as needed to support clinical team's decision-making for appropriate discharge planning disposition for patient when needed
g. Patient Grievance: Patients must be informed of their right to file grievances with AHS, California Department of Public Health (CDPH), or Joint Commission.
h. Legal/Office of General Counsel: Actively assist in MIH cases and provide legal guidance as needed.
i. Duration, Renewal, and Lift:
    i) Initial MIH: Up to 24 hours or until circumstances change.
    ii) Reassessment of patient's behavior:
        (1) Minimum every 4-6 hours by nursing, and daily for physicians/APPs.
        (2) If based on specific circumstances (for example, if a patient is being held until test results are completed, the reevaluation should take place once the test results are completed and explained to the patient)
    iii) Renewal:
        (1) May be renewed in 24-hour increments not exceeding 72 hours. Continued efforts to use less invasive methods should be reattempted with MIH renewal when less invasive methods are not successful.
        (2) Justification with rationale must be clearly documented.
        (3) A second attending physician review is needed for a hold that would exceed 72 hours.
    iv) Termination: MIH lifted when patient regains decisional capacity, or when surrogate is identified, then discussion of involuntary hold and safety measures would be discussed with the surrogate. If it is unlikely that the patient will regain decisional capacity (e.g., due to dementia), then refer to Policy for Healthcare Decision-Making for Incapacitated Unrepresented Patients. When appropriate, the initiation of conservatorship could be considered.

v) Emergency Treatment: This policy does not alter the emergency exception to consent. Emergency treatment may proceed without consent if the patient is incapacitated, there is no known or available surrogate decision-maker, and failure to provide the treatment will pose a threat of loss of life/limb or severe disability.

8) De-escalation: If a patient without decision-making capacity becomes agitated or attempts to leave after MIH has been issued, then every effort should be made to deescalate the patient with early intervention. See Appendix: Early intervention techniques.

a) The least restrictive methods will be used to deescalate the patient. Document all deescalation efforts in the medical record.
b) Restraints should be used as a last resort when the patient is a danger to themselves/others and is escalating,
c) Consider application of restraints to keep the patient and staff safe.
d) Patient may be restrained according to AHS RESTRAINTS AND SECLUSION IN ACUTE CARE POLICY AND PROCEDURE which requires careful consideration of the patient's safety and autonomy, and use of minimal restraints required to address each situation.
e) Do not stop patient from leaving if they become violent towards staff or others. This is considered an elopement.
f) Security staff to assist clinical team as needed. If a patient is trying to leave, use the least amount of force to overcome resistance.
   i. Types of Force Authorized:
      a. **Low-level (soft empty-hand control):** Guiding, escorting, or holding techniques used to prevent elopement or injury.
      b. **Intermediate force:** Physical restraint in coordination with clinical staff when lesser means are ineffective, and safety is at risk.
      c. **Mechanical restraints:** Only when ordered or authorized by qualified clinical staff and consistent with hospital policy and regulatory standards. Security team assists clinical team in stabilizing patient limbs, while qualified clinical team applies restraints.
      d. **Prohibited actions:** Strikes, pain-compliance holds, use of weapons (batons, chemical agents, TASERs, firearms), or chokeholds.

11) **Procedure for elopement**

a) If any staff member has concerns that a patient may be attempting or thinking about leaving the unit without authorization, then concerns should be shared with their supervisor, patient's nurse, or physician.
   i) If a patient is missing from their room (left unannounced and undetected), attempts will be made by the unit staff to locate the patient by searching the unit first. This includes, but is not limited to any visitor areas, waiting rooms, other patient rooms, offices, and halls.
   ii) Notify Security of elopement.

iii) Notify House Supervisor if Security not on site. Provide pertinent patient information. Make every attempt to locate the patient.

iv) Notify the attending physician, charge nurse, and house manager. Notify law enforcement if patient is a minor or is a danger to themselves or others, or gravely disabled.

v) Notify the patient's next of kin and/or surrogate decision-maker and document good faith attempt(s) to contact the patient's emergency contact.

vi) If the patient leaves with any devices or IV access in place, contact the patient and ask them to return to the hospital for removal or return of equipment.

vii) All attempts to locate the patient will be documented in the medical record.

viii) Submit a patient safety MIDAS report.

b) If the patient has been located, all efforts should be made to have the patient return to the facility so that treatment may be continued.

Table 1: Criteria for Decision-Making Capacity

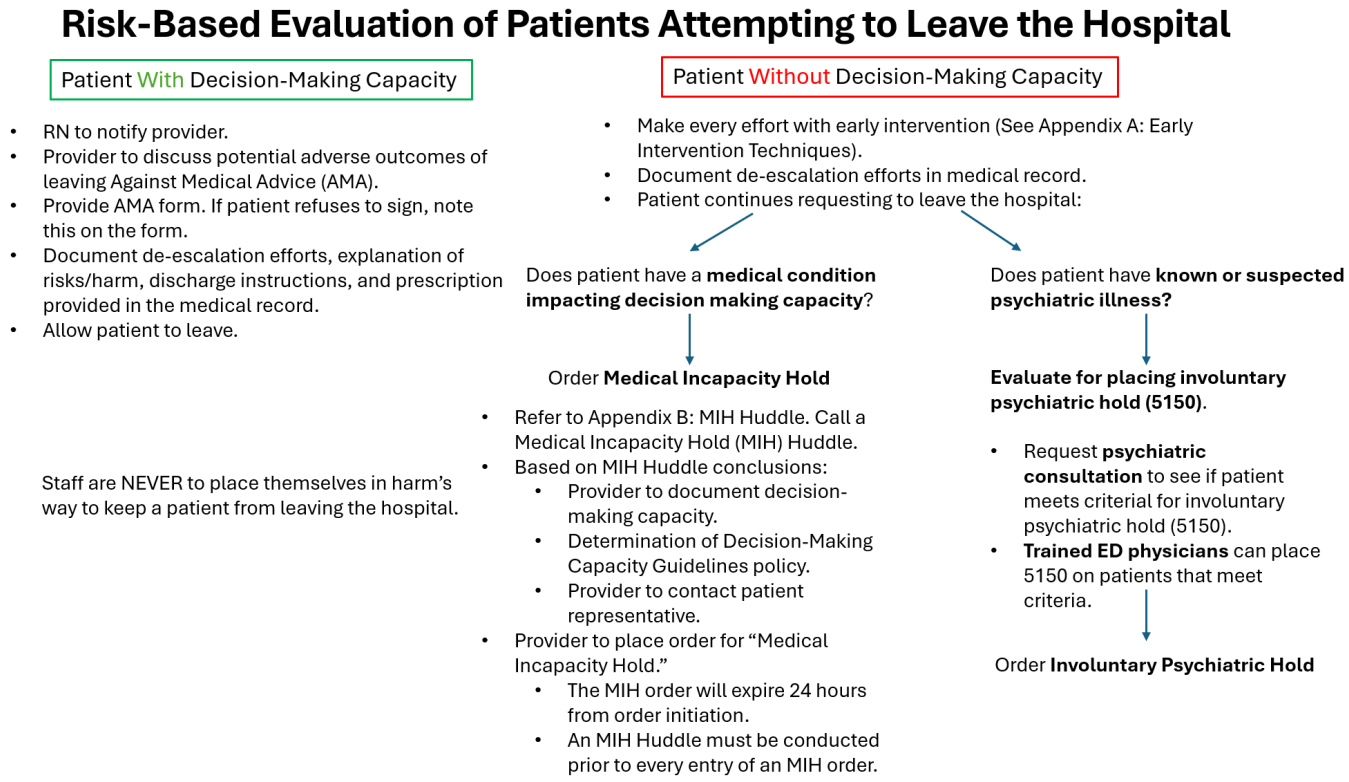
Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient.

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make valid decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make "unreasonable" choices

* Questions are adapted from Grisso and Appelbaum.[31] Patients' responses to these questions need not be verbal.

Source: Assessment of Patients' Competence to Consent to Treatment | New England Journal of Medicine

Figure 1: Risk-Based Evaluation of Patients Attempting to Leave the Hospital



Appendix A: Early Intervention Techniques

- Attempt to redirect the patient
- Involve family members/patient representative in de-escalation and/or redirecting the patient
- Explore and address reasons why patient desires discharge; Common reasons include:
  - Disagreement with clinical judgment/mistrust
  - Lack of coordination among healthcare providers
  - Financial/employment/personal obligations (caring for children or other family members)
  - Feeling disrespected, stigmatized, or unheard
  - Perceptions of poor quality of care
- Initiate discussion with patient representative/family early in admission:
  - Assess history of aggression, wandering, or elopement with past hospitalization, known triggers, successful de- escalation strategies, etc.
  - Explain to patient representative: If staff is unable to persuade the patient to remain in the hospital, here is a review of our policies and processes
- Develop Plan of Care (include patient and representative, as appropriate)
  - Patient Observer or Remote Patient Observation needed?

- Sensory – hearing aids, glasses, dentures
- Build Empathy ("What you are experiencing is difficult")
- Low Stimulation Environment
- Document and monitor early warning signs of escalation, triggers, calming measures
- Keep patient informed of progress and developments
- Assess pain, hunger, other physical needs
- Provide diversional activities (music, games, etc.)
- Provide choices
- Provide simple instruction (single step with time to respond)
- Prioritize verbal de-escalation
- Assess appropriateness of PRN medication to treat anxiety/agitation

- Review Plan of Care in Shift Huddle and handoff reports
- Provider to review medications i.e. identify opportunity for PRNs for possible/predicted hospital behaviors

Appendix B: MIH huddle

A. When a patient still desires to leave AMA after involving the patient representative, or we are unable to identify and/or notify the patient representative, the provider should conduct a risk-based evaluation to determine whether the patient could meet criteria for a Medical Incapacity Hold (MIH):
    1. Determine medical decision-making capacity: Has the provider determined the patient to be currently incapacitated, such that they cannot make their own medical decisions related to discharge from the hospital?
    2. Is there imminent and expected risk of an adverse outcome if healthcare is not provided within 24 hours?
        a. According to CMS, an adverse outcome is defined as serious injury, serious harm, serious impairment, or death which result in, or are likely to result in:
            i. Death
            ii. A significant decline in physical, mental, or psychosocial functioning (not solely due to normal progression of a disease or aging process)
            iii. Loss of limb, or disfigurement
            iv. Avoidable pain that is excruciating, and more than transient
            v. Other serious harm that creates life-threatening complications/conditions
B. If "YES" to both questions above, a MIH Huddle is required to determine whether the patient meets criteria for MIH. Provider, primary nurse, Charge RN, and when available, can involve the Nursing Supervisor to call an MIH Huddle:
    a. Ask the provider- "Please provide a brief case review including rationale that led to calling MIH Huddle."
    b. Has the provider determined the patient to be currently incapacitated, such that they cannot make their own medical decisions?

c. Which element(s) of decision-making capacity does the patient lack (refer to 4 Cs-context, consistency, consequences, choice)?
d. Is there an imminent and expected risk of an adverse outcome if healthcare is not provided within 24 hours?
    i. What is the imminent and expected risk the patient will experience?
e. Any further questions or concerns from the group? Anyone in opposition of implementing an MIH for this patient for the next 24 hours?
f. If yes to both questions above and all efforts to de-escalate the patient are unsuccessful, provider to enter order "Medical Incapacity Hold."
g. Provider to update clinical team with changes to Plan of Care during the next 24 hours while MIH in place, with goal of progressing patient to medical stability and/or decision-making capacity.
    i. Reminder to call MIH Huddle at 24 hours if criteria remains unmet and patient continues to request discharge.
h. If no to at least one of the questions above, patient does not meet criteria for an MIH.
    i. Prepare to discharge the patient. Provide support and follow-up, as able, including arranging transportation, prescriptions, follow-up care, etc.
    ii. Attempt to reduce risks as patient will allow
    iii. Notify patient representative immediately
    iv. Staff are NEVER to place themselves in harm's way to keep a patient from leaving the hospital
    v. Evaluation the need to notify law enforcement/security

APPENDIX C: PHYSICIAN/PROVIDER DOCUMENTATION TEMPLATE

INVOLUNTARY MEDICAL INCAPACITY HOLD FOR PATIENT LACKING DECISION-MAKING CAPACITY

In my clinical assessment, the patient named above lacks medical decision-making capacity to provide informed consent with regards to leaving against medical advice, as well as regarding:
_____ (testing or treatment)
for _____ (presumed diagnosis)

based on at least one of the following (please check all that apply)
[ ] inability to understanding the relevant clinical information, including the risks and benefits, regarding the decision being made
[ ] inability to use reason to make a decision
[ ] inability to effectively communicate a choice

Describe the situation that led to the initiation of emergency medical detention (see clinical chart for full details):

I hereby certify that this patient qualifies for physical detainment in the emergency department or inpatient setting for medical evaluation and treatment until the patient's condition is no longer considered emergent, the patient regains decision-making capacity, or a surrogate decision-maker is identified and makes the appropriate decisions.

Please Check One of the Following:
[ ] I have identified and will discuss this course of action with the patient's legal surrogate decision-maker
[ ] I will recruit the assistance of our emergency department social worker to help identify and contact a legal surrogate decision-maker

Regardless of decision-making capacity, the patient will remain informed of all decisions and who is making the decision.

Physician/Provider signature: _____ Physician/Provider printed name:_____
Date: _____ Time: _____
Based on Uniform Health Care Decisions Act: California Probate Code 4670-4743

REFERENCES

22 CCR § 70707 et seq., § 70717 et seq.
Probate Code § 810 et seq., § 1400 et seq., § 3200 et seq.
Health and Safety Code §§ 1317.1, 1418.8.
Welfare and Institutions Code § 1799.111.
Welfare and Institutions Code § 5150 et seq.

RELATED POLICIES

AHS RESTRAINTS AND SECLUSION IN ACUTE CARE POLICY AND PROCEDURE
AHS HEALTHCARE DECISIONS FOR INCAPACITATED UNREPRESENTED PATIENTS
AHS PATIENT RIGHTS AND RESPONSIBILITIES
AHS AGAINST MEDICAL ADVICE (AMA)
AHS EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)
AHS PATIENT INFORMED CONSENT

ALAMEDA HEALTH SYSTEM	Policy	
	MEDICATION CARTS, KITS AND TRANSPORT BOXES FOR SPECIFIC DEPTS. AND DIVISIONS	**29923 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 6/2025

Policy

To provide access and storage to medications in boxes or kits to specific areas where Automated Dispensing Machines (ADM, e.g. Pyxis) are not accessible and/or certain specific drugs are not included in crash carts. These departments/divisions may include however not limited to Allergy Clinic, Anesthesiology, Cardiology, Diagnostics, Oral Surgery, Operating Room, Emergency Department, and Radiology.
Other medication kits are assembled and put in ADM by pharmacy for the ease of removal under specific situations.

Procedures

A. Preparation

1. Pharmacy staff fills medications listed in the boxes and kits. Non-medicinal supplies in oral surgery boxes are filled by the Oral Surgery division.
2. Pharmacy staff records expiration dates of mediations on the content list.
3. Pharmacy staff who prepares the box or kit will sign and date on the content list.
4. Pharmacist will check all medications against the content list for correct quantity and expiration.
5. Pharmacist will sign and date the content list after checking the box or kit.
6. The signed and dated content list will be put inside the box or kit.
7. A copy of this content list can be put outside the box or kit. Or a sticker with the name of earliest expired drug and expiration date will be put outside the box or kit. This is to identify when to replace the content of the box or kit.
8. Pharmacy will put a tamper resistance lock on the checked box or kit to ensure the box or kit is secured before being dispensed.

B. Dispensing

1. When a box or kit is needed for a procedure by a department/division, the department/division staff will come to pharmacy to pick up the specific box or kit.
2. Pharmacy staff, before dispensing the box or kit, will make sure the lock is secured and medications are not expired.
3. Pharmacy staff fills out the dispensing log to indicate when and where the box/kit is dispensed.

C. Storage

1. Each department/division is responsible for storing the box/kit in an area where direct supervision of its usage is allowed until the procedure is complete.
2. Anesthesia department, oral surgery division and radiology department will store the boxes/kits in their areas until replacement.
3. Such storage areas should be easily monitored by the department or division staff to prevent unauthorized usage.

D. Administering and Returning
   1. When a medication is needed, the department staff will break the lock to open the box or kit.
   2. The department/division staff will put the patient addressograph sticker on the content list for subsequent billing by pharmacy.
   3. The department/division staff will return the used box or kit with the patient stamped content list to pharmacy for replacement.
   4. In the situation where the lock is found broken in the department/division, but medications are not used, the box or kit should be returned to pharmacy for checking.

E. Replacement
   1. Pharmacy will follow the procedures under "Preparation" in this policy to replace and refill any medications used in the box or kit that is returned from the department/division.

F. Medication kits stored in Automated Dispensing Machine (ADM, e.g. Pyxis)
   1. These kits are assembled in pharmacy and checked by pharmacist before putting in ADM.
   2. Kits are removed from ADM according to the ADM procedure.
   3. A refill or stock out report will be printed in the pharmacy to prompt for replacement.
   4. Used kits should be placed in the "return to pharmacy" bin for pick up and return to pharmacy.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Pharmacy and Therapeutics (P&T)	**Date:**	2/2026		
Clinical Practice Council (CPC)	**Date:**	3/2026		
Medical Executive Committee	**Date:**	3/2026		
Board of Trustees	**Date:**	4/2026		

ALL Acute Care Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Radiology	Radiology Contrast Allergic Reaction Kit	4
Critical Care	RSI kit	5
Employee Health Kit	Adult Anaphylaxis Kit	6
Anesthesia	Anesthesia Support Kit	7

Radiology Contrast Allergic Reaction Kit

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (in light protection bags)	2	
Methylprednisolone Inj.125 mg Vial	1	

Epinephrine Dosing: Hypersensitivity Reaction (e.g. anaphylaxis):
IM administration in the anterolateral aspect of the middle third of the thigh is preferred in the setting of anaphylaxis. Subcutaneous administration results in slower absorption and is less reliable.

IM (preferred anterior thigh): **Adults:** 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution every 5 to 15 minutes. **Peds:** 0.01 mg/kg (Max 0.3 mg) of 1 mg/ml solution (AAAAI [Lieberman 2015]; AHA [Vanden Hoek 2010]; WAO [Kemp 2008])

Rapid Sequence Intubation (RSI) Kit

Quantity	Medication	Expiration
1	Etomidate 2 mg/ml vial (total 10 mL)	
1	Rocuronium 10 mg/ml vial (total 10 mL)	
2	Succinylcholine 20 mg/ml inj (total 10 mL)	

Employee Health Adult Anaphylaxis Kit

Quantity	Medication	Expiration date
2	Diphenhydraime 25mg caps	
1	EpiPen 0.3mg/0.3mL prefilled syringe	
1	BD syringe, Leur-lok (1 ml syringe)	
1	BD Eclipse 25G needle	
2	Isopropyl alcohol 70% prep pads	

Anesthesia Support Kit

Quantity	Medication	Expiration
1	Ephedrine 50 mg/ml (1 ml) vial/ampule	
1	Etomidate 2 mg/ml (10 ml) vial	
1	Norepinephrine 1 mg/ml (4 ml) ampule	
1	Propofol 10 mg/ml (20 ml) vial	
1	Rocuronium 10 mg/ml (10 ml) vial	
1	Succinylcholine 20 mg/ml (5 ml) syringe	

Back up medications for situations like power outage and Pyxis failure. The kit is stored in a locked box.

Wilma Chan Highland Hospital Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Anesthesiology	• Anesthesia Intubation Kit (to be put in the transport bag)	9
Cardiology	• Cardiac CT Scan/Nuclear Medicine Box	10
	• Electrocardiography (EKG) Kit	11
	• Heart Alert (STEMI) Kit	12
Critical Care	• Adult Transport/Code Box	13
	• Neonatal Transport Box	14
	• Pharmacist code stroke kit	15
	• Non-Cytotoxic Vesicant Medication and Fluids Extravasation Kit	16
	• Phenylephrine Kit	17
Maternal Child Health	• Operation OB – Medication Box	18
	• OB Procedural Box	19
Oral Surgery	• Oral Surgery Box	20
Heme/Onc	• Hypersensitivity Kit for Infusion Center	21
Emergency Department	• ED Block Cart	22
	• ED Code bag	23

Anesthesia Intubation Kit (to be put in Anesthesia Airway Backpack)

Drug	Quantity	Expiration
Atropine Inj. 0.1 mg/ml 10 ml syringe	1	
Epinephrine Inj. 0.1 mg/ml (1:10,000) 10 ml syringe	1	
Etomidate Inj. 2 mg/ml 10 ml vial	1	
Phenylephrine Inj. 100 mcg/ml 10 ml syringe	1	
Propofol Inj. 10 mg/ml 20 ml vial	2	
Rocuronium Inj. 10 mg/ml 10 ml vial	1	
Succinylcholine Inj. 20 mg/ml 5 ml syringe	1	
Sugammadex 100 mg/ml 5 ml vials	3	

Cardiac CT Scan/Nuclear Medicine Box

Drug	Quantity	Expiration
Albuterol Inhaler 90 mcg/puff 8 gm inhaler	1	
Aminophylline Inj. 25mg/ml 10 ml vial	2	
Caffeine inj 60mg/3mL	1	

Electrocardiography (EKG) Kit

Medication	Strength	Quantity	Expiration
Atropine inj	1mg/1mL Vial	1	
Diphenhydramine inj.	50 mg/1 ml Vial	1	
Metoprolol inj.	5 mg/5 ml Vial	1	
Nitroglycerin SL tablet	0.4 mg	2 bottles (25 tabs/bottle)	

HEART ALERT (STEMI) Kit

(STEMI = ST-Elevation Myocardial Infarction)

Medication Name	Dose Given	Time	Route	Documented in MAR	Quantity in Kit	Exp. Date	Quantity Used
Atropine Inj 1mg (0.1 mg/ml) 10 ml prefilled syringe				☐	1		
Epinephrine Inj 1mg (1:10,000) 10 ml prefilled syringe				☐	1		
Amiodarone Inj 150mg (50mg/ml) 3 ml vial				☐	2		
Diphenhydramine Inj 50mg/ml 1 ml vial				☐	1		
Nitroglycerin 0.4 mg sublingual tablets				☐	1 bottle		

ADULT TRANSPORT/CODE BOX

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag)	1
Epinephrine 1:10000 1mg/10mL syringe	1
Oral glucose gel 15g	1
Normal saline 10mL flush	3
Angiocath starter kit*	1
Empty syringe 3mL	1
Empty syringe 10mL	3
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

Generic drug name	Quantity
RSI meds grouped together	
Etomidate 2mg/mL (10mL)	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

Neonatal Transport Box- Pharmacy Section

Pharmacy Section ONLY

Epinephrine 1:10,000 (0.1 mg/mL) 10mL Syringe- 1 ea____ (√)

(Dose of Epinephrine= 0.1 to 0.3 mL/KG of Epinephrine 1:10,000 IV)

Pharmacist Code Stroke Kit

Quantity	Medication	Expiration Date
2	30mL syringe	
2	10mL syringe	
5	5mL syringe	
1	BD Alaris Pump Infusion Set (REF 2426-0500)	
6	18G Eclipse Needles	
6	Saline Flush 10mL	
1	Nicardipine 25mg in 100mL (either NS or D5)	
1	Tenecteplase 50mg kit	
1	Labetalol hydrochloride 100mg / 20mL vial	
N/A	Miscellaneous: labels, tapes, and dosing sheet	

Non-Cytotoxic Vesicant Medication and Fluids Extravasation Kit

Quantity	Medications	Expiration Dates
2	Phentolamine mesylate for injection 5 mg/vial	
2	Hyaluronidase (Amphadase®) 150 units/ml, 1 ml vial (Hyaluronidase is STORED IN PYXIS REFRIGERATOR)	
2	0.9% Sodium chloride for injection, preservative free, 10 ml	
3	Nitroglycerin Ointment USP, 2% (NITRO-BID®) 1 inch (1 gram) foilpac®	

Phenylephrine Kit

To make a phenylephrine 50mg/250mL NS bag: Draw out 50mg = 5mL of phenylephrine from the vial and infuse it into a 250mL bag

Medication	Quantity	Expiration
Phenylephrine 50mg/5mL vial	1	
NS 250mg bag	1	
10mL syringe	1	
18-gauge needle	1	

Beyond Use Date (BUD): Administer within 1 hour of mixing for immediate use.
After starting administration, the bag is good for a total of 24 hours from time of mixing.

Operation OB – MEDICATION BOX

Quantity	Drug	Expiration Date
2	Oxytocin (Pitocin) 10 units/ml 1 ml vial	
5	Misoprostol (Cytotec) 100 mcg tablet	

OB Procedure Cart

Nursing:
Stamp with patient's name, place in medication box and return to pharmacy

Quantity	Medication	Expiration
2	Calcium gluconate 1g vials	
1	Hydralazine 20mg/mL vial	
1	Labetalol100mg/20mL (5mg/mL) vial	
1	Magnesium sulfate 20g/500mL bag	
2	Magnesium sulfate 50%, 5gm/10mL, 10mL vials	
5	Misoprostol 200mcg tab	
1	Naloxone 2mg/2mL syringe	
1	Nitroglycerin spray 0.4mg/spray	
2	Oxytocin 30 units/500mL bag	
4	Oxytocin 10 units/mL, 1mL vial	
3	Nifedipine 10mg, Immediate Release tabs	
1	Terbutaline1mg/mL vial	
1	Tranexamic Acid 1000mg/10ml	

The following medications are in the **9W** Pyxis Refrigerator under "**OB PPH Emergency Kit**", to access:

- Log in to pyxis
- Hit "remove meds" button
- Hit "kit" button at the bottom of the screen
- Choose the "**OB PPH Emergency Kit**"
- Remove the below meds

Pyxis items in the OB Code Kit	
Quantity	**Medication**
1	Hemabate 250mcg ampule (refrigerator in zip-lock bag)
2	Methergine 0.2mg/mL ampule (refrigerator in zip-lock bag)
5	Misoprostol 200mcg tab

****Diazepam inj** must be **removed separately from Pyxis** when needed

Oral Surgery Box

Supplies	Qty.
Alcohol Pads	8
BD 10ml Syringe w/ Luer Lock Tip Blunt Fill Needles	2
BD 5 ml Syringe	3
BD Eclipse 18G x1½" Needles	4
BD Eclipse 3 ml Syringe w/ 21G x1½" Needle	3
CPR Mask	1
Extension Set w/ y-site	1
IV Catheter 18G x1¼"	2
IV Catheter 20G x1¼"	2
IV Catheter 22G x1"	2
IV Start Kit w/Chloral Prep	2
Oxygen Mask	1
Regular IV Set	1

Drugs	Qty.	Expiration Date
Albuterol Inhaler	1	
Aspirin 325mg	2	
Atropine Inj. 0.4 mg/ml 1 ml Vial	2	
Dextrose 50% Inj. 0.5 gm/ml 50 ml Syringe	1	
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Ephedrine Inj. 50 mg/ml 1 ml Ampule w/ Filter needle	1	
Epinephrine 1:1000 Inj. 1 mg/ml 1 ml Ampule (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1	
Esmolol 100mg/10ml	1	
Flumazenil Inj. 0.1 mg/ml 5 ml Vial	1	
Hydralazine 20mg/mL (1mL) vial	1	
Labetalol Inj. 5 mg/ml 20 ml vial	1	
Lidocaine Gel 2% 5 ml Tube	1	
Methylprednisolone Inj. 125 mg Vial	1	
Naloxone Inj. 0.4 mg/ml 1 ml Vial	2	
Nitroglycerin SL Tablet 0.4 mg/tab #25 tab Bottle	1	
Normal saline 10ml vial	2	
Normal Saline 250 ml Bag	1	
RSI Kit	1	
Sterile Water Inj. 10 ml Vial	1	

Drugs are replaced by pharmacy. Supplies are replaced by dental dept. oral surgery staff

Hypersensitivity Reaction Kit for Infusion Center

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Methylprednisolone Inj.125 mg Vial	1	
Epinephrine 1mg/mL vial (Refer to "MANAGEMENT OF ACUTE ADVERSE REACTIONS (ADR) POLICY: CHEMOTHERAPY/BIOTHERAPY/IMMUNOTHERAPY: policy for dosing)	1	

Famotidine inj. 20 mg/2ml vials are in Pyxis Refrigerator.

- Atropine vial and/or syringe are in the pyxis machine
- Kit will include one 3mL syringe, one 18-gauge needle and one 21-gauge needle.

ED Block Cart

Quantity	Medication
Rescue/LAST Treatment	
12	Preferred choice: Intralipid (Fat Emulsion) 20% inj 200 - 250 ml bag with 1.2 micron filter tubing OR 2nd choice: SMOFlipid 20% - 100mL bags x2 with 1.2micron filter tubing + ASRA checklist for treatment of local anesthetic systemic toxicity (LAST) [both original and simplified versions]
2	16 gauge needles
2	50mL syringes

ED Code Bag

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag) **during D50W shortage only**	1
Epinephrine 1:10000 1mg/10mL syringe	1
Etomidate 2mg/mL (10mL)	1
Glucose gel (oral) 15g	1
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Tenecteplase kit	1
Supplies	**Quantity**
Normal saline 10mL flush	4
Angiocath starter kit*	1
Empty syringe 3mL	2
Empty syringe 10mL	2
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

Alameda Hospital Only Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Critical Care	• Anaphylaxis Kit • CCU Difficult Airway Cart	25 26
Critical Care/ED	• Kcentra kit • TNKase kit	27 28
Misc.	• Pain Medication Tray	29

ANAPHYLAXIS KIT

KEEP AT BEDSIDE FOR PACLITAXEL (TAXOL), L-ASPARAGINASE, PEPASPARAGINE INJECTION

PATIENT NAME
RN NAME

Quantity	Generic Name	Trade Name	Strength	Size	Form
1	Diphenhydramine	Benadryl	50mg/ml	1ml	SDV
1	Epinephrine (1:1000) (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	Adrenalin	1mg/ml	1ml	Ampule
1	Filter Needle			19G	Needle
1	Methylprednisolone	Solu-Medrol	125mg/2ml	2ml	SDV
1	Albuterol Solution	Proventil	2.5mg/3ml	3ml	SDV
3	Syringe			3ml	Syringe
3	Needle 18G			18G	Needle
3	Alcohol Prep Pad			Each	Pad

RETURN TO PHARMACY AFTER INFUSION.

FIRST EXPIRING DRUG:	**EXPIRATION DATE:**

TECH/RPH	**/**

CCU Difficult Airway Cart Drug List

Patient Addressograph

Drugs	Quantity	Quantity Used
Lidocaine 2% Jelly 30ml	2	
Lidocaine 2% 50 ml Multiple Dose Vial	1	
Hurricaine Topical Spray	1	
Phenylephrine Nasal Decongestant Spray	1	

First Drug(s) to Expire:_____ Expiration Date:_____

Filled/Checked By:_____/_____ Date:_____

***Return entire kit to pharmacy for replacement after each use**

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____

Date Used: _____

PATIENT HOSPITAL LABEL STICKER

***Return entire kit to pharmacy for replacement after each use**

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange "Medication Added" sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange "Medication Added" sticker, STEMI flyer	1	x

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____ Kit #: _____
NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

Pain Medications Tray List

Drugs	Exp Date	QTY	QTY Used
Lidocaine 1% P.F. (10 mg/mL) – 5 mL		25	
Lidocaine 2% P.F. (20 mg/mL) – 5 mL		10	
Bupivacaine 0.25% P.F. (2.5 mg/mL) – 10 mL		10	
Dexamethasone P.F. 10 mg/mL – 1 mL		25	
Kenalog (Triamcinolone Acetonide) 40 mg/mL – 1 mL		12	
Bupivacaine 0.5% P.F. (5 mg/mL) – 30 mL		9	
MethylPREDNISolone acetatae injectable suspension (Depo-medrol) 80mg		4	

San Leandro Only Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Cardiology	• Cardiology Drug Kit	31
	• Dobutamine Stress Test Kit	32
Critical Care	• Rapid Response Kit	33
	• Ancillary ICU Code Box	34
	• Kcentra Kit	35
	• TNKase Kit	36
OR	• OR Eye Medication Tray 1 Drug List	37
	• OR Eye Medication Tray 2 Drug List	38
	• OR Bleeding Kit	39
Radiology	• Radiology Emergency Drug (CT-Box)	40
Misc.	• Procedure Room Drug Box	41

Cardiology Drug Kit

Cardiology Drug Kit	Aminophylline 500mg vial	1
Cardiology Drug Kit	Atropine 1mg/10ml	1
Cardiology Drug Kit	Esmolol 100mg/10ml	1
Cardiology Drug Kit	Nitroglycerin 0.4mg tabs	25
Cardiology Drug Kit	Verapamil 5mg/2ml	1
Cardiology Drug Kit	22ga x1.5” safety needle	1
Cardiology Drug Kit	Diltiazem 5mg/ml 10 ml vial	1

Dobutamine Stress Test Kit (prepared upon order)

Dobutamine stress test kit (prepared upon order)	Dobutamine 250mg/d50w 250ml
Dobutamine stress test kit (prepared upon order)	d5w 500ml
Dobutamine stress test kit (prepared upon order)	esomolol 100mg/10ml
Dobutamine stress test kit (prepared upon order)	atropine 1mg/10ml inj

Rapid Response Kit

Rapid Response Kit	Ipatroprium/Albuterol 0.5mg/3mg amp	1
Rapid Response Kit	Nitroglycerin 0.4mg	1
Rapid Response Kit	Aspirin 325mg tab	1
Rapid Response Kit	Dextrose 50% 50ml	1
Rapid Response Kit	Naloxone 0.4mg	1
Rapid Response Kit	NS 1000ml IV	1

Ancillary ICU Code Box

Ancillary ICU Code Box	Amiodarone 150mg/3ml inj.	3
Ancillary ICU Code Box	Dextrose 5% 100ml bag	1
Ancillary ICU Code Box	Filter - 0.2 Micron	1
Ancillary ICU Code Box	Adenosine 6mg/2ml inj	3
Ancillary ICU Code Box	Atropine 1mg/10ml syringe	3
Ancillary ICU Code Box	Calcium Chloride 10% syringe	1
Ancillary ICU Code Box	Dextrose 50% 50ml syringe	1
Ancillary ICU Code Box	Dopamine 800mg/250ml D5W IV drip	1
Ancillary ICU Code Box	Epinephrine 1mg/10ml syringe	4
Ancillary ICU Code Box	Lidocaine 0.4% 250ml IV drip	1
Ancillary ICU Code Box	Lidocaine 100mg syringe	2
Ancillary ICU Code Box	Magnesium 1gm/2ml vial (Dilute with 9ml NS)	2
Ancillary ICU Code Box	Naloxone 2mg/2ml syringe	2
Ancillary ICU Code Box	Sodium Bicarbonate 8.4% syringe	2
Ancillary ICU Code Box	Sodium chloride flush 10ml syringe	4
Ancillary ICU Code Box	Sterile water 10ml	2
Ancillary ICU Code Box	Vasopressin 20 units/1 ml inj.	2

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____

Date Used: _____

PATIENT HOSPITAL LABEL STICKER

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange "Medication Added" sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange "Medication Added" sticker, STEMI flyer	1	x

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____ Kit #: _____

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

SLH OR Eye Medication Tray 1 Drug List

Drugs	Exp Date	QTY	QTY Used
Cyclopentolate (Cyclogyl) Soln 2% - 2 mL		1	
Cyclopentolate (Cyclogyl) Soln 1% - 2 mL		1	
Tropicamide 1% - 3 mL		1	
Phenylephrine (AK-Dilate) Soln 10% - 5 mL		2	
Sulfacet/Pred (Blephamide) Oint 3.5gm		1	
Gentamicin Soln 5 mL		2	
Gentamicin Oint 3.5 gm		1	
Erythromycin Oint 3.5 gm		2	
Ciprofloxacin (Cipro) Soln 0.3% - 2.5 mL		1	
Neo/Poly B/Dex (Maxitrol) Oint 3.5 gm		10	
Atropine Soln 1% - 2 mL		2	
Epinephrine PF Soln amp 1% - 2 mL		2	
Lidocaine PF Injection amp 1% - 2mL		10	
Cefazolin Injection Vial 1 gm		3	
Sterile Water for Injection SDV 10 mL		3	
Atropine Oint 1% - 3.5 gm		2	
Homatropine Soln 5% - 5 mL		2	
Lidocaine PF Injection 4% - 5 mL		6	
Gentamicin Injection SDV 80 mg/2mL		6	
Dexamethasone Injection SDV 4 mg/mL		8	

SLH OR Eye Medication Tray 2 Drug List

Drugs	Exp Date	QTY	QTY Used
Timolol Soln 0.5% - 5 mL		2	
Lidocaine/Epi Injection SDV 2%/1:200K – 20 mL		1	
Tetracaine Sterile Soln 0.5% - 2 mL		2	
Liquifresh PM Oint 3.5 gm		2	
Brinzolamide (Azopt) 1% - 10 mL		6	
Prednisolone (Pred-Forte) Soln 1% - 5 mL		3	
Fluorescein Sodium Ophth Strip 0.6 mg		3	
Lidocaine/Epi Injection SDV 1%/1:100K – 20 mL MDV		1	
Acetylcholine (Miochol-E) Soln – 2mL		3	
Trypan Blue (Vision Blue) Soln Syr 0.06% - 0.5 mL		5	
Pilocarpine Sterile Soln 2% - 15 mL		2	
Tetracaine Soln 0.5% - 15 mL		2	
Bupivacaine 0.75% - 10 mL		6	
Lidocaine Inj MDV 2% - 5 mL		6	
Lidocaine 2% - 50 mL		1	
Tetracaine (TetraVisc) Soln 0.5% - 5 mL		6	
Gatifloxacin (Zymaxid) Soln 0.5% - 2.5 mL		8	

OR Bleeding Kit

OR Bleeding Kit	GELFOAM (SIZE 100)	2
OR Bleeding Kit	Recothrom (5000 units)	4
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 10 ML	3
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 30 ML	1
OR Bleeding Kit	Gentamicin (80 MG/ 2 ML) 2 ML	4
OR Bleeding Kit	PROTAMINE (10 MG/ ML) 5 ML	1
OR Bleeding Kit	Visipaque (320mg/ml) 50ml	3
OR Bleeding Kit	30 ML SYRINGE	1
OR Bleeding Kit	18 GA HYPO NEEDLE	1
OR Bleeding Kit	MED LABELS	2

Radiology Emergency Drug (CT-box)

Radiology Emergency Drug (CT-Box)	Syringe w/ needle 3ml	3
Radiology Emergency Drug (CT-Box)	Atropine 1mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Benadryl 50mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1
Radiology Emergency Drug (CT-Box)	Ammonia Inhalants	4
Radiology Emergency Drug (CT-Box)	Benadryl 25mg cap	4

Procedure Room Drug Box

Procedure Room Drug Box	Fentanyl 100mcg/2ml	8
Procedure Room Drug Box	Midazolam 5mg/5ml	8

Alameda Health System

Medical Assistants: Medication Administration and Handling

Department	Ambulatory	***Effective Date***	9/2017
Campus	Highland, Mobile Health, Eastmont, Hayward, Newark, Marina, Kate Creedon	***Date***	7/2023, 3/2026
Unit		***Next Scheduled Review***	3/2029
Manual		***Author***	Ambulatory –Director of Nursing
Replaces the following Policies: n/a		***Responsible Person***	Ambulatory-Chief Administrative Officer

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

Purpose

This protocol references the list of medications that Medical Assistants are authorized to administer at Alameda Health System. In addition, it authorizes Medical Assistants to deliver medications to providers and document medication administration by providers.

Medications Medical Assistants can administer in addition to immunizations

1. Acetaminophen 325 Mg
2. Acetaminophen 500 Mg
3. Ammonia Inhalant
4. Aspirin 325 Mg
5. Aspirin Chewable 81 Mg
6. Bacitracin / Polymyxin B Ointment
7. Buprenorphine; Sublingual, SQ or transdermal patch
8. Cyanocobalamin 1000 Mcg 1 Ml
9. Hydroxyprogesterone Caproate 250 Mg 1 Ml
10. Ibuprofen 200mg
11. Ibuprofen 400 Mg
12. Ibuprofen 800 Mg
13. Leuprolide 3.75mg/1ml
14. Medroxyprogesterone 150mg/1ml
15. Neomycin/Baci/Poly Abx Oint
16. Triple Antibiotic Oint
17. Tuberculin Purif Prot Deriv

Protocol for obtaining medications for others to administer

Medical Assistants may obtain medications from a pyxis, clinic storage or pharmacy and deliver them to a provider, LVN or RN for administration. Exceptions include:

1. Controlled substances (with the exception of Buprenorphine oral, topical, SQ products mentioned above)
2. Anesthetics (with the exception of lidocaine products)
3. Medications formulated for IV administration only
4. Chemotherapy

Protocol for documentation of medications administered by providers

Medical Assistants may document administration of a medication or device by a provider once the following criteria have been met:

1. The provider must fully document the medication (order and sign) in the medical record. Medical Assistants do not take verbal orders.
2. If the Medical Assistant is not present when the medication/device is administered, the provider must provide to the Medical Assistant the site, dose administered if less than ordered,NDC, Lot number and time of administration.
3. The Medical Assistant documents the elements required of a clinic administered medication as well as the name of the provider who administered the medication/device (see Clinic Administered Medication tip sheet).

Approvals

Departmental-Ambulatory Operations Council	**Date: 2/2026**
Pharmacy and Therapeutics Committee	**Date: 2/2026**
Clinical Practice Committee	**Date: 3/2026**
Medical Executive	**Date: 3/2026**
Board of Trustees	**Date: 4/2026**

review

ALAMEDA HEALTH SYSTEM	Policy	
	INTRAVENOUS ADMIXTURE PROGRAM POLICY	**29764 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 12/1/2023 LAST REVIEW DATE: **2/2026**

POLICY STATEMENT

The Department of Pharmacy at all acute care sites which include Wilma Chan Highland Hospital, San Leandro Hospital and Alameda Hospital shall ensure the quality, safety, and regulatory compliance of all compounded sterile preparations administered to patients within this facility.

PURPOSE

The Department of Pharmacy shall follow policies and procedures outlined in this document to comply with the guidelines, standards, and requirements for Compounded Sterile Preparations (CSPs) established by the United States Pharmacopeia (USP) – General Chapter <797> and the American Society of Health-System Pharmacists (ASHP) in accordance with Federal and California State Board of pharmacy laws and regulations.

SCOPE

This system policy encompasses all the campuses of Alameda Health System that engage in the practice of sterile compounding in accordance with Federal and California State board of pharmacy laws and regulations.
Each individual campus is responsible for creation, implementation, execution and maintenance of their own Site Specific Standard Operating Procedure (SS-SOP) to outline the campus specific guidelines as defined by this Policy.

DEFINITIONS

1. Administration = direct application of a sterile product or preparation to a single patient by injecting, infusing or otherwise providing a sterile product or preparation in its final form.
2. BSC = Biological Safety Cabinet
3. BUD = Beyond Use Date – defined as the date, or hour and date, after which a CSP must not be used. The BUD is determined from the date and time that preparation of the CSP is initiated.
4. Category 1 = are compounded under the least controlled environmental conditions and therefore are assigned a BUD of 12 h or less at controlled room temperature or 24 h or less when refrigerated
5. Category 2 = require more environmental controls and testing than category 1 CSPs and may be assigned a BUD of greater than 12 hours at controlled room temperature or more than 24 hours if refrigerated, but not to exceed the limits established
6. Category 3 = preparations undergo sterility testing, supplemented by endotoxin testing when applicable and have more requirements than category 2 CSPs for personnel qualification, use of sterile garb, use of sporicidal disinfectants, frequency of monitoring, and stability determination
7. CSP = Compounded Sterile Preparations

8. Expiration Date = The time during which a product can be expected to meet the requirements of the USP-NF monograph, or maintain expected quality provided it is kept under the specified storage conditions
9. Designated Person: One or more individuals assigned to be responsible and accountable for the performance and operation of facility and personnel as related to the preparation of CSP's.
10. Assigned trainer = One or more individuals assigned by the designated person(s) to be responsible and accountable for directly providing the training, observation, and evaluation of personnel for the preparation of CSPs
11. GFT = gloved fingertip and thumb sampling
12. Sterile Compounding = defined as combining, admixing, diluting, pooling, reconstituting, repackaging or otherwise altering a drug product or bulk drug substance to create a sterile preparation13. CSPs include:
    a. Injections, including infusions.
    b. Irrigations for internal body cavities
    c. Ophthalmic dosage forms
    d. Aqueous preparations for pulmonary inhalation
    e. Baths and soaks for live organs
    f. Implants
    g. Hazardous Drugs
13. Immediate Use CSPs = a sterile preparation prepared outside of an air quality less than ISO class 5, the preparation involves not more than 3 different sterile products
14. LAFW = Laminar Air Flow Workbench
15. PECs = Primary Engineering Controls; includes LAFW, and BSC
    SECs = Secondary Engineering Controls; a temperature and air flow-controlled environment in which PECs are placed
16. Preparation Per Approved Labeling = Compounding does not include mixing, reconstituting, or other such acts that are performed in accordance with directions in approved labeling provided by product's manufacturer. Preparing a manufactured sterile product per the manufacturer's approved labeling is outside the scope of USP chapter 797 only if the product is prepared as a single dose for an individual patient; and the approved labeling includes information for the diluent, resulting strength, container closure system, and storage time.
17. Proprietary bag and vial systems = Docking and activation of proprietary bag and vial systems in accordance with the manufacturer's labeling for *immediate* administration to an individual patient is not considered compounding and may be performed outside of an International Organization for Standardization (ISO) Class 5 environment.
18. Repackaging: Repackaging of a sterile product or preparation from its original container and into another container must be performed in accordance with the requirements in USP Chapter <797>.

PROCEDURES

A. Designated Person(s)

The compounding facility must designate one or more individuals (i.e., the designated person(s)) to be responsible and accountable for the performance and operation of the facility and personnel in the preparation of CSPs and for performing other functions determined by United States Pharmacopeia (USP) – General Chapter <797> and the American Society of Health-System Pharmacists (ASHP) in accordance with Federal and California State Board of pharmacy laws and regulations.

The Designated Person(s) must be identified in the facility's SOP's.

The Designated Person(s) must be qualified and trained to serve as the subject matter expert and be responsible for the content outlined in this policy.

The Pharmacist-in-Charge may serve as the Designated Person for a facility.

B. Pharmacist-in-Charge (PIC) Responsibility:

1. On a biennial basis, before July 1 of every odd-numbered year, the pharmacist-in-charge (PIC) shall review and complete the self-assessment form 17M-39 (Rev. 01/2022) for compounding. This may be obtained from the California Board of Pharmacy website.

2. On an annual basis, the pharmacist-in-charge (PIC) and/or the designated person(s) shall review this Intravenous Admixture Program policy and standard operating procedures for compliance with any and all changes related to the practice of compounding sterile preparations.

3. Any changes to policy, procedures, and standard operating processes will be communicated to assigned compounding staff through any/or all of the following: email, newsletter, pharmacy huddles, training and/or additional competency testing.

4. The PIC and /or designated person(s) are responsible for creating and implementing a training program for personnel and ensure that all personnel who prepare CSPs:

- have direct oversight of compounders;
- perform restocking or cleaning and disinfection duties;
- are initially trained and qualified by demonstrating the knowledge and competency in maintaining a sterile compounding area before being allowed to perform their job functions independently.
- Training may be performed by the designated person(s) or an assigned trainer.

C. Pharmacy Personnel Responsibilities:

1. Only pharmacy staff who successfully completed all required IV admixture competency training, aseptic media fill manipulation skills testing and fingertip glove sampling testing, shall be allowed to prepare compounded sterile products (CSPs).

2. Personnel allowed to perform tasks in a sterile compounding environment shall receive and complete appropriate didactic and calculation competency initially and at least every 12 months in regard to appropriate sterile compounding principles and practices.

3. Garbing and Hand Hygiene competencies are administered biannually for personnel preparing category 1 and 2 CSPs. (Please See SS-*SOP – Training of Sterile IV Compounding Staff and Support Personnel)*

4. All medications intended for neonatal patients shall be prepared, compounded, appropriately labeled, and dispensed exclusively by the Pharmacy Department. This includes all sterile IV admixtures, parenteral nutrition solutions, and any high-risk or weight-based compounded products. Nursing personnel shall not prepare or compound intravenous medications for neonatal patients except in circumstances approved by Pharmacy leadership or in emergency situations.

5. Pharmacy Technician: Each assigned technician is responsible to:
   a. Garb and perform proper hand hygiene (Refer to SS-SOP – *Garbing for Non-Hazardous and Hazardous Parenteral Compounding*)
   b. Clean the PEC prior to compounding.
   c. Work only on one drug preparation at a time.
   d. Select appropriate drugs, additives, diluents, solutions, supplies, and other devices needed and calculate quantities for compounding based on the prescription.
   e. Check the condition of the packaged items, their labels and expiration dates.
   f. Any damaged or outdated items shall be removed from the area and will be returned/credited from the manufacturer or discarded.
   g. Items used in the PEC are kept in direct airflow to minimize the chance of airborne contamination.
   h. Visually inspect for particulates, turbidity, or other unexpected changes during the compounding process.
   i. Place all necessary items in the work area before beginning admixture to prevent frequent interruptions and breach of aseptic technique. Keep all unnecessary items out of the PEC work area.
   j. Record all drugs compounded (see Record Keeping)
   k. Notify the pharmacist immediately upon completion of a STAT or NOW medication.
   l. Properly dispose of needles, syringes, and supplies used in the designated containers.
   m. Stock the IV room with sufficient quantity of medications, solutions, and supplies.
   n. All exterior packaging of items and supplies must be wiped with sterile isoprophyl 70% alcohol before introduction into the IV room (i.e. IV bags, vials, etc.)
   o. Order supplies needed to replenish stock.
   p. Complete and document the following as defined in the SS-SOP

i. PEC cleaning
ii. IV room bins, racks, shelves, carts cleaning
iii. Temperature logs

q. Abide by all compounding preparation techniques and procedures as defined by hospital policy (Please See SS-*SOP – Sterile Hazardous and Non-Hazardous Compounding Preparations*

6. Pharmacist(s) is(are) responsible to:
   a. Check all IV orders for incompatibilities (physical, chemical, and therapeutic), allergies, instabilities, contraindications, dosage, appropriate diluents, infusion time and rate using professional knowledge, appropriate references, etc. Contact the prescriber if problems are identified and communicate with the patient's nurse if any delay is expected.
      i. If physical compatibility, stability, or solubility of an admixture is dependent on solution pH, temperature, or other factors beyond the control of the pharmacy department, use of a final in-line filter may be recommended.
   b. Enter IV orders into the electronic health record accurately with appropriate administration times.
   c. Ensure the proper storage and delivery of the product to the patient based on the drug's package insert or manufacturer recommendations.
   d. Verify all components prepared by the technician for the compounding process BEFORE and AFTER compounding.
      i. Inspects the expiration date and integrity of each drug, diluent, and solution used.
      ii. Inspects each vial for the appropriate amount withdrawn to ensure potency and review the appropriate calculations performed to ensure appropriate strength of the final CSP.
      iii. Inspects each vial for the absence of harmful levels of contaminants such as particulates or discoloration to ensure quality of each drug ingredient used.
      iv. Initial all completed CSPs labels prior to dispensing.
   e. Ensure all CSPs are labeled appropriately and include:
      i. Hospital pharmacy name
      ii. Minimum of 2 patient identifiers
      iii. Patient room number
      iv. Name and concentration/strength of ingredients of the CSP.
      v. Date/time drug is compounded.
      vi. Route and rate of administration
      vii. Instructions for storage and handling (i.e. Refrigerate, protect from light), if applicable.

viii. Final expiration date/time of the CSP

7. Personal Hygiene and Garbing
    a. Individuals entering a compounding area must be properly gowned and garbed.
    b. Personnel must maintain proper personal hygiene to minimize risk of contamination to the environment and CSPs.
    c. Food and drink are not permitted within the compounding areas.
    d. Personnel must remove:
        i. Outer garments (e.g., bandanas, coats, hats, jackets, sweaters, or vests)
        ii. Cosmetic products
        iii. Hand, wrist, and exposed jewelry including ear/facial piercings.
        iv. Earphones or ear buds
        v. Nail polish, artificial nails – nails must be kept clean and neatly trimmed.
    e. Wipe eyeglasses, if worn, with appropriate cleansing wipes
    f. Individuals with rashes, recent tattoos, oozing sores, conjunctivitis, or active respiratory infections must report these conditions to the designated person(s)and/or supervising pharmacist.
    g. Designated person(s) and/or supervising pharmacist are responsible for evaluating and determining whether these individuals shall be excluded from working in the compounding areas before their conditions have resolved.

D. Training, Competencies, and Evaluation in Aseptic Manipulation Skills

1. Training Program
    a. Personnel who prepare CSPs must complete and pass competencies before being assigned to sterile compounding activities.
    b. Observation: During the fingertip and media-fill tests, the personnel's garbing, hand hygiene, and sterile technique are validated by observation by another staff member trained in the compounding of sterile products.
    c. The following shall be assessed initially and at a minimum every 12 months:
        i. Cleaning and Disinfection
        ii. Didactic coursework, pharmacy calculations [examination questions shall be updated annually]
        iii. Aseptic technique
        iv. Documentation of compounding process (e.g master formulation and compounding record)
        v. Proper use of PECs

vi. Principles of high-efficiency particulate air (HEPA)-filtered unidirectional airflow within the ISO Class 5 area
vii. Principles of movement of materials and personnel within the compounding area

d. Personnel must score at least 90% on all didactic examinations to pass.
e. Results of all competency evaluations and corrective actions performed for failures must be documented and documentation maintained to provide a record and assessment of personnel competency. Documentation shall include:
   i. Name of Person Evaluated
   ii. Evaluation date/time
   iii. Media components used including manufacturer, lot/expiration dates
   iv. Temperatures for each interval of incubation
   v. Dates of incubation
   vi. Results
   vii. Name or identifier of competency observer and documenter of results.

2. Garbing and Hand Hygiene Competency
   a. Compounding personnel must successfully complete an initial garbing competency evaluation with no fewer than 3 separate garbing processes in succession - failure of any of the 3 initial garbing competency evaluations requires repeat testing until personnel completes 3 garbing evaluations successfully in a row.
      i. Each garbing competency consists of a visual observation and a gloved fingertip and thumb (GFT) sampling of both hands.
      ii. Failure is indicated by visual observation of improper hand hygiene and/or garbing procedures.
      iii. Failure of gloved fingertip/thumb testing is sampling results that exceed the action levels described below in *section d.v*:
   b. After successful initial competency demonstration, personnel shall complete the garbing competency every 6 months for compounding of category 1 and category 2 CSPs.
   c. Personnel who have direct oversight of compounding personnel, **but do not compound**, may complete garbing competency every 12 months. Personnel who have direct oversight of compounding are not allowed to compound unless they successfully complete the garbing competency at the same requirement for compounding personnel.
   d. Competency in garbing and hand hygiene shall be assessed by means of:
      i. Finger-tip glove testing for aseptic manipulative skills initially and every 6 months.
      ii. A qualified evaluator will have each personnel sample the glove fingertips onto a TSA with lecithin and polysorbate 80 agar media

after proper garbing and hand hygiene but prior to applying any disinfectant.

iii. Three sets of gloved fingertip samples should be performed before initial compounding is allowed.

iv. Samples are covered, inverted, and placed into an incubator at 30-35°C for no less than 48 hours and then at 20 to 25 ºC for no less than 5 days.

v. Personnel must have a result of zero (0) colony forming units (CFUs) at the end of the incubation period to pass.

3. Aseptic Manipulation Competency
   a. Pharmacy personnel shall successfully complete an aseptic manipulation competency prior to beginning the compounding of category 1 and category 2 CSPs.
   b. The aseptic manipulation competency evaluation consists of visual observation, media fill testing, followed by post compounding gloved fingertip and thumb sampling, as well as surface sampling of the direct compounding area.
   c. Personnel compounding category 1 and category 2 CSPs shall successfully complete an aseptic manipulation competency initially and every 6 months.
   d. Personnel who have direct oversight of compounding personnel, **but do not compound**, may complete aseptic manipulation competency every 12 months. Personnel who have direct oversight of compounding are not allowed to compound unless they successfully complete the aseptic manipulation competency at the same requirement as for compounding personnel.
   e. Media-fill testing for aseptic manipulative skills shall be performed initially and every 6 months.
      i. Immediately following completion of the media-fill test, GFT sampling must be performed on both hands inside of an ISO class 5 PEC.
      ii. Surface sampling of the direct compounding area must occur after compounding completion. A failure in the media fill, GFT, or surface sample constitutes an overall failure of the aseptic manipulation competency.
      iii. Bags are examined daily for turbidity. Turbidity indicates positive growth of microorganisms which fails the test.
      iv. If the minibag is clear, the test is negative, and the compounding personnel has passed the test.
      v. Successful completion of GFT post compounding is defined as less than or equal to 3 CFU as a total from both hands. Microbial identification is not required for gloved fingertip and thumb sampling.

f. Media fill tests shall simulate the most difficult and challenging aseptic compounding procedures encountered; the components shall be replaced with the use of soybean-casein digest media. The media fill test must capture factors that may affect sterility of a CSP including but not limited to:
   i. Length of the process that can create contamination risk (e.g., operator fatigue, quality of equipment)
   ii. Number of aseptic additions or transfers
   iii. Number, type, and complexity of manipulations.
   iv. Number of personnel in the buffer room or SCA
g. If commercial sterile microbial growth media is used, a certificate of analysis must be on record from the supplier stating that the lot of growth media will support the growth of microorganisms.
h. Growth media shall be stored according to manufacturer instructions.

4. Compounding Personnel who fail any aspect of the aseptic manipulation any of the above competencies will be unable to work in the IV compounding room until competence is certified and will be placed on a performance improvement plan. The employee will be retrained and re-evaluated to assure correction of all aseptic practice deficiencies and will repeat the competency testing in 6 months.
5. A person with only direct supervision who fails any of the above competencies may continue to provide direct supervision for no longer than 30 days after a failure of any aspect of the competency while training and competency evaluation results are still pending.
6. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.

E. <u>Facilities and Equipment Controls</u>

1. Facility Design
   a. The surfaces, ceilings, walls, floors, doors, door frames, fixtures, shelving, work surfaces, counters, and cabinets in the classified clean room area must be smooth, impervious, free from cracks and crevices, and non-shedding so they may be cleaned and disinfected and to minimize spaces in which microorganisms and other contaminates can accumulate.
   b. Surfaces should be resistant to damage by cleaning agents, sporicidal and other types of disinfectants and tools used to clean.
   c. Seals and sweeps should not be installed at doors between buffer rooms and anterooms. Access doors should be hands free. Tack mats must not be placed within ISO classified areas.
   d. Junctures between the ceiling and the walls and between the walls and the floor must be sealed to eliminate cracks/crevices where dirt can accumulate.
   e. If ceilings consist of inlaid panels, panels must be caulked around each panel to seal them to the support frame.

f. Walls must be constructed of durable material and integrity must be maintained. Panels must be joined together and sealed to each other and the support structure.
g. Floors must include coving to the sidewall, or the juncture between the floor and the wall must be caulked.
h. Ante rooms must have a line of demarcation to separate the clean side from the dirty side. The anteroom shall be entered through the dirty side, and the clean side is closest to the buffer room.
i. Classified areas should minimize dust collecting overhangs such as ledges and windowsills. If present, the overhangs, and windowsills must be easily cleanable.
j. Surfaces within an SCA should be smooth, impervious, free from cracks and crevices, and non-shedding so that they can be easily cleaned and disinfected to minimize microorganisms and other contaminant accumulation.
k. Surfaces in an SCA should be resistant to damage by cleaning agents, sporicidal and other types of disinfectants and tools used to clean.
l. SCA areas should minimize dust collecting overhangs such as ledges and windowsills. If present, the overhang and windowsills must be easily cleanable.
m. Water Sources and Sink Placement: The facility where CSP's are prepared must be designed so that activities such as hand hygiene and garbing will not adversely affect the ability of the PEC to function as designed. Sinks should enable hands-free use.
    i. If the sink is located outside of the anteroom, it must be located in a clean space to minimize the risk of bringing contaminants into the anteroom.
    ii. If the sink is located outside of the anteroom, it may be placed on either the clean or the dirty side of the anteroom.
    iii. The buffer room must not contain plumbed water sources.
    iv. The anteroom must not contain floor drain(s)
    v. In a facility with an SCA design, a hand- washing sink must be placed not closer than 1m to the PEC and may be either inside the SCA or in close proximity to the SCA.

2. Ante-area
    a. Environmental services (EVS) staff will clean floors daily when no aseptic operations are in progress and document the cleaning on the EVS cleaning log.
    b. Racks, bins, equipment, and shelving will be cleaned weekly and documented on the EVS cleaning log.
    c. Ceilings and walls will be cleaned weekly by EVS staff and documented on the EVS cleaning log.
    d. Air quality testing will be done every 6 months and surface quality testing will be done every month by a qualified certification company.
3. Buffer Area

a. Environmental services (EVS) staff will clean floors daily when no aseptic operations are in progress and document the cleaning on the EVS cleaning log.
b. Racks, bins, equipment, and shelving will be cleaned weekly and documented on the EVS cleaning Log.
c. Ceilings and walls will be cleaned weekly by EVS staff and documented on the EVS cleaning log.
d. Air quality testing will be done every 6 months and surface quality testing will be done every month by a qualified certification company.
e. Air pressure gradients between the buffer area and the ante area will be monitored daily.

4. Equipment Controls
   a. All intravenous (IV) solutions with additives made in the pharmacy shall be prepared in a PEC, either a horizontal laminar airflow workbench (LAFW) or in a vertical LAFW which is also known as a Class II Biological Safety Cabinet type B2 (BSC) and dispensed by the pharmacy department.
   b. Compounded sterile products shall be prepared in an ISO Class 5 environment (LAFW orBSC) located within an ISO Class 7 buffer area and separated from the pharmacy proper by an ante-area.
   c. The exception to this shall be for "Immediate Use" products which may be prepared by trained registered nurses or providers in an urgent/emergent situation.
   d. The PECs shall be located in a buffer room of a clean room suite or SCA that minimizes conditions that may increase risk of microbial contamination.
   e. A PEC may be located within an unclassified area without an anteroom or buffer room; this design is referred to as a segregated compounding area (SCA). The SCA must be located away from unsealed windows, doors that connect to outdoors, and traffic flow. The area within 1 meter of the PEC should be dedicated only for sterile compounding.
   f. ISO classified anterooms and buffer rooms must be separated from surrounding unclassified areas by fixed walls and doors. Classified rooms must be equipped with a pressure-differential monitoring system.

Summary of Minimum Requirements for Placement of PECs for Compounding of Non-Hazardous CSPs

PEC Type	Device Type	Placement for Compounding Only Category 1 CSPs	Placement for Compounding Category 2 and 3 CSPs

LAFS	LAFW	Unclassified SCA	ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom
	BSC	Unclassified SCA	ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom
	CAI	Unclassified SCA	ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom

5. Air Quality, Air Exchanges, Air Pressure Differential and Monitoring
    a. Clean room suites are required to maintain adequate HEPA filtered airflow to buffer rooms and ante rooms. Air supplied to the cleanroom suite must be introduced through HEPA filters that are located in the ceiling of the buffer and anteroom. Air quality standards are listed in the table below:

    b. A minimum of 30 total HEPA filtered air changes per hour (ACPH) must be supplied to ISO class 7 rooms
        i. The total HEPA filtered air change rate must be adequate to maintain ISO class 7 during dynamic operating conditions.
        ii. At least 15 ACPH of the total air change rate must come from the HVAC through HEPA filters located in the ceiling.
        iii. The HEP filtered air from PECs when added to the HVAC-supplied HEPA filtered air must increase the total air changes to at least 30 ACPH.
    c. A minimum of 20 total HEPA filtered ACPH must be supplied to ISO Class 8 rooms
        i. The total HEPA filtered air change rate must be adequate to maintain ISO class 8 during dynamic operating conditions.
        ii. At least 15 ACPH of the total air change rate in a room must come from the HVAC through HEPA filters located in the ceiling.
    d. Air Returns in the cleanroom must be low on the wall unless a visual smoke study demonstrates absence of stagnant airflow.

Summary of ISO Classification and Particulate Matter in Room Air

ISO Class	Particle Count per Cubic Meter

3	35.2
4	352
5	3520
6	35,200
7	352,000
8	3,520,000

Summary of ACPH Requirements for Non-Hazardous Sterile Compounding Areas

Compounding Area	ACPH Requirement
Unclassified SCA	No requirement
ISO Class 7 room(s)	Greater than or equal to 30 ACPH
ISO Class 8 room (s)	Greater than or equal to 20 ACPH

6. Air Pressure Differential Monitoring:
    a. Air pressure gradients between the buffer room, ante-area, and the pharmacy proper shall be monitored continuously using a pressure differential monitoring device and documented at least daily when compounding is occurring.
    b. Continuous air pressure differentials are required to minimize airflow from an area with lower air-quality classification to an area of higher air quality classification.
    c. No pressure differential is required between an SCA and the surrounding areas.

Air Pressure Differential Range Requirements

Type of Pressure Gradient	Range	Alarm Set Point
Positive (+)	0.02 to 0.05 “WC	Less than (+) 0.02
Negative (-)	-0.01 to -0.03 “WC	More than (-) 0.01

7. Temperature and Humidity Monitoring:
    a. The cleanroom suite should be maintained at a temperature of 20 ºC (68 F) or cooler and a relative humidity of 60% or below.
    b. Temperature and humidity must be monitored and documented daily for each day that compounding activities are performed.
    c. Temperature and humidity in the cleanroom suite must be controlled through a heating, ventilation, and air conditioning (HVAC) system.
    d. Free standing air conditions, humidifiers, and dehumidifiers must not be used within the classified areas or the SCA.
8. Primary Engineering Controls (PECs) and Equipment:
    a. Horizontal Laminar Airflow Workbench (LAFW):

i. *Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area* – for guidance on cleaning procedures and requirements.
ii. *Refer to SOP – Quality Assurance of Compounded Sterile Products and Certification of Sterile Compounding Area* – for guidance on certification procedures and requirements.

b. Biological Safety Cabinet (BSC):
   i. *Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area* – for guidance on cleaning procedures and requirements.
   ii. *Refer to SOP – Quality Assurance of Compounded Sterile Products and Certification of Sterile Compounding Area* – for guidance on certification procedures and requirements.

c. Refrigerators
   i. Temperatures will be recorded and maintained in accordance with hospital policy. (Please See *AHS Medication Storage policy)*

d. Incubators
   i. Temperatures will be recorded and maintained in accordance with hospital policy. (Please See *AHS Medication Storage policy)*

e. (If applicable) Measuring equipment will be calibrated and certified annually by the California Department of Weights and Measures.

F. Sterile Compounding Area Certification and Recertification

1. Designated Person(s) Responsibilities:
   a. The designated person(s) must ensure that each area and PEC meet the classified air quality standard(s) for appropriate activities to be conducted in those areas.
   b. A corrective action plan must be implemented and documented in response to any out-of-range results.
   c. Data collected in response to corrective actions must be reviewed to confirm that the actions taken have been effective.

2. PEC, SEC Certification and Frequency:
   a. Certification of the classified areas including the PEC must be performed initially, and at least every 6 months. Testing must include:
      i. Airflow testing
      ii. HEPA Filter Integrity Test
      iii. Total Particle Count
      iv. Dynamic Airflow Smoke Patter Test
   b. Classified areas must be recertified if there are changes to the areas including, redesign, construction, replacement, or relocation of any PEC

c. Classified areas must be recertified if there are alterations in the configuration of the room that may affect airflow or air quality
d. Number of persons present in PEC and SEC during total particle count testing and dynamic airflow pattern certification testing must be documented
e. All records must be reviewed by designated person(s) to ensure that the classified environments meet the minimum requirements.
    a. Documentation of review must occur. Any corrective action must also be documented.

3. Microbiological Air and Surface Monitoring
    a. The monitoring program involves collection and evaluation of samples from various air and surface locations. Results of microbiological air and surface sampling shall be reviewed in conjunction with personnel data to assess the state of control and identify potential risks of contamination.
    b. Microbiological air and surface sampling must be conducted in all classified areas during dynamic operating conditions
    c. The microbiological air and surface monitoring program must be clearly described in the facility's SOP, which must include a diagram of sampling locations, procedures for collecting samples, frequency of sampling, size, time of day of sampling in relation to activities in the compounding area, and action levels that will trigger corrective action.
    d. Air and surface sampling must be incubated in an incubator at the temperatures specified.
    e. Incubator must be placed in a location outside of the of the sterile compounding area.
    f. The incubator temperature must be monitored during incubation using either manual or continuous recording device.
    g. Results must be reviewed and documented for air and surface sampling.
    h. Sampling must include:
        i. Viable impact volumetric airborne particulate sampling
        ii. Surface sampling

    i. Viable Air Sampling must be performed at least every 6 months.
    j. Sterile Compounding Areas that compound category 1 and 2 CSPs must perform viable surface sampling at least monthly.

Compound Type	Viable Sample Type	Frequency
Category 1 & 2	Air	Every 6 months
Category 1 & 2	Surface	Every 1 month

4. Microbiological Sampling Data Evaluation and Action Levels
    a. Evaluation of the CFU counts against the action levels referenced and previous data shall occur to identify any adverse results or trends in environmental monitoring.
    b. If two sampling media devices are collected at a single location, all recovered growth on each must be documented and action levels applied to each sampling media device separately.
    c. If action levels are exceeded, the cause must be investigated, and corrective action taken
    d. Data collected as part of a corrective action plan must be reviewed to confirm effectiveness. Corrective action plan must be dependent and responsive to the CFU count and types of microorganisms recovered. The investigation should include an evaluation of trends.
    e. If measured levels exceed the action limits, an attempt must be made to identify microorganisms to the genus level.
    f. The corrective action plan must be documented.

Action Levels for Surface Sampling

ISO Class	Surface Sampling Action Levels (CFU/media device)
5	>3
7	>5
8	>50

Action Levels for Air Sampling

ISO Class	Air Sampling Action Levels [CFU/Cubic Meter (1000 liters) of air/media device]
5	>1
7	>10
8	>100

5. Equipment Failure:

    If the sterile compounding equipment or environment fail(s) to meet any required specification, after attempts to remediate pursuant to the facility's SOPs are unsuccessful, an immediate use CSP may be compounded without the requirement for there to be loss of life

or intense suffering of an identifiable patient. This provision may only be used for 48 hours after such failure(s). All such failures shall be documented in accordance with facility's SOP. Failures requiring use of immediate use provisions shall be reported to the Board within 72 hours of the transition to immediate use provisions.

G. Cleaning of Sterile Compounding Area(s)

1. Refer to *SOP – Cleaning & Disinfecting Sterile Compounding Area for Pharmacy & Supporting Personnel*
    a. All cleaning and disinfecting activities must be performed by trained and appropriately garbed personnel using facility approved agents and procedures.
    b. Cleaning must be performed in the direction of cleanest to dirtiest areas.
    c. Floor Mops may be used to clean a non-hazardous buffer room and ante room but in that order to ensure areas are being cleaned from most clean to dirty.
    d. Cleaning equipment used in HD compounding areas may not be used to clean any other areas.
    e. All documentation logs for cleaning shall be maintained and stored in the pharmacy for three years from when it was created.
    f. Cleaning of surfaces in classified areas used to prepare category 1 and 2 CSPs must be:
        i. Cleaned
        ii. Disinfected
        iii. Sporicidal Disinfectants applied
    g. Environmental services (EVS) staff will perform the following when no aseptic operations are in progress and document in the EVS cleaning log
        i. Clean and sanitize IV room floors and empty trash daily
        ii. Clean racks, bins, equipment, exterior workbench surfaces, ceilings and walls shelving weekly with approved disinfectant solution
        iii. Non-shedding wipes and mops are dedicated for Pharmacy use only
    h. Pharmacy staff will perform and document the following in the cleaning log:
        i. Clean sink area, IV room counters, work-top surfaces, and baskets daily
        ii. Clean IV PEC(s) each shift and as needed.

H. <u>Storage and Handling of CSPs</u>

1. Compounding personnel are responsible for ensuring that CSPs are accurately identified, measured, diluted, mixed, and are packaged, sealed, labeled, stored, dispensed, and distributed appropriately.
2. Solutions, medications, supplies, and equipment used to prepare sterile products will be stored in accordance with manufacturer or USP requirements.

3. When CSPs are known to have been exposed to storage or temperatures outside of the recommended parameters, the manufacturer will be contacted for specific lot and expiration information and instructions for shortened dating or disposal.
4. Temperatures in refrigerators and/or freezers used to store medications and compounded sterile products will be monitored and documented twice daily if such monitoring is not done though the Pyxis Smart Remote System.
5. When a temperature falls out of range, engineering will be contacted, and documentation of out-of-range temperatures will be recorded.
6. Cytotoxic drugs (if any) shall be handled and safely disposed of in accordance with the *AHS policy on Medications: Hazardous Drugs Preparation and Handling*.
7. Spills of hazardous drugs shall be handled and cleaned up using chemo spill kits, material safety data sheets (MSDS) and in accordance with Occupational Safety and Health Administration (OSHA) laws and regulations.
8. Medications, supplies, and compounding equipment will be stored on shelves, cabinets, and carts to facilitate appropriate cleaning.
9. Products that have exceeded their expiration date will be removed from active storage areas and will be placed in a segregated, clearly defined area of the pharmacy.
10. Before any item is brought into the clean side of an anteroom, placed into a pass-through, or brought into the SCA, it must be wiped with a sporicidal disinfectant, EPA-registered disinfectant, or sterile 70% IPA using low-lint wipes by personnel wearing gloves.
    a. The wiping procedure should not compromise the packaging integrity or render the product label illegible.
11. Before any item is introduced into the PEC, it must be wiped using sterile 70% IPA using low-lint wipes and allowed to dry before use.
    a. The wiping procedure should not compromise the packaging integrity or render the product label illegible.
12. Before use, each medication, ingredient, and container will be visually inspected for damage, defects, and expiration date.
13. Critical sites must be wiped with sterile 70% IPA in the PEC to provide both a chemical and mechanical action to remove contaminants. The sIPA must be allowed to dry before entering the package.

I. Record Keeping of Compounded Sterile Products

1. Master Formula Records
    a. No drug product may be compounded until the pharmacy has first prepared a written master formula record that includes at least the following elements:
        i. Name and Strength of the compounded drug preparation.
        ii. Active ingredients to be used.
        iii. Equipment to be used.
        iv. Inactive ingredients to be used.
        v. Process and/or procedure used to prepare the drug.

vi. Quality reviews required at each step-in preparation of the drug.
vii. Post-compounding process or procedures required, if any.
viii. Expiration dating/Beyond Use dating requirements.
ix. Instructions for product labeling, storage, and handling.

2. Where a pharmacy does not routinely compound a particular drug product, the master formula record for that product may be recorded on the prescription document itself.
3. The pharmacy maintains formula record(s) for each compounded drug product. These records are maintained and readily retrievable for at least three years from the date the record was created. The record shall include:
    a. The master formula record
    b. Active ingredient used.
    c. Inactive ingredient used.
    d. IV solution or diluents
    e. Date the drug product is compounded
    f. Two patient identifiers and order number
    g. Drug lot number, manufacturer, expiration date and quantity or volume of each component used in preparing the drug product
    h. The quantity or amount of the final compounded drug product
        i. Pharmacy shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products and components used in compounding
        ii. Chemicals, bulk drug substances, drug products, and components used to compound drug products shall be obtained from reliable suppliers. The pharmacy shall acquire and retain any available certificates of purity or analysis for chemicals, bulk drug substances, drug products, and components used in compounding. Certificates of purity or analysis are not required for products that are approved by the Food and Drug Administration
    i. Equipment used in compounding the drug product
    j. Pharmacy assigned reference or lot number for the compounded drug product
    k. Technician initial who prepared the drug product
    l. Pharmacist initial who reviewed the final drug product
    m. Beyond Use Date (BUD) of the final compounded drug product.

4. All records shall be created and maintained in a manner to provide an audit rail for revision and updates. Prior versions of each record will be maintained for at least 3 years from the date that it was created or modified. The audit trail must include the changes to the document, who made the changes and the date of each change.

I. Beyond Use Date Determination

1. CSPs prepared by the pharmacy department will have appropriate beyond use dates clearly indicated on the label.
2. Beyond-use dates are assigned according to the chemical and physical stability of the medication and based on USP <797> guidelines established for category 1, 2, and 3 products for sterility. The dates shall be supported by references, literature searches, written documentation, and/or published studies from reliable sources.
3. Product labels shall be legible and accurate indicating the date and time of beyond use or expiration.
4. Beyond-Use Dating will apply to the following:
    a. Compounded Intravenous Admixtures – beyond use dating is based on USP <797> guidelines and is determined by the risk level assigned to the product.
    b. Category 1: must be prepared in an ISO Class 5 or better primary engineering control that may be placed in an unclassified segregated compounding area. Beyond use dating is determined by medication stability, but cannot exceed the following:
        i. 12 hours at CRT (controlled room temperature)
        ii. 24 hours in a refrigerator
    c. Category 2: CSPs must be prepared in a cleanroom suite. Beyond use dating is determined by medication stability, but depending on the following factors, cannot exceed the following:
        i. If aseptically processed, no sterility testing, and only sterile starting components:
            1. 4 days at CRT
            2. 10 days in a refrigerator
            3. 45 days in a freezer
        ii. If aseptically processed, no sterility testing and one or more nonsterile starting component(s)
            1. 1 day at CRT
            2. 4 days in a refrigerator
            3. 45 days in a freezer
    d. Immediate Use Compounding: CSPS have a maximum of 4 hours BUD
    e. Proprietary bag and vial system -
        i. Docking for immediate use is not considered compounding
        ii. Docking for future activation and administration is considered compounding

J. Compounded Sterile Product Recall

Steps to be taken in the event of a drug recall. Based upon California Business and Professional Code Section No. 4127.9(a):

A pharmacy licensed pursuant to Section 4127.1 or 4127.2 that issues a recall notice regarding a sterile compounded drug shall, in addition to any other duties, contact the recipient pharmacy, prescriber, or patient of the recalled drug and the board as soon as possible within 12 hours of the recall notice if both of the following apply:

- (1) Use of or exposure to the recalled drug may cause serious adverse health consequences or death.
- (2) The recalled drug was dispensed, or is intended for use, in this state for more details please refer to Medication – Drug Recall policy and SS-SOP: Recall of Sterile Compounded product.

K. Complaint Handling: All complaints including but not limited to concerns or reports on quality, labelling or possible adverse reactions related to a specific CSP will be handled appropriately.

A designated person(s) must review all complaints to determine whether

i. The complaint indicates a potential quality problem with the CSP.
ii. If it does, a thorough investigation into the cause of the problem must be initiated and completed. The investigation must consider whether the quality problem extends to other CSPs. Corrective action, if necessary, must be implemented for all potentially affected CSPs.
iii. Consider whether to initiate a recall of potentially affected CSPs and whether to cease sterile compounding processes until all underlying problems have been identified and corrected.

- This will be handled throught the MIDAS – Safety Alert System and review must be initiated within 72 hours of receipt of complaint.

L. Adverse Drug Reaction

Adverse effects reported or potentially attributable to a pharmacy's sterile drug product shall be reported to the board within 12 hours and immediately reported to the MedWatch program of the federal Food and Drug Administration

M. Packaging and Transporting of CSPs

- Packaging materials should protect CSPs from damage, leakage, contamination, degradation, and adsorption while preventing inadvertent exposure to transport personnel.
- Alternative modes of transport and/or special packaging (e.g., tamper-evident closures) may be needed to protect the quality of CSPs. If the CSP is sensitive to light, light-resistant packaging materials must be used. In some cases, the CSP must be packaged in a special container (e.g., a cooler) to protect it from temperature fluctuations.
-

N. Quality Assurance Program

1. The CSP QA Program is intended to provide a mechanism for monitoring, evaluating, correcting, and improving the activities and processes described in USP 797.

2. The following must be documented:
    a. Training and competency of compounding and checking employees
    b. Master Formula Records used for compounding
    c. Refrigerator and freezer temperature logs
    d. Certification of LAFW/BSC
    e. Cleaning logs of the room and LAFW/BSC

3. The following tests will be performed to ensure sterility in compounding sterile room.
    a. Glove fingertip testing biannually for employees who compound CSPs.
    b. Media Fill Testing biannually for employees who compound CSPs.
    c. End product evaluation that includes endotoxins, sterility and potency testing will be performed on two compounded samples every six months.
    d. Results from end product evaluations will be reviewed and documented by the pharmacist-in-charge or a designated person.
    e. In the event a sample product is discovered to be outside the appropriate threshold or below the minimum standards for sterility, potency, or endotoxin, the following actions will be implemented:
        i. Designated person(s) will investigate and formalize an action plan.
        ii. A different staff member will perform the same test and a new sample product will be sent in for repeated testing.
        iii. If the new sample product meets standards, the staff who initially performed the below standards will repeat training and aseptic technique competencies with a designated pharmacist. Staff must pass competencies prior to resuming any compounding activities.
        iv. If the new sample product does not meet standards on the repeated test, the IV room will be sanitized and cleaned immediately before any patient care activities resume. A qualified certification company will be scheduled to come in for IV room and hood re-certifications.
    f. Results from end product evaluations will be reviewed and documented by the pharmacist-in-charge or a designated pharmacist.
    g. If an action plan must be implemented, it will include the following:
        i. Designated pharmacist will investigate and formalize an action plan.
        ii. Both pharmacy management and EVS management will be alerted and will immediately terminally clean the area.
        iii. Testing will be redone by a qualified company, and if the new sample does not meet testing standards, the area will be sanitized and cleaned immediately before any patient care activities resume

4. A summary report on the QA program will be presented to the Medication Safety Committee and Quality Council quarterly.

References

1. USP<797> 2022 Version May 1 2024.
2. California Pharmacy Lawbook 2026
3. ASHP Guidelines on Compounding Sterile Preparations 2014

Approvals

		System	SLH/HH/JF/FM	ALH
Departmental	**Date:**	**2/2026**		
System Pharmacy and Therapeutics Committee (P&T)	**Date:**	**2/2026**		
Clinical Practice Committee (CPC)	**Date:**	**3/2026**		
Medical Executive Committee	**Date:**	**3/2026**		
Board of Trustees	**Date:**	**4/2026**		

Alameda Health System

CHRONIC USE OF CONTROLLED MEDICATION IN AMBULATORY

Department	Ambulatory Care	***Effective Date***	3/2013
Campus	All	***Date Revised***	04/2025, 2/2026
Unit	All Service Areas	***Next Scheduled Review***	04/2029
Manual	Ambulatory Administration	***Author***	Manager, Ambulatory Care Pharmacy
Replaces the following Policies:		***Responsible Person***	ACMO-Ambulatory

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

Purpose

To guide the use of Controlled Medication Use Agreements (CMUAs, also called Controlled Medication Treatment Agreements)) in the care of patients who are being treated with controlled and habit-forming medications on a long-term basis.

Policy

1. Chronic therapy with controlled medications is only appropriate for patients who meet the following criteria:
    a. An appropriate diagnostic workup has been pursued and has failed to disclose a cause for symptoms which are remediable by other means.
    b. Safer, potentially effective and clinically possible therapies have been tried (e.g. physical therapy, acupuncture, exercise, cognitive behavioral therapy, and non-controlled medications).
    c. The risk of diversion and other forms of misuse has been assessed by taking a comprehensive history and consulting corroborating sources (such as the patient's medical record and CURES report).
    d. The efficacy of the controlled medication proposed for chronic use has been established for the patient in question by history or therapeutic trial.
    e. The risks of therapy have been clearly explained to the patient and informed consent for treatment has been obtained.

2. Chronic therapy is defined as a patient receiving treatment for three or more consecutive months.

3. The CMUA is intended to serve the following functions:
    a. It defines the circumstances of therapy with controlled and high-risk medications in the outpatient setting, including the circumstances under which such therapy may be discontinued.
    b. It serves as an opportunity to gain informed consent from the patient for therapies which pose considerable long-term risks, and as a record of that consent.
    c. It acts as means of communication with healthcare providers and healthcare entities regarding the patient's plan of treatment.

Exceptions

While the use of Controlled Medication Use Agreements for chronic controlled medication therapy is standard of care in most cases, there may be exceptions such as for patients less than 18 years old, patients on end-of-life care, patients with active cancer, or patients receiving substance use disorder treatment outside of primary care (low-barrier SUD services). The reason for the exception should be documented in the patient's medical record.

Procedure

1. All patients who are prescribed any of the following schedule II-IV drugs or drug classes to be taken for three or more consecutive months should have a CMUA on file:
    a. Opioids (including tramadol, buprenorphine, and opioid-containing preparations such as hydrocodone/acetaminophen)
    b. Benzodiazepines and Barbiturates
    c. Sedative-hypnotics (e.g. zalepon, zolpidem, and zopiclone)
    d. Stimulants (methylphenidate, amphetamine preparations, lisdexamfetamine, modafinil), excluding phentermine for obesity management

2. The CMUA should be completed at the initiation of chronic therapy with any of the above medications. Patients already on chronic therapy with the above drugs and drug classes should complete a CMUA with their provider at the earliest opportunity. The CMUA should cover all controlled and high-risk medications which the patient is taking. It does not need to document low-risk and non-controlled medications (e.g. gabapentin, venlafaxine, ibuprofen, etc). The provider completing the CMUA must make its provisions clear to the patient, obtain their informed consent for the treatment proposed, and document the discussion in the medical record.

3. The CMUA is completed electronically in the patient's chart, and a copy should be offered to the patient.

4. All patients who have a CMUA should be reviewed at least annually, and more frequently in the case of patients whose symptoms or regimen are dynamic, and attention the following points must be specifically documented in the patient's chart:
    a. The efficacy of therapy. Patients who are not benefiting from a planned titration of therapy should be transitioned to a different treatment.
    b. Concomitant disorders of psychological and behavioral health (e.g. depression, use disorders, aberrant behaviors surrounding the prescribed therapy which suggest use disorders, etc.).
    c. Changing symptomatology which may indicate an undiagnosed disorder.
    d. Misuse of controlled medications prescribed (e.g. with random urine testing and consultation of the CURES system).

Approvals

Ambulatory Operations Council	**Date: 6/9/25**
Pharmacy and Therapeutics Committee	**Date: 2/2026**

Clinical Practice Committee	**Date: 3/2026**
Medical Executive	**Date: 3/2026**
Board of Trustees	**Date: 4/2026**

	Policy	
ALAMEDA HEALTH SYSTEM	**AHS LANGUAGE ASSISTANCE SERVICES POLICY AND PROCEDURE**	**24789 5**
	Level ☑ System ☐ Site	**Effective Date:** 04/2026 **Last Review Date**: 10/2020
	Document Owner: Sambo Ly	

1. POLICY STATEMENT

1.1. Alameda Health System (AHS) provides qualified language assistance services free of charge to patients and their authorized representatives who seek and receive care across settings and levels of acuity during all hours of operation. Appropriate auxiliary aids and services are also available at no cost to ensure information is provided in accessible formats.

For assistance, call **510-437-4491**.
TTY: **1-800-735-2922 (English)** or **1-800-855-3000 (Spanish)**.

1.2. Patients have the right to receive qualified language assistance services at no cost whenever they are making decisions about their care or exercising their rights.

1.3. Patients must be informed that language assistance services are available free of charge. They will not be asked or required to bring their own interpreter to any visit. This notification and the patient's response must be documented in the patient's health record, including the **name or ID number of the individual who provided interpretation**.

1.4. Qualified language assistance services will be provided by phone, video, or in person whenever these methods are a reasonable step to ensuring meaningful access for individuals with limited English proficiency (LEP) or other communication barriers.

1.5. The use of family members, friends, or minors as interpreters is strongly discouraged as conversations may be inappropriate or emotionally distressing (e.g., end-of-life discussions, sexual history). It is permitted **only in emergencies** involving an imminent threat to the safety or welfare of an individual or the public when no qualified interpreter or Qualified Bilingual Staff (QBS) is immediately available.

1.6. A patient may request an accompanying adult to interpret. This is acceptable only when the adult agrees, and the healthcare professional determines that it is appropriate for the circumstances. The **name of the individual providing interpretation must be documented** in the patient's health record.

1.7. The use of untested or untrained bilingual employees, contractors, volunteers, or unapproved translation software (e.g., Google Translate) is strongly discouraged and should not be relied upon for interpretation or translation.

2. PURPOSE

Approval

2.1. AHS is committed to providing timely and appropriate language services to patients, their authorized representatives, and the health care team.

2.2. This policy ensures compliance with applicable state and federal laws and adherence to accrediting agency requirements for providing meaningful access to individuals with Limited English Proficiency (LEP), as well as those who are deaf, hard of hearing, or have physical or cognitive limitations. It supports meeting the linguistic, cultural, and accessibility needs of these individuals at all points of contact where language assistance can be reasonably anticipated.

3. SCOPE

3.1. This policy applies to all AHS employees, contracted workforce members, and volunteers who interact directly with, or provide qualified language assistance services to, individuals with Limited English Proficiency (LEP), as well as those who are deaf, hard of hearing, blind, or who have physical or cognitive limitations.

4. DEFINITIONS

Spoken language barriers: Experienced by individuals with limited or no English proficiency whose primary language group represents at least 5% of the service area or actual patient population.

Sign language barriers: Experienced by individuals who are deaf or mute and whose primary language is sign language.

In-House Medical/Healthcare Interpreter: An AHS employee classified as a Medical/Healthcare Interpreter-Translator, fluent in English and tested in designated specialty language(s), trained to provide accurate interpretation for medical and health-related interactions.

ASL Interpreter: A trained interpreter who facilitates communication between spoken English and American Sign Language (ASL) for individuals who are deaf, hard of hearing, or unable to speak but who use sign language.

Interpretation: The process of understanding and converting spoken or signed language into another language accurately and objectively. Interpretation may be provided in person, by telephone, or via videoconferencing.

Approval

Limited English Proficiency (LEP) individuals: Individuals whose primary language is not English and who have limited ability to read, speak, write, or understand English.

Qualified Bilingual Staff (QBS): A QBS is an AHS employee or contracted workforce member who has demonstrated validated proficiency in a non-English language and can communicate directly with LEP individuals and/or provide interpretation within the limits of their qualified skill level. QBS must wear program-issued identification (e.g., pins/badges) indicating their qualified language(s) and level(s). All QBS must pass the AHS Language Proficiency Test(s) and meet the requirements for their assigned level.

Telecommunication Device for the Deaf (TDD) / Text Telephone (TTY)
An electronic device used by individuals who are deaf, hard of hearing, or have speech difficulties to communicate through text over telephone lines or via Video Remote/Relay Interpretation (VRI).

Translation: The conversion of written text or audio recordings from one language into written text in another language.

Clinical Care Providers: Licensed healthcare professionals, employees or contractors who deliver direct patient care, including diagnosis, treatment, health management, and care coordination.

Vendor Medical/Healthcare Interpreter: A medical/healthcare interpreter employed by an AHS contracted language services vendor, fluent in English, tested in required specialty language(s), and trained to provide interpretation for medical and health-related interactions.

Video Remote Interpretation (VRI): The delivery of remote interpretation services using videoconferencing technology to connect patients and providers with qualified interpreters.

5. QUALIFIED BILINGUAL STAFF (QBS) LEVEL AND SCOPE

QBS Level I

Eligible bilingual staff who use their qualified language(s) in a dual-role, **non-clinical capacity** after completing required QBS training.

Scope:

- Perform regular job duties in a language other than English in non-clinical settings or when providing general, non-medical information (e.g., a bilingual Patient Services Representative registering a patient in the qualified language without an interpreter).
- May be asked, with supervisor/manager approval, to assist with customer service or non-medical encounters that do not require understanding or conveying medical terminology or clinical concepts.
- When interpreting, QBS Level 1 staff must maintain confidentiality and follow interpreter ethics and standards of practice established by the California Healthcare Interpreters Association (**CHIA**), the National Council on Interpreting in Healthcare (**NCIHC**), or the Registry of Interpreters for the Deaf, Inc. (**RID**).

Limitations: QBS Level I excludes the following:

- Interpret clinical, medical, or behavioral health information, including encounters involving diagnosis, treatment, informed consent, patient education, discharge instructions, or any communication requiring medical terminology or clinical judgment.
- Provide written translations of any kind.
- Substitute for a qualified healthcare interpreter when medical interpretation is required.

QBS Level II

Eligible bilingual staff who use their qualified language(s) in a dual-role, **clinical or non-clinical capacity** to communicate directly with patients and/or provide interpretation of general and medical information, consistent with their scope of practice and after completing required QBS training.

Scope:

- Perform regular job duties in a language other than English (e.g., a qualified bilingual medical assistant rooming a patient in the qualified language without an interpreter).
- With supervisor/manager approval, may provide language assistance for clinical encounters that require understanding and communication of medical terminology or concepts.
- When interpreting, must maintain confidentiality and follow interpreter ethics and standards of practice established by **CHIA**, **NCIHC**, or **RID**.

Approval

Limitations: QBS Level II excludes the following:

- Interpret informed consent, unless permitted under their scope of practice; such encounters must be handled by a professional medical/healthcare interpreter.
- Provide written translations of any kind.
- Substitute for a qualified healthcare interpreter when complex medical interpretation is required.

QBS Level II – Provider

A QBS Level II Provider is a physician, resident, or advanced practice provider (APP) who has passed the required AHS Provider Language Proficiency Test.

Scope:

- Directly communicate clinical information with patients and/or their authorized representatives – including obtaining informed consent – as permitted within the provider's scope of practice, without needing an interpreter.
- Interpret for another provider or staff in any clinical, medical, or behavioral health encounter is permitted only in emergencies involving an imminent threat to the safety or welfare of an individual or the public when no qualified interpreter or QBS is immediately available.

Limitations: QBS Level II Provider excludes the following:

- Provide written translations of any kind.
-
- Substitute for a qualified healthcare interpreter during family conferences, group meetings, or multidisciplinary care team discussions.

6. RESPONSIBILITIES

6.1. Healthcare professionals are responsible for ensuring clear communication with Limited English Proficiency (LEP) patients by:

- Using qualified medical/healthcare interpreters
- Avoiding reliance on untrained family or friends for interpretation
- Communicating directly with patients using clear, simple language

- Adhering to standards that ensure accurate, confidential, and culturally appropriate care

7. PROCEDURES

7.1. **Identifying and Documenting the Need/Use of Language Assistance Service:** The patient's preferred language, need for an interpreter, and clinical interactions using language assistance services are documented in the EHR/host system.

7.2. Patient Access and Ambulatory Call Center

7.2.1. Patient Access and Ambulatory Call Center staff must collect and complete the patient's preferred spoken and written language and interpreter needs at the time of registration and document this information in the corresponding demographic sections in the EHR/host system.

7.2.2. Preferred spoken and written language and interpreter needs information must be reviewed at each subsequent appointment check-in to ensure accuracy and appropriate language support.

7.3. Clinical Staff and Providers Responsibilities

7.3.1. Clinical staff and Providers must continually assess each patient's language and interpreter needs to ensure clear and meaningful communication

7.3.2. Clinical Staff and Providers must document in the EHR/host system whether language services were offered, used, or declined for any patient whose preferred language is not English.

7.3.3. When care is provided involving a qualified interpreter or Qualified Bilingual Staff (QBS), the interpreter's name or ID must be documented in the EHR/host system (e.g., Interpreter Services flowsheet, provider note).

7.3.4. If a family member, friend, or accompanying adult provides interpretation, their name must also be documented in the EHR/host system (e.g., Interpreter Services flowsheet, provider note).

7.4. **Request an interpreter**

7.4.1. **Accessing Interpreter Services.** For detailed instructions, refer to ***Attachment A: How to Access an Interpreter***.

Approval

7.4.2. **Video Remote Interpretation (VRI) Availability**

- Check with your department supervisor or manager to confirm VRI device availability.
- Follow the instructions provided with the device to access 24/7 remote language assistance services, including American Sign Language (ASL) support. Follow the instructions attached to the device.
- Where available, a VRI device:
  - has real-time, full-motion and audio over high-speed, wide-bandwidth video or wireless connection that delivers high quality video images;
  - has a sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; has a clear, audible transmission of voices;
  - and training and/or instructions provided to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video interpreting.

7.5. **Submitting a translation request.** For detailed information, refer to ***Attachment B: Written Translation Request Form***

7.6. **Requesting Assistance from the AHS Interpreter Dispatch Desk**

7.6.1. **On-Demand/Same-Day Requests**

- The Interpreter Dispatch Desk responds to on-demand requests based on urgency and priority during regular business hours: Monday–Friday, 8:30 AM – 5:00 PM, excluding AHS holidays.
- The Dispatch Desk will provide an estimated response or arrival time based on real-time staffing availability.
- The Dispatch Desk may also give instructions for accessing timely language assistance, such as setting up remote interpreting equipment.

7.6.2. **Pre-scheduled/Advanced Request:**

- The Interpreter Dispatch Desk responds to pre-scheduled or advanced requests in the order received during regular business hours.
- Staff may request pre-scheduled interpreter services by: **Calling (510)437-4491 or ext. 44491** and following the prompts to reach a dispatcher, **Emailing** InterpreterDispatchDesk@alamedahealthsystem.org or **via secure chat in the EHR/host system** to Interpreter Dispatch Desk Group.

- For detailed instructions, refer to ***Attachment C: Written Translation Request Form***.

7.7. AHS interpreter services dispatchers may update the patient's language preference and interpreter-need in the EHR/host system after obtaining confirmation from the patient.

8. REFERENCES

8.1. Americans With Disabilities Act. 42 U.S.C. Title 47 Chapter 5 Subchapter II Part I Sec 225 (1990).

8.2. California Health and Safety Code Section 1259 (2017).

8.3. Centers for Medicare and Medicaid Services. *Guide to Developing a Language Access Plan.* Retrieved from https://www.cms.gov/About-CMS/Agency- Information/OMH/Downloads/Lessons-from-the-Field-508.pdf

8.4. Civil Rights Act § 6, 42 U.S.C. § 2000d et seq (1964).

8.5. Effective communication for individuals with disabilities, 45 CFR § 92.202 (2019). Meaningful access for individuals with limited English proficiency, 45 CFR § 92.201 (2016).

8.6. Nondiscrimination under Federal grants and programs, 29 U.S.C. § 794 (1973).

8.7. Office of Minority Health (2013). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

8.8. SB 853. Chapter 713. Health care language assistance. (CA 2003).

8.9. The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010.

9. ATTACHMENTS

9.1. Attachment A –How to Access an Interpreter
9.2. Attachment B- Written Translation Request From
9.3. Attachment C- Language Assistance Services Pre-Scheduling (Advanced) Request Form

Approval

AHS Interpreter Services

What type of interpreter should I request?

Telephonic (OPI)	Video (VRI)	In-Person
• The patient is alert and oriented • The visit is routine or communication needed is short and straightforward • When communication needs to happen NOW due to time constraints (triage situations, rounds, walk-ins) • For more complex cases, if it is not feasible to find an in- person or video interpreter (a telephone interpreter is preferable to no interpreter)	• A more extended period of interpreter support is needed to assess or explain complex, or new plan of care of medical information • The provider needs help in navigating an unfamiliar cultural situation, and the visual cues and information that the interpreter could gather via video could be useful for that interaction • When in-person services are not available • When team or family members are in different locations	• The encounter involves multiple staff members to assess and treat patient, such as a family conference • The content of the communication is emotionally difficult to take in and/or will require major decisions from the patient • The provider needs help in navigating complex, culturally-specific family involvement with multiple speakers • The patient is anxious, confused or disoriented

How can I get an interpreter?

Telephonic (OPI)	Video (VRI)	In-Person
1. Dial **510-437-4491** or extension 44491 from any phone, 24/7 2. *For deaf patients with TTY enabled on their phone:* • Dial CA Relay Services 24/7 **800-735-2922** (for English) or **800-855-3000** (for Spanish), and provide the patient's phone # • A communication assistant will voice the typed messages from the TTY user to the speaker, and relay spoken messages by typing it to the TTY user.	1. Check with your manager if you have tablets available in your clinic or unit, 24/7 including ASL 2. Follow instructions attached to the device	1. Dial **510-437-4491** or extension 44491 from any phone and follow prompts to speak to the Dispatcher, 2. Email InterpreterDispatchDesk@alamedahealthsystem.org to schedule an interpreter for a future encounter, or 3. Send a Secure Chat to **Interpreter Dispatch Desk Group** in EPIC.

ALAMEDA HEALTH SYSTEM

Interpreter Services Department
WRITTEN TRANSLATION REQUEST FORM

Title of document(s) to be translated: _____

_____

_____

Language(s) requested: _____

_____

Requesting Department: _____

5-digit Cost Center of Requesting Department: _____

Contact Person of Requesting Department: _____

Requestor's QIC: _____ Requestor's Telephone: _____

Requestor's Email: _____

Preferred date that translation is needed: _____

Special Instructions (if any): _____

_____

_____

NOTES:

1. Please provide the final document file in MS Word, Excel or Powerpoint. Ongoing edits may cause issues with version control and other delays in completion.
2. The request may be handled in-house or by a contracted vendor depending on the nature and volume of the document(s) and the due date.
3. In-person, telephonic or video interpreter (verbal) services for patients and AHS staff are generally prioritized over translation (written) services.
4. Vendor translation:
    a. A price quote will be provided if the request is urgent and/or needs to be sent to a qualified vendor.
    b. The requesting dept will need to request a Purchase Order for the translation.
    c. The requesting dept will receive an invoice and process payment for the translation services.

Interpreter Services Department

Date Received: _____
Assigned to: _____
Date Assigned: _____
Date completed: _____
Date sent back: _____
Index #: _____

Updated Nov. 2022

Interpreter Services Department

Language Services Pre-Scheduling Request Form

Spoken Languages and American Sign Language

Requester Name:	
Department:	
Provider Name:	
Location, Building, and Room #:	
Best way to contact requester:	
Appointment Date:	
Time:	
Duration:	
Language:	
Patient Name:	
Patient Medical Record #:	
In-Patient? Yes or No	

NOTES:

1. Please email completed form to: InterpreterDispatchDesk@alamedahealthsystem.org
2. For any changes to your initial request, please contact us immediately by **email** or **call** 510-437-4491 **options** 1, 3, 0 to reach an AHS dispatcher during business hours.
3. An email acknowledgement for request submission will be sent to you within 24 business hours. If you do not hear from us beyond the response time frame, please call the dispatch desk for assistance at 510-437-4491 **options** 1, 3, 0.

Updated Nov. 2022

ALAMEDA HEALTH SYSTEM	Policy	
	HR Section 1.00 – Policy 1.36 New Hire & Annual Employee Health Screening/Physical Examination and Drug Testing Policy	**Reference # tbd**
	LEVEL ☒ System ☐ Site	EFFECTIVE DATE: 4/2026

PURPOSE

To establish Pre-Placement Post Offer Health Screening/Physical Examination, Drug Testing, and Annual Physical Examinations as a condition of employment at Alameda Health System.

POLICY STATEMENT

All AHS employees shall have a pre-placement, post offer Health Screening, Physical Examination, and Drug Testing prior to hiring. Employees assigned to an Intermediate Care Facility, i.e. Skilled Nursing, shall have an annual physical examination. Employee Health Screening is mandated by Title 22, the Americans with Disabilities Act (ADA), and the Centers for Disease Control Immunization guidelines. All New Hires will be required to undergo drug testing as part of the pre-employment process, in accordance with Alameda Health System Drug Free Workplace Policy.

PROCEDURES

A. When an applicant is extended a job offer by Alameda Health System, the applicant will be informed that the job is contingent upon the successful completion of the pre-placement, post offer Physical Examination and Drug Testing.

B. All New Hires will be scheduled for a post offer Health Screening, Physical Examination, and Drug Testing appointment.

C. Health Screening will include medical history, physical examination, lab work as indicated and an immunization evaluation to determine that the applicant/employee is free of disease, able to perform the assigned duties and does not have any health problems that would create a hazard to themselves, other employees or patients.

D. The Examiner will be lawfully authorized to perform the Health Screening, Physical Examination, and Drug Testing.

E. The Health Screening, Physical Examination and Drug Testing will be completed and signed by the person who performed the exam. The report shall be maintained in the Employee Health Record for each employee and kept a minimum of thirty (30) years following termination of employment. The Physical Examination Summary and Drug Test results are considered proprietary information.

F. The Pre-placement Health Screenings includes but is not limited to the following as per Infection Control Employee Health Program Policy:

1. Tuberculosis Screening as per Infection Control Employee Health Program
2. Respiratory Fit Testing per Cal-OSHA guidelines if applicable and annually thereafter.
3. Proof of Immunity (Titers) or proof of vaccination to the following:

a. Rubeola (Measles) – 2 doses of MMR
b. Mumps – 2 doses of MMR
c. Rubella – 1 doses of MMR
d. Varicella – 2 doses of Varicella
e. Hepatitis B or Declination
f. T-dap – 1 doses booster or Declination
g. Flu Shot – 1 dose annually or Declination (Based on Local Requirements)
h. COVID Vaccination (Based on Local and State Requirements for Healthcare)
i. Meningococcal Vaccine or Declination if applicable

4. 8 Panel Oral Drug Test Screening to include the following:
    i. Amphetamine
    ii. Methamphetamines
    iii. Cocaine/Benzoylecgonine
    iv. Marijuana (**Active Metabolites**)
    v. Opiates (Codeine, Morphine, Hydrocodone, Hydromorphone)
    vi. 6-Acethylmorphine (6AM)
    vii. Oxycodone (Oxycodone, Oxymorphone)
    viii. Phencyclidine (PCP)

G. Post Offer/Pre-Employment Physical & Annual Examination includes but is not limited to the following:
    1. Medical History
    2. Physical Examination (Head to Toe Assessment including Back/Spine and Neurological Assessment)
    3. Height & Weight
    4. Vital Signs
    5. Vision and/or Color-Blind Testing if applicable
    6. Annual Tuberculosis Screening

H. The Physician and APP indicates one of the following based on their findings:

☐ Medically acceptable for the position offered and free of any communicable diseases at this time, detectable by a general physical exam.

☐ Medically acceptable for the position offered, except that a condition exists which limits work as follows: *

***Reasonable Accommodations will be determined by the employer through the initiation of a Good Faith Interactive meeting as defined by the Americans with Disabilities Act, if it is determined, by the examiner, that the employee is unable to perform any portion of the essential functions of their job or has work restrictions.**

I. Pre-employment Post Offer Substance Abuse/Drug Screening Test (DST). New Hires must complete an 8 Panel Oral DST during the Physical Examination appointment.

1. Employee Health Manager/Director, Director of Talent Management or Assigned Person may extend the deadline to complete Oral DST if there are extenuating circumstances.
2. If the Oral Drug Test results are inconclusive, the new hire must complete the Oral Drug Test within 3 business days. Failure to complete within that timeframe will result in the offer of employment being rescinded.
3. New Hires with a positive Oral DST will result in the offer of employment being rescinded.
4. New Hires with a positive Oral DST may be reconsidered for employment after 12 months.

REFERENCES

1. Title 22 California Code of Regulations, Division 5 Licensing and Certification of Health Facilities, Section 72535. Employees' Health Examination and Health Records
2. The Americans with Disabilities Act of 1990
3. CDC Recommended Vaccines for Healthcare Workers www.immunize.org/catg.d/p2017.pdf • Item #P2017
4. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP) Recommendations and Reports November 25, 2011 / 60(RR07); 1-45
5. HR Section 1.00 – Policy 1.35 Drug Free Workplace

ALAMEDA HEALTH SYSTEM	Policy	
	OUT OF SERVICE - DO NOT USE - EQUIPMENT TAG	**28349 2**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 4/2026 NEXT REVIEW DATE: 4/2029

Purpose

To maintain safe practices for the use of equipment as supported by the Equipment Management plan.

Policy

When equipment is in need of repair, determined to be unusable or has been identified for disposal, staff shall place the "Do Not Use – Out of Service" on the equipment. This tag is designed to be used to enhance communication by providing high visibility and alerting staff that the equipment has been pulled from service.

Procedure

1. Identify equipment that is in need of repair, is broken and unusable; or needs to be disposed.

2. Pull the equipment out of service by placing an equipment tag on it that reads, "Do Not Use – Out of Service."

3. Notify Biomedical Services for medical equipment or Engineering for all other equipment and provide pertinent information e.g. model, serial number, campus, building, department, room number and contact person's name. Staff must obtain tags from the appropriate department—Biomedical Services for medical equipment and Engineering for all others.

4. Use departmental procedures to place the equipment in a designated room (e.g. dirty utility) for pick-up.

5. Log the equipment in the department's equipment communication logbook to track when the equipment was picked up and returned to service.

Patient Incident:

    1. In the event that a medical device is involved in a patient incident. Staff is required to sequester the device and all accessories whenever possible.
    2. Staff shall notify the appropriate department about the incident.
    3. Equipment involved in a patient incident must be removed from service and properly identified.
4. Staff should submit a MIDAS alert and provide the email address with phone number.

approval

ALAMEDA HEALTH SYSTEM	Policy	
	Chemical and Biological Testing and water analysis - Biomed Facilities	**29418 2**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 4/2026

Purpose

To ensure the availability and use of safe, high-quality water for hemodialysis and to clearly define roles and responsibilities for water quality management and hemodialysis equipment maintenance.

Policy

1. The hospital, through Engineering / Facilities, is responsible for:
    - Maintenance of water treatment and distribution systems used for hemodialysis.
    - Performing required chemical and biological testing of water used in hemodialysis.
    - Ensuring corrective actions and repairs are completed when water quality does not meet required standards.
2. All water testing, maintenance, and corrective actions will be documented and retained in accordance with hospital policy and regulatory requirements.
3. Engineering / Facilities will provide documentation of water testing results upon request and communicate any identified water quality issues to clinical leadership and the contracted dialysis provider.
4. The third party company (Davita) will identify proper test procedures, regulations, standards, and scheduling as applicable
    - The third-party company (Davita) is responsible for managing preventive maintenance and repairing hemodialysis equipment included within their contract, assuring the proper function according to the manufacturers' specifications.
    - Hemodialysis machines are maintained under contract by the third-party provider, **DaVita**.
        - The third-party provider is responsible for:
        - Identifying applicable **testing procedures, regulations, standards, and schedules** related to hemodialysis equipment.
        - Performing **preventive maintenance and repairs** on hemodialysis equipment included in the contractual scope.
        - Ensuring equipment functions in accordance with **manufacturer specifications**.

- All preventive maintenance and repair activities related to hemodialysis equipment will be **documented and maintained** by the third-party provider.

PROCEDURE:

1. Water Systems (Engineering / Facilities)
   - Engineering / Facilities will maintain and monitor water treatment systems supporting hemodialysis.
   - Chemical and biological water testing will be performed at required intervals.
   - Identified deficiencies will be addressed promptly, and corrective actions will be documented.

2. Hemodialysis Equipment (Third-Party Vendor)
   - All hemodialysis equipment included under contract with DaVita will:
   - Receive preventive maintenance according to manufacturer recommendations.
   - Be repaired or removed from service as required.
   - Maintenance and repair records will be maintained by the third-party provider and made available to the hospital upon request.

TERMS & DEFINITIONS:

Hemodialysis Water System:
The water treatment, storage, and distribution systems that supply water used for hemodialysis.

Hemodialysis Equipment:
Dialysis machines and associated equipment used to perform hemodialysis treatment.

Third-Party Provider:
An external organization contracted to maintain and service hemodialysis equipment.

approval

ALAMEDA HEALTH SYSTEM

March 25, 2026

TO: Quality Professional Services Committee

FROM: Berenice Perez, M.D., Alameda Health System Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** B3

Meeting Date: March 25, 2026

Item Description: Medical Staff Policies and Procedures

COMMITTEE ACTION: **Recommend Approval of Medical Staff Policies and Procedures**

Background:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff align policies and procedures to provide continuity across the two Medical Staffs.

New policies are developed and existing policies are revised in accordance with best practice, legal and regulatory requirements.

The Medical Staff policies provide alignment of credentialing and privileging processes by offering a systematic approach to assessment across our facilities.

Analysis:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff policies align with the Bylaws and are key to the operational functions and compliance with regulatory requirements.

Board Action Requested: Approval of Medical Staff policies and procedures.

New Polices for AHS & AH Medical Staff:

- Medical Staff Peer Case Review

Revised Polices for AHS & AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Application Levels

Alameda Health System

MEDICAL STAFF PEER CASE REVIEW

Department	Medical Staff	***Effective Date***	
Campus	AHS, AH	***Date Revised***	
Unit		***Next Scheduled Review***	2/2029
Manual	Medical Staff	***Author***	Chief of Staff
Replaces the following Policies: *Medical Staff Peer Review Policy*		***Responsible Person***	Vice Chief of Staff

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

I. PURPOSE:

To ensure that Alameda Health System (AHS) and Alameda Hospital (AH) hospital, through the activities of its medical staff, (1) identifies professional practice trends that impact quality of care and patient safety by assessing the ongoing professional practice of individuals granted clinical privileges or scope of practice guidelines through individual case review and, (2) when a concern is identified, uses the results of such assessments, to perform focused professional practice evaluations (FPPE) and to assist medical staff members and allied health practitioners (AHPs) in providing safe, high quality patient care.

Goals:

- Create a culture with a positive approach to peer review (just culture) by recognizing practitioner excellence as well as identifying improvement opportunities using consistent and transparent processes.
- Assistance in formation focused professional practice evaluation for concern when concerns arise indicating potential significant practitioner improvement opportunities are identified
- Provide accurate and timely performance data for practitioner feedback
- Assure that the process for peer case review administered and directed by the organized medical staff is clearly defined, fair, defensible, timely and useful.
- Promote efficient use of practitioner and quality staff resources
- Support medical staff goals to improve patient care including education and quality improvement initiatives.
- Provide a link with the hospital performance improvement structure to assure responsiveness and loop closure to system improvement opportunities identified by the medical staff

II. DEFINITIONS:

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life

- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others

- **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care

- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams

- **Professionalism:** Practitioners are expected to demonstrate professionalism that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society

- **Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare

- **Peer:** A "peer" is an individual practicing in the same profession and who has a sufficient level of clinical knowledge and experience in the relevant subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For quality issues related to general medical care, a physician (MD or DO)/Advanced Practice Provider may review the care of another physician/Advanced Practice Provider. For specific clinical issues, a peer is an individual who is well-trained and competent in that specialty area.

- **Peer review:** "Peer review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve quality of care and patient safety. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or by a system. During this process, the practitioner is not considered to be "under investigation" for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

  Peer review is conducted using multiple sources of information including, but not limited to 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the medical staff and clinical standards, and 3) use of rate measures in comparison with established benchmarks or norms as determined by MS PRC.

- **Peer Review Body:** The peer review body designated to perform the initial review by the medical executive committee (MEC) or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital. The initial peer review body will be the Medical Staff Peer Review Committee (MS PRC) unless otherwise designated for specific circumstances by the Medical Executive Committee.

- **Medical Staff Peer Review Committee (MS PRC):** The centralized Medical Staff Committee charged with responsibility for primary case review; oversight of any case review work being done by delegated subcommittees.

- **Ongoing Professional Practice Evaluation (OPPE):** The routine, ongoing monitoring and evaluation of competency for medical staff members as defined by the six Joint Commission/ACGME general competencies.

- **Focused Professional Practice Evaluation For Concern (FPPE-C):** The establishment and confirmation of an individual practitioner's current competency when used to evaluate and monitor concerns which are raised through the Case review, OPPE or other peer review processes. These activities include, but are not limited to, what is typically called proctoring or focused case review, depending on the nature of the circumstances.

- **Conflict of Interest:** A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion.
    - An absolute conflict of interest would result if the physician/Advanced Practice Provider is the provider under review or is a first degree relative or spouse.
    - Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician/Advanced Practice Provider involved as a direct competitor, partner, or key referral source.

  Merely practicing in the same specialty and/or same geographic area does not automatically result in a finding of a conflict of interest. It is the obligation of the individual reviewer or committee member to disclose to the committee the potential conflict. It is the responsibility of the peer review body in consultation with the Chief of Staff and if necessary Medical Executive Committee to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the peer review process.

III. RESPONSIBILITIES

The primary responsibilities of the MS PRC are to:

1. Define and maintain the practitioner performance case review indicators as approved by the MEC.

2. Evaluate practitioner performance to determine if improvement opportunities exist through the case review process.
3. Assure accountability by the medical staff departments for the development of improvement plans when appropriate
4. Oversee any other medical staff peer case review activities as provided for in this policy.

There are a number of practitioner performance areas that fall outside of the purview of the MS PRC and are handled by other bodies or individuals. These include:

1. **Professionalism**- Individual behavioral events will be adjudicated by the appropriate Medical Staff leadership as delineated in the Medical Staff Code of Behavior
2. **Utilization**- Concurrent individual utilization issues will be handled by the Utilization Review process.
3. **Infection Control-** Policies and practices will be the responsibility of the Infection Control Committee and the MEC
4. **Blood Use-** Blood use policies will be the responsibility of the MEC
5. **Medication Use-** Medication policy and formulary decisions will be the responsibility of the P & T Committee and the MEC
6. **Patient Safety-** Policies regarding patient safety will be the responsibility of the MEC
7. **Health Information Management-** Policies regarding documentation, manual and/or electronic, will be the responsibility of the MEC

IV. POLICY

1. All peer case review information is privileged and confidential in accordance with medical staff and hospital bylaws, rules and regulations, state and federal laws, and regulations pertaining to confidentiality and non-discoverability, i.e. Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and California Evidence Code1157
2. The medical staff will use peer case review results in making its recommendations to the Credentials Committee and/or MEC regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
3. The Medical Staff Services Department will keep provider-specific quality information in a secure location. Provider-specific quality information consists of information related to:
   - Individual practitioner performance data
   - The individual practitioner's role in sentinel events, significant incidents, or near misses
   - Correspondence to the physician/Advanced Practice Provider regarding commendations, comments regarding practice performance, and corrective action
4. Only the final determinations of the peer review process and any subsequent actions or recommendations and correspondences between the committee and the practitioner are considered part of an individual provider's quality file. Any written or electronic documents related to the review process other than the above shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes.

5. Peer case review information in the individual practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or Medical Staff Services or Quality Department employee(s) to the extent necessary to carry out their assigned responsibilities.
6. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:
    - The specific provider (to the extent that the Chief of Staff believes such access is appropriate and as consistent with the Medical Staff Bylaws),
    - The Chief of the Medical Staff,
    - Medical staff Department Chairs (for members of their departments only)
    - Members of the Medical Executive Committee, Credentials Committee, Professional Practice Committee, and Medical Staff Services professionals for purposes of considering reappointment or correction action,
    - Medical staff leaders and Quality Department supporting the peer review process,
    - Individuals surveying for government agencies or accrediting bodies with appropriate jurisdiction (e.g. The Joint Commission or state/federal regulatory bodies),
    - Individuals with a legitimate purpose for access as determined by the hospital Board of Trustees,
    - Peer review committees and Judicial Review Committees.
    - Medical staff consultants or attorneys, as deemed necessary by the Chief of Staff, or Medical Staff Services professionals.
7. No copies of peer review documents will be created and distributed unless authorized by medical staff or hospital policy.

V. PROCEDURES:

Circumstances requiring peer case review: Peer case review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedures for conducting peer case review for an individual case is described in Attachments.

Circumstances requiring external peer review: Either the MEC, MS PRC or the Board of Trustees can make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the determining bodies indicated above.

Circumstances that may result in external peer review (EPR) include the following:

- Litigation: when potential for a lawsuit exists when there are vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner's membership or privileges.
- Lack of internal expertise: when no one on the medical staff or allied health staff has adequate expertise in the specialty under review; or when practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the

practitioner under review as describe above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or Governing Board.

- Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees.
- Credibility: when or if the medical staff or board needs to verify the overall credibility of the internal peer review process typically as an audit of routine peer review findings.
- Benchmarking: when an organization is concerned about the care provided by its physicians/Advanced Practice Providers relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.
- Lack of internal resources: when the medical staff has the expertise but lacks sufficient time to perform EPR.
- Miscellaneous issues: when the medical staff needs an expert witness for a fair hearing for potential corrective action or for evaluation of a credential file.

Selection of physician/Advanced Practice Provider performance measures

Measures of physician/Advanced Practice Provider performance will be selected to reflect the six general competencies and will use multiple sources of data described in the Medical Staff Case Review Indicator List in Attachment C and in the separate OPPE Policy. When appropriate, the validation process will be utilized before the data is incorporated into the files.

Individual case review and timeframe

Peer Case review will be conducted by the medical staff in a timely manner. The cases for review will be identified based on the Medical Staff Case Review Indicators. The goal is for routine cases to be completed within ninety (90) days from the date the chart is reviewed by the quality department staff and complex cases to be completed within one hundred and twenty (120) days. Exceptions may occur based on case complexity or reviewer availability. The timelines for this process are described in Case Review Process Attachment (Attachment A). The rating system for determining results of individual case reviews is described in the Case Review Worksheet (Attachment B). The results of all cases reviewed will be maintained and reported on a regular basis.

Oversight and reporting

Direct oversight of the peer case review process is delegated by the MEC to the MS PRC. The responsibilities of the MS PRC related to peer review are described in the medical staff bylaws. The MS PRC will report to the MEC for each MS PRC meeting. The MEC will report to the Board of Trustees at least quarterly, and as frequently as necessary.

The MEC has overall oversight responsibility for the MS PRC. The MEC has administrative oversight responsibilities and shall conduct a quarterly performance review of the MS PRC on a regular basis.

VI. Medical Staff Peer Review Committee:

Responsibilities:

1. Measurement System Management

- At least annually review all the case review indicators, targets, screening tools and referral systems for effectiveness in collaboration with the medical staff department chairs and recommend changes to the MEC.
- Data from sub-specialty databases supported by the hospital shall be shared with the MS PRC based on MEC approved indicators.
- Assist in the design of focused professional practice evaluation for concern FPPE-C studies when necessary to further analyze practitioner performance.

2. Evaluation of Practitioner Performance

A. Evaluation of Individual Cases

- Based on approved Case Review indicators and policy.
- Obtain reviews and recommendations from specialties on the medical staff or from external specialists when required.
- Communicate with the practitioner involved with the case to obtain input prior to making determinations that opportunities for improvement may exist.
- Make determinations regarding individual practitioner opportunities for improvement based on: individual or multiple case reviews and/or aggregate rate data.
- Perform focused professional practice evaluation for concern FPPE-C evaluation when necessary to further define if an improvement opportunity exists. Refer to FPPE-C policy.
- Identify and communicate potential Hospital systems or nursing practice opportunities for improvement to the relevant committees.

3. Improvement Opportunity Accountability

The role of the MS PRC is to assure when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed. This will be detailed in the Case Review Process (Attachment A).

4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

Some medical staff departments or committees will continue to evaluate practitioner performance as a quality control mechanism or for educational purposes. Such discussions will be considered part of the medical staff quality function and are protected from discovery as long as the appropriate policies and procedures of the medical staff are followed.

The MS PRC will oversee the process used to perform this evaluation and the indicators selected by the specialty for the following areas:

- Image Based Specialties(Pathology, Radiology, Cardiac Images): Routine quality reviews of diagnostic image interpretation by practitioners (e.g. surgical pathology or cytology slides, radiological images) will be performed internally.

Department wide and practitioner specific data based on MEC approved indicators will be reported to the MS PRC at least every six months. Cases potentially meeting case review indicator criteria will be referred to the Quality Department to be reviewed using the case review process. The addendum will document the process for the Image Based Specialties.

- Trauma- The Trauma Committee will continue the delineated multi-specialty trauma review process to maintain compliance with requirements of the national trauma certification process. Cases resulting in significant adverse outcomes potentially related to practitioner care as defined by Review indicators will be referred to the MS PRC.

Membership

The MS PRC will be comprised of 13 voting members who are active or affiliate members of the medical staff. The committee shall be composed of at least one physician/Advanced Practice Provider member from each of the following specialties:

- Ambulatory and Preventive Medicine
- Anesthesiology, Perioperative and Pain Medicine
- Emergency Medicine
- Surgery
- Internal Medicine/Hospitalist
- Pulmonary and Critical Care Medicine
- Obstetrics, Midwifery and Gynecology
- Pediatrics
- Psychiatry

Representation from the Advanced Practice Provider will be in an ex-officio (non-voting) role. The remaining committee members shall be appointed from at large with a maximum of three members from any single specialty on the full committee. The committee chairs will be included in the final count of the committee membership. Physicians and Advanced Practice Providers from other specialties may be invited to the meeting as needed.

Department Chairs shall be excluded from committee membership.

Appointment and Terms

The Chief of Staff will appoint the members of the MS PRC based on the recommendations from the department chairs and the MS PRC Chair and approved by the MEC.

Voting members will be appointed for a three-year term except for initial committee members who will have staggered terms to initiate the process (i.e. 1/3 for 4 years, 1/3 for 2 years and 1/3 for 3 years).

Voting members may not be appointed for additional terms unless approved by the

Committee Chair.

Chair selection

The MS PRC Chair will be appointed by the Chief of Staff and approved by the MEC.

To be eligible for appointment as Chair (other than the initial Chair), the individual must be a current voting MS PRC member and have served as a voting MS PRC member at some point in time for at least one year. The Chair will serve for a term of one year and may have an unlimited number of consecutive terms as long as the chair is eligible to be PPRC member. The MS PRC Chair will be an ex-officio member of the MEC.

Member Responsibilities

MS PRC members will be expected to attend at least two thirds (2/3) of the scheduled MS PRC meetings over a twelve-month period and perform assigned case reviews according to peer review policies and procedures to maintain membership. If a member fails to fulfill their responsibilities, they will be replaced using a process similar to that used for initial appointment to the MS PRC. MS PRC members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing MS PRC responsibilities.

If a member of the medical staff who is not a MS PRC member is requested to perform a case review, it is that individual's responsibility to perform that review in a timely manner according to MS PRC policies.

Meetings

The MS PRC will meet at least 10 times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of 50% of the voting MS PRC members at a regularly scheduled meeting. A majority will consist of a majority of voting MS PRC members present.

Statutory Authority
This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and California Evidence Code 1157. All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.

Attachments:
Attachment A: Case Review Process
Attachment B: Case Review Worksheet
Attachment C: Case review Indicators
Attachment D: Case Review Process Overview Flowchart

Approvals

		AHS	AH
Medical Executive Committee	**Date:**	**3/18/2026**	**3/20/2026**
QPSC	**Date:**		
Board of Trustees	**Date:**		

Alameda Health System Medical Staff and Alameda Hospital Medical Staff
Case Review Process

Action	Procedure	Time
Case Gathering and Screening	Potential cases shall be gathered from the hospital information management system, from generic screens and from individual reports (incident and informal). The Quality Department (QD) will screen the cases against the Case Review Indicators. If they contain a potential Case Review issue, the case will be sent for review.	3 working days of case receipt.
Case Summary and Reviewer Assignment	QD provides a case summary, identifies key issues and assigns case to a physician/Advanced Practice Provider reviewer per the Peer Review policy. Initial reviewer shall be a member of the committee. Cases will be typically be assigned to committee members on a rotating basis. However, if based on the nature of the case, the QD identifies the potential need for review by a physician/Advanced Practice Provider with a specific specialty expertise, the QD will contact the MS-PRC Chair for case assignment.	5 working days of receiving the chart.
Initial Physician/ Advanced Practice Provider Review	The physician/Advanced Practice Provider reviewer reviews the case and completes initial review section of Case Review Form for the physician/Advanced Practice Provider whose care is being reviewed.	Review will be completed within 2 weeks of assigning chart.
Completed Case Review	Completed reviews will be submitted to the QD by the physician/Advanced Practice Provider review immediately upon completion to enter into the case review tracking system. Only cases with completed case rated forms will be place on the MS-PRC agenda.	3 days prior to the Committee meeting will be reported to the committee. Late or incomplete reviews will be deferred to the next meeting.
Initial Reviews Rated Quality of Care	Initial reviews that find appropriate physician/Advanced Practice Provider care are submitted to the QD. The MS-PRC Chair reviews these cases and, if there are no	

Action	Procedure	Time
Appropriate	concerns, the cases are reported to the MS-PRC in summary form. Any concerns raised results in presentation of the case to the entire MS-PRC.	
Initial Reviews Rated Opportunity for Improvement Minor or Major	Reviews indicating potential Opportunity for Improvement Minor (OFMi) and/or Opportunity for Improvement Major (OFMa) are presented to the committee for discussion and confirmation or change in preliminary scoring. If the committee feels that care may be OFMi or OFMa, it will communicate with the involved physician(s)/Advanced Practice Provider(s) by letter with signature receipt. The involved physician(s)/Advanced Practice Provider(s) are informed of the key questions regarding the case and asked to respond in writing and, at the option of either the physician/Advanced Practice Provider or the MS-PRC, appear in person to answer specific questions in a limited timeframe.	Physician/Advanced Practice Provider under review will respond to committee within 2 weeks. If no response from the provider within two (2) weeks, the physician/Advanced Practice Provider will be notified by secure email to respond within another 2 weeks or the committee will finalize rating based on the available information. The QD department will contact the physician/Advanced Practice Provider by through appropriate channels to determine if physician/Advanced Practice Provider is unavailable due to special circumstances.
Communicating Findings to Physicians/ Advanced Practice Providers	For final case reviews indicating appropriate physician/Advanced Practice Provider care, the involved physicians/Advanced Practice Providers are informed of the decision by routine letter. Physicians/Advanced Practice Providers with final case reviews of OFMi or OFMa care are informed of the decision by secure email with copies sent to the Department chair and peer review file.	All completed case review findings will be communicated by letter to the involved physician/Advanced Practice Provider within 5 days of the Committee meeting.
Appeal Process	If the involved physician/Advanced Practice Provider disagrees with the final rating of a case, he/she has the right to ask for a review within two weeks by the MEC whose decision shall be final. Additionally, if a department Chair disagrees with the MS-PRC care rating, then they also have the right to ask the MEC to review the case. The	

Action	Procedure	Time
	MEC has the final authority on case ratings. If the practitioner disagrees with the final MEC rating then he/she has the right to place a letter of rebuttal in their quality file.	
Tracking Review Findings	The QD department will enter the results of all final review findings into the database for tracking.	Results will be entered in the database within 1 week of the Committee meeting finalizing the rating.
Improvement plan development	If the results indicate a need for individual physician/Advanced Practice Provider performance improvement, the issue will be referred to the appropriate Department Chair. The Department Chair will work to create and implement the improvement action plan. The MS-PRC Chair shall be ready to assist the Department Chair if requested.	The department chair will create and implement the improvement plan within 30 days of the Committee decision.
Medical Executive Committee involvement	If Committee Chair or Department Chair has concerns that the improvement plan may be more complex than usual, they will discuss the issue with the MEC Chair for resolution. Recommendations that may result in “adverse action” (e.g., restriction of privileges or membership) will be addressed in accordance with the procedures in the Medical Staff Bylaws and Rules.	Committee Chair will discuss with the MEC Chair within 30 days of the Committee decision.
Referrals to the Hospital Performance Improvement Committee	For those cases determined to have potential opportunities for improving system performance or potential issues with nursing care, the Committee Chair will communicate the issue to the appropriate Hospital Committee.	The hospital committee receiving the referral will discuss the issue and communicate action plan to the MS-PRC /MEC.

High-risk Cases	Sentinel Events requiring peer review, will have immediate review by the Peer Review Committee Chair or designee. Additional information (such as a literature search, second opinion, or external peer review) may be necessary before making a decision on action.	Initial Physician/Advanced Practice Provider review will be performed within three (3) working days of sentinel event case identification, with committee discussion at the next committee meeting or within 30 days of the event if there is not regularly scheduled meeting within 30 days. If additional information is needed, the timelines may be extended after approval from the governing body or its designee or the Medical Executive Committee.
Precautionary or Summary Suspensions	The processes and time frames in this document do not apply to precautionary suspensions or summary suspensions under the Medical Staff Bylaws and Rules.	Refer to the Medical Staff Bylaws and Rules.

ALAMEDA HEALTH SYSTEM

Physician/Advanced Practice Provider Peer Review Form

Confidential Quality Document – Protected by California Evidence Code 1157

QM No:

Patient Name: **Age: Gender:** **MRN:** **Acct No:**

Admit Date: **Discharge Date:** **Location:**

Event Date: **Event:** **Impact:**

Physician/APP: **Service:** **Procedure:**

Case Summary:

Provider Review(s):

Completed by: ☐ PEC ☐ Physician/Advanced Practice Provider Reviewer

Peer Review Score: *(check one)*

Overall Practitioner Care:		
	E	Exemplary Care
	0	Appropriate Care
	1	Minor Opportunity for Improvement
	2	Major Opportunity for Improvement

**4 Minor OFI Scores within 12 months and 2 Major OFI Scores within 3 months may warrant FPPE*

Documentation Rating:

A.	No documentation issues identified	
B.	Documentation does not substantiate clinical course/ treatment	
C.	Documentation not timely to communicate with other caregivers	
D.	Other:	

Issue Identification:

If care rated as 1 or 2, identify issues of physician/Advanced Practice Provider performance identified: (Check as many as appropriate)

a.	Issue type could not be identified from review	
b.	Diagnosis	
c.	Clinical Judgment/Decision-making	
d.	Technique/Skills	
e.	Knowledge	
f.	Communication/Responsiveness	
g.	Planning	
h.	Follow-up/Follow-through	
i.	Policy Compliance	
j.	Supervision (House Physician/Advanced Practice Provider or AHP)	
k.	Other:	

ALAMEDA HEALTH SYSTEM

Physician/Advanced Practice Provider Peer Review Form

Confidential Quality Document – Protected by California Evidence Code 1157

QM No:

Final Disposition: *(check one if Opportunity for Improvement is present)*

Action:
☐ Console ☐ Education/ Training ☐ FPPE ☐ Proctoring ☐ Privilege Modification ☐ Other: _____ _____ _____

Justification of Score:_____

_____

CME Opportunity:_____

_____

☐ **CME form Submitted to CME Committee**

ALAMEDA HEALTH SYSTEM

Physician/Advanced Practice Provider Peer Review Form

Confidential Quality Document – Protected by California Evidence Code 1157

QM No:

Harm Score: *(check one)*

Harm Score	Definition
☐ **Near Miss**	An event occurred but did not reach the patient.
☐ **No Harm**	An event occurred that reached the patient but did not cause patient harm.
☐ **Temporary Harm**	An event occurred that may have contributed to or resulted in temporary harm to the patient and required intervention or prolonged hospitalization.
☐ **Permanent Harm**	An event occurred that may have contributed to or resulted in permanent patient harm.
☐ **Death**	An event occurred that may have contributed to or resulted in the patient's death.

System Issue(s): *(enter all that apply)*

☐ **Human Factor**	☐ **Equipment**	☐ **Staffing**
☐ **Communication**	☐ **Environment**	☐ **Action Planning**
☐ **Information Management**	☐ **Education and Training**	☐ **Psychosocial Vulnerability**
☐ **Medication Management**	☐ **Leadership and Culture**	☐

Description of System Issue	Action Plan	Responsible	Accountable	Consulted	Informed

Reviewer Signature:_____ **Date:** _____

PEC Chair Signature:_____ **Date:** _____

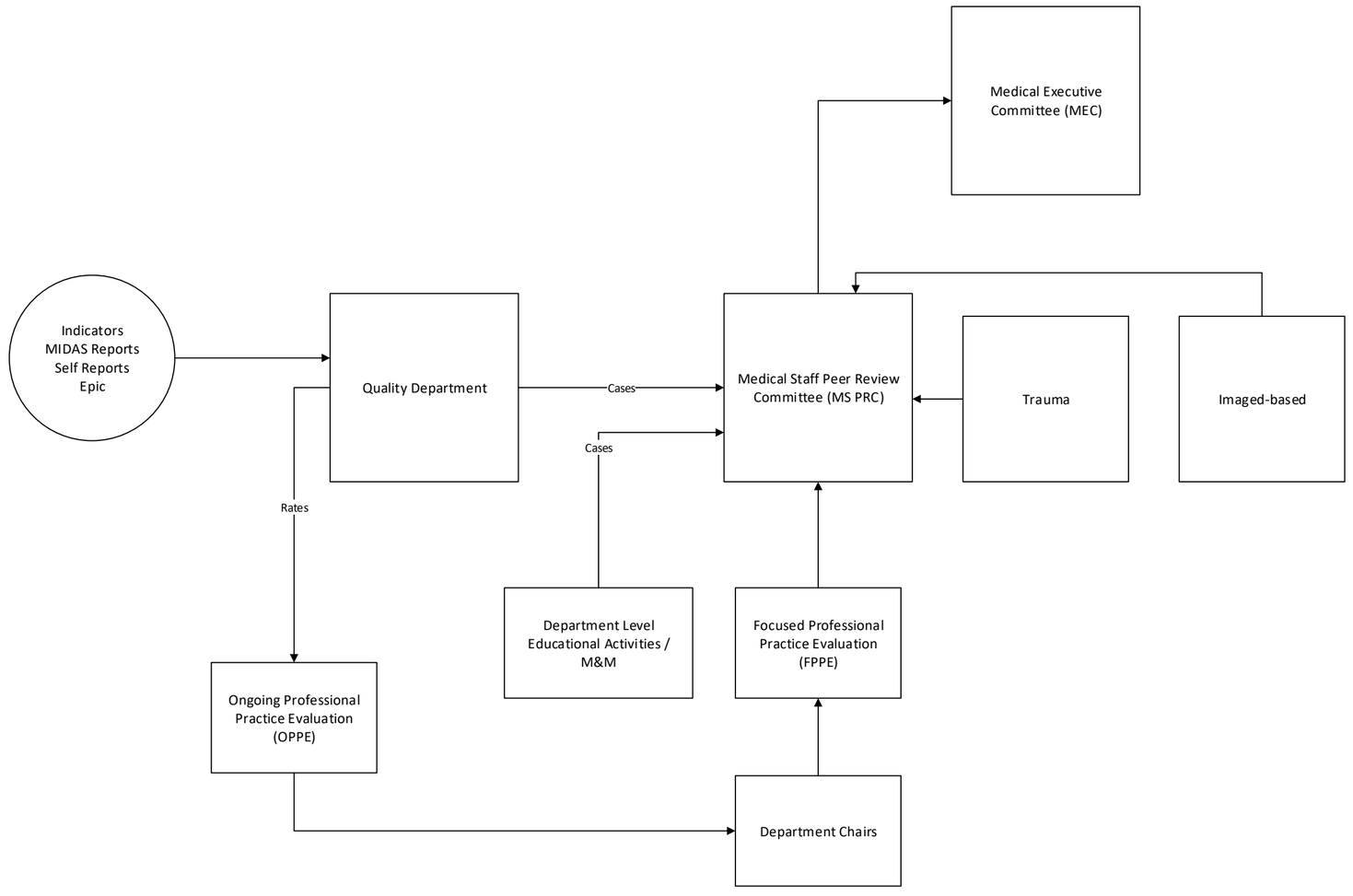
Alameda Health System Medical Staff and Alameda Hospital Medical Staff
Case Review Indicators

Dept	Compentency	Indicator	Indicator description	Type
All Depts	Pt. Care	Unanticipated death	As identified by pre reviewer screening or by use of severity adjusted outcomes to identify unexpected or low probability deaths.**Surgical:** Peri-procedural mortality w/in 30 days of initial procedure excluding paliative care or severe trauma; **Medical:** Deaths of medical inpatients excluding admissions for palliative care, end stage disease, or medical conditions with known expected death rates (e.g. CHF, acute AMI, pneumonia) or deaths in the ED of patients presenting in stable condition; **OB/Peds:** maternal death within 30 days, newborn or intrapartum fetal death with gestational age greater than 25 weeks excluding infants with severe congenital anomalies;	Review
All Depts	Pt. Care	Transfer to another facility for significant/unanticipated change in clinical condition.	Exclusion: transfers for higher level of services not available or transfers not based on potential physician/Advanced Practice Provider care issues	Review
All Depts	Pt. Care	Missed/ misdiagnosis resulting in significant change in patient treatment plan.	Includes transfer to ICU or invasive procedure interventions	Review
All Depts	Pt. Care	Unanticipated Cardiac or Respiratory arrest		Review
All Depts	Pt. Care	Unplanned return to ICU at same admission	Excludes: Return for clinical issue unrelated to initial admission problem	Review
All Depts	Pt. Care	Patient admitted for medical condition (non-surgical) with complication resulting in additional interventions	Additional intervention: Unanticipated ICU transfer or need for unanticipated surgical procedures.	Review
All Depts	Pt. Care	Autopsy with unexpected findings potentially affecting patient care.	Findings of autopsy that were not known prior to death and could potential impact clinical course and treatment.	Review
All Depts	Pt. Care	Significant tissue discrepancy between pre and post op diagnosis in the absence of treatment prior to surgery	Exclusions: Documented prior treatment by biopsies, excisions, radiation therapy or chemotherapy or procedures monitored by rates (non malignant hysterectomies, appendectomy, percutaneous needle biopsy and gallbladder procedures)	Review
All Depts	Pt. Care	Delay in treatment/consultation resulting in significant deterioration in patient condition		Review
All Depts.	Pt. Care	Risk management referral for significant clinical concern not otherwise classified.	Risk Mgt referral not otherwise covered by specific review indicators	Review
All Med	Pt. Care	Unanticipated readmission of medical patient 7 days after discharge for problems related to initial hospitalization		Review
All Surg, Anesthesia	Pt. Care	Major perioperative complication of patient undergoing anesthesia	Inclusion: Perioperative cardiac/resp arrest, acute MI, and central neurological deficit.	Review
All Surg	Pt. Care	Unanticipated removal of an organ during surgical procedure		Review
All Surg	Pt. Care	Significant complication of surgical procedure resulting in prolonged inpatient stay	Inclusion: Length of stay greater than 2 times Medicare LOS. Exclusions: Staged procedures or patients with known high pre operative morbidity or severe trauma or emergent cases.	Review

Alameda Health System Medical Staff and Alameda Hospital Medical Staff
Case Review Indicators

All Surg	Pt. Care	Unanticipated return to surgery for significant complication.	Inclusion: Evisceration, repair of organ or obstruction Exclusion: Failed dialysis access, unrelated procedures, planned returns or a specific complications monitored by rule and rate indicators, (e.g bleeding or hematoma)	Review
All Surg	Pt. Care	Significant intra or post procedural complications	Inclusion: Additional procedures required due to medical or surgical complications of the original procedure or as defined by ICD-9	Review
All Surg	Pt. Care	Unplanned readmission within 30 days of procedure for problems related to initial procedure	Exlusion: Complications monitored by rates; e.g. surgical infection	Review
All Surg	Pt. Care	Unscheduled admission following outpatient procedure requiring inpatient admission to critical care		Review
All Surg	Pt. Care	Unintentional retained foreign body placed at this institution		Review
Cardiol	Pt. Care	Emergent CABG due to Cardiology procedure complication		Review
GI	Pt. Care	Significant Complications of endoscopy, colonoscopy or ERCP	Includes: Any prolonged length of stay (greater than 48 hours) or critical care admission.	Review
Invasive Card	Pt. Care	Acute coronary artery closures related to interventional cardiology procedure		Review
OB/Gyn	Pt. Care	Possible permanent or serious infant injury	Inclusions: Shoulder dystocia resulting in asphyxia or Erb's palsy, skull fracture, brachial palsy, paralysis, etc. Any injury which will require significant follow-up beyond a palliative nature.	Review
OB/Gyn	Pt. Care	Post delivery maternal readmission within 7 days	Exclusion: Readmission for predictable known complications of eclampsia	Review
OB/Gyn	Pt. Care	Eclampsia	Exlusion: patients presenting with full eclampsia with no prenatal care provided by medical staff.	Review
OB/Gyn	Pt. Care	Mother transferred to ICU post-delivery	Exclusion: Patients in ICU pre delivery	Review
OB/Gyn	Pt. Care	Excessive maternal intra or peripartum blood loss	Inclusion: Transfusion of greater than three units	Review

Alameda Health System Medical Staff and Alameda Hospital Medical Staff
Case Review Process Overview Flowchart



Medical Staff Peer/Case Review Policy- Attachment D

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

Department	Medical Staff	***Effective Date***	5/2011
Campus	AHS, AH	***Date Revised***	5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025; 8/2025; 11/2025; 3/2026; 4/2026
Unit	Medical Staff	***Next Scheduled Review***	4/8/2029
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff Bylaws this policy will establish the mechanism for gathering relevant data, which involves the collection, verification and assessment of applicant information that will serve as the basis for decisions regarding credentialing and privileging of licensed practitioners and Advanced Practice Providers (APP), collectively referred to herein as "provider", who provide patient care services within the Alameda Health System.

Policy Statement

It is the policy of the AHS/AH Medical Staff to ensure that licensed practitioners and APPs meet minimum credentialing, privileging and performance standards for membership and/or privileges/practice prerogatives as outlined in the Medical Staff Bylaws and policies. The credentialing process is performed jointly where applicable, however, membership appointments and granting of privileges are independently recommended to the Governing Body by the respective Medical Staff.

All applications for appointment and/or reappointment to the Medical Staff/Advanced Practice Provider, and requests for clinical privileges, will be evaluated based on critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Any applications that meet the application criteria during the verification process shall be categorized in accordance with policy.

Credentialing is required for all physicians (medical or osteopathic), dentists, podiatrists, or clinical psychologists as well as those advanced practice providers approved by the Board of

Trustees, which include acupuncturists, audiologists, optometrists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and physician assistants.

Nondiscriminatory Statement and Audit Process

The AHS and AH Medical Staff credentialing, and privileging process acts in compliance with all federal and state and local laws and regulations governing discrimination involving patients, employees, vendors, visitors and other individuals and entities associated or involved with AHS. This policy reaffirms the commitment of the AHS Medical Staff and AH Medical Staff to maintaining a discrimination-free credentialing and privileging process.

The AHS and AH Medical Staff will not engage in discrimination or harassment of any person employed or seeking employment or medical staff credentialing or patient care within AHS on the basis of race, color, natural origin, age, disability, religion, sexual orientation, gender identity, gender expression, physical or mental disabilities, medical condition, pregnancy, HIV status, ancestry, marital status, citizenship, or status as a covered veteran or the type of procedure in which the provider specializes. The Medical Staff does not retaliate against a person for pursuing their right under this policy and/or for the purpose of investigatory proceedings. Non-discriminatory information is available in alternative forms of communication to meet the needs of persons with sensory impairments.

The AHS and AH Medical Staff will not discriminate against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California

On an annual basis, each member of the AHS and AH Credentials Committee will sign a confidentiality statement that will include an affirmative statement that all decisions are made in a non-discriminatory manner.

The Medical Staff Services Department will monitor through periodic audits of credentials files and provider complaints about possible discrimination, by performing audits of decisions recommended by the Credentials Committee. The findings will be reported to the Credentials Committee and the Medical Executive Committee on an annual basis to protect against discrimination and to maintain a nondiscriminatory credentialing process.

Procedure

All applications for appointment, reappointment, and requests for clinical privileges are processed as described below. The initial application process requires completion of a pre-application step prior to the initial application being issued. Telemedicine credentialing by proxy will be processed in accordance with policy.

Applicants will provide an attestation that all information submitted for credentialing and privileging is accurate and agree to immediately report any change in status of the information maintained in the Credentials files.

If any submitted items differ from information received through the verification process, the applicant will be required to resolve discrepancies. This may require further consultation between the applicant and the Department Chair or Division Chief.

Applications for membership and clinical privileges will be processed and verified as indicated herein.

Pre-Application

A pre-application will be issued via email to potential applicants requesting staff membership and/or clinical privileges. The pre-application will be used to determine if the applicant meets the basic qualification for medical staff membership/advanced practice provider status as delineated in the Medical Staff Bylaws, Rules, and Policies. The pre-application process will be waived for applicants who have previously submitted a preapplication within the prior year.

Potential applicants will be provided instructions outlining the basic requirements to apply for membership and/or privileges along with a link to an electronic pre-application. Once the pre-application is submitted a cursory review of the applicants' qualifications will be performed including review of the following:

1. Professional license(s); including all states and other jurisdictions
2. Medical Board of California License Verification System (LVS) – Health Facility/Peer Review Reporting Form (805 report)
3. Drug Enforcement Administration (DEA) registration, if applicable
4. California Radiology/Fluoroscopy permit/certificate number, if applicable
5. National Provider Identifier Registry (NPI)
6. National Practitioner Data Bank (NPDB)self-query
7. Office of Inspector General (OIG) exclusion database
8. System for Award Management (SAM) exclusion list
9. Department of Health Care Services (DHCS) Medi-Cal Providers Suspended and Ineligible Provider list
10. California Secretary of State Business look-up
11. Centers for Medicare and Medicaid Services (CMS) Opt Out List
12. Internet search query

The applicant will be notified if they do not meet criteria and the initial application will not be released. Such action shall not give rise to hearing and appeal rights pursuant to the Medical Staff Bylaws, nor require reporting to the National Practitioner Data Bank and/or licensing body. If a potential applicant believes that they meet the criteria, that individual must submit evidence to substantiate such, in writing, to the Medical Staff within thirty (30) days after notice that criteria was not met.

If the applicant meets criteria, instructions and a link to the portal to access the initial application packet and privilege forms approved by the Medical Executive Committee will be sent. The communication will outline the time frame and basic requirements for processing the request.

Initial Application for Appointment

Providers who meets criteria to apply for membership and/or privileges must submit a complete application along with copies of other documents as applicable including, but not limited to, the following:

1. California Medical License (copy or wallet license [via the CA Medical Board's "Wallet License Generator") required.)
2. Out of State Medical License, if applicable
3. DEA registration, if applicable
4. Other relevant certificates or permits (i.e., PALS, BLS/ACLS, Fluoroscopy, etc.)
5. Diploma, Education and Training Certificates (may be requested by Provider Enrollment if required by payer(s))
6. Curriculum vitae (CV) / Resume
7. Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
8. Board Certification or Advanced Practice Provider National Certification (may be requested by Provider Enrollment if required by payer(s))
9. NPI Number
10. Evidence of current and any prior malpractice coverage of $1 million per occurrence/$3 million aggregate
11. Malpractice Insurance Declaration of Coverage for the past 10 years (recent graduates must provide malpractice during their residency)
12. Copy of a State-issued photo identification (i.e., driver's license). The name on this document will be used as the provider's official name of record.
13. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
14. Procedure or clinical case log activity for the last two years
15. Application fee
16. Immunization/Vaccines in accordance with policy
17. Written documentation explaining gaps in education, practice and work history of 90 days or more Covering provider(s)

The following forms must be completed and signed:

1. Background Investigation Acknowledgement Form
2. Information Release/Acknowledgment
3. AHS/AH Medical Staff Sharing Agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Information Services (IS) Epic Training Data Collection Form
8. Electronic Signature authorization
9. Photography and Videotaping Attestation
10. Medicare and Tricare Acknowledgement
11. Professional Code of Conduct Agreement

12. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
13. Relevant APP agreements and standardized procedures as applicable.

The applicant's identity must be verified via presentation of an original government-issued identification document prior to appointment/granting of privileges.

Reappointments

Reappointment to the Medical Staff and requesting of clinical privileges shall occur within a period not to exceed 24 months. The provider shall be required to submit a complete application along with copies of documents as applicable including, but not limited to, the following:

1. New Malpractice Insurance Declaration of Coverage not currently on file
2. Any new, relevant licensure or certification not currently on file
3. An update CV/Resume, if applicable
4. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
5. Reappointment application fee

The following forms must be completed and signed.

1. Background Investigation Acknowledgement
2. Information release/acknowledgment
3. Sharing agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Professional Code of Conduct Agreement
8. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
9. Relevant APP agreements and standardized procedures as applicable.

Reappointment Applications will be sent via the Practitioner Portal to providers approximately four (4) months prior to their appointment expiration date and are expected to be completed on-line and submitted within 35 days.

Three reminders will be made, sent approximately every 10 days, for unreceived reapplications. If the provider fails to submit a completed application in the timeframe outlined on the written notice, a phone call/text will be made to the provider and a final email reminder will be sent. See Attachment A for template reminders. Failure to submit reappointment application shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.

Medical Staff Services sends reappointment applications as outlined in the Medical Staff Bylaws. Communication templates are outlined in Attachment A.

If the provider fails to submit a completed application by the date as stated on the written notice, a final reminder will be made to the provider, which includes an attempt to reach the provider via phone call. Failure to do so shall be deemed as a voluntarily resignation of membership and/or privileges. The procedural rights set forth in the Medical Staff Bylaws shall not apply to voluntary resignation.

Verification and Processing

When the application for appointment or reappointment is submitted, a review for completeness is performed by Medical Staff Services. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process, including resolution of any discrepancies. Failure to submit the requested information within thirty (30) days shall be considered a withdrawal of the application. Such withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws. In accordance with the Bylaws, the Medical Staff will not take action on an application that is not "complete".

All information gathered on the application will be verified by the primary source (when applicable) and saved in the provider's credentials file. When oral verification is conducted, a documented record entry will include the name and contact information of the individual who provided the verification. Primary source documentation is dated and labeled with the name/user identification of the individual who performed the validation.

The following queries, along with the applicable source/location, will be conducted:

1. California Professional License/Professional Licenses from Other States
   Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board via the California Department of Consumer Affairs Licensing Board Website. Other State Medical and Professional Boards for active professional licenses will be verified with the relevant State Board.

2. DEA Certification
   All providers must have a valid DEA certificate, with a California address, with the exception of Pathologists. For Advanced Practice Providers, DEA requirements are based on scope of service. Providers who are required to have a DEA, must have an unexpired DEA, without limited schedules or an out of state address, otherwise privileges shall be suspended until evidence of a valid DEA is verified. Primary source verification is obtained via the DEA Controlled Substances Act Registration Information Database.

3. Fluoroscopy or Radiography Certification
   A copy of the permit/certification is required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not acceptable as a Fluoroscopy Certificate. Temporary primary source verification will be obtained via the California Department of Public Health (CDPH) Radiologic Health Branch (RHB).

Medical Staff Services shall provide a monthly report to Radiology and Perioperative Services of all providers with a valid Fluoroscopy certificate.

4. Hospital Affiliations and/or Work History
   Written verification of ten (10) years of clinical work history from hospitals or other health care organization affiliations is required for initial appointment and the prior two (2) years for reappointment. Verifications must be received directly from the organization or their designated third party.

   If verification of an affiliation is not obtained after three attempts with the applicant's assistance, including a phone call to the facility, the file may then move through the evaluation process without verification. In such instance, a file note will be recorded.

5. Graduation from Medical/Professional School and Completion of Residencies and Fellowships
   Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database, National Student Clearing House (NSCH) (upon confirmation the organization uses NSCH as their 3rd party) or Federation of State Medical Boards (FSMB) for closed residency programs or state licensing agency, if the state verifies.

   Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Verification of foreign graduation will be conducted.

6. Board Certification
   Board Certification is verified querying the American Board of Medical Specialties on-line database, American Osteopathic Association (AOA), or primary source verification directly from the certification board.

   Advanced Practice Registered Nurses and Physician Assistants are required to maintain national certification by any of the following bodies:
   - American Academy of Nurse Practitioners (AANP)
   - American Nurses Association – American Nurses Credentialing Center (ANCC)
   - Pediatrics Nursing Certification Board (PNBC)
   - National Certification Corporation (NCC) for Nurse Practitioner certification
   - American Association of Critical-Care Nurses (AACN)
   - American Midwifery Certification Board (AMCB)
   - National Board of Certification & Recertification for Nurse Anesthetist (NBCRNA)
   - National Commission on Certification of Physician Assistants (NCCPA)

7. Current, Adequate Malpractice Insurance
   Professional Liability Insurance coverage and the amount of coverage must be verified directly with the carrier.

8. Professional Liability Claims History
   Verification of ten (10) years of claims history for new appointments and the previous two (2) years for reappointments must be obtained from the current and/or previous carriers. If after three (3) attempts with the applicants' assistance, including a phone call to the facility, the insurance carrier does not respond, the NPDB will be used as primary source verification. The NPDB query may be used as evidence of settlement and judgment history.

9. Background Checks
   Background checks will be conducted on all applicants at the time of initial appointment and reappointment in accordance with state and federal laws. Applicants must consent to this process by signing and submitting the Notice Regarding Background Check Investigation. Failure to complete this form shall result in the application being deemed incomplete.

   Signature on the Notice Regarding Background Investigation acknowledges and authorizes Medical Staff Services to search the following databases:
   - Social Security Number (SSN) Trace and Death Index
   - Maiden & Alias Name Search
   - Criminal Records Search – Federal, State and County Levels
   - National Wants and Warrants
   - National Sex Offender Registry
   - General Services Administration (GSA)
   - U.S. Government Terrorist List/Office of Foreign Assets Control (OFAC)

10. National Practitioner Data Bank (NPDB)
    The NPDB must be queried for all new appointments, reappointments and at the time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be a query for every facility to which the provider is applying. All providers will be enrolled in the NPDB Continuous Query and will be reviewed at initial appointment, reappointment, temporary privileges, and request for additional privileges.

11. Medicare/Medicaid Sanctions
    Sanction verifications for Medicare and Medicaid will be obtained via Sanctions Exclusions Report published by the Office of Inspector General (OIG) and Excluded Parties List System (EPLS) for all new appointments and reappointments.

12. Centers for Medicare & Medicaid Services (CMS) Opt Out
    CMS will be queried for all new appointments and reappointments to confirm whether a provider has opted out of participating in the Medicare program.

13. Professional References
    Three (3) professional references for providers with the same credentials are required for new applicants and two (2) for reappointments. These references must be from individuals

familiar with the applicant's work, either via direct clinical observations or through a close working relationship within the prior two years and preferably someone from the same specialty area. Relatives or spouses may not be used as a reference. References should also include the following:

- At least one provider from each medical staff for which the applicant holds privileges;
- A provider outside of the applicant's practice group or with whom they have no financial relationship, if applicable.
- A provider that holds the same credentials as the applicant (i.e., DPM must list one DPM; PA must list one PA); and
- For an Advanced Practice Provider (APP), one reference from a physician within the same department that has direct observation of care provided (i.e., supervising physician).

All other references must hold a physician/surgeon license to practice medicine (exception for Ph.Ds who may list all Ph.D licensed references).

14. Continuing Medical Education
    A signed statement indicating that the provider has met or exceeded continuing medical education requirements for licensure must be included with the application for appointment or reappointment. Courses must reflect appropriate training for the specialty and privileges requested and meet any state-mandated CME requirements.

15. Provider Enrollment
    For applicants who are assigning billing, collected information will be distributed to health plans as required for purposes of billing and enrollment. Providers may be required to complete various payor-specific forms. Provider Enrollment has access to the information in the Medical Staff Services database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

16. Ongoing Professional Practice Evaluation (OPPE)
    Ongoing Professional Practice Evaluation (OPPE) is the continuous evaluation of provider's performance. Information contained in OPPE reports are factored into the decision to maintain existing clinical privilege(s), to revise, or to revoke an existing clinical privilege prior to or at the time of reappointment.

17. Additional Information
    Departments and Clinical Services may also require additional documentation or standards. Privilege criteria is defined in the specialty-specific privilege request forms. Other information as deemed necessary may also be collected and considered at the request of the Medical Executive Committee or designee.

18. Timeliness of Information
    The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the

application is complete. An application must be signed within 120 days of Credentials Committee review. The attestation must be signed within 180 days of Credentials Committee review. Verification of licensure, board certification, sanctions, current work history, malpractice claims history must be verified within 120 days of Credentials Committee review.

Requests for Modification of Privileges

Providers may request a modification of additional privileges at any time. These requests are handled as follows:

1. The provider must complete the request for a modification of privileges request and privilege form along with any supporting documentation regarding training or experience, as required.

2. The following primary source verification will be conducted:
   - CA Medical or Professional License(s)
   - LVS 805 Report
   - NPDB

3. FPPE/Proctoring shall be considered by the Department Chair at the time of a request for additional privileges.

4. The privileges requested and supporting documentation is made available to the appropriate Division Chief and/or Department Chair/designee for review and recommendation to the Credentials Committee with final review and recommendation for approval by the Medical Executive Committee (MEC) to the Governing Board.

Appointment/Privilege Approval Notifications

Following Board approval, providers will be issued a Board approval notification letter outlining the approved membership and privileges within ten (10) business days of the Quality Professional Services Committee (QPSC)/Board determination.

Application Fees

Providers are required to submit an application fee for membership and/or privileges. An application is incomplete until payment is received. Application fees are non-refundable once the submitted application has been received and processing has started. Reappointment fees are applied in full, regardless of the reappointment term.

1. Medical Staff Fees:
   a. AHS/AH application fee for Temporary Privileges ONLY of $100.00.
   b. AHS application fee of $300.00 and reappointment fee of $500.00.
   c. AH application fee of $300.00 and reappointment fee of $500.00.

2. Advanced Practice Provider (APP) e.g., PA, NP, etc. Fees:
   a. AHS application fee of $150.00 and a reappointment fee of $150.00.
   b. AH application fee of $200.00 and a reappointment fee of $200.00.

3. Providers who apply for membership or privileges at more than one Medical Staff within Alameda Health System the provider will receive a 50% discount of their initial application and/or reappointment fees at the second facility.

AHS and AH Category Assessments

The number(s) of patient care activities for the associated status categories are defined in the AHS/AH Medical Staff Bylaws. During the reappointment process, each applicant's clinical care activity reports will be reviewed to determine appropriate category assignment.

Voluntary Resignation

Providers who wish to resign their Medical Staff membership and/or privileges shall complete a Voluntary Resignation form.

Medical Staff Services will process the voluntary resignation and complete the necessary steps for deactivation of Alameda Health System computer access. The provider will attest that their charting and medical records for any care provided will be completed on or before their voluntary resignation (H&Ps, procedure notes, orders, discharge summaries). In addition, they will acknowledge that their AHS network logon and all application access will be automatically deactivated on the indicated date of their voluntary resignation. Any changes to the voluntary resignation date or a desire to rescind this resignation MUST be communicated verbally and in writing to the Medial Staff Office and the Department Chair. Failure to communicate any changes in dates will result in the resignation being effective as of the date on the Voluntary Resignation Form and all systems access will cease as outlined in the deactivation process.

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be notified, asked to resolve this discrepancy, and expected to do so within thirty (30) days of the request. All identified and/or requested amendments will be included in the provider's file for consideration.

Providers are allowed access to their own credentials files as outlined in the respective Medical Staff policy.

Providers have a right to be informed of the status of their application. Upon submission of an application, an auto-generated email confirming receipt is sent to the provider. Initial applicants are provided with an estimated board appointment date. Applicants may request the status of their application via email or phone call to the medical staff office. Contact information for medical staff services is provided in application correspondence and is posted on the intranet. A representative of the medical staff office will respond within three (3) business days.

RELATED DOCUMENTS
Alameda Health System and Alameda Hospital Medical Staff Bylaws, Rules & Regulations, Privilege Forms, Policies and Procedures

Approvals:

		AHS	AH
Credentials Committee	**Date:**	**3/12/26**	
Medical Executive Committee	**Date:**	**3/18/26**	**3/20/26**
QPSC	**Date:**	**3/25/26**	
Board of Trustees	**Date:**	**4/8/26**	

Medical Staff Credentialing and Privileging of Providers
Attachment A

The email templates below will be used as reminders and final notices.

First reminder to provider (*if reappointment application was not submitted after 10 days of invitation*):

> *Subject: **Action Needed** Application for Reappointment Alameda Health System and/or Alameda Hospital*
>
> *Dear <Full Name>,*
>
> *Please consider this a friendly reminder that your application for reappointment to the Alameda Health System and/or Alameda Hospital Medical Staff has not been received. Please submit this information to Medical Staff Services using the below link to access the application portal:*
>
> *https://onlineapp.alamedahealthsystem.org/PractitionerPortal/Login.aspx?ReturnUrl=%2fPractitionerPortal%2fmain.aspx*
>
> *Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.*

Second/Third reminders to provider, copied to chief and chair (*if reappointment application was not submitted after 20 days/30 days of invitation*):

> *Subject: **Action Needed - 2nd (or 3rd) Reminder** - Application for Reappointment AHS / AH*
>
> *Dear <Full Name>,*
>
> *This is a second reminder to notify that your application for reappointment to the Alameda Health System/Alameda Hospital Medical Staff has not been received. It has been 20 (or 30) days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at Alameda Health System/Alameda Hospital.*
>
> *Following voluntary resignation, you will be required to reapply for membership and privileges via initial application for appointment. If you have any questions, please contact Medical Staff Services at Alameda Health System/Alameda Hospital.*
>
> *If you wish to maintain your membership and privileges, please submit the application using the below link to access the Practitioner Portal:*

https://onlineapp.alamedahealthsystem.org/PractitionerPortal/Login.aspx?ReturnUrl=%2fPractitionerPortal%2fmain.aspx

**Note: Mozilla Firefox Browser is NOT supported by the vendor. Please do not attempt to complete your application using this browser.*

Subject Line: **Final Notice** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief (if applicable), Credentials Committee Chair(s), VP Physician Services, MS Manager

Regular Failure to Submit Email: *Used for the final notice that an application was not submitted, and patient care is ending.*

Dear (insert provider's name),

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 0% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – *[enter month/date/year]*
- Second reminder - *[enter month/date/year]*
- Third reminder – *[enter month/date/year]*

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

As of *[enter month/date/year],* your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Partial Action on Application for Reappointment: *Used if the application has been started but was not completed/submitted.*

Subject Line: **Final Notice Requiring Action** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief if applicable, Credentials Committee Chair(s), VP Physician Services, MS Manager

Dear (insert provider's name)

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on *[enter month/date/year]*, and the application remains at *[enter %]* complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – *[enter month/date/year]*
- Second reminder - *[enter month/date/year]*
- Third reminder – *[enter month/date/year]*

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

Please consider this our final attempt to collect your application for reappointment for processing, which if not received by close of business *[enter month/date/year],* will result in expiration of Medical Staff Membership and/or Privileges.

As of *[enter month/date/year]*, your Medical Staff Membership and/or Privileges at Alameda Health System and/or Alameda Hospital will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Alameda Health System

MEDICAL STAFF APPLICATION LEVELS

Department	Medical Staff	***Effective Date***	5/03
Campus	AHS, AH	***Date Revised***	5/03, 10/05, 10/08, 3/2011, 6/2014, 6/2017, 6/2019, 6/2022; 6/2023; 8/2024; 4/2026
Unit	All	***Next Scheduled Review***	4/8/2029
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Policy

As an extension of the Alameda Health System and Alameda Hospital Medical Staff Bylaws, this policy will establish the mechanism for categorizing Initial and Reappointment applications, which will direct the process for recommending action.

Procedure

All initial and reappointment applications will be labeled into one of the two categories defined below:

1. Level I: Clean files, with no identified issues; or files with cautionary issues as defined in Attachment A.
2. Level II: Files with critical issues identified as defined in Attachment A
    a. Division Chief and/or Department Chair recommendation of Level II files must be accompanied by supporting documentation.
    b. A member of the Credentials Committee will be assigned review of Level II files.
    c. Level II files will be flagged on the credentials report.

In accordance with the Medical Staff Bylaws, a complete application shall require recommendation by the Division Chief, if applicable, and Department Chair. Upon favorable recommendation of the Department Chair, the application will be forwarded to the Credentials Committee. Upon favorable recommendation of the Credentials Committee, the application will be forwarded to the Medical Executive Committee. Upon favorable recommendation of the Medical Executive Committee, the application will be forwarded to the Board for final approval.

Approvals

		AHS Core	Alameda
Credentials Committee	**Date:**	**3/12/26**	
Medical Executive Committee	**Date:**	**3/18/26**	**3/20/26**
QPSC	**Date:**	**3/25/26**	
Board of Trustees	**Date:**	**4/8/26**	

Attachment A

Alameda Health System and Alameda Hospital Medical Staffs
APPLICATION CRITERIA FOR LEVEL I / II FLAGS
Medical Staff Application Levels

Yellow Flags – Level I (Cautionary Issues)

- National Practitioner Data Bank reports of dismissed, closed, or settled malpractice claims without payment within the past 10 years for initial appointments or any since the last reappointment cycle.
- Claims history closed without payment.
- Gaps of 3 months or more in training or clinical practice, in past 10 years for initial appointment or any since the last reappointment cycle.
- Change in training programs.
- Privileges outside scope of practice.
- Discrepancies on application (information not disclosed including prior affiliation, work history, licensure in other states) that are clarified without any adverse associated information.

Red Flags – Level II (Critical Issues)

Note: Level II files DO NOT qualify for temporary privileges (exceptions may be made by the Chief of Staff, or designee).

- Claims history (open, pending and closed with payment) in the past 10 years for initial appointments or any since the last reappointment cycle.
- National Practitioner Data Bank reports (exception: any malpractice claims older than 10 years ***OR*** dismissed, closed, settled malpractice claims without payment within the past 10 years for initial appointment (as captured as a yellow flag), or any reports previously reported in the prior reappointment).
- Adverse information from peer references.
- Discrepancies on application (information not disclosed including prior affiliation, work history, licensure in other states) that remain unclarified or contain questionable/adverse information.
- Behavioral issues in the past 10 years for initial appointments or any since the last reappointment cycle.
- Quality of care occurrences that triggered a “for cause” FPPE since the last reappointment cycle.
- Action, challenge/accusation to licensure or registration.
- Involuntary termination of membership and/or privileges.
- Loss or revocation of privileges.
- Provider wellbeing issues.
- Adverse criminal background check reports.
- Requests for waiver of bylaws, rules and regulations or policy.
- All State or Federal professional licensing board investigation(s), including DEA or other licensing agencies.
- Affirmative attestation response.

Contract Approvals
April 2026

1) Renewal agreement with Hyland Software, Inc. for provision of enterprise content management services. The term of this agreement is effective May 1, 2026 through April 30, 2029. The estimated impact of this agreement is $2,599,491.
Christine Yang, Chief Information Officer

2) Renewal agreement with Mission Linen Supply for provision of linen rental and laundry services. The term of this agreement is effective May 1, 2026 through April 30, 2029. The estimated impact of this agreement is $13,325,000.
Mark Fratzke, Chief Operating Officer

Recommendation: Motion to Recommend Approval for the above contract to the Board of Trustees

Contractor/Vendor Name:	Hyland Software, Inc. (“Hyland”)
Description:	In April 2023, Alameda Health System (“AHS”) renewed a Master Agreement with Hyland, an enterprise content management (“ECM”) vendor whose OnBase platform integrates with Epic Systems, AHS’ electronic health record (“EHR” or “Epic”) system. The OnBase platform provides document and content management functionality that allows AHS to capture, store, and manage clinical and administrative documents and make those documents accessible within Epic workflows. Among other functions, OnBase integrates with Epic to support document scanning and retrieval during patient registration and enables Health Information Management (“HIM”) staff to manage document-related workflows directly within Epic. These services serve as a critical component of AHS’ broader EHR design by ensuring clinical and administrative documentation can be efficiently captured, stored, and accessed within the patient record. The 2023 agreement also expanded AHS’ use of OnBase to support a digitized invoice processing system for Accounts Payable (“AP”). This system improves the efficiency, accuracy, and traceability of invoice processing for the more than 100,000 invoices received annually by AHS. Given the operational importance of uninterrupted document management and Epic integration services, and the efficiency of the AP invoice management system, AHS leadership has evaluated the current provider and determined that Hyland continues to provide the most reliable and cost-effective solution. Accordingly, AHS is requesting Board approval of the proposed renewal agreement. The proposed renewal (“Renewal”) includes a 3-year Software-as-a-Service (“SaaS”) subscription for the OnBase platform supporting AP and HIM workflows integrated with Epic, including one Epic Community Connect client. The Renewal also accounts for expected audited enterprise user fees during the contract term and a required platform upgrade necessary to maintain vendor-supported versions of the software. Services and costs under the proposed agreement include: 1. **SaaS Subscription (3-year term)** – Access to the OnBase AP invoice management and document management system suite integrated with Epic. 2. **Audited Enterprise User Fees** – Periodic vendor audits of enterprise full-time equivalent (“FTE”) users, estimated at approximately 10% of SaaS subscription fees and expected to occur twice during the 3-year term.

<table>
<tr><td></td><td>3. Platform Upgrade & Optimization Services – Upgrades will no longer be required for each individual instance. Rather, they will be incorporated into a new annual Open Access subscription, which will also include any necessary optimization work.</td></tr>
<tr><td>Contract Type and Term:</td><td>Renewal Agreement
May 1, 2026 through April 30, 2029</td></tr>
<tr><td>Termination Clause:</td><td>Early termination in case of breach with 30 days’ written notice.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Hyland Software</td><td>$2,599,491</td><td>$2,599,491</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$2,599,491</td></tr>
</table>
</td></tr>
<tr><td>Cost Savings:</td><td>No rate increase in Renewal Year 1 over Current Agreement. Annual escalators in Years 2 and 3 reduced to 1.5% compared to 3% escalators in Current Agreement. Total savings to AHS = $228K.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>We recommend Hyland due to its demonstrated performance, seamless integration with Epic Systems, and the efficiency realized through the OnBase platform. Transitioning to an alternative solution would require significant changes which include system redesign, retraining, and implementation costs.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th><th>All other Campuses</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Administrative Review:</td><td>Vice President, Applications</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>The Board approved two previous agreements with Hyland regarding the same upgrades in 2018 and 2023</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Information Officer</td></tr>
</table>

Contractor/Vendor Name:	Mission Linen Supply ("Mission")
Description:	Alameda Health System's ("AHS") commitment to deliver the highest quality, affordable, and regulatorily compliant health care to the community includes providing reliable laundry and linen services system-wide ("Services"). The incumbent provider ("Mission") has been our service provider since 2020 from its award of an initial agreement. Mission's current agreement ("Current Agreement") served as a renewal of the initial agreement with services expanded to include the following: 1. Linen rental program (hospital bed sheets and spreads, towels, scrubs, etc.). 2. Cleaning and laundry services for all linen types. 3. Pick-up of soiled linen and scrubs / Drop-off of clean linen and scrubs. 4. Provide IT software/hardware to order clean linen from plant. 5. Provide in-service training (linen loss prevention, linen utilization, etc.). 6. Generate and submit quarterly reports of services rendered for all items provided (e.g. rejected linen, fill rates and lost linen). 7. Adhere to formal quality assurance and process improvement standards. The Current Agreement specifically provides for the inclusion of critical performance thresholds, targets and metrics (collectively, "Key Performance Indicators" or "KPI(s)") to enable transparent and regular assessment of Services delivery. KPIs of note are "pounds of linen per adjusted patient day" and "scrub usage and loss". The Current Agreement links KPI threshold performance parameters to financial penalties should those parameters be breached. AHS has added microfiber cleaning products to its list of items rented under the proposed renewal agreement ("Renewal"). These products are designed for cleaning high-touch, hard-to-reach areas removing > 99% of dirt and microbes. They were previously processed in-house, but internal processing was determined to be insufficient to clean these items to our preferred standard. Outsourcing properly cleaned microfiber products will add an additional $1,000,000 to the cost of services. Mission is a Vizient vendor and pays fees based upon AHS's spend. Of the fees paid by Mission to Vizient, 68% is returned to AHS as a rebate. This represents a $90,000 annual rebate to AHS. In light of the proven ability to deliver high quality Services even in the most difficult of circumstances, at a highly competitive rate, Mission has distinguished itself as a reliable provider of essential services and has proven a valued partner in our mission of providing trusted and affordable care to the community. To ensure uninterrupted provision of reliable and affordable Services, AHS leadership is requesting Board approval to enter into a Renewal with Mission on the terms described above and below.
Contract Type and Term:	Renewal Contract Term: 5/01/2026 – 4/30/2029
Termination Clause:	Without Cause Termination: At any time after the one-year anniversary of the effective date, either party may terminate this Agreement without cause and without further liability by providing One Hundred and Eighty (180) days' notice, in writing, to the other party.

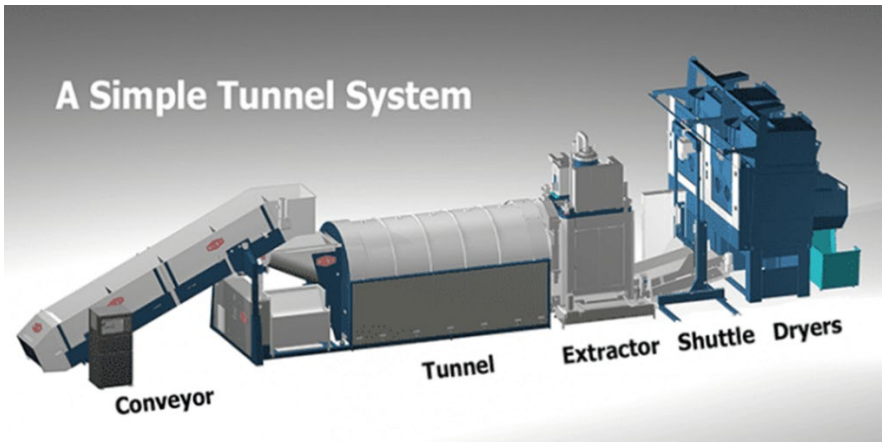
Total Spend with Vendor:

Description	Board Approval	Total
Additional Funding (Current Agreement)		$490,000
Renewal Agreement (5/01/2026 – 4/30/2029)		$12,201,000
5% Contingency		$634,000
Total	**Approval Requested**	**$13,325,000**

Estimated Cost Savings:

Renewal Agreement rates will remain flat in the first year and increase at the Consumer Price Index ("CPI"), not to exceed 3.5%. In addition, AHS leadership anticipates that with the assistance of Mission's productivity tracking tools we will be able to realize reductions in the KPIs and have targeted savings in total spend of up to $400,000 annually.

Alternatively, if AHS were to bring linen processing in-house, it would require the acquisition of a tunnel washing system (illustration below), a building to house the system and staff to process the laundry. AHS uses an average of 6000 pounds of clean linen daily. These systems range in costs from $3M - $10M. Additional required equipment would include sorters, linen folding machine, conveyor systems, ironing systems, tables, carts, scales, and box vans for transportation. A commercial facility to house the system is estimated to be 40,000 sq ft in size. Total startup costs are estimated to be between $12.5M and $29.2M, not including the cost of acquiring real estate. Although AHS leadership is careful to consider all opportunities to bring key services in-house wherever possible, the financial realities in this case are clear and support continued partnership with a trusted vendor with the resources and ability to reliably meet our needs.



Fiscal Implications: Anticipated FY 26 spend under the Replacement Agreement has been included in the FY 26 budget request.

Quotes Received AHS did not consider any other vendors because there are not any other large linen companies in the area.

<table>
<tr><td>Reasons for Recommendation:</td><td>Upon careful analysis, including performance of Mission under the Current Agreement, evaluation of the costs incurred were AHS to change vendors or bring Services in-house, AHS leadership has concluded that maintaining our relationship with Mission under terms of the proposed Renewal Agreement offers the best value for AHS in obtaining this critical service.</td></tr>
<tr><td>Impacted Facilities:</td><td><table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table></td></tr>
<tr><td>Coordination with Medical Staff:</td><td>Included on monthly reporting to Quality Steering Committee for medical staff review.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: System Director of Environmental Services
Secondary: V.P., Support Services</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>Current Agreement approved April 2023</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Operating Officer</td></tr>
</table>

ALAMEDA HEALTH SYSTEM

BOT Previously Approved Contracts - FY26 (July 1, 2025 - June 30, 2026)

#	Vendor	Amount Requiring BOT Approval	Start Date	Ending Date	BOT approved Date	Agenda Summary	Expectation	Executive Sponsor
1	Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology	$3,333,044	4/23/2025	4/22/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of mobile imaging services.		Chief Operating Officer
2	CareFusion Solutions, LLC	$7,206,000	8/19/2025	8/18/1930	FC - 7-2-25 BOT Approved 7-9-25	Provision of infusion pumps and supplies.		Chief Clinical Officer
3	East Oakland Community Project	$1,593,600	8/1/2025	7/31/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of respite care services.		Chief Clinical Officer
4	The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery	$7,594,371	8/1/2025	7/31/2027	FC - 7-2-25 BOT Approved 7-9-25	Provision of neurological surgery professional services.		Chief Medical Officer
5	Entisys Solutions, Inc. dba E360	$1,499,410	9/29/2025	9/28/2028	FC - 9-3-25 BOT Approved 9-17-25	Citrix virtual access platform		Chief Information Officer
6	GuidePoint Security LLC	$1,457,310	9/30/2025	6/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Arctic Wolf cybersecurity monitoring and recovery services		Chief Information Officer
7	Xerox, Inc.	$3,983,160	11/1/2025	10/31/1930	FC - 9-3-25 BOT Approved 9-17-25	Printer equipment and services.		Chief Information Officer
8	Anthem Blue Cross Life and Health Insurance Company	$5,930,739	1/1/2025	12/31/2027	FC - 9-3-25 BOT Approved 9-17-25	Third-party administrator services for AHS employee health insurance plan.		Chief Human Resources Officer
9	Cardea Health	$6,394,800	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Respite housing services.		Chief Clinical Officer
10	Lifepoint Rehabilitation of California, LLC	$4,211,233	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Inpatient rehabilitation management services.		Chief Operating Officer

11	McKesson Corporation	$447,180,000	4/1/2026	3/31/1931	FC - 9-3-25 BOT Approved 9-17-25	Wholesale pharmaceutical supply services.		Chief Clinical Officer
12	Quest Diagnostics	$13,280,743	3/1/2022	2/28/2026	FC - 9-3-25 BOT Approved 9-17-25	Reference laboratory services.		Chief Clinical Officer
13	Nelson T. Lewis Construction Co., Inc.	$3,197,080	10/15/2025	6/15/2026	FC - 10-1-25 BOT Approved 10-8-25	St. Rose Hospital cath lab upgrade.		St. Rose Chief Administrative Officer
14	ePlus Technology, Inc.	$1,800,000	11/1/2025	10/31/2028	FC - 10-1-25 BOT Approved 10-8-25	Data loss protection services.		Chief Information Officer
15	Switch, Ltd.	$1,509,294	2/16/2026	2/15/1931	FC - 10-1-25 BOT Approved 10-8-25	Data center services.		Chief Information Officer
16	Lescure Company, Inc.	$1,668,200	11/1/2025	3/31/2027	FC - 10-1-25 BOT Approved 10-8-25	Architectural and structural work for Alameda Hospital HVAC replacement project.		Chief Operating Officer
17	Matrix HG, Inc.	$1,214,436	11/1/2025	10/31/2026	FC - 10-1-25 BOT Approved 10-8-25	Installation of COVID prevention HVAC upgrades at JGPH.		Chief Operating Officer
18	Symplr Care Management LLC	$1,112,847	1/1/2026	12/31/2028	FC - 11-5-25 BOT Approved 11-12-25	Patient safety and quality reporting software.		Chief Information Officer
19	LAZ Parking California, LLC	$6,937,194	1/1/2026	12/31/2028	FC - 11-5-25 BOT Approved 11-12-25	Parking services.		Chief Operating Officer
20	Agiliti Health, Inc.	$9,138,690	2/1/2026	1/31/2029	FC - 1-7-26 BOT Approved 1-14-26	Equipment rental services.		Chief Operating Officer
21	Smith-Karn Architecture	$1,492,525	1/15/2026	1/15/2029	FC - 1-7-26 BOT Approved 1-14-26	Architectural services for remodel of SLH medical detoxification clinic.		Chief Operating Officer
22	VTP Holdings, LLC dba VIC the PICC	$1,620,000	2/1/2026	1/31/2029	FC - 1-7-26 BOT Approved 1-14-26	PICC line placement services.		Chief Clinical Officer
23	Roelz Enterprises, LLC dba ELS Prestige Home Care	$2,200,000	10/15/2025	10/14/2027	FC - 2-4-26 BOT Approved 2-11-26	SNF sitter services.		Chief Operating Officer

24	Fisher Scientific Company LLC dba Fisher Healthcare	$6,600,000	4/1/2026	3/31/2029	FC - 3-4-26 BOT Approved 3-11-26	Laboratory supplies		Chief Operating Officer
25	Hill-Rom Company, Inc.	$1,430,000	3/12/2026	3/11/2027	FC - 3-4-26 BOT Approved 3-11-26	Replacement nurse call system for SNFs		Chief Operating Officer
	Total Amount for FY 26 year to date	$543,584,676						

ACTION/DISCUSSION: Approve a First Amendment to the Agreement on the Repayment of Alameda Health System Debt to the Consolidated Treasury (the March 2016 Permanent Agreement) to increase the fiscal year end Net Negative Balance (NNB) limit to $100 million for FY 2026 and FY 2027 and increase the intra year maximum from $50 million to $100 million for FY 2026 and FY 2027

FIRST AMENDMENT TO AGREEMENT ON THE REPAYMENT OF ALAMEDA HEALTH SYSTEM DEBT TO THE CONSOLIDATED TREASURY OF THE COUNTY OF ALAMEDA

This First Amendment to Agreement on the Repayment of Alameda Health System Debt to the Consolidated Treasury of the County of Alameda ("Amendment") is made and entered into by and between the County of Alameda ("County") and Alameda Health System ("AHS") as of the _____ day of _____, 2026.

Recitals

WHEREAS, the County and AHS entered into the Agreement on the Repayment of Alameda Health System Debt to the Consolidated Treasury of the County of Alameda (the "Permanent Agreement") on or about April 9, 2016; and

WHEREAS, the purpose of the Permanent Agreement was to provide ongoing liquidity support to AHS by allowing AHS to maintain a net negative balance in the Consolidated Treasury and establishing a schedule for repayment while enabling AHS to establish operating and capital reserves; and

WHEREAS, AHS is deferring planned reductions in force and program closures until June 30, 2026 with an estimated fiscal impact of $14.1 million; and

WHEREAS, the County and AHS desire to amend the Permanent Agreement to assist AHS in addressing the subsequent FY 2025-26 budget imbalance resulting from the deferrals, and to provide temporary relief and flexibility to AHS regarding the fiscal year end net negative balance and the intra year flexible maximum for Fiscal Year 2026 and 2027.

Amendment to Permanent Agreement

The County, acting by and through its Board of Supervisors, and AHS, acting by and through its Board of Trustees hereby agree to amend the Permanent Agreement as follows.

A. The Net Negative Balance (NNB) Limit and Reduction Schedule (attached to the Permanent Agreement as Schedule A) is amended to modify the NNB limit at June 30 and the Intra Year Flexible Maximum only for Fiscal Year 2026 and Fiscal Year 2027, as follows:

FY	NNB Limit at June 30th	Intra-Year Flexible Maximum	Total Availability
2026	$100,000,000	$100,000,000	$200,000,000
2027	$100,000,000	$100,000,000	$200,000,000

B. Except as expressly modified in this Amendment, all other terms and conditions of the Permanent Agreement are and shall remain in full force and effect.

C. Counterparts - This First Amendment may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

This First Amendment is hereby executed by authorized representatives of the parties:

COUNTY OF ALAMEDA

President David Haubert Date
Board of Supervisors

APPROVED AS TO FORM:

DONNA R. ZIEGLER, County Counsel

By: _____
Andrea L. Weddle
Chief Assistant County Counsel

ALAMEDA HEALTH SYTEM

Chair, _____ Date
Board of Trustees

James Jackson, CEO Date
Alameda Health System

APPROVED AS TO FORM:

AHMAD AZIZI, General Counsel

_____

ACTION/DISCUSSION: FY 27 Preliminary Budget Update

ALAMEDA HEALTH SYSTEM

FY 27 Preliminary Budget and HR 1 Fiscal Impacts Board of Trustees

Kimberly Miranda
Grace Mesina
John Minot-Schwartz
April 8, 2026

Budget Goals & Guiding Principles

Preliminary Budget Framework

- Use Run Rate actuals from CY2025 for volume, revenue and cost assumptions as Budget starting point.
- Scrub for known changes/differences:
  - Correct for any material one-time items that impacted the baseline.
  - Update supplemental program revenue to reflect latest available information
- Incorporate factors that may not be reflected in the baseline but likely impact the budget, such dental services, Union COLAs and contracts.
- Incorporated full year staffing, as needed, including physician services.

External and Financial Drivers

- Address HR 1 and other state and federal budgetary changes that will likely increase the uninsured, reduce utilization and lead to delayed care and worsening health outcomes.
  - Utilization decreases/no volume growth
  - Outreach to fill provider schedules
  - Assignment of Medi-Cal members
  - Partner with county on HPAC growth
  - Uncompensated care
- Maintain fiscal discipline to control expenses necessary to stabilize operations from fluctuations in funding.

Sustainable Continuous Improvement

- Ensure compliance with the County Permanent Agreement including NNB requirements
- Prioritize revenue capture over volume growth.
- Prioritize funding toward initiatives that demonstrate near-term financial impact or risk mitigation, while limiting or deferring investments that do not meet defined return or strategic thresholds.
- Execute GRIT and other key initiatives to reduce costs and strengthen financial performance

Focus on mitigations now to offset potential utilization drops driven by HR 1

Restart Alliance assignment & increase utilization of existing and new capacity with improved care coordination

- Call center
  - Hire or realign panel management supervisor
  - Call patients when cancellations occur to secure appointment for Alliance members
- Patient panel digital communications
  - “Hello World” - send initial welcome packet, along with tracking & following up on new patient appointments
  - MyChart enrollment of new members
- Patient onboarding – initial clinical intake
  - Establish patient care for new members through FQ qualified telehealth video visits conducted by a Nurse Practitioner or Physician Assistant

Preliminary Budget

(in thousands)	Actual 2025	Projection 2026	Budget 2027	Variance Proj2026 vs Budget 2027	% Variance (Proj 2026 vs. Budget2027)
Operating Revenue ----------					
Net Patient Revenue	$ 942,426	$ 970,539	$ 993,414	$ 22,875	2.4%
Capitation Revenue	55,600	53,599	53,601	2	0.0%
Other Government Programs	563,927	530,716	541,080	10,365	2.0%
Other Revenues	63,966	72,500	70,264	(2,236)	-3.1%
Total Revenue - All Sources	**$ 1,625,920**	**$ 1,627,353**	**$ 1,658,359**	**$ 31,006**	**1.9%**
Collection %	***19.6%***	***18.5%***	***19.3%***	***0.8%***	
Operating Expenses ----------					
Salaries & Wages	$ 675,936	$ 732,135	$ 771,608	39,473	5.4%
Salaries & Wages (Providers)	150,009	155,329	163,592	8,263	5.3%
Registry	52,211	39,924	36,413	(3,511)	-8.8%
Physician Contract Services	41,338	45,084	43,266	(1,819)	-4.0%
Employee Benefits (Taxes, Ins)	196,870	202,404	224,984	22,580	11.2%
Retirement	96,797	98,709	107,221	8,512	8.6%
Total Labor Expenses	**$ 1,213,161**	**$ 1,273,586**	**$ 1,347,084**	**$ 73,498**	**5.8%**
Purchased Services	$ 105,279	$ 105,072	$ 108,976	3,903	3.7%
Materials and Supplies	154,414	167,472	171,238	3,766	2.2%
Facilities	41,248	44,851	46,058	1,207	2.7%
Depreciation & Amortization	37,542	28,304	28,153	(151)	-0.5%
General and Administration	53,335	42,013	43,014	1,000	2.4%
Total Non-Labor Expenses	**$ 391,817**	**$ 387,713**	**$ 397,438**	**$ 9,726**	**2.5%**
Total Operating Expenses	**$ 1,604,978**	**$ 1,661,298**	**$ 1,744,522**	**$ 83,224**	**5.0%**
Operating Income (Loss)	***$ 20,941***	***$ (33,945)***	***$ (86,163)***	***$ (52,218)***	**153.8%**

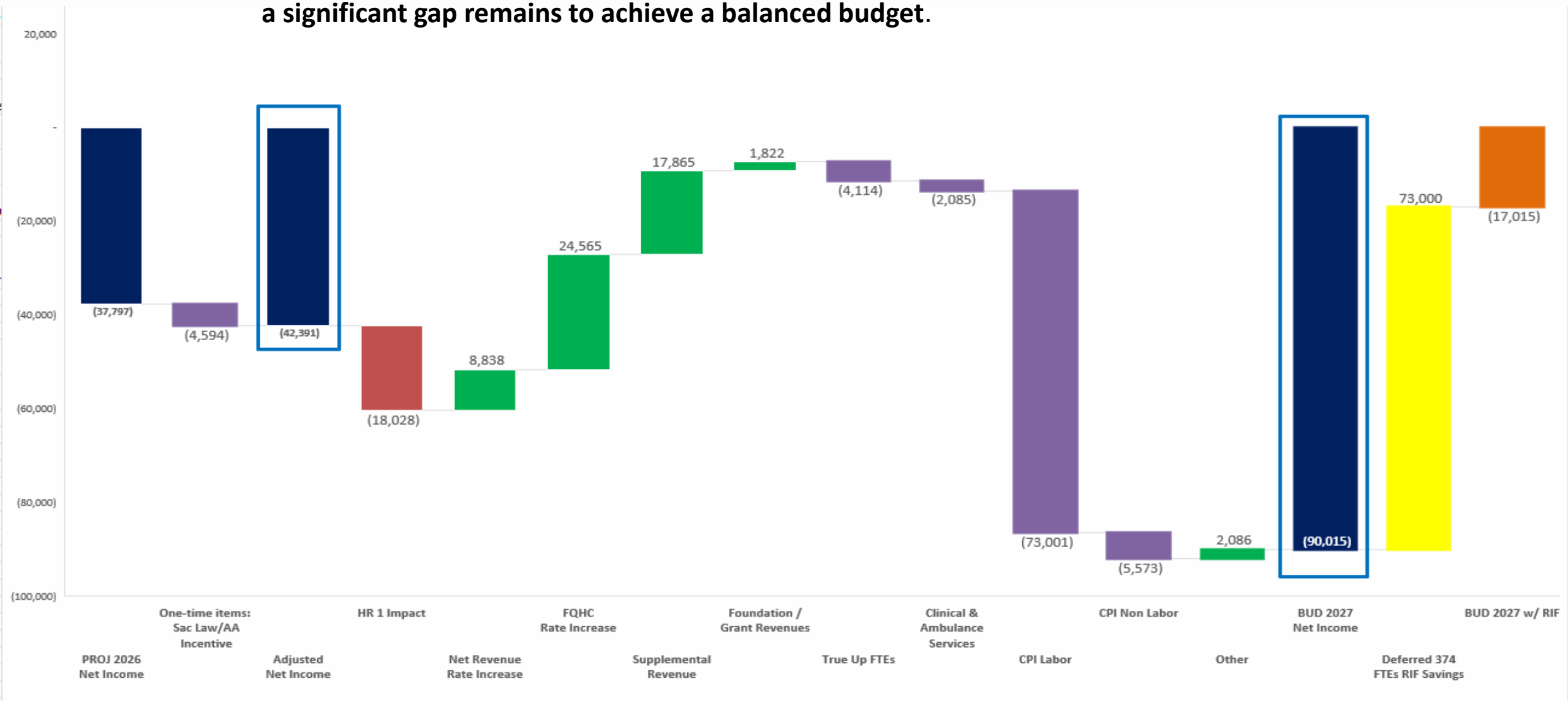
ALAMEDA HEALTH SYSTEM

Preliminary Budget

(in thousands)	Actual 2025	Projection 2026	Budget 2027	Variance Proj2026 vs Budget 2027	% Variance (Proj 2026 vs. Budget2027)
Non-Operating Activity ----------					
Interest Income (Expense)	$ 2,899	$ (3,860)	$ (3,860)	(0)	0.0%
Other nonoperating Revenue	(253)	8	8	(0)	0.0%
Total Non Operating Activity	**$ 3,152**	**$ (3,869)**	**$ (3,852)**	**$ (0)**	**-0.4%**
Net Income (Loss)	**$ 17,790**	**$ (30,077)**	**$ (90,015)**	**$ (52,218)**	**199.3%**
EBIDA Adjustments					
Interest Income (Expense)	$ 2,899	$ 3,860	$ 3,860	0	0.0%
Depreciation & Amortization	37,542	28,304	28,153	(151)	-0.5%
Amortization (GASB-68, GASB-75)*	160	-	-	-	
Total EBIDA Adjustments	**$ 40,601**	**$ 32,164**	**$ 32,013**	**$ (151)**	**-0.5%**
EBIDA	**$ 58,390**	**$ 2,088**	**$ (58,002)**	**$ (52,369)**	**-2878.4%**
Operating Margin	1.3%	-2.1%	-5.2%	-3.1%	
EBIDA %	3.6%	0.1%	-3.5%	-3.6%	
FTEs	**5,166**	**5,204**	**5,213**	**9**	**0.2%**
Salaries per FTE (incl Registry)	**$ 169,975**	**$ 178,207**	**$ 186,401**	**$ 8,194**	**4.6%**
Adjusted Patient Days	**364,454**	**368,736**	**368,097**	**(639)**	**-0.2%**

Net Income Roll Forward / Reconciliation

- **Expenses continue to outpace revenues. The deferred RIF has introduced uncertainty, and a significant gap remains to achieve a balanced budget.**



Budget Entity Financials

In Thousands	ALAMEDA	FAIRMONT	FQ CLINIC	HIGHLAND	JOHN GEORGE	SAN LEANDRO	SYSTEM OVERHEAD	Grand Total
Operating Revenue ----------								
Net Patient Revenue	128,935	33,507	132,156	470,332	96,903	131,581	-	993,414
Capitation Revenue	2,219	388	17,352	26,021	-	7,621	-	53,601
Other Government Programs	33,941	9,681	105	119,297	-	25,051	-	188,075
Other Revenues	1,091	763	1,605	64,717	754	1,334	-	70,264
Total Revenue - All Sources	**166,186**	**44,339**	**151,218**	**680,367**	**97,657**	**165,586**	**-**	**1,305,354**
Collection %	***16.0%***	***19.5%***	***59.9%***	***16.7%***	***29.9%***	***15.9%***		***19.3%***
Operating Expenses ----------								
Salaries & Benefits	130,959	53,576	93,128	463,368	92,130	120,464	186,601	1,140,226
Purchased Services	7,528	2,489	1,595	35,277	3,845	6,314	51,927	108,976
Contracted and Provider	6,790	2,223	45,979	108,133	18,898	23,938	897	206,858
Materials and Supplies	11,999	4,325	7,309	126,973	1,923	16,996	1,712	171,238
Facilities	7,108	3,092	2,001	17,743	2,183	4,167	9,763	46,058
Depreciation	4,721	449	3,789	4,522	323	3,234	11,114	28,153
General & Administration	474	106	213	1,915	45	325	39,936	43,014
Total Operating Expenses	**169,579**	**66,260**	**154,015**	**757,931**	**119,348**	**175,438**	**301,951**	**1,744,522**
Contribution Margin After Physician Fees Allocation	**(3,393)**	**(21,921)**	**(2,796)**	**(77,564)**	**(21,692)**	**(9,852)**	**(301,951)**	**(439,168)**
Total Non Operating Activity	**(448)**	**(188)**	**(376)**	**(2,037)**	**(332)**	**(472)**	**0**	**(3,852)**
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	299	2,804	10,491	39,337	(10,298)	8,422	301,951	353,005
Net Income (Loss)	**(3,542)**	**(19,305)**	**7,319**	**(40,264)**	**(32,322)**	**(1,901)**	**0**	**(90,015)**

ALAMEDA HEALTH SYSTEM

Provider salaries are based on their primary (home) location, pending the ability to allocate costs to other locations where they work

GRIT Initiatives to Close FY27 Budget Gap

Accountable	Program	Initiative Description	Budget Category	Revenue/Expense (Net) FY27
Ad Hoc Commit	Unidentified Savings Inititative	Pending identification of additional savings initiatives through Ad Hoc Committee review		
Shari Johnson	Revenue Integrity	Charge Capture/DRG Assurance	Revenue	5,500
Dr. Laurent	Length of Stay Optimization	Leverage EPIC modules and nursing control towe	Labor Expense	(5,000)
Mark Fratzke	Contract Management	Identify savings during negotitations of expiring contracts.	Labor Expense	(7,500)
Mark Fratzke	Attrition Management	Execute attrition strategy to lower labor expense toward benchmark median	Labor Expense	(63,780)
Mark Fratzke	Non Labor Budget Cuts	Bottom up submission/review of annual spend.	Non Labor Expense	(10,000)
			Total Revenue Impact	5,500
			Total Labor Expense	(76,280)
			Total Non-Labor Expense	(10,000)
			Total Capex	
			Net Impact	91,780

- Ongoing refinement and governance: **Initiatives will continue to evolve through Ad Hoc Committee discussions,** including key decisions such as **the scale and timing of RIF actions**, which remain under evaluation and introduce uncertainty to the current estimates.
- Initial gap coverage identified: Current initiatives represent a partial solution to the FY27 budget shortfall, reflecting early-stage opportunities across revenue, labor, and non-labor levers.
- Figures reflect preliminary submissions and require validation and refinement by accountable owners; amounts are expected to evolve through iterative budget cycles.

Key Budget Assumptions

Baseline is based on CY2025

Volumes

- In light of HR 1 and expected and unknown utilization changes, volumes and charges are slightly lower and consistent with current trends; overall adjusted patient days decreased 0.2%

Revenues

- Increase in pricing (chargemaster) 3%
- Net revenue rate increases
  - Commercial based on contracts $2.2M
  - Government Payors $6.3M
- Behavioral Health Contract at current rate of $81.2M
- FQHC rate increases at HGH ($453) and EWC ($479 Rate) of $24.6M

Labor Expenses

- Budgeted FTEs based on:
  - Variable FTEs: determined by current labor standard based on CY2025 volumes
  - Fixed FTEs: hired as of February 1, 2026; excludes vacancies
  - SEIU Physicians FTEs: hired as of February 1, 2026
  - Registry FTEs: at run rate adjusted for hired employees
- Labor COLA - Consistent with union contracts, includes registry and UNREP at $42.5M

Key Budget Assumptions

- Employee Benefits ($22.5M)
  - FICA is based on same percentage of salary as FY25
  - FICA HI is based on 1.45% of salary
  - Health Self Funded is based on Amount per FTE with CPI at 9.5% effective January 2027
  - Health (Kaiser) is based on Amount per FTE with CPI at 9.1% effective January 2027
  - Dental is based on Jan 2026 annualized expense with 5.0% CPI effective January 2027
- Retirement at same percentage of salary as FY25 ($8.5M)

Contracted Physicians

- Physician Contracts based on CY25 run rate

Non-Labor

- Non labor overall increase is 2.3%
  - Utilities CPI: Electricity 3%; Gas 9%; Water 7%
  - Supplies: 2.4% effective 1/1/27
  - Drugs CPI: 3.6 to 3.9% effective 1/1/27
  - Purchased Services, IT, Repairs & Maintenance at CY2025
- Donation to St. Rose at $9.5M, consistent with current year

Key Budget Assumptions

Foundation

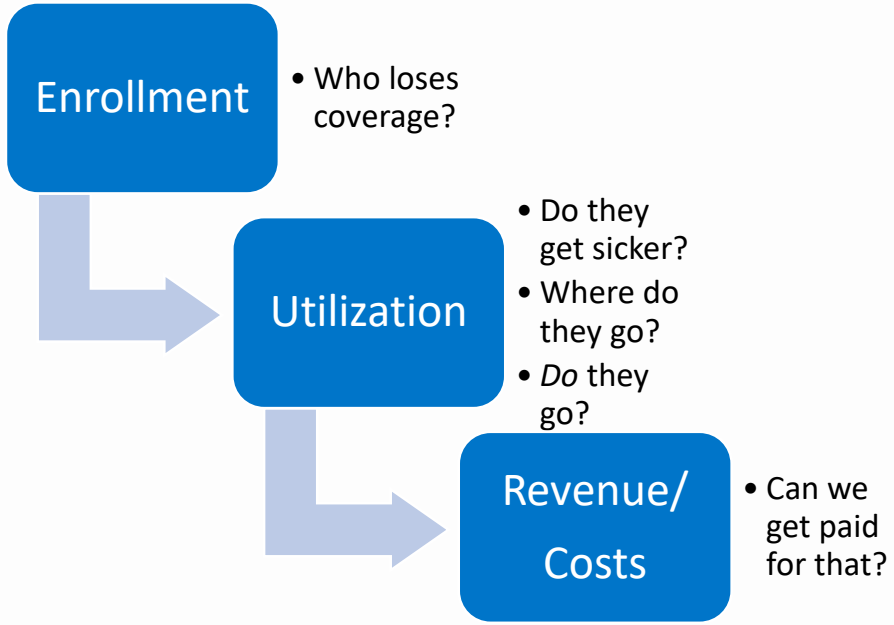
- Funded total operating cost of $5.2M
- Grants and fundraising revenue is $10.9M, an increase of $1.8M over projected FY2026

Capital

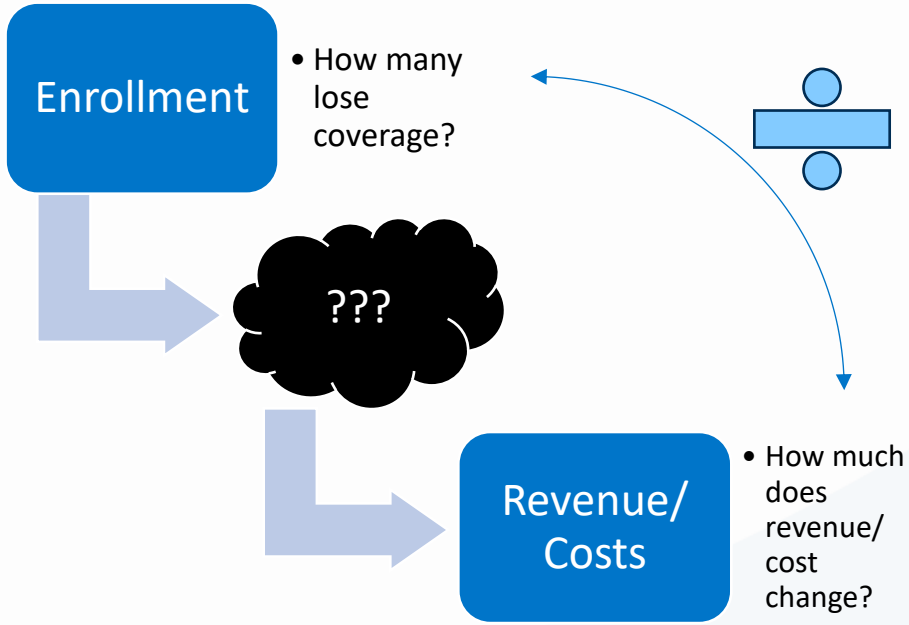
- Historically, AHS spent an average of $20.6M cash per year on capital

Two Styles of Model to Plan Through Uncertainty

1. Patient-Level Simulation – Every Step of the Way

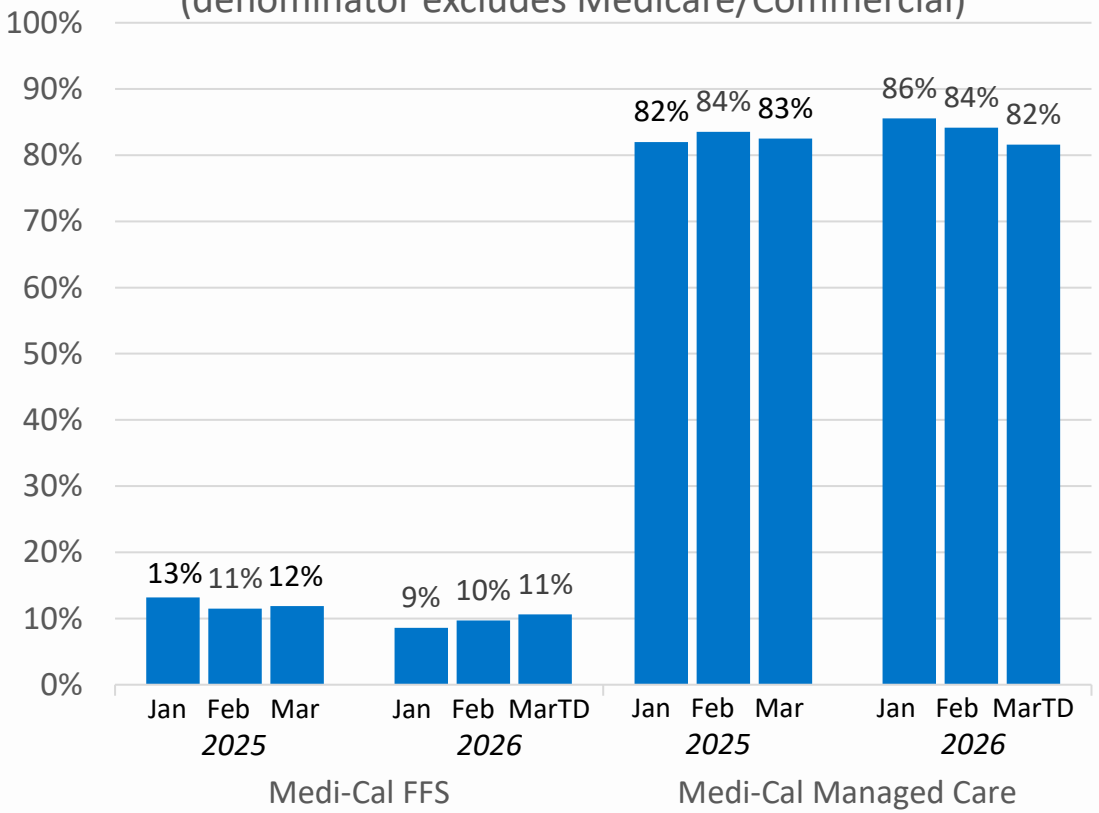


2. Empirical Observation – Outputs and Inputs, Black Box in the Middle

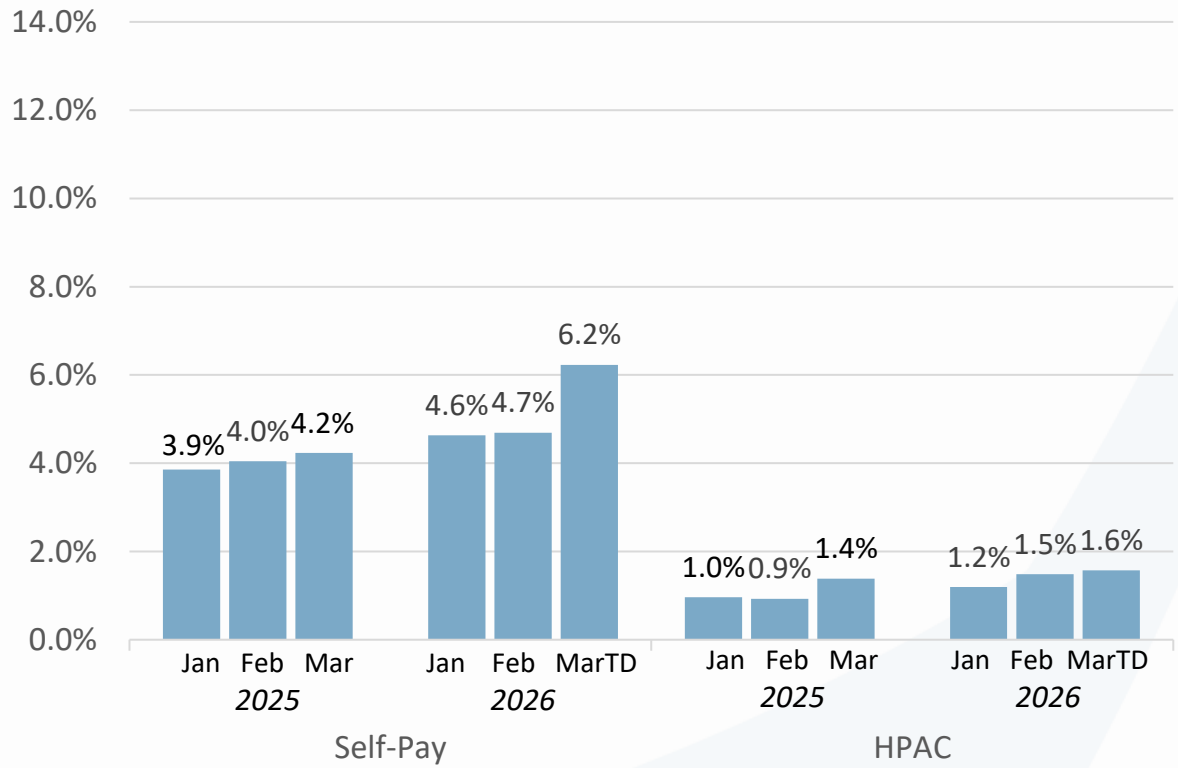


State reduction (freeze) to UIS coverage, effective Jan 2026, has potential as basis of estimates—but data in YTD paints no clear picture as yet

AHS Medi-Cal payer mix within safety net, by month (denominator excludes Medicare/Commercial)

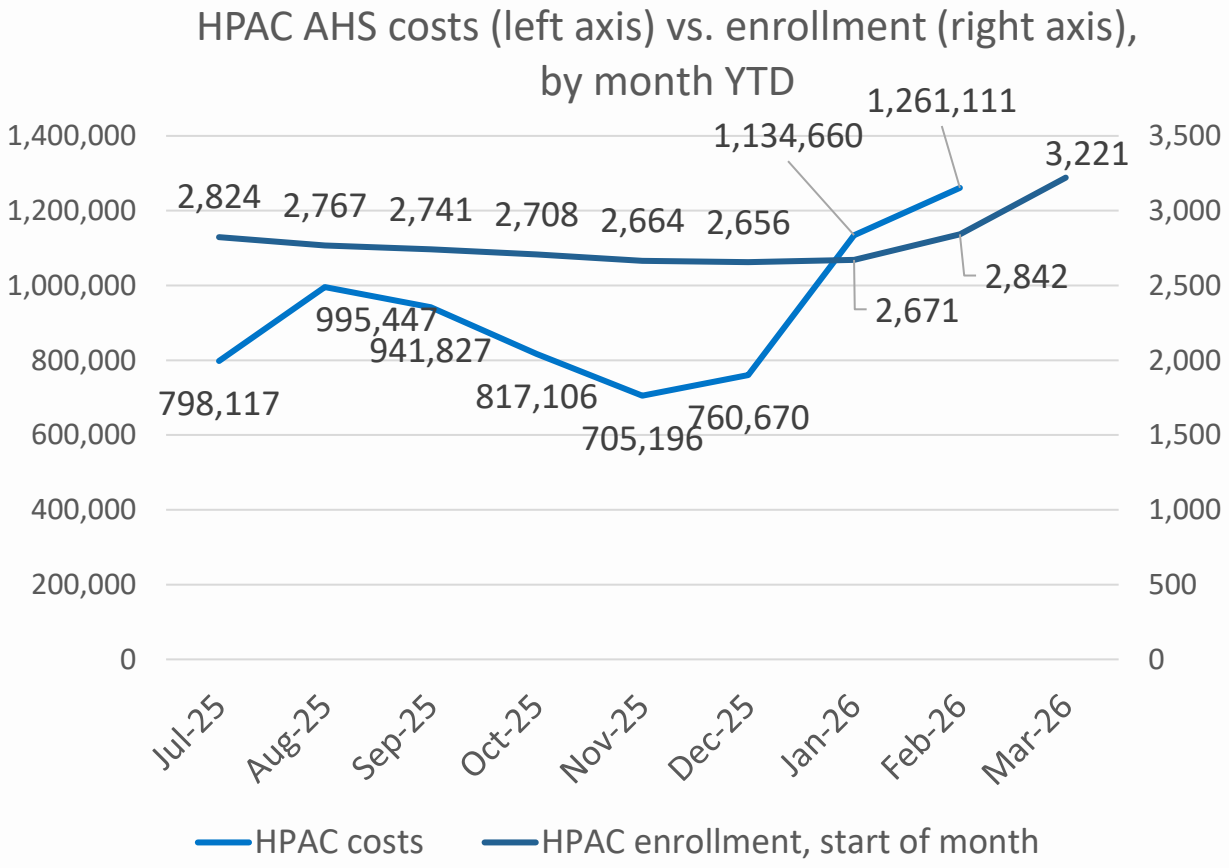


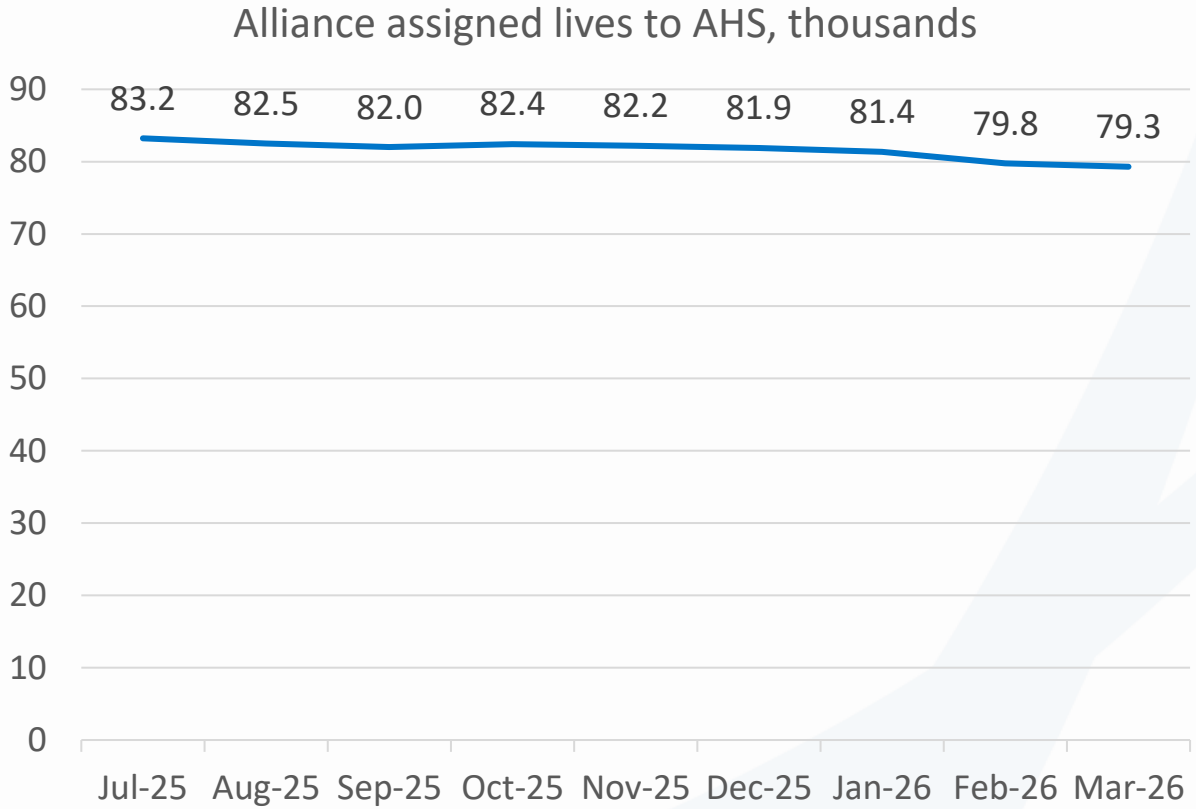
AHS HPAC/self-pay payer mix within safety net, by month (denominator excludes Medicare/Commercial)



ALAMEDA HEALTH SYSTEM

Enrollment: HPAC increase and Medi-Cal decrease





→ Approx. 52% of our Alliance assignees receive **no care** (at AHS or elsewhere) in a given year!

Budgeting in uncertainty – known impacts first

HR 1 or state budget change known	Reflected in current budget	Range in previous presentations
Patient care revenue / cost impacts	Volumes reduced by 0.2%. Will strive to backfill utilization drop. Building dashboards to actively track coverage change impacts	$0 - $33.0M in FY 2026-27
Reduction to fed. matching rate for certain Emergency Medi-Cal patients (HR 1)	$9.0M	Same
Certain known impacts to supplementals from HR 1	$7.5M, as most supplementals see more delayed impact	$7.0-12.0M in CY 2027
Reduction in dental coverage, some FQHC rates (state budget change for UIS)	Continue monitoring; work to fill schedules with outreach	N/A
Increasing Access to Quality Care Fund	Raise support through AHS Foundation	N/A

Budget Calendar

Tasks	Responsibility	Target Due Date
Presentation of Preliminary Budget to Finance Committee	Chief Financial Officer	4/1/2026
Review COT/GRIT Initiatives; Finalize to close the gap	Budget Oversight Committee	4/7/2026
Presentation of Preliminary Budget to Board of Trustees	Chief Financial Officer	4/8/2026 Post 4/3/2026
Department Leaders to Review Budget for errors	Department Leaders	4/6 - 4/17/2026
Adjust Budget for idenditied Errors, COT/GRIT Initiatives Incorporate Capital Budget Preparation of Budget Packet for presentation	Finance Department	4/6 - 4/27/2026
Present Proposed Budget Packet at Executive Operations Team	Chief Financial Officer	4/28/2026
Presentation to the Finance Committee	Chief Financial Officer	5/6/2026 Post 5/1/2026
Presentation to the Co-Applicant Board (CAB)	Chief Financial Officer	5/12/2026
Presentation to the Board of Trustees	Chief Financial Officer	5/13/2026
Presentation to Board of Supervisors/Health Committee	Chief Financial Officer	TBD
Finance Committee Approval	Chief Financial Officer & Finance Committee	6/3/2026 Post 5/29/2026
Board of Trustees Approval	Chief Financial Officer & Board of Trustees	6/10/2026 Post 6/5/2026

- **BOS Ad Hoc meetings continues through June 3rd.**
- **What is the plan to close the gap?**

- **Budget cycle was truncated due to requirement to bring the budget to the BOS prior to AHS approval.**

ALAMEDA HEALTH SYSTEM

APPENDIX

Volumes

- ***Note: In light of HR 1, volumes are slightly lower than current trends***

	ACTUAL2025	ACTUAL2026 Ann Feb 2026	BUDGET 2027	Var to Act Annl Feb 2026	% to Act Annl Feb 2026 Orig
GENERAL ACUTE					
Patient Days	76,737	72,194	71,217	(977)	*-1.4%*
Observation Days	7,768	8,911	8,911	0	*0.0%*
Discharges	14,554	14,780	14,681	(99)	*-0.7%*
Average Daily Census	*209.7*	*197.8*	*195.1*	*(2.7)*	*-1.4%*
ALOS: Average Length of Stay	*5.3*	*4.9*	*4.9*	*0.0*	*-0.7%*
Adjusted Patient Days	141,078	136,685	135,646	(1,039)	*-0.8%*
Adjusted Discharges	26,757	27,982	27,963	(20)	*-0.1%*
Emergency Visits	109,570	112,790	112,790	-	*0.0%*
Surgeries	8,480	8,030	7,979	(50)	*-0.6%*
IP Surgeries	3,577	3,485	3,464	(21)	*-0.6%*
OP Surgeries	4,903	4,545	4,515	(30)	*-0.7%*
Deliveries	1,541	1,602	1,555	(47)	*-2.9%*
PSYCH					
Patient Days	23,788	24,026	24,093	68	*0.3%*
Discharges	2,473	2,490	2,497	7	*0.3%*
Average Daily Census	*65.2*	*65.8*	*66.0*	*0.2*	*0.3%*
ALOS: Average Length of Stay	*9.6*	*9.6*	*9.6*	-	*0.0%*
Adjusted Patient Days	28,400	28,611	28,755	144	*0.5%*
Adjusted Discharges	2,952	2,965	2,980	15	*0.5%*
REHAB					
Patient Days	8,360	8,333	8,402	69	*0.8%*
Discharges	615	612	617	5	*0.8%*
Average Daily Census	*22.9*	*22.8*	*23.0*	*0.2*	*0.8%*
ALOS: Average Length of Stay	*13.6*	*13.6*	*13.6*	-	*0.0%*
Adjusted Patient Days	8,360	8,333	8,402	69	*0.8%*
Adjusted Discharges	615	612	617	5	*0.8%*
SNF					
SNF Patient Days	100,381	100,985	100,957	(27)	*0.0%*
SNF Discharges	209	242	241	(0)	*0.0%*
CLINIC VISITS	411,554	428,879	426,922	(1,957)	*-0.5%*
Total Adjusted Discharges	31,089	32,513	32,439	(74)	*-0.2%*
Total Adjusted Patient Days	364,454	368,736	368,097	(638)	*-0.2%*

Other Government Revenue

($ in thousands)

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	FY28	FY29	FY30	FY31	Comments
Global Payment Program (GPP)	$ 139,537	$ 103,437	$ 91,320	$ 91,426	$ 78,419	$ 78,230	$ 79,013	$ 79,803	GPP reduction reflects loss of SNCP portion due to expiration of federal waiver 12/31/2026 (renewal submission has presupposed loss of that portion). Most likely remainder amount will revert to being Medicaid DSH, which is available under federal statute without requiring federal approvals, but does require traditional cost-based claiming excluding non-hospital facilities.
Old Waiver	1,000	(1,961)	-	-	-	-	-		Adjustment from $31.1M on books to $29.2M to be received as cash by 5/26/2026
Medi-Cal Waiver	***$ 140,537***	***$ 101,476***	***$ 91,320***	***$ 91,426***	***$ 78,419***	***$ 78,230***	***$ 79,013***	***$ 79,803***	
Measure A	$ 146,177	$ 148,245	$ 148,000	$ 148,000	$ 148,000	$ 148,000	$ 148,000	$ 148,000	Based on sales tax increment approved by county voters (one-half cent).
AHD Parcel Tax	4,049	4,049	4,049	4,049	4,049	4,049	4,049	4,049	Tax per property parcel in City of Alameda.
Measure A & Parcel Tax	***$ 150,226***	***$ 152,294***	***$ 152,049***	***$ 152,049***	***$ 152,049***	***$ 152,049***	***$ 152,049***	***$ 152,049***	
FEMA FUNDING	5,830	223	-						Approved claims from FEMA for COVID relief.
Covid Funding	***$ 5,830***	***$ 223***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	

Other Government Revenue

($ in thousands)

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	Cash Flow FY28	Cash Flow FY29	Cash Flow FY30	Cash Flow FY31	Comments
HPAC Amendment	$ 50,125	$ -	$ -	$ -	$ -	$ -	$ -		$0 revenue expected in FY27 due to increase in supp. revenues which flow through a model to project zero "gain". Will update in May Revise if any potential Amendment money is projected at that near-final point.
AB85 Redirection Reserve	(42,093)	-	-	4,789	(45,600)	-	-	-	True-up of FY24 received during FY27 estimating a small amount regained (we received no HPAC Amendment during FY24); then true-up of FY25 during FY28 estimating almost all received will be paid back (we received full HPAC Amendment during FY25); thereafter zero amendment, zero true-up
Medi-Cal SNF Cost Settlement	382	420	462	(1,659)	462	478	531	586	Decreases started Jan 2023 and deepened as virtually all Medi-Cal FFS SNF service moved to Medi-Cal Managed Care where this supplemental is unavailable; HR1 results in small cuts FY27; payback in FY27 reflects FY22 final reconciliation hitting FY27 cash (not yet calculated but likely similar to FY21)
PNPP (Physician SPA)	3,450	1,707	1,778	1,778	1,839	1,876	1,951	4,141	Reflects adjustment to closer to what is being actually received in cash, since CMS has never started paying the ACA portion and the audits that would allow this payout have no schedule to restart, so even if we are technically owed it we do not have any immediate prospect of getting it
Rate-Range IGT (RR)	42,592	51,953	38,775	45,831	44,081	41,187	40,735	41,550	Actual 2024 amounts trended forward, with HR1 reduction est.; higher cash in FY27 reflects payout of CY2025 with less reduction, but 5% reserve added
Enhanced Payment Program (EPP)	68,131	83,085	84,833	114,733	84,833	84,833	76,281	67,728	Like last year, budget incorporates 25% increase 2024 (seen in payment cycle Spring 2026) followed by 48% increase 2025, plus reduction reflecting some of the new new money being tied to Cost, Efficiency, Productivity, and Access Program (CEPA) which we may not earn 100%; reduction from FY26 budget reflects slightly lower utilization than projected; cash is higher only because EPP payment acceleration will pay us for 18 months during the year on a one-time basis, whereas budget amount is the lower amount earned for services in the year. HR1 cuts will not kick in until 1/1/2028, & will not be seen in cash until fall 2029, FY30.
Quality Incentive Program (QIP)	82,504	80,964	113,685	113,685	113,685	113,685	102,317	90,948	CMS approved 70% increase to overall program starting CY2025, grandfathered thereafter; 100% of CY2024 assumed earned, 90% of CY2025 and onward; constant distribution. Settlement typically 2 years after year earned. This increase was not reflected in FY26 budget as it would not be in cash for some time, but CY 2025 is expected to be paid out in full during FY 2027 so the full increase is assumed. Under HR1, like EPP, cuts will kick in from 1/1/2028 and cash will affected starting fall 2029 (FY30)

Other Government Revenue

($ in thousands)

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	FY28	FY29	FY30	FY31	Comments
Hospital Fee	7,129	3,720	3,670	3,670	3,670	3,670	3,670	3,670	Direct grant portion only. 50% reduction for FY26, FY27, and onward reflects that under new HR1-related constraints, entire HQAF for CY 2025 may significantly reduce, and related to that, hospital community may reduce public hospital portion of it.
Medi-Cal Graduate Medical Education (GME)	18,191	14,199	14,153	14,232	13,732	13,492	13,334	3,748	Some HR1 cuts assumed due to lower Medi-Cal utilization, otherwise has relatively stabilized
AB915	6,535	8,740	8,759	8,812	8,759	8,041	8,310	8,588	Trending based on 3% cost trend, 1% revenue trend, known FMAP changes, and some drop for state-only transition out of FFS, and small HR1 cuts due to lower Medi-Cal utilization.
DPNF Pass Through	19,281	23,775	23,447	23,447	-	-	-	-	3-year limited-time program, calendar 2023-2025. Little transparency on amounts paid before they are actually paid. Amount received for CY2024 in Dec 2025 was about $2M less than expected in budget. FY27 amount is final year of program to be paid during FY27.
Prop 56	(830)	240	240	240	240	240	240	240	State tobacco tax revenue spent on Medi-Cal enhancements. Amount is subject to change. Alliance overpaid us the past two years, new # reflects expected payment.
County EMS	395	395	395	395	395	395	395	395	Same amount each year.
County Trauma	5,266	5,266	5,266	5,266	5,266	5,266	5,266	5,266	Funded through Measure C (parcel tax for trauma services approved 1997). Same amount each year.
CalAim ECM (Enhanced Care Mgmt)	1,383	1,048	1,048	1,048	1,048	1,048	1,048	1,048	Patient care funding for Enhanced Care Management services, a Medi-Cal managed care benefit created under CalAim for patients approved as eligible by Alameda Alliance. Reimbursement is only provided if Medi-Cal managed care member is eligible for services in a month, received ECM services from AHS in that month and AHS submits appropriate documentation and billing.
Other (P4P, BHCS)	4,892	1,209	1,200	1,200	1,200	1,200	1,200	1,200	P4P
Supplemental Programs	***$ 267,333***	***$ 276,722***	***$ 297,711***	***$ 337,467***	***$ 233,610***	***$ 275,411***	***$ 255,278***	***$ 229,108***	
Total Other Government Programs	***$ 563,927***	***$ 530,715***	***$ 541,080***	***$ 580,942***	***$ 464,078***	***$ 505,690***	***$ 486,340***	***$ 460,960***	

ACTION/DISCUSSION: Adoption of Resolution of Commitment to Trauma Care

ALAMEDA
HEALTH SYSTEM

BOARD OF TRUSTEES

RESOLUTION NO. 2026-001

RESOLUTION OF COMMITMENT TO TRAUMA CARE

WHEREAS, Alameda Health System ("AHS") has a long-standing history of providing comprehensive trauma care to the people of Alameda County; and

WHEREAS, Alameda Health System is committed to providing high-quality trauma care to the citizens of Alameda County by maintaining the organization's designation as a Level I Trauma Center for Alameda County; and

WHEREAS, the Alameda County Emergency Medical Services Agency has officially designated Alameda Health System as a Level I trauma provider for the citizens of Alameda County; and

WHEREAS, the Administration and Medical Staff at Alameda Health System have, since 1987, cooperated to provide Trauma Center services to the citizens of Alameda County; and

WHEREAS, maintaining Level I Trauma Center designation requires ongoing coordination, collaboration, and compliance with the standards of the American College of Surgeons and applicable California state regulations;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of Alameda Health System reaffirms its full support of Alameda Health System as a Level I Trauma Center and maintains its unwavering commitment to providing trauma services in accordance with the standards of the American College of Surgeons and California state regulations for trauma centers, including Title 22, Division 9, Chapter 7; and

BE IT FURTHER RESOLVED, that the Board of Trustees acknowledges the establishment and ongoing work of a collaborative task force between the Administration and Medical Staff, and supports that effort as an important mechanism to ensure Alameda Health System's continued compliance with all requirements necessary to maintain Level I Trauma Center designation.

THE FOREGOING Resolution was presented this 8th day of April 2026, to wit:

I hereby certify under penalty of perjury that the President of the Board of Trustees was duly authorized to execute this document on behalf of Alameda Health

System by majority of vote of the Board on April 8, 2026 and that a copy has been delivered to the President.

ATTEST:

Ronna Jojola Gonsalves
Clerk of the Board of Trustees

Date:

APPROVED AS TO FORM:

Ahmad Azizi
General Counsel

Date

THE FOREGOING Resolution was **PASSED** and **ADOPTED** by the Alameda Health System Board of Trustees this 8th day of April, to wit:

David Sayen
President, Board of Trustees
Alameda Health System