CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
December 20, 2021
12 to 2:00p

As the elected leadership of the CCRMC/HCs Medical Staff, we stand against racism and hate. *We recognize the negative impact of longstanding structural racism on health, and we commit to take action to combat this in our own system and work for health equity for our patients.*

Join Zoom Meeting
https://cchealth.zoom.us/j/8544948118
Meeting ID: 854 494 8118
****If you are on phone only for the Zoom, use *6 to mute/unmute**

Agenda Topic	Status	Time
Call to Order		
Review of November 15, 2021 Minutes	See attached Draft Minutes.	2 min.
Announcements (3 min)		
• **January 24, 2022 MEC meeting reports to Sue by January 12, 2021** ○ Cancer Committee-Dr.Gynn ○ Psychiatry-Dr. Berlingieri Please use the standard SBAR form for your reports -You will be given 5 minutes in which to present your report. Please number the pages of your report. **PLEASE DATE YOUR REPORT AND NUMBER THE PAGES.** **Next meeting January 24, 2022**		
ADMINISTRATIVE REPORTS		
Anna Roth, Health Services Director Chris Farnitano, M.D.-Health Officer Pat Godley, CFO for Health Services Jaspreet Benepal, RN, Chief Nursing Officer Samir Shah, M.D., Chief Executive Officer/Chief Medical Officer Vacant - Chief Quality Officer David Runt - Chief Operations Officer Gilbert Salinas, Chief Equity Officer, HS	Rajiv Pramanik, M.D.- CMIO Gabriela Sullivan, M.D.- Specialty/Ambulatory Medical Director Ori Tzvieli, M.D., Public Health Director Sharron Mackey, MHS, Chief Executive Officer CCHP Dennis Hsieh, M.D., Medical Director/Chief Medical Officer CCHP Sergio Urcuyo, M.D.- Hospital Medical Director Sonia Sutherland, M.D.-Medical Director, Detention Health	
NEW BUSINESS		
JCC Nominations – Dr. Porteous/Dr. Goheen Vote Needed	Dr. Moeller	3 min.
Approval of interim ED chair, Dr. Pyra Aarden-vote needed	Dr. Moeller	3 min.
Funds Approval-Vote Needed-Credentialing Education Course for MSO staff $2,495.	Dr. Moeller	3 min.

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CHAIR-KRISTIN MOELLER, M.D.
December 20, 2021
12 to 2:00p

Agenda Topic	Status	Time
Review of Ambulatory Policy 1072 Patient Treatment Management Plan	Dr. Moeller	3 min.
Nominations Open January 1 for the Following: (Term 7/1/2022 - 6/30/2024) **Department Heads:** **ED** **Surgery** **Psychiatry/Psychology** **Diagnostic Imaging** **OB/GYN** **Critical Care** **Division Heads:** **DFAM West County** **DFAM Far East County**		
OLD BUSINESS		
Consent Agenda		
Medication Safety Committee-Dr. Ataii **2021 Q1 ADR report for *medical staff***	See report. Share with department members.	5 min.
PCP&E-Dr. Forman **Nursing Policies-Helena Martey** 400 NURSING: Negative Pressure Wound Therapy: Application, Maintenance 204-A NURSING: Adult- Crash Cart Check Log 310 CCU: Care of the Patient Undergoing Bronchoscopy 2.92 NURSERY: Terbutaline Sulfate Administration 2. 50 L & D: Magnesium Sulfate Therapy: Nursing Care Initiation and 2.50- AProtocol for Administration of Magnesium Sulfate 2.50- B Eclampsia Algorithm 2.50- C Magnesium Sulfate in L&D 3 . 160 NURSING: Urine Specimen Collection	See report. Please ask if you wish to see a specific policy and it will be sent to you.	5 min.
COMMITTEE REPORTS		

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
December 20, 2021
12 to 2:00p

Agenda Topic	Status	Time
Credentials Committee- Dr. Mbanugo List of Candidates - Vote needed	See report	3 min.
Patient Safety and Performance Improvement Committee		3 min.
APC - Dr. Mbanugo 3037 W/7 Attachments on EOC 4200 Appendix 3-Standardized protocols for resource nurses 3037A-Front Entrance 3037B-Registration-waiting areas 3037C-Employee only areas 3037 D-Clinical areas 3037E-Exam Rooms 3037 F Administration Record Keeping checklist 3037 G-Biannual safety inspection EOC correction plan 4029 Total Cast	See report	3 min.
Contra Costa Health Plan-Sharron Mackey	Pending	
DEPARTMENT & DIVISION REPORTS		
DFAM Martinez-Dr. Katzman	Pend to January	5 min.
Pediatrics Department-Dr. Jolton	See report	5 min.
Pathology Department-Dr.Das	Pending	5 min.
Dental Department-Dr. Garcia	See report	
Med Staff Assistance Committee-Dr. Wadle	Pending	5 min.
ADJOURN TO CLOSED SESSION-VOTING MEMBERS ONLY		
Adjournment. Next Meeting Date: January 24, 2021		

CONTRA COSTA REGIONAL MEDICAL CENTER HOSPITAL AND HEALTH CENTERS		AC NURSING POLICY NO:3037-A ADDENDUM A			
FRONT ENTRANCE/LOBBY		KEY= USE #1 FOR YES, NO AND/OR N/A			
#	ITEMS TO INSPECT/REVIEW	COMPLIANT			
		YES	NO	N/A	ACTION
	ENVIRONMENTAL/OTHER				
1	Visit rate schedule is posted and rates are current.				
2	Clinic hours posted are consistent with Ambulatory Care Policy 3034				
3	Patient Rights and Responsibility signs are posted in English and Spanish				
4	"Language Assistance Services" information sheet is posted				
5	Current CCRMC license is posted				
6	Emergency evacuation routes are posted				
7	No smoking signs are present at all patient entrances				
8	"Welcome to Health Center" brochures (English/Spanish)				
9	"Advanced Directives" brochure (Multiple Languages)				
10	"Information about the Interpreter Services" Brochures				
11	Wallet Cards and Speak Up Flyers				
12	Patient comment cards (English/Spanish)				
13	CCRMC & CCHS brochures				
14	If applicable, elevator permit is current				
15	Floors/carpets are clean and in good repair				
16	No hand written signs are taped to walls, signage is professional and clear				
17	Front entrance and lobby area of clinic are clean, organized and clutter free				
18	Signs reminding staff to respect patient's privacy are posted in appropriate areas				
19	Public and TTY phones are available if applicable				
20	"Discrimination Against the Law" is posted				
	INFECTION CONTROL				
21	Trash cans at exterior doors are not overflowing				
22	Drinking fountains are operational and, if applicable, water is cold? Also there is no water around the drinking fountain.				
23	Bathrooms are clean and in good repair				

24	No shared children's' play toys are present in the health center				
		0	0	0	
	PERCENTAGE	#DIV/0!			

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

AC NURSING POLICY NO:3037-B
ADDENDUM B

REGISTRATION/WAITING AREAS		KEY= USE #1 FOR YES, NO AND/OR N/A			
#	ITEMS TO INSPECT/REVIEW	COMPLIANT			
		YES	NO	N/A	ACTION
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				
1	Emergency evacuation routes are posted				
	ELECTRICAL				
2	Waiting areas and other areas where children may frequently be present contain childproof electrical sockets				
3	Walkways are free of clutter/equipment				
4	There are no extension cords in use				
5	All areas have flashlights in working order				
	ENVIRONMENTAL/OTHER				
6	"Welcome to Health Center" brochure (English/Spanish)				
7	Visit rate schedule is posted in registration and rates are current				
8	Medicare/Medi-Cal participation notices posted (English/Spanish)				
9	"Advance Directives" brochure (Multiple languages)				
10	"Information about the Interpreter services" brochure				
11	Wallet cards and Speak Up Flyers				
12	Patient Comment cards (English/Spanish)				
13	CCRMC & CCHS brochures				
14	"Language Assistance Services" information sheet is posted				
15	"Five Steps for Patients to Safer Health Care" flyers (English/Spanish) are posted in waiting areas				
16	ADA (Americans Disabilities Act) notice (English/Spanish) are posted in waiting areas				
17	Prostate & Breast Cancer notices (English/Spanish) are posted				
18	No hand written signs are taped to walls, signage is professional and clear				
19	Floors/Carpets are clean and in good repair				
20	Waiting area furniture is properly placed and torn/broken items removed				

21	Multi-colored "Emergency Action Plan" flipchart is visibly available in all work areas				
22	All staff wearing ID badges				
23	Registration areas have a designated area for proper disposal/pick up of discarded stickers				
24	Computer monitor either have privacy screens or are positioned in a way that patient specific information is not visible to the public				
25	Patient education material display is present in waiting areas				
26	All areas of clinic are clean, organized and clutter free				
27	Bulletin boards are neat and orderly and any posted policies are current				
28	Website address to MSDS icon is on all PCs				
	INFECTION CONTROL				
29	There are no shared children's play toys present in the health center				
30	Drinking fountains are operational				
31	Bathrooms are clean and in good repair				
	TOTAL	0	0	0	
	PERCENTAGE	#DIV/0!			

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

AC NURSING POLICY NO:3037-C
ADDENDUM C

EMPLOYEE ONLY AREAS		KEY= USE #1 FOR YES, NO AND/OR N/A			
		COMPLIANT			
#	ITEMS TO INSPECT/REVIEW	YES	NO	N/A	ACTION
	ELECTRICAL				
1	If emergency exit signs are lighted, lights are working				
2	There are no extension cords in use				
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				
3	Interior hallways have at least 44" clearance and items in the hallway are only on one side				
4	All door stops are removed				
5	Nothing is stored under sink cabinets				
6	Walkways are free of clutter/equipment				
7	Storage areas do not have boxes on the floor or items stored within 18" of a sprinkler head				
8	Fire extinguisher inspection is current and the extinguisher safety seal is intact				
9	Fire extinguisher have clear unobstructed access				
10	The view of all exit signs are not obstructed				
11	Back door entrances not intended for public use are locked from the outside to ensure security of staff-only areas; however, emergency exiting is allowed				
12	Medical gas zone valves are correctly labeled				
13	At bulk O2 storage tanks, there is signage "Oxygen-No Smoking-No Open Flames"				
14	In kitchen, min 16" clearance between grease fryer & surface flames from adjacent equipment				
15	Signage in kitchen for Emergency Natural Gas Valve shutdown in place				
16	Kitchen Only. Ventilation baffles are properly placed without surrounding gaps.				
	ENVIRONMENT/OTHER				
17	Employee posting included in the Annual Labor Law posters:				

	Safety				
	* Workers' Compensation Notice to Employees (AK-230)				
	*CAL OSHA Safety and Health on the Job				
	*Emergency poster				
	*Emergency action plan				
	Personnel				
	*Drug Free Workplace				
	*Harassment prevention				
	*Unemployment insurance/disability notification				
	Affirmative Action				
	*EEOC Discrimination (DFEH-162)				
	*American Disability Act				
18	Emergency evacuation routes are posted				
19	Multi-colored "Emergency Action Plan" flip chart visibly available in all work areas				
20	Freestanding shelves and cabinets are secured to walls				
21	Floors/Carpets are clean and in good repair.				
22	All areas of clinic are clean, organized, and clutter free				
23	No hand written signs are taped to walls, signage is professional and clear				
24	Shelving has a "lip" to prevent spillage during an earthquake (for applicable storage materials)				
	INFECTION CONTROL				
25	Supplies of toilet paper and paper towels are not stored in "dirty" housekeeping closet				
26	Drinking fountains are operational and in good repair.				
27	Bathroom are clean and in good repair				
	TOTAL	0	0	0	
	PERCENTAGE	#DIV/0!			

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

AC NURSING POLICY NO:3037-D
ADDENDUM D

CLINICAL AREAS		KEY= USE #1 FOR YES, NO AND/OR N/A			
		COMPLIANT			
#	ITEMS TO INSPECT/REVIEW	YES	NO	N/A	ACTION
	CHEMICAL/STORAGE AREAS				
1	Biological/medical waste is disposed in appropriate biohazard container				
2	Biomedical waste posters are displayed in appropriate areas				
3	Contaminated trash is disposed of properly				
4	Sharp containers in suites/nursing areas are not past the "full" line				
5	Locked biohazard storage areas contain only biohazard material				
6	O2 tanks and liquid nitrogen tanks are secure				
7	All secondary containers are properly labeled				
8	Emergency Eyewash/Shower maintenance tag is present and weekly maintenance complete (if applicable)				
9	Emergency Eyewash/Shower is unobstructed (if applicable)				
10	No more than 12 full compressed gas cylinders stored in an oxygen storage space				
11	Compressed gas E cylinders stored in secured, upright position				
12	Oxygen storage rooms caution signage posted in locations where 12 or more oxygen tanks.				
13	Compressed gas H cylinders double strapped/chained with protective caps in place				
14	Proper personal protective equipment is available.				
15	EVS/Mechanical/Electrical/Telecom/Data closets are clean and free of clutter.				
16	No ladders blocking electrical panels. Ladders hung on wall out of the way.				
17	Biohazard/Sharps/Pharmecutical waste containers not more than 3/4 full (not above fill line)				
18	Clean and dirty equipment and supplies are stored separately				
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				

19	Emergency Exits: egress unobstructed & doors unlocked				
20	Exits Clearly marked with illuminated signs				
21	Emergency lighting provided for all occupied areas and tested monthly and annually.				
22	All doors in exit path kept closed				
23	Lighting is functioning properly (e.g. no lights missing, broken, burnt out)				
24	Handrails provided on all stairs are secure.				
25	Fire sprinkler escutcheons securely in place and flush with ceiling				
26	Fire sprinkler heads clean, without dust, debris				
27	Smoke detectors flush with ceiling and in good repair				
28	Fire extinguisher maintenance tag is in date for both monthly, annual, and safety seal is intact.				
29	Fire doors are self closing and latching				
30	Roll down fire doors unobstructed				
31	Interior hallways have at least 44" clearance and items in the hallway are only on one side				
32	Emergency evacuation plans/routes are posted				
33	The view of all exit signs is not obstructed				
34	If emergency exit signs are lighted, lights are working				
35	Fire extinguishers have clear unobstructed access				
36	Storage areas do not have boxes on the floor or items stored within 18" of a sprinkler head				
37	Back door entrances not intended for public use are locked from the outside to ensure security of staff-only areas; however, emergency exiting is allowed				
38	Medical gas zone valves are correctly labeled				
39	At bulk O2 storage tanks, there is signage "Oxygen-No Smoking-No Open Flames"				
40	In kitchen, min 16" clearance between grease fryer & surface flames from adjacent equipment				
41	Signage in kitchen for Emergency Natural Gas Valve shutdown in place				
42	Kitchen Only. Ventilation baffles are properly placed without surrounding gaps.				

	ELECTRICAL				
43	All electrical cords are in good condition				
44	Extension cords are not used in lieu of permanetly installed fixed wiring				
45	Extension cords are not connected to patient care equipment				
46	No daisy chaining of electrical cords				
47	Cover plates, switches, outlets, etc are in good condition				
48	Electrical panel boxes unobstructed, closed and accessibility is not blocked (36" clear)				
49	Power strips used with patient care equipment are hospital grade and in good repair				
50	Patient care equpiment is grounded with a hospital grade power cord or double insulated				
51	Patient care equipmnet is in good repair, no cracking, loose hardware and fittings, not soiled				
52	Gas & Control panels have a minimum 36" of unobstructed work space in front and are closed				
53	All areas have flashlights in working order				
	ENVIRONMENTAL/OTHER				
54	All floors are clear of debris and dry				
55	Shelves and racks are of adequate strength and are secured				
56	All walk off mats are in good condition				
57	Wet Floor signs used properly				
58	Inventoried patient care equipment has BEC tags and preventative maintenance is current				
59	Ceiling tiles are in good condition (e.g. not broken or stained)				
60	No holes or penetrations in walls/ceilings/floors				
61	No cardboard stored in patient care areas				
62	Solid bottom shelf on linen storage carts				
63	No tape, tape residue on patient care equipment				
64	Under sink areas clean, no leaks, in good repair. No under sink storage (check inside)				
65	No broken door or counter laminate, flooring. Surfaces are intact and are non porous				

66	Clean linen carts covered				
67	Ceiling/wall registers clean and in good repair				
68	No broken guardrail corners				
69	No sharp edges				
70	No bump hazards				
71	No falling hazards				
72	All telephones in clinic suites contain current California Poison control stickers with phone number (To order, call 1 800 582 3387)				
73	Bulletin boards in nursing suites are neat and orderly and any posted policies are current				
74	Multi-colored "Emergency Action Plan" flip chart visibly available in all work areas				
75	Website address to MSDS on line is visibly available to all staff at all PCs				
76	Code yellow report are available at all workstations				
77	All staff are wearing ID badges				
78	Protected Health Information is properly disposed in containers labeled "SHRED".				
79	Computer monitors either have privacy screens or are positioned in a way that patient specific information is not visible to the public				
80	Copies of licenses of Laboratory staff and Diagnostic Imaging staff are posted and are current (if applicable)				
81	All door stops are removed				
82	All areas of clinic are clean, organized and clutter free				
83	No hand written signs are taped to walls, signage is professional and clear.				
84	Floors are clean and in good repair				
85	Freestanding shelves and cabinets are secured to wall				
86	Shelving has a "lip" to prevent spillage during an earthquake (for applicable storage materials)				
87	In dental areas, exposure plan is available				
88	Triplicate paper secured (as needed) in locking paper trays and locked filing cabinets.				
89	Protected Health Information are secured always				

90	Medical equipment which is included in Biomed's preventive maintenance schedule has a Biomed tag not more than 1 year old Examples: ____Infant Scales ____Digital Adult Scales ____Audiometers ____Tympanometry ____EKG Machines ____Centrifuge ____Steris machine ____Colposcopes ____ AED ____HEPA Filters ___Electric Exam Tables _____Jaundice Meters ____Lift System ____Microscopes _____Sterilizers ____Suction Pump _____Freezers _____Refrigerators ____Vital Sign Monitors				
	INFECTION CONTROL				
91	Environmental surfaces are cleaned with an EPA-approved disinfectant that is clearly labeled.				
92	Dirty linen if present is closed/covered				
93	Equipment is clean and no tape residue				
94	Storage area is dust-free and dry				
95	Food, meds and specimens are not stored together anywhere				
96	If specimens are collected they have a biohazard label, and are stored appropriately				
97	Refrigerator/freezer temps are recorded daily and action is taken for an out-of-range of temps (meds 36-46F, food 32-40F, freezers <32F)				
98	No under sink-storage				
99	If sterile items are present, wrapping on sterile items is intact				
100	PPE is available near the point-of-care/SPD/entry to areas				
101	Sharps disposal containers are readily available in clinical areas & not overfull				
102	Specimens are properly contained and labeled				
103	Biohazards are labeled with the universal biohazard symbol and/or color (red/orange)				
104	Red bag waste is covered				
105	Specimen transport containers are sturdy and covered				
106	Food and drink are not present in areas where clinical specimens are handled/stored				
107	Supplies are available to foster good hand hygiene practices				

108	No outdated meds. Multi-use items are dated when opened. Multi-use vials expire 28 days after opening or on expiration date (whichever comes first)				
109	Any open solution bottles are dated and timed. Expire 24hr after opening if there is not preservative. (Except one-time use)				
110	Exam tables are cleaned or disposable paper covers are changed between each pt. Surfaces are disinfected when the paper is torn, wet, or visibly soiled.				
111	Disposable thermometer sheaths are used once and then discarded.				
112	Supplies for drawing blood are organized and tubes are within labeled "use by" dates				
113	Sterilizers are clean and free of build up.				
114	Sterilizers logs (Sterilizer cleaning, Biologic resuls, Validation testing) up to date				
115	Staff is appropriately dressed				
116	Temperature and Humidity Parameters within accepatable limits.				
117	Vents clean and dust free				
118	Medication refrigerators contain only medications or lab reagents (stored in sealed container)				
119	No food or specimens are present				
120	Medication refrigerators are locked and in a secured area.				
121	Personal Protective Equipment (e.g. gloves, goggles, masks, etc.) are readily available and staff are aware of location)				
122	Surgical instruments are not stored in examination rooms				
123	All syringes and medications are secured.				
124	No drug samples are present in clinic area				
125	Formalin is not present in exam rooms				
126	No shared children's' play toys are present in the health center				
127	OT/PT areas have temperature check logs for equipment which requires temperature checks (i.e. paraffin, baths, hydrocollator, if applicable)				
128	All items that have NDC numbers are stored in humidity/temperature controlled environments.				
		0	0	0	
	PERCENTAGE	#DIV/0!			

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

AC NURSING POLICY NO:3037-E
ADDENDUM E

EXAM ROOMS		KEY= USE #1 FOR YES, NO AND/OR N/A			
#	ITEMS TO INSPECT/REVIEW	COMPLIANT			
		YES	NO	N/A	ACTION
	CHEMICALS/STORAGE AREAS				
1	Contaminated trash is disposed of properly in Red Biohazard containers				
2	Biohazard/Sharps/Pharmaceutical waste containers not more than 3/4 full (not above fill line)				
3	Biohazards containers are labeled with the universal biohazard symbol and/or color (red/orange)				
	ENVIRONMENTAL/OTHER				
4	Patient Health Information is always secured.				
5	Exam tables and chairs are in good repair				
6	Regular trash is properly labeled				
7	Nothing is stored under sink cabinets				
8	Shelving has a "lip" to prevent spillage during an earthquake (for applicable storage materials, if applicable)				
9	Floors are clean and in good repair				
	INFECTION CONTROL				
10	There are no outdated drugs, culture tubes, blood tubes, Fit Kits, KY Jelly, KOH, NS, sterile equipment, etc. (Remember every drawer and cabinet may be				
11	All opened multi-dose injectables are dated and signed when opened; Expiration date is current and not more than 28 days after date of open except for vaccines, follow manufacture dates.				
12	Topical, Oral, and injectables and lab reagents are separated				
13	Personal Protective Equipment (e.g. gloves, goggles, masks, etc.) are readily available and staff is aware of location.				
14	Surgical instruments are not stored in examination rooms.				
15	All syringes and medications are in a secured area at all times.				
16	No drug samples present in the clinic area				
17	Formalin is not present in exam rooms				
18	Dirty linen hampers are closed/covered (if applicable)				

TOTAL	0	0		
PERCENTAGES	#DIV/0!			

CONTRA COSTA REGIONAL MEDICAL CENTER HOSPITAL AND HEALTH CENTERS		AC NURSING POLICY NO:3037-F ADDENDUM F			
ADMINISTRATION RECORD KEEPING CHECKLIST		**KEY= USE #1 FOR YES, NO AND/OR N/A**			
		COMPLIANT			
#	ITEMS TO INSPECT/REVIEW	YES	NO	N/A	ACTION
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				
1	Documentation of quarterly fire drills is complete				
2	Documentation of safety inspections every six months is complete				
3	Last fire inspection was within last 12 months and certificate is readily available				
4	Signage in kitchen for Emergency Natural Gas Valve shutdown in place				
	ENVIRONMENTAL/OTHER				
5	Ensure CCRMC license is posted and current (if applicable)				
6	Ensure Clinical and Public Health Laboratory registration and CLIA License is posted and current				
7	Ensure Hazardous Materials Permit to Operate is posted and current (if applicable)				
8	Ensure Enviornmental Permit to Operate is posted and current (if applicable)				
9	Ensure individual Lab licenses (copy okay) are posted for Laboratory draw stations and units (if applicable)				
10	A copy of Hospital & Health Center Policy & Procedure Manuals are present				
11	A copy of Ambulatory Care Policy & Procedure Manual is present				
12	A copy of CCHP Provider Manual is present				
13	A copy of Infection Control Manual is present				
14	MSDS binder is present and current				
15	Point of Care Procedure Manual is present				
16	After hours messages on main phone line to health center is working and accurate				
17	All health centers have staff complete asbestos notification form and it is available and organized in Personnel records (if applicable)				
18	Personnel Files (including those for contract and temporary employees are complete with):				

	*Current Licensure, if applicable				
	*Job Description				
	*Orientation documentation				
	*Competency assessment				
	Ongoing training and education, including				
	*SICR				
	*Harassment Prevention/Discrimination				
	*HIPPA				
	*Workplace Violence				
	*Professional Development Transcript				
19	Sterile Processing Department procedure is available online				
20	Signature sheets in manual current (updated every 3 years)				
	TOTAL	0	0	0	
	PERCENTAGES	#DIV/0!			

BI-ANNUAL SAFETY INSPECTION - EOC - CORRECTION PLAN

AC NURSING POLICY NO.: 3037-G

Department Manager is usually considered the person responsible for follow up **ADDENDUM G**

Include Door Numbers, work order numbers or specific location as appropriate

	PROBLEM AREA	DISCREPANCY / EXPLANATION FOR QUESTIONS ANSWERED "NO"	CORRECTIVE ACTION	TARGET DATE	DATE COMPLETED	PERSON RESPONSIBLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
	PROBLEM AREA	**DISCREPANCY / EXPLANATION FOR QUESTIONS ANSWERED "NO"**	**CORRECTIVE ACTION**	**TARGET DATE**	**DATE COMPLETED**	**PERSON RESPONSIBLE**
16						
17						
18						
19						

20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						

APPENDIX 3

STANDARDIZED PROTOCOLS FOR THE RESOURCE NURSE

I. The following are Standing orders for the treatment of the below infective diseases and or consultation to provide timely care of these patients. Consultation with a provider is available if needed for any reason.

A. CANDIDIASIS, VULVOVAGINAL:

1. Setting

a. Positive finding of Candida on Potassium Hydroxide (KOH) prep and patient reporting symptoms consistent with symptomatic Candida infection (vaginal discharge, vaginal or vulvar itching or discomfort or dysuria), OR

b. Antibiotics within the last 7days and symptoms consistent with candidiasis.

2. Recommended Treatment:

a. short course (1-7 days) of topical OTC formulations of Clotrimazole OR

b. Miconazole 2% vaginal cream, one applicator per vagina at bedtime for 7days OR

c. Clotrimazole 1% vaginal cream, one applicator per vagina at bedtime for 7 days OR

d. Fluconazole 150 mg oral tablet – single dose (non-pregnant.)

Pregnant or possibly pregnant (delayed period, not using contraception)

a. Clotrimazole 1% PV X7 Days or Miconazole 2% PV `x 7 days and avoid fluconazole.

3. Precaution: Allergies to medicine

4. Partner Treatment- Not indicated.

5. Education

a. Educate that this is not considered a sexually transmitted disease.

b. Educate that risk factors are antibiotics, diabetes, pregnancy and weakened immune system, use of douches or intravaginal agents that change the normal vaginal environment.

c. Treatment creams may weaken latex condoms and diaphragm (check product labeling.)

7. Follow-up – Routine follow-up not indicated unless symptoms persist.

8. Consultation

a. Consult with physician if treatment failure or contraindications to recommended treatments.

b. More than 3 documented episodes in past year (may need evaluation for other risk factors for recurrent infection.)

c. Children under 12 years old.

B. CHLAMYDIA

1. Setting:

Positive finding of Chlamydia on Nucleic Acid Amplication Testing (NAAT) testing of urine or genital/rectal/pharyngeal swab; or positive culture of any site.

See # 8 for patients to seek consultation prior to treating.

2. Recommended Regimen in Pregnancy and in patients who might be Pregnant (delayed menses or not on Birth Control Pills.

a. Azithromycin 1 gram orally as single dose.
b. Alternate Regimen: Amoxicillin 500mg orally 3 times/day for 7days.

3. Recommended Treatment for Adolescents, Adults and Partner Treatment if not Pregnant.

a. Doxycycline 100mg orally 2 times/day for 7days
b. Alternate Regimens (if intolerant or allergic):
a. Azithromycin 1g orally in a single dose OR
b. Levofloxacin 500mg orally once daily for 7days

4. Reinforce education at time of visit.
a. If prescribing a 7-day course of antibiotics, the prescription must be e prescribed to patient's pharmacy and patient will self-administer at home.
b. Alternate treatment option for those who do not have insurance, transportation, or any issue that prevents a patient from coming into the clinic, then the prescription will be e-prescribed, and education will be provided over the phone.

5. Precautions: Allergies to medicine.

6. Expedited Partner Treatment (EPT)
a. **First-choice partner management strategy:** Attempt to bring partners in for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic or Women's Health Clinic.
b. Those with partners who patient indicates are unable or unlikely to seek timely clinical services, can be given a prescription and educational material for the patient delivered partner therapy.
c. The Resource Nurse can "e prescribe" a prescription for patient and partner (all sexual partners) – see above Recommended Regimen in Pregnancy/Patients who might be Pregnant) and Recommended Treatment for Adolescents, Adults and Partner Treatment if not Pregnant.
d. The instructions should read "for the treatment of patient and partner".
Partner definition: Limited to the number of known sex partners regardless of presence of symptoms in previous 60 days (or most recent sex partner if none in the previous 60 days).

7. Education
a. Recommend abstinence until 7 days after partner and patient treated.
b. Discuss safe sex practices; encourage testing for other STDs including HIV not already done.
c. Patient should notify all partners in the last 60 days.
d. Instructions should include clear instructions, warnings, and clinic referrals should be provided.
e. If e-prescribing partner therapy, educational materials with clinic referral information directed to the partners should be given to patient to accompany patient-delivered partner therapy. (see attached appendices od sample materials).
f. Patients with a diagnosis of chlamydia should be tested for HIV, Gonorrhea and Syphilis.
g. MSM who are HIV Negative with a rectal chlamydia diagnosis should be offered HIV PrEP.

2. Follow-up
   a. Recommend patient schedule an appointment: STD Clinic, Women's Health Clinic (if female), or in any other family medicine or short notice clinic. Follow-up is recommended to re-test patient and to discuss safe sex education, and testing for other STDs.
   b. Follow-up testing is recommended 3-5 weeks after completion of treatment for pregnant women. All others follow-up testing recommended at 3-4 months after treatment.

3. Consultation
   a. Consult physician of treatment failure or contraindications to recommended and alternative treatments.
   b. Symptoms suggestive of Pelvic Inflammatory Disease (abdominal pain, fever, etc.).
   c. Symptoms of epididymitis or prostatitis (abdominal pain, fever, scrotal pain or swelling).
   d. Post-partum woman (infant may need treatment.)
   e. Children under 12 years old.
4. CMR reporting: Chlamydia is a reportable disease. Complete CMR form.

C. **GONORRHEA**

1. Setting
   Positive finding of uncomplicated gonorrhea on NAAT testing of urine, or pharynx/genital/rectal/swab; positive culture of any site.
2. Recommended Treatment
   For patients weighing 150kg or less: Ceftriaxone 500mg IM X 1
   For patients weighing 150kg or more: Ceftriaxone 1g IM
   If Chlamydia has not been excluded, treat for Chlamydia with Doxycycline 100mg orally 2 times /day for 7days (non-pregnant.) In Pregnancy and in patients who might be Pregnant (delayed menses or not on Birth Control Pills): Azithromycin 1 gram orally as single dose.

   Alternate Regimen in Pregnancy and in patients who might be Pregnant (delayed menses or not on Birth Control Pills): Amoxicillin 500mg orally 3 times/day for 7days.

   Alternate Treatment (If patient is allergic or unable to use Cephalosporin):

   a. **Cefixime 800mg orally (single dose) PLUS Doxycycline 100mg 2 times/day for 7days OR** If patient is allergic or unable to use cephalosporin but can come to the clinic for a one-time treatment-

   b. Gentamycin 240mg IM as a single dose plus Azithromycin 2g orally as a single dose.

   c. For pregnant patients and in patients who might be Pregnant (delayed menses or not on Birth Control Pill): - If allergic to cephalosporin, contact GYN On Call to discuss treatment option: Gentamycin vs Desensitization.

3. **Precautions**

Allergies to medicine including anaphylaxis to penicillin's or cephalosporins.

4. Expedited Partner Treatment (EPT)

a. **First-choice partner management strategy:** Attempt to bring partners in for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic.

b. Those with partners who patient indicates are unable or unlikely to seek timely patient delivered partner therapy

c. The Resource Nurse can e-prescribe a prescription for non-pregnant patients and all non-pregnant sexual partners for: **800mg Cefixime** (single dose) PLUS **Doxycycline 100mg 2 times/day for 7 days.** The instructions for both medications should read "for the treatment of patient and partner(s)". If partner is pregnant, they should consult their Prenatal Provider.

d. Partner definition: Limited to the number of known sex partners in previous 60 days (or most recent sex partner if none in the previous 60 days).

e. If e-prescribing partner therapy- education materials with clinic referral information directed to the partners should be given to patient to accompany patient-delivered partner therapy (see attached appendices of sample materials)

5. Education

a. Recommend abstinence until 7 days after initiation partner and patient treatment.

b. Discuss safe sex practices; encourage testing for other STDs including HIV if not already done.

c. Instructions should include clear instructions, warnings, and clinic referrals should be provided.

d. Patients with a diagnosis of gonorrhea should be tested for HIV, chlamydia and Syphilis.

e. MSM who are HIV Negative with a rectal gonorrhea diagnosis should be offered HIV PrEP.

6**. Follow-up**

a. Recommend patient schedule an appointment with PCP or, in STD Clinic, or in Women's Health Clinic (if female) or in any other Family Medicine or Short Notice Clinic. Follow up is recommended to discuss partner notification, safe sex education, and testing for other STDs.

b. Test of cure is unnecessary for persons with uncomplicated urogenital or rectal gonorrhea who are treated with any of the recommended or alternative treatment.

Retest all persons who have been treated for gonorrhea 3 months after treatment.

If retesting at 3months is not possible, retest within 12months after initial treatment.

Follow up testing in 3-5 weeks after completing treatment for pregnant women.

7. **Consultation**

a. Consult with physician if treatment failure or contraindications to recommended and alternative treatments.

b. Symptoms suggestive of Pelvic Inflammatory Disease (abdominal pain, fever, etc.).

c. Symptoms suggestive of epididymitis or prostatitis (abdominal pain, fever, scrotal pain or swelling.)
d. Post-partum woman (Infant may need treatment.)
e. Children under 12 years old.

8. CMR reporting: Gonorrhea is a reportable disease. Complete CMR form.

D. **STREPTOCOCCAL THROAT INFECTION**

1. **Setting**
Positive throat culture showing Group A Streptococcus

2. **Recommended Treatment**
a. Children less than 1yr old, consult PCP or on call Pediatrician.
b. Children over 1yo: **Amoxicillin 50mg/kg/day** as a single dose for 10d. Max daily dose **1000mg/day**
c. Adults over 27 kg: **Pen VK 500 mg TID** for 10 days or
Amoxicillin 500mg PO BID for 10d or
Penicillin G Benzathine (Bacilli L-A): 1.2million units IM as a single dose

3. **Alternative Treatments (if allergic to penicillin~~)~~**
a. Children less than one year: consult with a provider
b. Children more than one year: **Azithromycin 12mg/kg** (maximum 500 mg/dose) on day 1, followed by 6mg/kg (maximum 250mg/dose) on days 2-10. Given as a single daily dose for 10 days.
c. Adults: **Azithromycin 500 mg** on day 1, then 250 mg daily, day 2 through day 5 OR **Clindamycin 300mg po TID** for 10d

4. **Precautions**
Allergies to medicine

5. **Education**
a. Encourage generous fluid intake
b. Use warm saltwater gargles PRN
c. Complete all 10 days of medication, even if feeling better, to prevent rheumatic fever complications.
d. Infection Control: wash hands, don't share food or drinks, no kissing, discard present toothbrush to decrease risk of re-infection.

6. **Follow-up**
Seek care if symptoms persist, unable to keep down fluids or medications, any trouble breathing.

7. **Consultation with physician if:**
a. Severe symptoms or fever over 101 degrees F
b. Severe dysphasia or any dyspnea
c. Children under 2 years old.
d. If treatment failure or contraindications to recommended and alternative treatments.

E. **TRICHOMONAS**

1. Setting
   Positive finding of trichomonas on antigen test, wet prep, pap smear or urinalysis in non-pregnant patients only.

3. **Recommended Treatment**
   For Females: Metronidazole 500 mg orally twice a day for 7 days
   For Males: Metronidazole 2g orally single dose.
4. Precautions
   a. Allergies to medicine

5. Partner Treatment
   a. **First-choice partner management strategy:** Attempt to bring partners in for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic.
   b. Those with partners who are unable or unlikely to seek timely clinical services, the Resource Nurse can e-prescribe a prescription for patient and all partners regardless of symptoms:
   The instructions should read "For the treatment of patient and partner".
   c. Partner definition: Limited to the number of known sex partners in previous 60 days (or most recent sex partner if none in the previous 60 days).
   d. If e-prescribing partner therapy- educational materials with clinic referral information directed to the partners should be given to patient to accompany patient-delivered partner therapy (see attached appendices of sample materials).
6. Education
   a. Recommended abstinence for 7 days post treatment of patient and partner.
   b. Discuss safe sex practices; encourage testing for other STDs including HIV if not already done.
   c. Instructions should include clear instructions, warnings, and clinic referrals should be provided.

7. Follow-up
   Recommend patient make appointment with PCP, Women's Clinic, or STD Clinic for follow-up.

8. Consultation
   a. Consult with provider if treatment failure or contraindications to recommended.
   b. Children under 12.

F. **URINARY TRACT INFECTION**

Treatment for **uncomplicated** patients with symptoms of UTI such as pain and burning with urination, frequency, urgency, and /or suprapubic pain. Antibiotic therapy can generally be administered empirically without obtaining a urine culture.

Complicated patients defined as but not limited to:
Chronic renal disease

Diabetes Mellitus

Immunodeficiency (HIV+, patient's currently receiving chemotherapy or biotherapy, long term prednisone, organ transplant patient)

Fever, flank pain, nausea and vomiting present

Recent UTI (within 6 months)

Urologic abnormalities

12 years and under

Patients being followed by anticoagulation clinic

Males of all ages

1. Setting: For Non-Pregnant Women

a. Urine culture with >100,000 cfu/ml with or without signs or symptoms of lower urinary tract infection:

b. Urine cultures 50,000 – 100,000 cfu/ml with symptoms of lower urinary tract infection:

i) **Recommended Treatment:**
-Macrobid 100mg orally twice a day for 5days or
-**Bactrim DS** 160/800mg 1 PO BID for 3 days or
-Fosfomycin 3g orally single dose

IF THERE ARE REASONS TO AVOID THE RECOMMENDED TREATMENT ABOVE:

ii) **Choose a Beta-Lactam:**

- Cephalexin 250mg to 500mg orally tid for 5 to 7days or
-Amoxicillin-clavulanate 500mg orally bid for 5 to 7days or
-Cefpodoxime 100mg orally bid for 5 to 7days or
-Cefdinir 300mg orally bid d for 5 to 7days or
-Cefadroxil 500mg orally bid for 5 to 7days

IF THERE ARE REASONS TO AVOID THE RECOMMENDED TREATMENT AND ALSO THERE ARE REASONS TO AVOID A BETA-LACTAM:

iii) **Choose a Fluoroquinolone:**

-Ciprofloxacin 250 mg orally twice daily for 3 days
- Ciprofloxacin extended release 500 mg orally daily for 3days
- Levofloxacin 250 mg orally daily for 3 days.

IF THERE ARE REASONS TO AVOID THE RECOMMENDED TREATMENT AND

ALSO, REASONS TO AVOID A BETA-LACTAM AND A FLUOROQUINOLONE:

iv) -Obtain a Urine Culture and susceptibility testing; select antibiotics based on those results.

c. **For Group B Strep urine cultures:** Patients with urinary tract symptoms, pyuria, and urine culture positive for GBS (≥100,000 CFU/mL), with a non-contaminated specimen, patients should receive antimicrobial therapy as outlined below.

i) **Amoxicillin 500mg po tid** x 7 days or
ii) Beta-Lactam Drugs Listed on B(ii)
ii) **If allergies preclude, consult with a provider.**

Alternative Treatment for Pregnant females: Clindamycin is the only oral alternative (if the GBS isolate is susceptible), for those determined to have severe IgE-mediated hypersensitivity to penicillin and beta-lactams.

d. Urine culture<100,000 cfu/ml with no symptoms of lower urinary tract infection: Consult with a provider on all groups.

2. Setting for Pregnant Women:
   a. Treat if Urine culture with >100,000 cfu/ml: Antibiotics for asymptomatic bacteriuria in Pregnancy **should be held until c/s result is available,**
   b. **If** symptomatic treat without waiting for sensitivity result.

   c. Recommended Treatment for 5days -Choose one based on the sensitivities

   -Cephalexin (Keflex) 500mg tid—preferred if sensitivities not yet available
   -**Amoxicillin 500mg orally tid or**
   - amoxicillin 875 mg bid
   - Cefpodoxime 100mg bid

   - Nitrofurantoin (Macrobid): 100mg bid (avoid in first trimester and term after 38weeks if other options available)

b. If not sensitive to any of the above or allergies preclude use consult with a provider.
In the setting of a positive urine culture during pregnancy, the resource nurse consults the ordering provider, the PCP and the on-call OB/GYN (in that order) for any consultations and concerns.

3. Precautions
Allergies to medicine

4. Education
   a. Encourage generous fluid intake
   b. To reduce risk of infection patient should: urinate after sexual intercourse and wipe front to back after using restroom.

5. Follow-up
Seek care if symptoms persist, unable to keep down fluids or medications

6. Consultation
   a. All complicated patients as designated above.
   b. Available culture sensitivities show resistance to recommended and alternative treatments.
   c. Consult with physician if treatment failure or contraindications to recommended and alternative treatments

Revised by Ogo Mbanugo, MD – APC Chair.

APPROVED BY:
Ambulatory Policy Committee: 5/2019
Medical Executive Committee: 5/2019
Revised and Approved by APC:1/2021
Revised and Approved by APC: 11/2021
MEC 1/2021, 12/2021

CAST: TOTAL CONTACT

I. PURPOSE:

To provide guidelines for protecting the skin on the foot and alleviating pressure to affected area(s) when the cast is applied.

II. REFERENCE:

Available online at http://www.podiatrytoday.com/article/1853.

TJC 2016 Standard PC.02.01.05, "The hospital provides interdisciplinary, collaborative care, treatment and services."

III. POLICY:

Verify correct patient using two identifiers and perform a time-out with the patient to identify correct cast for site.

- Cast is applied by Ortho-tech per provider order.
- Serial casting is performed for 3-6 weeks.
- Provider evaluates the progression of healing prior to each re-application.

IV. AUTHORITY/RESPONSIBILITY:

Ortho-Tech

V. PROCEDURE:

A. Assemble equipment:
   1. Webril
   2. Stockinet
   3. Felt
   4. Fiberglass casting material
   5. Fiberglass reinforcement splint
   6. Rubber cast heel and ¼ "plywood sole or cast shoe
   7. Reston (sticky back sponge)

B. Applying cast:
   1. Place patient in sitting position with ankle at $90^{0.}$
   2. Put cotton or gauze between toes.
   3. Apply 4x4 over ulcer.
   4. Apply stockinet.
   5. Twist area so toes are not exposed yet not tightly over the toes.
   6. Apply felt pad over malleoli and up and down tibial crest (to protect bony prominent areas).
   7. Trim Reston and cover toes.
   8. Fold Reston in half so toes are not exposed.
   9. Trim Reston around first and fifth metatarsal.

10. Apply Webril sparingly.
11. Apply 3" or 4" fiberglass roll and mold well.
12. Apply reinforcement splints (if needed).
13. Apply plywood sole with additional plaster where necessary.
14. Apply rubber walking cast heel or cast shoe.

Note: Remember to keep the ankle at 90^0. ***THIS IS CRITICAL FOR AMBULATION AND TO PREVENT EQUINUS CONTRACTURE.***

C. Patient teaching:
   1. Review with patient "Cast Care" handout

D. Document in ccLink record:
   1. Placement of cast
   2. How patient tolerated procedure
   3. Instructions provided

VI. DOCUMENTATION:

Cast Care handout

REVIEWED BY :
ACPC :9/2008

REVISED BY:
ACPC: 2/2012, 2/2016

APPROVED BY:
Ambulatory Policy Committee: 5/2012
ACPC: 9/2021
APC:10/2021
MEC:12/2021

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
January 24, 2021
12 to 2:00p

As the elected leadership of the CCRMC/HCs Medical Staff, we stand against racism and hate. *We recognize the negative impact of longstanding structural racism on health, and we commit to take action to combat this in our own system and work for health equity for our patients.*

Join Zoom Meeting
https://cchealth.zoom.us/j/8544948118
Meeting ID: 854 494 8118
****If you are on phone only for the Zoom, use *6 to mute/unmute**

Agenda Topic	Status	Time
Call to Order		
Review of December 20, 2021 Minutes	See attached Draft Minutes.	2 min.
Announcements (3 min)		
• **February 28, 2022 MEC meeting reports to Sue by February 10, 2021** ○ Administrative Affairs Committee-Drs. Robello and Tyrrel ○ DFAM-West County-Dr. Sheldon ○ Medical Staff Assistance Committee ○ Surgery Department-Dr. Dosanjh Please use the standard SBAR form for your reports -You will be given 5 minutes in which to present your report. Please number the pages of your report. **PLEASE DATE YOUR REPORT AND NUMBER THE PAGES. Please include your executive summary which can be added to the minutes.** **Next meeting February 28, 2022**		
ADMINISTRATIVE REPORTS		
Anna Roth, Health Services Director Ori Tzvieli, Acting Health Officer Pat Godley, CFO for Health Services Jaspreet Benepal, RN, Chief Nursing Officer Samir Shah, M.D., Chief Executive Officer/Chief Medical Officer Vacant - Chief Quality Officer David Runt - Chief Operations Officer Gilbert Salinas, Chief Equity Officer, HS	Rajiv Pramanik, M.D.- CMIO Gabriela Sullivan, M.D.- Specialty/Ambulatory Medical Director Ori Tzvieli, M.D., Public Health Director Sharron Mackey, MHS, Chief Executive Officer CCHP Dennis Hsieh, M.D., Medical Director/Chief Medical Officer CCHPS Sergio Urcuyo, M.D.- Hospital Medical Director Sonia Sutherland, M.D.-Medical Director, Detention Health	
NEW BUSINESS		

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA
CHAIR-KRISTIN MOELLER, M.D.
January 24, 2021
12 to 2:00p

Agenda Topic	Status	Time
Dr. Jenny Guss as Interim Psychiatry Department Head - vote needed	Dr. Moeller	3 min.
APC Chair-Dr. Irina Pyrkova-Vote Needed	Dr. Moeller	3 min.
Updates from Acting Health Officer-Dr. Ori Tzvieli-Dr. Chris Farnitano has retired.	Dr. Moeller	3 min.
Nominations Open January 1 for the Following: (Term 7/1/2022 - 6/30/2024) **Nominations due on March 1, 2022** **Department Heads:** ED Surgery Psychiatry/Psychology Diagnostic Imaging OB/GYN Critical Care **Division Heads:** DFAM West County DFAM Far East County	Dr. Moeller	5 min.
OLD BUSINESS		
2022 Draft MS Bylaws – approved by county counsel with minor grammar changes only	AAC – information only	3 min.
Consent Agenda		
Medication Safety Committee-Dr. Ataii	See report.	5 min.
PCP&E-Dr. Forman **Infection Control-Kathy Ferris** 1072 Patient Treatment Management Plan **Nursing Policies-Helena Martey** 106 ED Nursing: Report of injuries to Local Law Enforcement Agencies 102 ED Nursing: Report of Injuries to Local Law Enforcement Agencies 320 CCU Nursing: Cardioversion (Synchronized Countershock) 351 CCU Nursing: Post Anesthesia Care	See report. Please ask if you wish to see a specific policy and it will be sent to you.	5 min.

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA
CHAIR-KRISTIN MOELLER, M.D.
January 24, 2021
12 to 2:00p

Agenda Topic	Status	Time
807 CCU Nursing: Fecal management System (FMS) 1421-A CCU/ IMCU Nursing: Set up & Planned Actions 514 Nursing Psych: Involuntary Admission Conservatorship and Temporary Conservatorship		
COMMITTEE REPORTS		
Credentials Committee- Dr. Mbanugo List of Candidates - Vote needed	See report	3 min.
Patient Safety and Performance Improvement Committee	Dr. Beach	3 min.
APC - Dr. Mbanugo	No policies	3 min.
Contra Costa Health Plan-Sharron Mackey	Pending	5 min.
DEPARTMENT & DIVISION REPORTS		
DFAM Martinez-Dr. Katzman	See report	5 min.
Pathology Department-Dr.Das	Pending to February	5 min.
Cancer Committee-Dr. Gynn	Pend to March	5 min.
ADJOURN TO CLOSED SESSION-VOTING MEMBERS ONLY		
Adjournment. Next Meeting Date: February 28, 2021		

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

ED NURSING POLICY NO: 106

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ABSENT WITHOUT LEAVE (AWOL)

I. PURPOSE:

To outline the procedure to be followed when a patient leaves the Emergency Department (ED) prior to completion of visit.

II. REFERENCES:

CCRMC Hospital Policy 609: Patient Leaving Against Medical Advice (AMA), Absent without Leave (AWOL) and Access to Outdoors

California Welfare and Institution Codes 5150, 5250, 5170

Lanterman-Petris-Short (LPS) Act

~~Conservatorship Public Health Hold - California Health & Safety Code 3285d, penalties 3251 & 3354~~

~~Safety Event Reporting System~~

TJC ~~2016~~ Standard: RI.01.02.01: "The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services."

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III. POLICY:

If a patient leaves without notice prior to completion of their ~~Emergency Department (~~ED~~)~~ visit ~~and/or discharge,~~ or if there is an unauthorized departure ~~(AWOL)~~ of an involuntary psychiatric patient ~~on voluntary or involuntary status~~, this will be handled according to this policy in order to ensure patient safety.

In the event ~~of~~ a Psychiatric patient leaves~~ing~~ (~~either~~ while on ~~voluntary or~~ involuntary status), the Hospital Deputy and the Medical Center Supervisor (MCS) ~~Nurse Program Manager~~ will be notified. ~~This is done to protect the safety of others, as well as to comply with legal requirements.~~

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IV. AUTHORITY/RESPONSIBILITY:

~~All levels of Emergency Department Staff~~Physicians

Registered Nurses

Licensed Vocational Nurses

V. PROCEDURE:

A. For patient *not on legal hold* and absence without notice or absent without leave (AWOL):

~~1. Patients may leave after ED medical exam, prior to final diagnoses and discharge instructions.~~

~~2.~~1. Once a patient is noted to be absent from the department, ~~check with staff,~~ notify Charge Nurse and physician ~~MD, and check the lobby~~.

~~3.~~2. Attempt to ~~C~~call ~~the~~ patient's listed contact~~demographic phone~~ number and ~~document outcome~~notify family/significant other that patient has left the hospital.

~~4.~~3. Document AWOL in the Safety Event Reporting System (SERS).

~~4. Document Triage Time, Triage Level, Chief complaint, Room time if known, or diagnosis if documented.~~

~~C.~~B. ~~Voluntary or~~ For patient on Involuntary ~~Public Health~~ Hold ~~or Psychiatric Patient~~:

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1. ED staff will search the Unit
2. Notify Charge Nurse, physician and MCS.
~~1.~~3. Contact Hospital Deputy via radio and provide patient's name, description of appearance, clothing, time of departure.
   - ~~ED staff is to search the ED~~
   - Hospital Deputy personnel will search grounds for patient and will notify Martinez Police.
~~2.~~4. Notify police agency of patient's home of record ~~of AWOL~~ if needed.
~~3. Notify Staffing Office - Ext. 5132.~~
~~4. Notify physician.~~
~~5. If patient has a~~ Notify legal representative (~~i.e.~~i.e., conservator, parent, Regional Center, lawyer, etc.) ~~they are to be notified~~if applicable.
~~Notify NPM, and Medical Center Supervisor.~~
5.

~~Document time and condition of patient when last seen on unit and time of notifications of the above persons in the Medical Record in ccLink.~~

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VI. DOCUMENTATION:

~~Emergency Department Record in ccLink~~
~~Electronic Order Entry~~
Safety Event Reporting System (SERS) ~~report~~

APPROVED BY:
~~Chief Medical Officer~~
~~ED Director~~
~~Clinical Practice Committee: 2/2017~~
~~Patient Care Policy & Evaluation Committee: 3/2017~~
~~Medical Executive Committee: 3/2017~~
Emergency Department: 2021
Clinical Practice Committee: 2021
Patient Care Policy & Evaluation Committee: 2021
Medical Executive Committee 2021

REVIEWED:
11/2001, 1/2003, 1/2006, 1/2007, 5/2010, 2/2018, 8/2021

REVISED:
1/2017, 8/2021

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CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

ED NURSING POLICY NO~~:~~ 102

REPORT OF INJURIES TO LOCAL LAW ENFORCMENT AGENCIES

I. PURPOSE:

To provide a mechanism by which the appropriate law enforcement agency is notified when a patient presents to the Emergency Department for treatment of injuries related to criminal conduct.

II. REFERENCES:

~~AB-1652~~

California Penal Code~~s~~ ~~Sections~~ 11160 ~~&and~~ 11161

~~TJC 2016 Standard PC.01.02.09, "The hospital assesses the patient who may be a victim of possible abuse and neglect."~~

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III. POLICY:

The appropriate law enforcement agency will be notified when~~ever~~:

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A. A patient who has sustained a wound or other injury inflicted by his or her own act or inflicted by another where the injury is by means of a knife, firearm, or other deadly weapon~~s~~.

B. Any patient suffering from any wound~~s~~ or other physical injury inflicted ~~upon the person where the injury is the~~ as a result of assault~~ive~~ or abus~~ive~~. ~~conduct arrives in the Emergency Department for treatment.~~

C. Law Enforcement must be notified immediately and sent a written report (MR155) within 2 working days.

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~~B. This notification takes place by:~~

~~1. An immediate phone report or as soon as practically possible;~~

~~AND~~

~~2. A written report (MR 155, attached) sent to the appropriate agency within 2 working days.~~

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IV. AUTHORITY/RESPONSIBILITY:

~~All levels of Emergency Department Staff~~

Physicians

Registered Nurses

Licensed Vocational Nurses

V. PROCEDURE:

~~A. In the Emergency Department, the first concern is to provide appropriate medical care for any injuries.~~

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~~B.~~A. The Triage Nurse or Primary Nurse will ~~obtain and document number in the Emergency Department Nursing Record the patient's Chief Complaint/HPI to~~ include the character and extent of injury; date of injury, and jurisdiction within which the injury occurred in the documentation~~.~~

~~C.~~B. The Triage Nurse or Primary Nurse will inform the patient of the requirement to report the injury to the appropriate law enforcement agency.

~~D.~~C. A phone report ~~detailing the patient's Chief Complaint/HPI~~ will be made ~~immediately or~~ as soon as ~~practically~~ possible to the appropriate law enforcement agency. ~~Any Emergency Department health care provider may make this report.~~ The Incident or Case Number provided will be documented in EMR.

~~E.~~D. A written report (MR155) is completed by nurse, physician or other health care practitioner.

~~F.~~E. A copy of the written report (MR155) is forwarded to the appropriate law enforcement agency within 2 working days by the Unit Clerk. Addresses and phone numbers for Contra Costa, Alameda, and Solano County law enforcement agencies are listed on the ~~reverse~~back of the MR155.

~~VI. DOCUMENTATION:~~

~~MR155 Report Injuries of Local Law Enforcement Agencies~~
~~Emergency Department Record (MR387-2)~~
~~Electronic Order Entry and Documentation in the Electronic Medical Record~~

FORMS:

MR155: Report of Injuries to Local Law Enforcement Agencies

APPROVED BY:

~~Chief Medical Officer~~
~~Clinical Practice Committee~~
Emergency Department: 2021
Clinical Practice Committee: 2021
Patient Care Policy & Evaluation Committee: 2021
Medical Executive Committee 2021

REVIEWED:

11/2001, 1/2003, 1/2006, 1/2007, 5/2010, 1/2017, 2/2018, 8/2021

REVISED:

8/21

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CARDIOVERSION
(SYNCRONIZED COUNTERSHOCK)

I. PURPOSE:

To provide guidelines for the Critical Care Unit Registered Nursing Staff in facilitating scheduling and assisting the physician during the cardioversion in the ICU or IMCU.

II. REFERENCES:

IC Policy #301 "Standard Precautions"
IC Policy #302, Transmission Based Precautions Isolation Precautions
NUR Policy #123 "Preadmission and Admission Procedure for Outpatient Procedures"
NUR Policy #1017 "Restraint and Seclusion."

III. POLICY:

Tachy-dysrhythmias will be terminated by cardioversion in a safe manner Cardioversions are to be performed only by qualified medical staff and moderate sedation trained nurse staffing at a 1:1 nursing level during the procedure and immediate post-procedure during recovery period.

The patient's safety and comfort will be maintained by the nurse during the procedure; restraints may be necessary to prevent significant harm to the patient. The policy on Restraints and Seclusions (#1017) will be followed in this circumstance. Emergency equipment is readily available with staff versed in its use.

IV. AUTHORITY/RESPONSIBILITY:

Registered Nursing Staff
Medical Staff with privileges for cardioversion
Respiratory Care Practitioners

V. PROCEDURE:

A. Procedure Scheduling:
   1. Physician will schedule the cardioversion in ccLink providing the patient's name, medical record number, telephone number, and date/time of procedure.
   2. Inform patient of pre-procedure instruction including lab –draw/NPO midnight before procedure.
   3. Physician should ascertain any relevant lab the day prior to the procedure.

B. Day of cardioversion:
   1. RN responsibilities:
      a. Conduct Universal protocol immediately before procedure.
      b. Verify the following items are in the room: Ambu bag, Soft wrist restraints, Functional Yankauer Suction, Adult Oral Airways, Nasal cannula, simple face mask, Capnometer, Crash cart just prior to the procedure.
      c. Verify the physician privileges for cardioversion and conscious sedation in the hospital Look-Up system.
      d. Confirm the patient has been NPO since midnight prior to the procedure.
      e. Ensure patent IV access with Normal Saline or Ringer's Lactate.

f. Check current lab results applicable for procedure (i.e., PTT is in the patient's record..
g. Confirm informed consent is present in the patient's record.
h. Document current weight on patient record.
i. Establish sedation plan including med, dosage. Have sedation med and reversal agent at bedside.
j. Apply Adult Plus Multifunction electrode pads (M3713) on patient:
   i. Preferred placement: Anterior-Apex (Transchest).
   ii. Bariatriac/Obese patient placement: Anterior –Posterior.
   Monitor patient's EKG by connecting the monitor cable to the EKG port on the side of the defibrillator
k. Attach slave cable between the EKG outport from the Phillips Heart start MRx defibrillator to the bedside monitor.
l. Verify defibrillator is in the Sync Mode.
m. Monitor patient's comfort, conscious level and physiologic status during the procedure.
n. Document medications administered, joules delivered, and patient tolerance.
o. Order 12-lead EKG post cardioversion.
p. Discharge the patient when they meet Discharge Criteria (See back of Conscious Sedation Form). Document Aldrete Score.

2. Respiratory Care Practitioner
   a. Attend to airway management.

VI. FORMS USED (when electronic record unavailable):
Conscious Sedation Orders and Nursing Assessment and Monitoring (MR696-0)
Authorization for Consent to Surgery or Special Diagnostic or Therapeutic Procedures (MR39A-1)
Interim Operative Note (MR372-4)
Post-Operative Discharge Instructions (MR421-6)
Document in ccLink Universal protocol and sedation document

APPROVED BY:
Critical Care Committee: 08/2015
Clinical Practice Committee: 2/25/2013, 08/2015, 2/2018
Patient Care Policy & Evaluation Committee: 3/6/2013, 9/2015, 3/2018
Medical Executive Committee: 09/2015, 5/2018

REVIEWED:
2008, 2012, 08/15, 2/17, 2/2018, 10/2021

REVISED:
5/20/2004, 05/2007, 2/2018

POST ANESTHESIA CARE

I. STANDARD OF PRACTICE:

Generally patients requiring post-anesthesia care will be recovered in the PACU. Special circumstances, including the critically ill patient, may make recovery more appropriate in the ICU. This decision will be made by the anesthesiologist.

II. PURPOSE:

To provide monitoring guidelines to the critical care nursing staff during post anesthesia recovery period

III. REFERENCES:

Procedure 205- "Recovery from General Anesthesia"
Procedure 206- "Discharge from PACU"

IV. POLICY:

Patients returning from surgery to the critical care units will receive a level of post-anesthesia care consistent with standards of care in the Post Anesthesia Care Unit (PACU).

V. AUTHORITY AND RESPONSIBILITY:

PACU Registered Nursing Staff, Critical Care Registered Nursing Staff, Anesthesiologist

VI. PROCEDURE:

A. If a patient bypasses the PACU and returns to critical care or is admitted directly to a critical care unit from surgery, a PACU Registered Nurse will assume responsibility for recovering the patient unless the patient was previously staffed at a 1:1 (nurse:patient) ratio prior to surgery.
B. All patients being recovered in a critical care unit will be staffed at a 1:1 (nurse:patient) ratio during the recovery period.
C. Patients returning directly to critical care for recovery will have - post anesthesia care orders completed - by the anesthesiologist.
D. During the recovery process, restraints may be necessary to prevent significant harm to the patient. The policy for medical restraints and seclusion (Policy #1017) will be followed in this circumstance.
E. During hand-off of care, receiving RN will verify assessment with PACU RN and – documented on EMR

VII. FORMS USED:

Post Anesthesia Recovery Report (MR142-0)
CPT Code Sheet (WAMT41-4)

REVIEWED:
10/2003, 9/2008, 8/2016, 2/2018, 10/2021

REVISED:
5/5/2004, 9/13/05

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

NURSING POLICY NO: #807

FECAL MANAGEMENT SYSTEM (FMS)

I. PURPOSE:

To provide guidelines for the insertion, maintenance, and removal of the fecal management system.

II. REFERENCES:

Flexi Seal Fecal Management System , ConvaTec, Product insert~~a~~ (2015) ~~Bristol-Myer-Squibb company (2012).~~
~~TJC 2018 Standard PC 01.02.01, "The hospital assesses and reassesses its patients."~~

III. POLICY:

A. Indications: for use to manage fecal incontinence through the collection of liquid to semi-liquid stool and to provide access to administer medications~~-the fecal management of patients with little or no bowel control, and liquid to semi-liquid stool.~~
B. A Physician order is required.
C. Nursing personnel will insert the fecal management system (FMS) using standard precautions. Patient safety, comfort and privacy will be maintained throughout the procedure.
D. The fecal management system is not to be used on patients with solid stools.
E. The FMS should not be used for more than 29 consecutive days.
F. Contraindications include:
1. Pediatric patients.
2. ~~Lower bowel or-~~ rectal surgery within the last 12 months.
3. Fecal impaction.
4. Any rectal or anal injury.
5. Severe hemorrhoids.
6. Severe anal or rectal stricture or stenosis. (Distal rectum cannot accommodate the balloon when inflated.)
7. Rectal mucosa impairment (severe proctitis, ischemic proctitis, mucosal lacerations).
8. Rectal or anal tumor(s).
~~8.~~9.Have any indwelling rectal anal device
~~9. Solid or soft-formed stool.-~~
10. -

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IV. AUTHORITY / RESPONSIBILITY:

Physician, RN, LVN

V. PROCEDURE:

A. **INSERTION:**
1. Materials needed:
- Fecal management system kit, (with catheter tube assembly, collection bag, 45ml luer -lock syringe, cinch clamp)
- Non-sterile gloves,
- Water soluble lubricant gel,
- Waterproof pad,

- ~~Silicone catheter tube assembly~~
- ~~45 ml luer-lock syringe,~~
- ~~Liter collection bags with collection bag cap~~
- ~~Non-permeable bag~~

2. Explain the procedure to the patient. Place waterproof pad under patient's buttocks.
3. Wash hands.
4. Apply non-sterile gloves.
5. Remove residual air from the balloon by attaching the syringe to inflation (white) port and withdrawing the plunger. Expel any air from the syringe.
6. Fill the syringe (marked ≤ 45 ml) with 45 mL tap water or saline. Attach syringe to the inflation port.
7. Secure collection bag to the connector at the end of the catheter.
8. Position the patient in left side-lying position. If unable to tolerate, position the patient so access to the rectum is possible.
9. Remove any indwelling or anal device.
10. Apply lubricant to gloved finger and perform a digital exam to assess for fecal impaction. If present, notify the MD to determine if impaction removal is appropriate.
11. Wash hands and change gloves.
12. Unfold the catheter to lay flat on the bed, extending the collection bag towards the foot of the bed. Insert lubricated gloved index finger into the blue retention balloon cuff finger pocket for digital guidance during device insertion. Coat the balloon end of the catheter with lubricating gel.
13. Grasp the catheter and gently insert the balloon end through the anal sphincter until the balloon is beyond the external orifice and well inside the rectal vault.
14. Inflate the balloon with 45 mL of water or saline by slowly depressing the syringe plunger. **Do not inflate the balloon with more than 45 mL.**
15. Once the balloon has reached the optimal fill level, the indicator bubble on the inflation(white) port will pop. The indicator could pop before the 45 mL has been inflated, if the space available for the balloon is smaller than the balloon. Filling should stop when the indicator pops out and stays out.
16. If the indicator bubble does not pop, the balloon is under-filled. Withdraw the liquid and reposition the balloon in the rectal vault. After repositioning, re-fill the balloon as described. When the indicator bubble deflates or appears excessively inflated, the retention balloon is no longer at the optimal level. Withdraw the fluid and re-fill the balloon as described. **Do not inflate the balloon with more than 45 mL.**
17. Remove the syringe from the inflation port and gently pull on the silicone catheter to check that the balloon is securely in the rectum and that it is positioned against the rectal floor.
18. Position the length of the catheter along the patient's leg avoiding kinks and obstructions.
19. Note where the position indicator line is relative to the patient's anus. Observe for changes in the location of the position indicator line as a means to determine movement of the retention balloon in the rectum. This may indicate the need for the balloon or device to be repositioned.
20. Hang the collection bag by the strap at a convenient location on the bedside.

21. Remove waterproof pad and dispose of all used and soiled supplies in the appropriate containers.
22. Remove gloves and wash hands.
23. Document the procedure and the patient's tolerance of it in ccLink.

B. **STOOL SAMPLINGS**
1. Wash hands and apply gloves.
2. Obtain ~~a slip tip~~ luer-slip syringe.
3. Verify the patient with 2 patient identifiers.
4. Locate the sample port on the catheter and then open the sample port cap.
5. Press the tip of the syringe through the slit inside of the sampling port to access the interior of the catheter.
6. Withdraw the syringe plunger to collect the stool sample.
7. Remove the syringe and close the sampling port cap.
8. Transfer stool specimen into a specimen cup.
9. Label the specimen cup at the patient's bed side.
10. Remove gloves and wash hands.
11. Dispose of the stool sampling syringe according to a red biohazard trash.

C. **MAINTENANCE IRRIGATION;** If the catheter becomes blocked with solid particles, it can be rinsed. Procedure:
1. Wash hands and apply non-sterile gloves along with any ~~other~~ personal protective equipment needed to avoid splashes.
2. Fill a syringe with tap water at room temperature.
3. Attach the syringe to the BLUE irrigation port (marked IRRIG) and flush device.
4. Repeat as needed. If repeated flushing does not return the flow of stool, inspect the device for external obstruction. If no obstruction is found, obtain an order to discontinue the FMS.
5. Remove gloves and wash hands.
6. Document in patient care record in ccLink.

D. **REMOVAL OF FECAL MANAGEMENT SYSTEM:**
1. Gather equipment.
2. Wash hands and apply non-sterile gloves.
3. Attach ~~a 60 mL~~ syringe to the WHITE inflation port and withdraw all the fluid from the balloon.
4. Disconnect the syringe.
5. Grasp catheter (as close to the patient as possible) and slowly slide the catheter out of the anus.
6. Dispose of the device in the red biohazard trash.
7. Remove gloves and dispose in appropriate trash container.
8. Wash hands.
9. Document in patient care record in ccLink.

E. **MEDICATION ADMINISTRATION**
1. Flush the irrigation line with 10 mLs of room temperature water.
2. Remove the cinch clamp from the kit packaging. Note that the cinch clamp has

two notches and therefore two closure positions. Without closing, position the cinch clamp around the catheter at the black indicator line.
3. Close the cinch clamp to the first closure position.
4. Prepare a new syringe with the medication as prescribed.
5. Connect the medication syringe to the BLUE~~blue--~~ irrigation port (marked "IRRIG"). Administer the medication as prescribed.
6. Remove the syringe once all the medication has been instilled. Dispose the syringe according pharmaceutical waste disposal policy.
7. Flush irrigation line immediately with at least 50 mL of room temperature tap water to ensure the delivery of medication into the rectum.
8. Tighten the cinch clamp completely by closing to the second closure position to ensure no medication flows back though the catheter.
9. Allow the medication to dwell in the rectum for the prescribed amount of time.
10. Then open the cinch clamp and remove it from the catheter. Flush the irrigation line once again with 10 mLs of room temperature tap water.

F. **PRECAUTIONS**

1. Close attention should be exercised with the use of the FMS device in patients who have inflammatory bowel conditions.
2. Small amounts of seepage and moisture around the catheter is anticipated. To avoid skin irritation, initiate appropriate skin care protocol. Keep skin clean, dry and protected with a moisture barrier product. Patients with very weak sphincter muscles may not be able to hold the device in place and may experience increased leakage of stool.
3. Solid or soft formed stool cannot pass through the catheter and will obstruct the opening.
4. If the catheter does become blocked with solid particles, it can be rinsed (see irrigation section). If obstruction of the catheter is due to solid stool, the device should be discontinued.
5. To avoid injury to the patient, do not insert anything into the anal canal while the FMS is in place (e.g., thermometers, suppositories, etc.). Remove the device prior to the insertion of anything into the anal canal.
6. Notify the physician if any of the following occur:
   a. Persistent rectal pain.
   b. Rectal bleeding.
   c. Abdominal distention.
7. If the patient's bowel control, consistency and frequency of stool begin to return to normal, discontinue use of the device.
8. The following adverse events could occur:
   a. Excessive leakage of stool around the device.
   b. Loss of anal sphincter muscle tone that could lead to temporary anal sphincter dysfunction.
   c. Infection.
   d. Pressure necrosis of rectal or anal muscles.
   e. Bowel obstruction.
   f. Perforation of bowel.

VI. DOCUMENTATION:

ICU/IMCU Flowsheet in ccLink
Patient Care Record in ccLink

APPROVED BY:
Critical Care Committee: 6/2015
Clinical Practice Committee: 7/2015
Patient Care Policy & Evaluation Committee: 11/2015
Medical Executive Committee: 12/2015

REVIEWED:
7/2008, 9/2009, 7/2015, 8/2016, 2/2017, 2/2018, 1/2020, 2/2021, 10/2021

REVISED:
8/2008, 6/2012, 7/2015

SET UP & PLANNED ACTIONS

Planned Action	Key Information

For OXIMAX® N-85 Portable Capnography/Pulse Oximeter and Microstream CO_2 Extension to Phillips Monitor

OXIMAX® n-85 set up

1. Turn on monitor by sliding the On/Off switch on top right of monitor.	1. Monitor is ready after a 30-second warm-up and self-check; **NO** calibration or zeroing is necessary.
2. Choose appropriate capnography CO_2 sampling line for patient.	2. The Smart CapnoLine Plus for non-intubated patients samples $ETCO_2$ selectively from the nose or the mouth. Oxygen is delivered through pinholes under the nose which increases the oxygen concentration at the level of the airway.
3. Open the FilterLine Input Connector door on the top left, under the word Microstream® (figure 1).	 Figure 1
4. Connect the luer lock-type end of the FilterLine to the monitor and turn clockwise until snug. DO NOT over-tighten. Pump will start automatically.	4. Autozero will appear at the top of the screen after patient monitoring is initiated to indicate the monitor is performing a self-calibration. No action is required.
5. Alarm silence is the top left button on the front of the monitor; press and quickly release the button to temporarily silence the alarms.	5. Do not permanently silence the alarms.
6. To change alarm limits, press and hold the bottom right button to bring up the alarm limits menu. Press and release the same button to scroll through and highlight choices. Highlight the parameter you want to change and use the toggle buttons to increase or decrease the parameter's value.	6. Default alarm settings are restored each time the unit is turned off.
7. Press and hold the bottom left button anytime to return to the monitoring screen.	7. If no actions are taken in 15 seconds, the monitor defaults back to monitoring screen.

8. Press and release large arrow button, bottom right for 30 minute and 8-hour trend information.

9. For intubated patient, place FilterLine H-set proximally to the endotracheal tube.

10. Draw arterial blood gases (ABG) at 30 minutes after connecting a sampling line to the patient.

10. Establish baseline correlation between capnography numeric value and $PaCO_2$ value from ABG readings.

Microstream CO2 extension to Phillips Monitor set up

1. Plug in the Microstream CO_2 extension to the Multi-Measurement Module.

2. Choose appropriate capnography CO_2 sampling line for patients.

3. Open the FilterLine connector door on the front (figure 2).

4. Connect the luer lock-type end of the FilterLine to the monitor and turn clockwise until snug. DO NOT over-tighten. Pump will start automatically.

5. Set up the alarm limits on Phillips monitor.

6. For intubated patient, place FilterLine H-set proximally to the endotracheal tube.

7. Draw arterial blood gases at 30 minutes after connecting a sampling line to the patient.

Figure 2

Reviewed 2/2018, 10/2021

INVOLUNTARY PATIENTS ~~ADMISSION~~: CONSERVATORSHIP AND TEMPORARY CONSERVATORSHIP

I. PURPOSE:

To provide guidelines for protecting the rights of patients ~~requiring involuntary~~who are conserved or who meet requirements for ~~admission and/or conservatorship status~~ temporary conservatorship while they receive psychiatric treatment in the Psychiatric Emergency Services (PES) or Inpatient Psychiatry (Units 4C and 4D).

II. REFERENCES:

Title 22: Section 70717.
Welfare & Institution Codes: 5250, 5252.1, 5152.1, 5358, 6004, 6005, 7103
The Joint Commission (TJC) 2021~~16~~ Standard RI.01.01.01, "The hospital respects, protects and promotes patient rights."

III. POLICY:

Legal status of all patients is verified and/or updated based on psychiatric evaluation in the Psychiatric Emergency Services (PES) and Inpatient Psychiatry Service (Units 4C and 4D). Patients ~~admitted involuntarily under~~with the legal status of ~~Conservatorship or Temporary Conservatorship~~Conserved or Temporary Conservatorship retain all rights accorded to patients.

IV. AUTHORITY/RESPONSIBILITY:

Psychiatry Chief(s), Nursing~~e~~ Program Manager(s), Psychiatrists, Mental Health Program Manager, Mental Health Program Supervisor, Mental Health Clinical Specialist/Medical Social Worker II (MHCS/SW), RN, LVN, LPT, Discharge Planner, Clerk~~MHCS, RN, LVN, LPT, Discharge Planner~~

V. PROCEDURE:

A. Upon intake to PES or admission to Inpatient Psychiatry, ~~the Mental Health Clinic Specialist (MHCS)~~ Social Services staff will verify the legal status of the patient and contact the patient's conservator for the appropriate signatures. This can be done by checking ~~the monthly list of~~information about Public Conservators ~~and Conservatees, or~~, or, for private conservators, a copy of the Conservatorship Decree will accompany the patient.

~~A.~~B. If a patient is conserved in another county, social services staff should communicate this information to the attending psychiatrist.

~~B.~~C. All patients with a conservator or temporary conservatorship or those who are placed on a ~~conservatorship or~~ temporary conservatorship while at Contra Costa Regional Medical Center (CCRMC) will have a "Request for Voluntary Admission and Authorization for Treatment" (MR-94) signed by their conservator or temporary conservator.

~~C.~~D. All patients with a conservator or those who are placed on a conservatorship while at CCRMC will have the Informed Consent for Psychotropic Medication forms signed by their conservator.

E. The clerk or Charge Nurse/Team Leader should update the legal status of the patient on admission to Inpatient Psychiatry service using the Legal Status book.

~~D.~~ The psychiatrist should complete an order in ccLink for the legal hold (Conserved or Temp Conserved) and document the legal status in the Intake or Psychiatric H&P note and progress notes as appropriate.

F. ~~All patients on a temporary conservatorship or placed on a temporary conservatorship while at CCRMC will have Informed Consent forms signed by their temporary conservator if medications are indicated.~~

~~E.~~

VI. DOCUMENTATION~~FORMS USED~~:

Application for Voluntary Admission and Authorization for Treatment (MR-94)
Court appointed Conservatorship papers
Informed Consent for Psychotropic Medications (MR-650)
Inpatient Psychiatry Legal Status Book
Patient Care Record in ccLink

~~**VII. RESPONSIBLE STAFF PERSON:**~~

~~Program Chief Detention and Mental Health/Psychiatry, Chief Psychiatrist(s), Nurse Program Managers~~

REVIEWED: 6/92, 10/96, 8/97, 3/01, 5/04, 12/16, 09/21

REVISED: 12/94, 11/15, 09/21

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CONTRA COSTA HEALTH SERVICES

Committee Name: PCP&E Committee, MEC and PIC
Meeting Date: December 2021

Issue Name: Medication Safety Committee Updates from the November 2021 meeting to PCP&E, PIC, and MEC	**Presenter(s):** Shideh Ataii, Pharm.D., APH Director of Pharmacy SVCs, CCRMC and Clinics

Situation: To share all Medication Safety Committee updates/information pertaining to the medication management process at CCRMC and clinics with the PCP&E committee members. These updates will also be shared with the Medical Executive Committee (MEC), and PIC as applicable. These committees will be responsible for disseminating the information within the report to their respective departments. For complete detailed reports, refer to Medication Safety Committee files.

Background:

The Medication Committee updates include the following but are not limited to:

- Monthly and quarterly medication error reports with the following severity ratings:
  - A. Event has capacity to cause error
  - B. Error did not reach the patient
  - C. Error occurred that reached the patient, but no harm
  - D. Error occurred that reached the patient, monitoring required, but no harm
  - E. Error occurred that contributed to temporary harm and required intervention
  - F. Error occurred that may have contributed to temporary harm and required initial or prolonged hospitalization
  - G. Error occurred that may have contributed to permanent patient harm
  - H. Error occurred that required intervention necessary to sustain life
  - I. Error occurred that may have resulted in patient death
- Literature review including any regulatory updates such as AFLs from CDPH, ISMP updates, TJC etc.
- Quarterly reports including Drug Recalls, clinical monitors, pharmacy interventions, override reports etc.
- Quarterly reports from SPI including anticoagulation updates, Medication Reconciliation

Assessment/Findings:

Medication Error Report for October 2021:

All medication errors were reviewed for the month of October. The total number of medication events/errors reported in SERS for October 2021 was 41 events compared to 53 events reported in the previous month. There were 2 errors reported which involved RXe-Source pharmacy (1 in the previous month). There were 93,141 doses dispensed this month compared to 95,449 doses dispensed in the previous month. This calculates to a 0.04% error rate, which is slightly lower than the previous month (0.05% in September 2021).

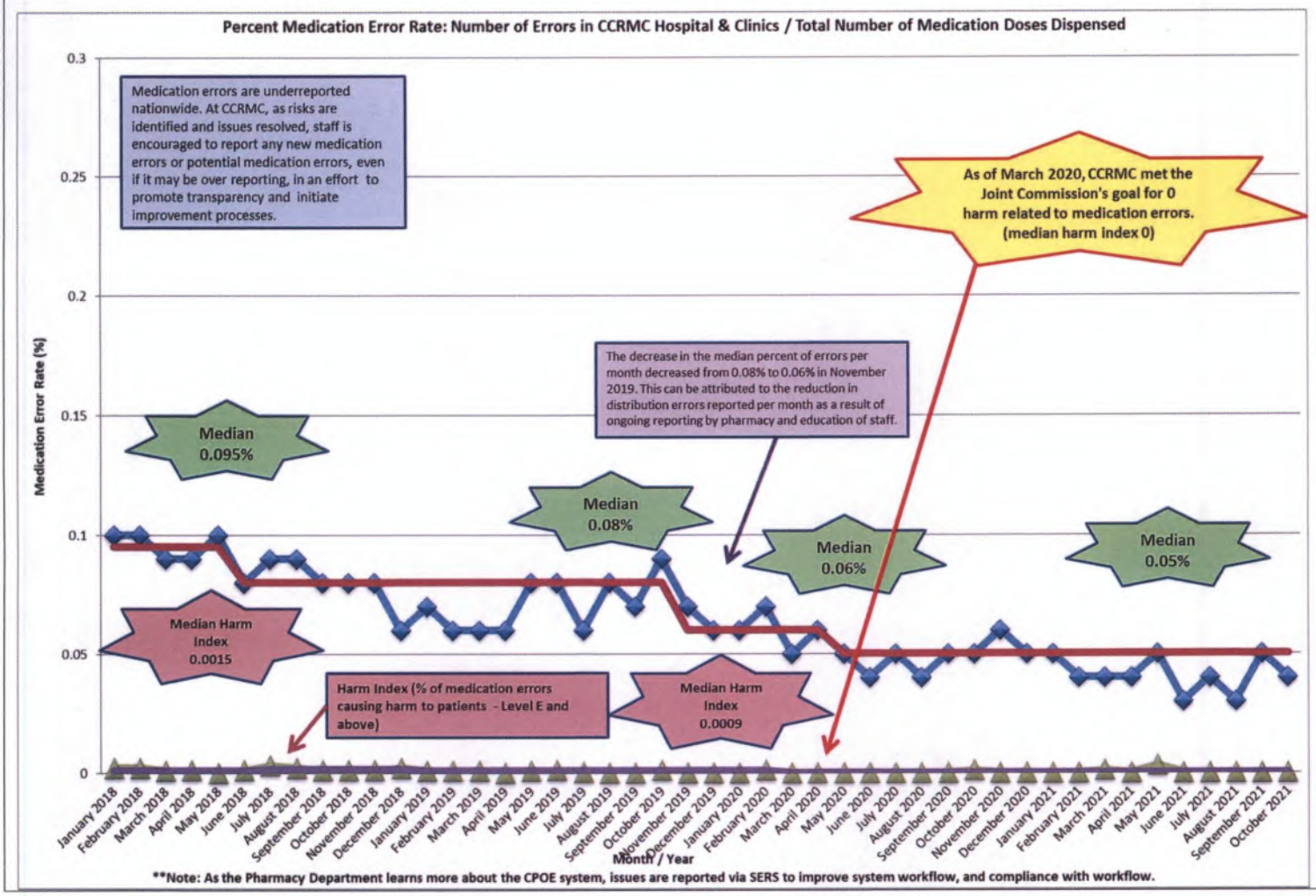
The MERP Elements that did not contribute to any errors this month were Prescription Order Communication, Product Labeling, Packaging, and Nomenclature, Technology, and Transitions in care.

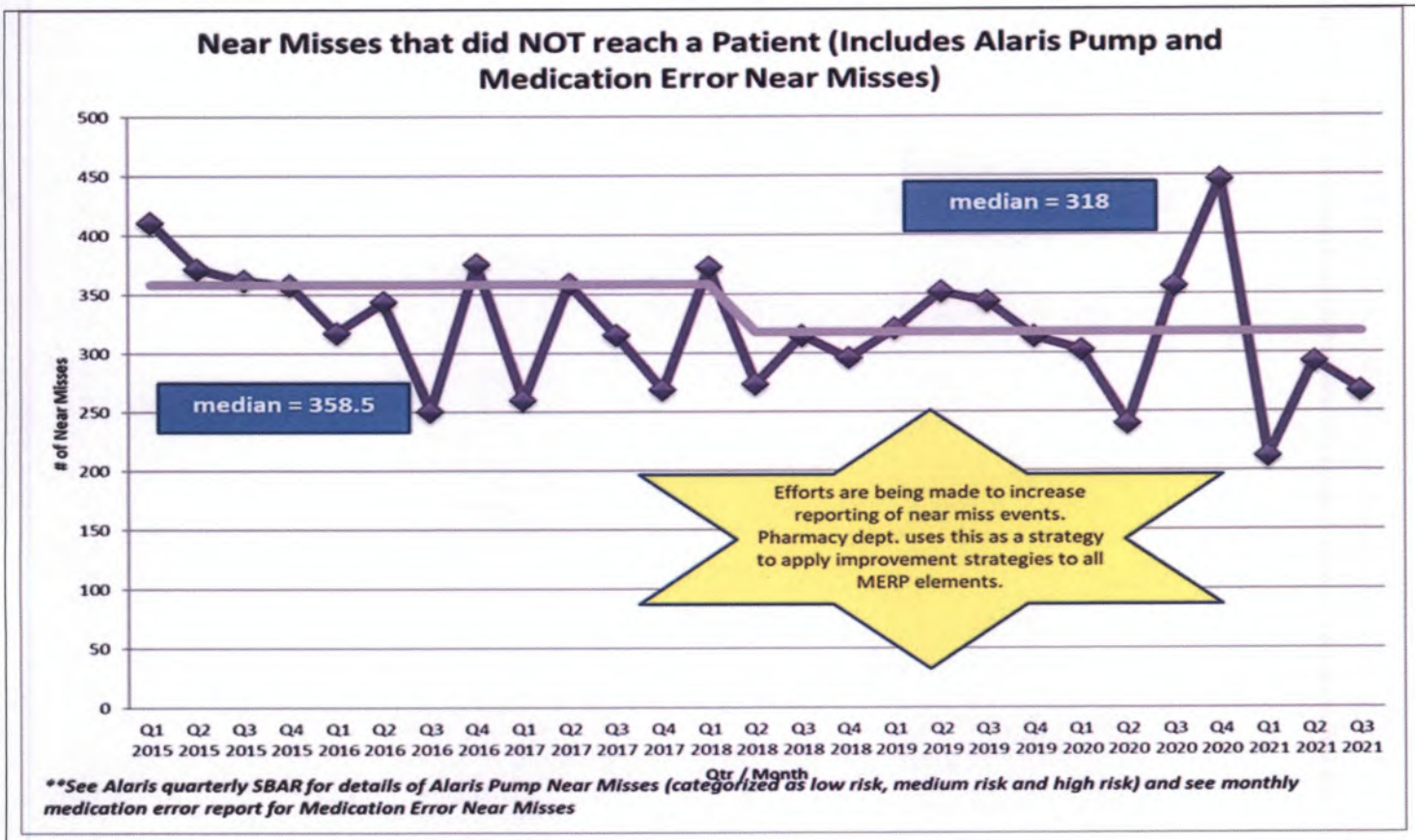
The following MERP elements contributed to the SERS for the month of October:

Distribution: 22 events
Administration: 13 events
Prescribing: 1 event
Monitoring: 6 events
Compounding: 1 event
Dispensing: 3 events
Education: 6 events

100% of the events closed were evaluated for Level of harm from A-I. Events were classified as: Level A (1), Level B (24), C (19), D (1). There were no LEVEL E events to report for this month.

No system changes are pending for this month. A few of the system changes from the previous month are currently still pending





See Alaris quarterly SBAR for details of Alaris Pump Near Misses (categorized as low risk, medium risk and high risk) and see monthly medication error report for Medication Error Near Misses

Pharmacy observed medication pass audit:

Medication pass survey was completed in anesthesia workstations, infusion clinic, 3D, 3E, 4A, 4B and 5D in November of 2021. Assessment: 5 units were audited in the month of November (3D, 4B, 5D, OR workstations, and infusion) and no error was found.

Audit of Pharmacy dispensing practices:

The medication dispensing practices were met with 100% compliance across all areas. Pharmacy will continue to audit dispensing practices.

Controlled Substance Documentation Compliance Report for the Anesthesiology Dept-(Period Q2 2021 and Q3 2021):

Data Highlights:

- Current overall compliance rate median: 97.73%.
- Q2 2021 compliance with zero waste documentation percentage: 97.23%.
- Q3 2021 compliance with zero waste documentation percentage: 97.06%.
- Q2 2021 compliance with waste documentation percentage: 95.83%.
- Q3 2021 compliance with waste documentation percentage: 99.12%.
- Q2 2021 compliance with return documentation percentage: 90.32%.
- Q3 2021 compliance with return documentation percentage: 82.76%.
- Current overall non-compliance rate median: 2.27%.
- Q2 2021 non-compliance with zero waste documentation percentage: 2.77%.
- Q3 2021 non-compliance with zero waste documentation percentage: 2.94%
- Q2 2021 non-compliance with waste documentation percentage: 4.17%.
- Q3 2021 non-compliance with waste documentation percentage: 0.88%.
- Q2 2021 non-compliance with return documentation percentage: 9.68%.
- Q3 2021 non-compliance with return documentation percentage: 17.24%.

SEE GRAPHS AT THE END OF THIS REPORT

Qualitative and Quantitative Analysis of Compounded Sterile & Non-Sterile Products, Quarter 2 2021:

During the **2nd quarter of 2021**, the pharmacy sent a total of 4 **samples** as described below, to an outsourced laboratory by the name of DynaLabs.

Compounding Facility	Compound Type	Description of Compound	Potency Test Performed?	Sterility Test Performed?	Endotoxin Test Performed?
CCRMC Outpt Pharmacy – Negative Hood	Sterile	**Phenylephrine HCl 100 mg/ 500 mL NS**	**Yes**	**Yes**	**Yes**
CCRMC Outpt Pharmacy – Positive Hood	Sterile	**Phenylephrine HCl 100 mg/ 500 mL NS**	**Yes**	**Yes**	**Yes**
CAPS	Sterile	**Epinephrine 2 mg/ 250 mL D5W**	**Yes**	**Yes**	**Yes**
Nephron	Sterile	**Labetalol 20 mg/ 4 mL inj syringe**	**Yes**	**Yes**	**Yes**

Assessment:

All ***compounded sterile products*** from CCRMC Outpatient Pharmacy **passed the qualitative and quantitative checks** for *sterility* (testing for absence of bacteria, fungi [mold, and yeast] in both aerobic and anaerobic broths), *potency* (within the acceptable range defined in the USP General Chapter or drug-specific monograph), and *endotoxin* (limit defined by drug-specific monograph).

All of the ***compounded sterile products*** from CAPS and Nephron 503b Pharmacy **passed the qualitative and quantitative checks** for *sterility* (testing for absence of bacteria, fungi [mold, and yeast] in both aerobic and anaerobic broths), *potency* (within the acceptable range defined in the USP General Chapter or drug-specific monograph), and *endotoxin* (limit defined by drug-specific monograph).

Qualitative and Quantitative Analysis of Compounded Sterile & Non-Sterile Products, Quarter 3 2021:

During the 3rd **quarter of 2021**, the pharmacy sent a total of 4 **samples** as described below, to an outsourced laboratory by the name of DynaLabs.

Compounding Facility	Compound Type	Description of Compound	Potency Test Performed?	Sterility Test Performed?	Endotoxin Test Performed?
CCRMC Outpt Pharmacy – Negative Hood	Sterile	**Phenylephrine HCl 100 mg/ 500 mL NS**	**Yes**	**Yes**	**Yes**
CCRMC Outpt Pharmacy – Positive Hood	Sterile	**Phenylephrine HCl 100 mg/ 500 mL NS**	**Yes**	**Yes**	**Yes**
CAPS	Sterile	**Norepinephrine 4 mg/ 250 mL D5W**	**Yes**	**Yes**	**Yes**
Nephron	Sterile	**Labetalol 20 mg/ 4 mL inj syringe**	**Yes**	**Yes**	**Yes**

Assessment:

All ***compounded sterile products*** from CCRMC Outpatient Pharmacy **passed the qualitative and quantitative checks** for *sterility* (testing for absence of bacteria, fungi [mold, and yeast] in both aerobic and anaerobic broths), *potency* (within the acceptable range defined in the USP General Chapter or drug-specific monograph), and *endotoxin* (limit defined by drug-specific monograph).

All of the ***compounded sterile products*** from CAPS and Nephron 503b Pharmacy **passed the qualitative and quantitative checks** for *sterility* (testing for absence of bacteria, fungi [mold, and yeast] in both aerobic and anaerobic broths), *potency* (within the acceptable range defined in the USP General Chapter or drug-specific monograph), and *endotoxin* (limit defined by drug-specific monograph).

ADR report, 1st quarter 2021:

Breakdown of ADRs by Report Source	
Total number of events reported by Medical Records coding:	*103*
Total number of voluntary reports (SERS,etc.)	*39*
Total number of ADRs reported from Omnicell	*31*
Total number of events reported by Dashboard Reports	*1*

Breakdown of True ADRs by Setting	
Total number of ADRs from in-patient setting	*11*
Total number of ADRs from out-patient/Amb. Care setting (includes Emergency Department)	*92*

Number of ADRs reported	
Total number of all ADRs reported	*173*
TOTAL NUMBER OF TRUE ADRs in 1st Quarter of 2021	***103***
Note that the eliminated number of ADRs include untrue ADRs, duplicate reports from prior months/years, and coded line items in error.	

Findings:
For the 1st quarter of 2021, there were 331,839 medication orders. For the 1st quarter of 2021, the ADR rate (true ADR) was **0.03%** (compared to 0.017% in 4th quarter of 2020). A data deficiency is that the denominator is the total number of medications prescribed, not the total number of prescriptions filled. This is because CCRMC can only keep track of prescription fills for patients with CCHP, but not for patients with other insurance carriers.
All ADR reports are categorized as either "Allergic" reactions, "Supratherapeutic" events or "Toxic" events. The potentially preventable events were shared with providers.

Omnicell XT implementation:

The timeline for the Omnicell XT conversion at CCRMC was shared with committee members. The implementation is currently ongoing.

Medication Shortage List:

Findings:
In the month of November 2021, there were 146 medications on the drug shortage spreadsheet. The breakdown of these medications by color-coding was:

- Green = 46% (68)
- Yellow = 49% (71)
- Red = 5% (7)

Of the medications coded as red, the following medications have been especially problematic and have resulted in necessary action (see attached TABLE for full details):

Drug on Shortage	Alternative Agents	CCRMC Actions	Current Status
Ammonia Inhalant	None	CCRMC has sufficient quantity on hand but will check with alternative suppliers	CARES act now requires a new drug application before the manufacturer can resume marketing the product. The manufacturer is reaching out to FDA for guidance on extending the grace period based on public health need. No ETA provided.
Bupivacaine 0.5% with epinephrine	Other anesthetic agents	CCRMC able to procure limited supply	On shortage due to increased demand and manufacturing delays. ETA unknown.
Cefotetan IV premix bags	Cefotetan 1g and 2g vials are available	Cefotetan 1 g and 2 g doses to be compounded by Pharmacy. Vials added to OR Omnicells for after-hours use.	On backorder due to manufacturing delays. ETA of 12/2021
Desmopressin nasal spray (150 mcg/0.1 mL)	Injectable desmopressin available	IV and SubQ desmopressin available and can be used for the same indication as intranasal 150 mcg/0.1 ml (hemophilia A)	Recalled due to higher amounts of desmopressin than specified. Company cannot estimate a release date. Currently on backorder.
Homatropine 5% ophthalmic solution	Atropine eye drops	Pharmacy to consider formulary change if discontinued by manufacturer. Atropine on hand (more potent)	Unavailable for ordering due to manufacturing delays. Estimated availability date end of 2021.
Isoniazid 100 mg/mL Injection	Isoniazid tablets remain available as an alternative	Pharmacy actively monitoring availability.	On shortage due to manufacturing delays. No ETA provided.
Protamine Sulfate injection 50mg/5mL	None	CCRMC currently able to order 250mg/25mL vials	Not available due to manufacturing delays. ETA of December 2021.

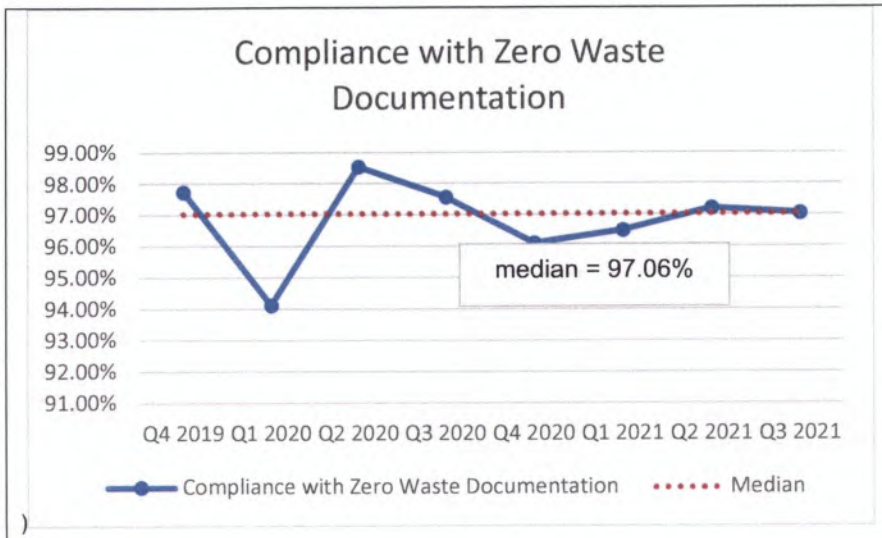
Recommendations/Actions: What actions should the committee take?

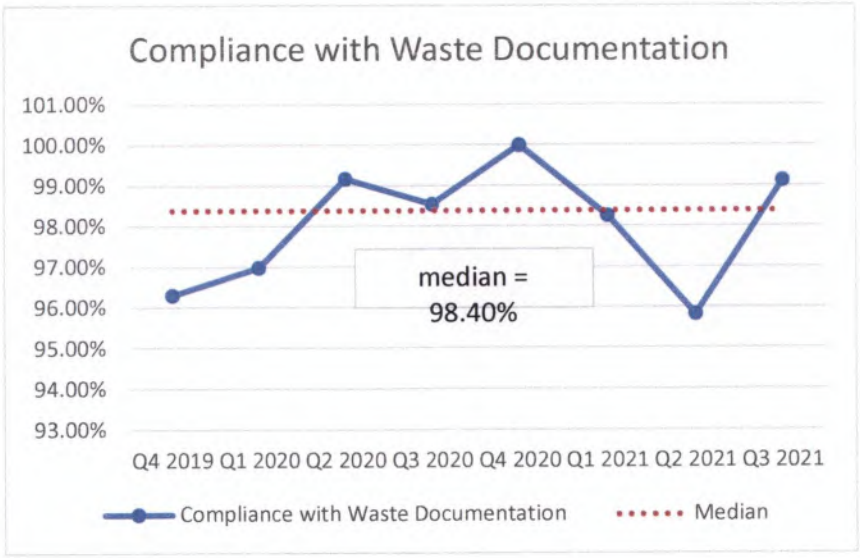
❒ Check here if presenter does not have a recommendation to the Committee

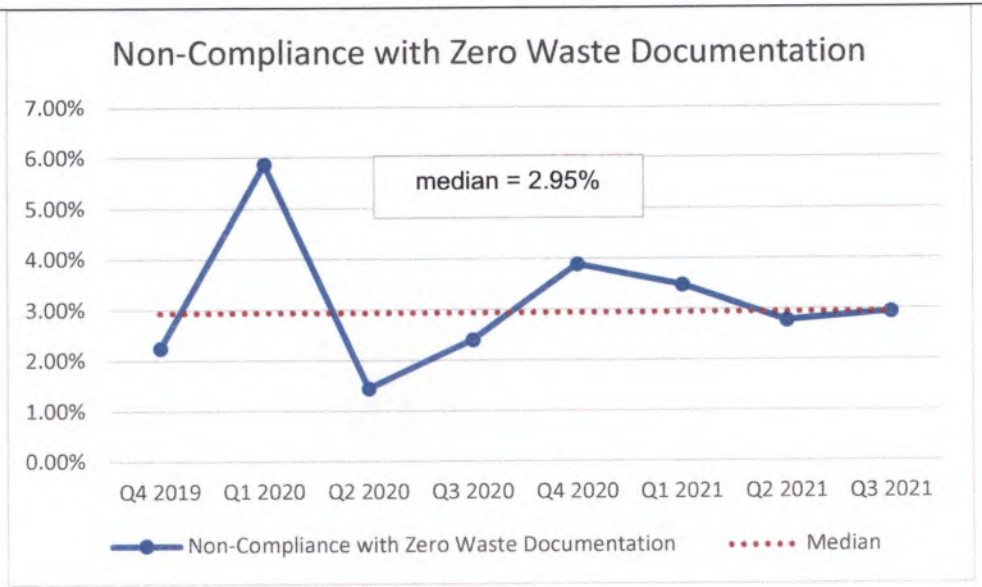
Note: The committee will track and expect a report back on any actions it adopts or otherwise requires.

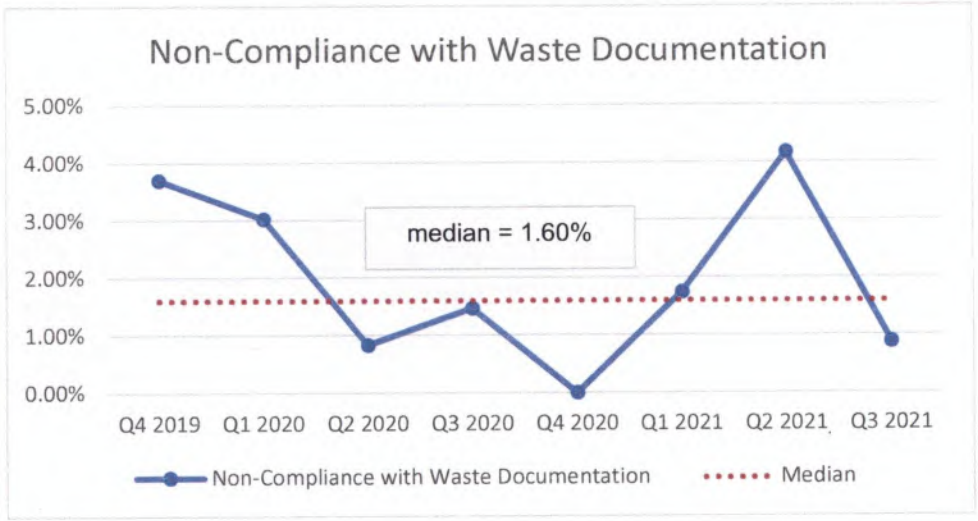
Who	What	When
Director of Pharmacy Services	Report to PCP&E, MEC and PIC as applicable	**Recurring**

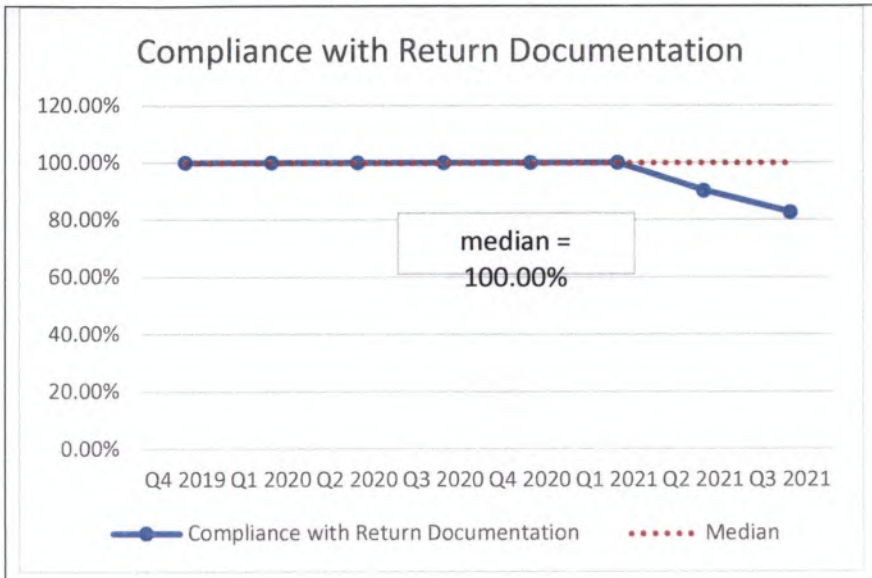
NEXT PAGE:
Controlled Substance Documentation Compliance Report for the Anesthesiology Dept- (Period Q2 2021 and Q3 2021):

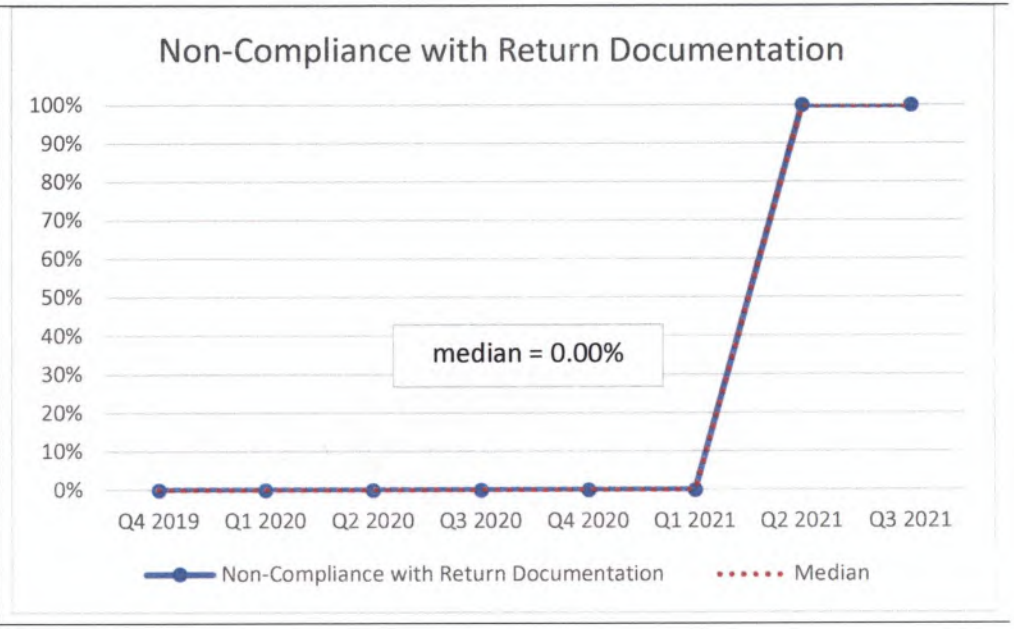

Compliance with Zero Waste Documentation
99.00%
98.00%
97.00%
96.00%
95.00%
94.00%
93.00%
92.00%
91.00%
median = 97.06%
Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021 Q2 2021 Q3 2021
Compliance with Zero Waste Documentation
Median


Compliance with Waste Documentation
101.00%
100.00%
99.00%
98.00%
97.00%
96.00%
95.00%
94.00%
93.00%
median = 98.40%
Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021 Q2 2021 Q3 2021
Compliance with Waste Documentation
Median


Non-Compliance with Zero Waste Documentation
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
median = 2.95%
Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021 Q2 2021 Q3 2021
Non-Compliance with Zero Waste Documentation
Median


Non-Compliance with Waste Documentation
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
median = 1.60%
Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021 Q2 2021 Q3 2021
Non-Compliance with Waste Documentation
Median


Compliance with Return Documentation
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
median = 100.00%
Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021 Q2 2021 Q3 2021
Compliance with Return Documentation
Median


Non-Compliance with Return Documentation
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
median = 0.00%
Q4 2019 Q1 2020 Q2 2020 Q3 2020 Q4 2020 Q1 2021 Q2 2021 Q3 2021
Non-Compliance with Return Documentation
Median

CONTRA COSTA
HEALTH SERVICES

TO: *All Medical Staff / Residents*
All Nursing Staff

DATE: *11/3/2021*

BY: *Marjan Orellana, Pharm.D.*
Adeebeh Fakurnejad, Pharm.D.
Department of Pharmacy

SUBJECT: *Pharmacy and Formulary Updates*

FORMULARY CHANGES:
None

FDA BLACK BOX WARNING:

1. JAK Inhibitors Safety Review – Tofacitinib (Xeljanz®, Xeljanz XR®), Baricitinib (Olumiant®), Upadacitinib (Rinvoq®)

Based on a completed U.S. Food and Drug Administration (FDA) review of a large, randomized safety clinical trial, we have concluded there is an increased risk of serious heart-related events such as heart attack or stroke, cancer, blood clots, and death with the arthritis and ulcerative colitis medicine tofacitinib.

This trial compared tofacitinib with another type of medicine used to treat arthritis called tumor necrosis factor (TNF) blockers in patients with rheumatoid arthritis. The trial's final results also showed an increased risk of blood clots and death with the lower dose of tofacitinib. A prior drug safety communication based upon earlier results from this trial, reported an increased risk of blood clots and death only seen at the higher dose.

Baricitinib and upadacitinib have not been studied in trials similar to the large safety clinical trial with tofacitinib, so the risks have not been adequately evaluated. However, since they share mechanisms of action with tofacitinib, FDA considers that these medicines may have similar risks as seen in the tofacitinib safety trial.
Two other JAK inhibitors, ruxolitinib and fedratinib, are not indicated for the treatment of arthritis and other inflammatory conditions and so are not a part of the updates being required.

Revisions to boxed warning to include information about risks. In addition, limiting all approved uses to certain patients who have not responded or cannot tolerate one or more TNF blockers.

FDA MEDWATCH ALERTS/DRUG SAFETY COMMUNICATIONS

FDA MedWatch alerts are reviewed monthly and selected medication label changes and alerts are presented here. Please refer to FDA website for a complete list of label changes and safety alerts.
https://www.accessdata.fda.gov/scripts/cder/safetylabelingchanges/index.cfm?event=searchResult.page
https://www.fda.gov/drugs/drug-safety-and-availability/drug-safety-communications

1. Alcohol Based Hand Sanitizers

(Drug Safety Communication) - The U.S. Food and Drug Administration (FDA) is warning that getting alcohol-based hand sanitizer in the eyes from splashing or touching the eyes after use of hand sanitizer can result in serious injury, including severe irritation and damage to the surface of the eye. Eye exposure to hand sanitizer has been reported in all age groups; however, it has occurred most often in children. Such eye injuries have become much more frequent, likely due to the marked increase in the use of alcohol-based hand sanitizer during the COVID-19 pandemic.

2. Cefazolin (Ancef®) – *formulary*

Postmarketing Experience: Skin and subcutaneous tissue disorders – Acute generalized exanthematous pustulosis (AGEP)

3. Isoflurane (Forane®) – *formulary*

Contraindications: history of confirmed hepatitis due to a halogenated inhalational anesthetic or a history of unexplained moderate to severe hepatic dysfunction (e.g., jaundice associated with fever and/or eosinophilia) after anesthesia with isoflurane or other halogenated inhalational anesthetics.

Warnings: *Hepatic Reactions* - Cases of mild, moderate and severe postoperative hepatic dysfunction or hepatitis with or without jaundice, including fatal hepatic necrosis and hepatic failure, have been reported with isoflurane. Clinical judgment should be exercised when isoflurane is used in patients with underlying hepatic conditions or under treatment with drugs known to cause hepatic dysfunction.

As with all halogenated anesthetics, repeated anesthetics within a short period of time may result in increased effects, particularly in patients with underlying hepatic conditions, or additive effects in patients treated with drugs known to cause hepatic dysfunction. Evaluate the need for repeated exposure in each individual patient and adjust the dose of isoflurane based on signs and symptoms of adequate depth of anesthesia if repeated exposure in a short period of time is clinically indicated.

QTc Prolongation - QTc prolongation, with rare instances of torsade de pointes, have been reported. Monitor QT interval when administering isoflurane to susceptible patients.

4. Linezolid (Zyvox®) – *non-formulary*
Warnings and Precautions: *Hyponatremia and/or Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH)* - Postmarketing cases of hyponatremia and/or Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) have been observed in patients treated with linezolid. In reported cases, the signs and symptoms included confusion, somnolence, generalized weakness, and in severe cases led to respiratory failure and even death. Monitor serum sodium levels regularly in the elderly, in patients taking diuretics, and in other patients at risk of hyponatremia and/or SIADH while taking linezolid. If signs and symptoms of hyponatremia and/or SIADH occur, discontinue linezolid, and institute appropriate supportive measures.

5. Mycophenolate (Cellcept®) – *non-formulary*
Warnings and Precautions: *Serious infections* - viral infections reported include … COVID-19 (*new addition*) Consider dose reduction or discontinuation of mycophenolate in patients who develop new infections or reactivate viral infections, weighing the risk that reduced immunosuppression represents to the functioning allograft.

Acute Inflammatory Syndrome Associated with Mycophenolate Products - Acute inflammatory syndrome (AIS) has been reported with the use of MMF and mycophenolate products, and some cases have resulted in hospitalization. AIS is a paradoxical pro-inflammatory reaction characterized by fever, arthralgias, arthritis, muscle pain and elevated inflammatory markers including, C-reactive protein and erythrocyte sedimentation rate, without evidence of infection or underlying disease recurrence. Symptoms occur within weeks to months of initiation of treatment or a dose increase. After discontinuation, improvement of symptoms and inflammatory markers are usually observed within 24 to 48 hours.

Monitor patients for symptoms and laboratory parameters of AIS when starting treatment with mycophenolate products or when increasing the dosage. Discontinue treatment and consider other treatment alternatives based on the risk and benefit for the patient.

6. Ondansetron (Zofran®, Zofran ODT®) – *formulary*
Warnings and Precautions: *Myocardial Ischemia* - Myocardial ischemia has been reported in patients treated with ondansetron. In some cases, predominantly during intravenous administration, the symptoms appeared immediately after administration but resolved with prompt treatment. Coronary artery spasm appears to be the most common underlying cause. Therefore, monitor or advise patients for signs or symptoms of myocardial ischemia after oral administration of ondansetron.

7. Rifampin (Rifadin®) – *formulary*
Warnings and Precautions (newly added information): Postmarketing cases of paradoxical drug reaction (recurrence or appearance of new symptoms, physical and radiological signs in a patient who had previously shown improvement with appropriate antimycobacterial treatment, in the absence of disease relapse, poor treatment compliance, drug resistance, side effects of treatment, or secondary infection/diagnosis) have been reported with

rifampin. Paradoxical drug reactions are often transient and should not be misinterpreted as failure to respond to treatment. If worsening of symptoms or signs occurs during antimycobacterial treatment, consider paradoxical drug reaction in the differential diagnosis, monitor, or treat accordingly.

8. Sodium Zirconium Cyclosilicate (Lokelma®) – *formulary*
Warnings and Precautions: *Diagnostic Tests* (*newly added section*) - Sodium Zirconium Cyclosilicate has radio-opaque properties and, therefore, may give the appearance typical of an imaging agent during abdominal X-ray procedures.

PHARMACY POLICIES:
The following Pharmacy policy was revised. Updated policies can be found on iSite.
►**Policy 3216** – Concentrated Electrolyte Solutions
►**Policy 3219** – Crash Cart, Adult - Medication Tray Contents

RECALL SUMMARY OCTOBER 2021
1. Total number of recalls received and reviewed: 1
2. Of recalled items, total number of "RECALLS" illustrating products with a purchase history by CCRMC: 1
3. Of purchased items, total number of medications/products returned due to recall: 0
4. Itemization of medications/products returned due to recall: N/A
5. Action Taken

(Note: a summary of these recalled items are placed onto the PCP&E Physician memos monthly):

- Products with recalled lot numbers were removed quickly from all patient care units and pharmacy and were quarantined.
- Quarantined products were returned.

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
February 28, 2022
12 to 2:00p

As the elected leadership of the CCRMC/HCs Medical Staff, we stand against racism and hate. *We recognize the negative impact of longstanding structural racism on health, and we commit to take action to combat this in our own system and work for health equity for our patients.*

Join Zoom Meeting
https://cchealth.zoom.us/j/8544948118
Meeting ID: 854 494 8118
****If you are on phone only for the Zoom, use *6 to mute/unmute**

Agenda Topic	Status	Time
Call to Order		
Review of January 24, 2022 Minutes	See attached Draft Minutes.	2 min.
Announcements (3 min)		
• **March 21, 2022 MEC meeting reports to Sue by March 10, 2022** ○ Medical Staff Assistance Committee ○ Surgery Department-Dr. Dosanjh ○ Psychiatry/Psychology Department-Dr.Guss ○ Cancer Committee-Dr. Gynn ○ Diagnostic Imaging Department-Dr. Liebig ○ Utilization Management Committee-Dr. Rael ○ Peer Review Oversight Committee-Dr. Moeller Please use the standard SBAR form for your reports -You will be given 5 minutes in which to present your report. Please number the pages of your report. **PLEASE DATE YOUR REPORT AND NUMBER THE PAGES. Please include your executive summary which can be added to the minutes.** **Next meeting March 21, 2022**		
ADMINISTRATIVE REPORTS		
Anna Roth, Health Services Director Ori Tzvieli, Health Officer, Director of Public Health Pat Godley, CFO for Health Services Gilbert Salinas, Chief Equity Officer, HS Jaspreet Benepal, RN, Chief Nursing Officer Samir Shah, M.D., Chief Executive Officer/Chief Medical Officer Vacant - Chief Quality Officer David Runt - Chief Operations Officer	Rajiv Pramanik, M.D.- CMIO Gabriela Sullivan, M.D.- Specialty/Ambulatory Medical Director Sergio Urcuyo, M.D.- Hospital Medical Director Sonia Sutherland, M.D.-Medical Director, Detention Health Sharron Mackey, MHS, Chief Executive Officer CCHP Dennis Hsieh, M.D., Medical Director/CMO CCHP	
NEW BUSINESS		

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA
CHAIR-KRISTIN MOELLER, M.D.
February 28, 2022
12 to 2:00p

Agenda Topic	Status	Time
Quality Indicators-Vote Needed	Dr. Moeller	5 min.
Nominations Due March 1 for the Following: (Term 7/1/2022 - 6/30/2024) **Department Heads:** ED Surgery Psychiatry/Psychology Diagnostic Imaging OB/GYN Critical Care **Division Heads:** DFAM West County DFAM Far East County	Dr. Moeller	3 min.
OLD BUSINESS		
Bylaws Vote Count-76 ballots received **#1Prerogs for Allied Health** **69 Yes/7 No** **#2Update current division names** **70 Yes/5 No/1 Abstain** **#3 Committees** **67 Yes/9 No**	Dr. Moeller	3 min.
Consent Agenda		
Medication Safety Committee-Dr. Ataii	See report.	5 min.
PCP&E-Dr. Forman **Hospital Wide Policies** 357 Roles of the Deputy Sheriff at Hospital and Health Center Sites 360 Security Program **Nursing Policies-Helena Martey** 3.142 Sodium Bicarbonate, Intravenous Administration 3.70 Formula: Safe Preparation, Storage and Feeding 3.70 A Formula Preparation Handout (English) 3. 70 B Formula Preparation Handout (Spanish)	See report. Please ask if you wish to see a specific policy and it will be sent to you.	5 min.

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA
CHAIR-KRISTIN MOELLER, M.D.
February 28, 2022
12 to 2:00p

Agenda Topic	Status	Time
COMMITTEE REPORTS		
Credentials Committee- Dr. Mbanugo List of Candidates - Vote needed	See report.	3 min.
Patient Safety and Performance Improvement Committee - Dr. Beach	No report this month.	3 min.
APC - Dr. Pyrkova	Pending	3 min.
Contra Costa Health Plan-Sharron Mackey	Pending	5 min.
DEPARTMENT & DIVISION REPORTS		
DFAM West County-Dr. Sheldon	See report	5 min.
Pathology Department-Dr.Das	Pending	5 min.
ADJOURN TO CLOSED SESSION-VOTING MEMBERS ONLY		
Adjournment. Next Meeting Date: March 21, 2022		

ROLE OF THE DEPUTY SHERIFF AT HOSPITAL AND HEALTH CENTER SITES

I. PURPOSE

To define the role of the Deputy Sheriff at CCRMC and HCs. Criminal behavior will not be tolerated and may be prosecuted.

II. REFERENCES

HR Job Description for Deputy Sheriff
H & HC Policies 359, 360 and 361

III. POLICY

To improve the overall safety and security of HSD sites where a deputy sheriff is assigned and may be called to intervene when anyone engages in criminal behavior.

IV. AUTHORITY AND RESPONSIBILITY

All Hospital and Health Center Staff

V. PROCEDURE

Deputy Sheriffs are not to get involved in patient care matters.

Staff members may reach the assigned deputy via pager, two-way radio or overhead page. The Security office distributes the pager information.

The physician in collaboration with the patient treatment team will determine whether the patient's act was related or unrelated to a mental or medical disorder. If the act is determined to not be part of the patient's clinical condition the deputy may be called. If the Deputy is to take law enforcement action, the patient will be discharged. Deputies may become involved in order to prevent death, assaults or great bodily harm.

For the purposes of this policy, an assault is a purposeful act of choking, hitting, kicking, biting, pushing, scratching, punching, pulling hair, or unwanted forceful physical contact by a patient against another person (another patient, visitor, staff member or provider) that has the potential for or causes bodily injury.

VI. FORMS

None

VII. RESPONSIBLE STAFF PERSON

Security Chief

WRITTEN: 10/2013
REVIEWED: 11/2021
REVISED: 12/21

SECURITY PROGRAM

I. PURPOSE

The purpose of this policy is to enunciate and clarify the role of the Health Services Security Program for Contra Costa Regional Medical Center and Health Centers.

II. REFERENCES

California Labor Code, Chapter 3, Section 6401
The Joint Commission EC.02.01.01, EC.04.01.01, EM.02.02.05
Contra Costa Regional Medical Center Policy No. 108, "Adverse Event Reporting."
Ambulatory Care Policy No. 1040, "Adverse Event Reporting."
California Health and Safety Code 1257.7

III. POLICY

It is the policy of the Contra Costa Regional Medical Center and Health Centers to provide adequate security to patients, clients, staff, and property through the Department's Security Program. The program is administered and enforced by the Chief, located at the Hospital, and by Deputy Sheriffs, and Sheriff's Rangers at various Health Centers (including the CCRMC). The primary mission of the Security Unit is to protect persons and secondarily to protect property. Whenever possible, Security Personnel will act to defuse a potentially violent situation verbally, without physical contact and with as little disruption of normal activities as possible.

IV. AUTHORITY/RESPONSIBILITY

A. Chief – HSD Security Unit – Telephone 370-5331, FAX 370-5906
The HSD Security Chief holds the rank of LT in the CCCSO and is primarily responsible for the administration and enforcement of the Security Program. He/she works under the direction of the Chief Executive Officer and provides security information and advice to other staff as requested. He/she serves as a member of the CCRMC and Health Centers Environment of Care Committee.

B. Assistant Manager – HSD Security Unit – Telephone 370-5192~~330~~

1. The Assistant Manager – HSD Security Unit holds the rank of Sgt in the CCCSO and is primarily responsible for the day-to-day operations of the Security Unit as well as direct supervision of all Security Personnel. His/her supervisory responsibilities include the establishment and enforcement of security standards and reporting requirements and the development of security plans, policies, and procedures, and developing and maintaining the Security Unit Training Program. He/she works under the supervision of the Chief.
2. All Security Unit personnel are under the direct supervision of the Assistant Manager. However, because of the assignments to outpatient clinics, Security personnel will function administratively under the general guidance of their Health Center site coordinators or their designees. Day-to-day administrative instructions of Health Center Administrators must not conflict with the security standards, reporting requirements, plans, policies, and procedures established by the HSD Security Unit Chief/Assistant Manager.

C. CCRMC & Health Centers Security Program Offices

Location	Telephone
CENTRAL COUNTY SITES	
Contra Costa Regional Medical Center 2500 Alhambra Avenue, Martinez	Days - 925-370-5330 Nights - 925-370-5000 CCRMC - Dial 0 (routine) Emergency -333 (Stat Line) FAX - 925-370-5906
EAST COUNTY SITES	
Pittsburg Health Center 2311 Loveridge Rd., Pittsburg	Days 925-431-2319
WEST COUNTY SITES	
West County Health Center 13601 San Pablo Ave., San Pablo	Days 510-231-9496
North Richmond Center for Health 1501 Fred Jackson Way ~~3~~rd Street, Richmond	Days~~—~~ 510-231-1355~~370-7176~~

V. PROCEDURE

A. Chief of HSD Security

The Chief administers the Security Program, conducts periodic inspections/visits and coordination with Security Unit Program offices at various county locations. Maintains a liaison with all county Police Departments and the Sheriff's Office.

B. Assistant Manager

The Assistant Manager – Security Unit responds to security requirements when available on-site at HSD facilities during day and evening operations. Assists with periodic inspections/visits and coordination with Security Offices at outpatient clinic locations and maintains liaison with all county Police Departments and the Sheriff's Office. He/she may consult with Clinic Administrators and Security Unit personnel in carrying out responsibilities for the design and implementation of security systems.

C. HSD Security

Security Unit Personnel patrol designated areas, protect patients, clients, staff, and property at outpatient clinic locations in accordance with instructions from the Assistant Manager and in coordination with their respective Clinic Administrators. They report immediately by phone to the Assistant Manager of any unusual security problems or violations and follow-up oral reports by written, Adverse Event Reports (SERS), Security Program reports, and/or Police reports as applicable. Security Unit

personnel will secure their building at the conclusion of the business day unless otherwise directed.

At the Medical Center, Security will ensure all exterior doors except the third floor Allen Street and ambulance entrance are secured at 2030 hours. These doors remain locked until 0530. Security Unit personnel will also ensure that the other buildings on the CCRMC campus have been properly secured at the end of their business day.

D. Disaster

In event of a major disaster at any site where Security Unit personnel are located and especially disasters involving the Hospital, HSD Security Unit personnel from other locations may be brought in to the disaster site to provide security assistance until returned to their normal stations by the Chief.

VI. FORMS USED

Safety Event Reporting System (SERS)
Health Services Department Security Unit Report Form (Public Service 2 & 3).
Health Services Department Security Unit F.I. Card (PSO1)
Health Services Department Security Unit Activity Cards

VII. RESPONSIBLE STAFF PERSON

Chief of HSD Security

REVIEWED/REVISED 9/98; 5/01, 10/03, 5/07; 10/10, 5/13

SODIUM BICARBONATE, INTRAVENOUS ADMINISTRATION

I. PURPOSE:

To specify the nursing methodology to be used when administering IV Sodium Bicarbonate to newborns.

II. REFERENCES:

Sodium Bicarbonate. Micromedex products (2021). https://www.micromedexsolutions.com/micromedex2/librarian/PFActionId/evidencexpert.GetNeofaxDrugMonograph?navitem=neofaxDrugMonographDocRetrieval&drugName=Sodium+Bicarbonate&tabSelected=neonatal#.

TJC. 2021. MM 06.01.01. *The hospital safely administers medications*. PC 02.02.21. *The hospital recognizes and responds to changes in the patient's condition.*

III. POLICY:

A ~~trained~~ registered nurse ~~with nursery experience~~ will safely administer sodium bicarbonate per physician's orders~~. and in accordance with the recommendations of the Neonatal Resuscitation Program, 5th edition~~.

Recommended dosing:

2 mEq/kg/dose, given as a 4.2% concentration solution (0.5 mEq/ml). ~~at a rate no faster than 1 mEq/kg/min.~~

~~BACKGROUND:~~

~~Sodium bicarbonate neutralizes hydrogen ion concentration and raises blood and urinary pH. It is used to manage metabolic acidosis following birth asphyxia.~~

~~**When sodium bicarbonate mixes with acid, carbon dioxide is formed. The lungs must be adequately ventilated to remove the CO2 before administering sodium bicarbonate.**~~

~~Sodium bicarbonate is very caustic and hypertonic and therefore must be given into a large vein, preferably the umbilical vein. Be sure that there is good blood return from the line before administering the sodium bicarbonate.~~

IV. AUTHORITY/RESPONSIBILITY:

~~Experienced~~ Nnursery nurses and~~,~~ physicians ~~pediatricians, pharmacists~~

V. PROCEDURE:

A. ~~Obtain~~ Acknowledge MD order ~~from physician and check that the dose is in the recommended range.~~
B. Obtain vital signs and O2 saturation prior to administration
C. Ensure adequate ventilation by verifying good chest rise and bilateral breath sounds.

D. Obtain sodium bicarbonate 4.2% concentration solution from the Nursery Omnicell
E. ~~Fax order to pharmacy~~ Check medication concentration and dose with a second Nursery RN
F. ~~Assure~~ Ensure that umbilical venous catheter or peripheral IV is set up and ~~is~~ patent. ~~with good blood return.~~
G. ~~Assure that good breath sounds are heard bilaterally and chest movement is present with ventilation.~~
~~H. Obtain vital signs and O2 saturation prior to administration.~~
I. ~~Obtain sodium bicarbonate 4.2% solution from the infant crash cart.~~
~~J. Assure UVC line and tubing are set up correctly.~~
~~K. Check medication concentration and dose with a second RN.~~
~~L. Assure that~~ Communicate to the ~~resuscitation team is aware that sodium bicarbonate infusion has begun and when it is completed.~~
M. ~~Obtain MD order for Rr~~Repeat blood gas analysis post administration per MD orders.
N. Document administration ~~completed~~ in ccLink on MAR.

VI. DOCUMENTATION:
ccLink
Intensive Care Nursery Flow sheet MR517-4
Medication Administration Record MR727-4

APPROVED BY:
Pediatric Department: 11/2021
Clinical Practice Committee:
Patient Care Policy and Evaluation Committee:
Medical Executive Committee

REVIEWED/REVISED:
4/2010, 5/2017, 1109/2021

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~~**FORMULA FEEDING OF THE NEWBORN**~~

FORMULA: SAFE ~~FORMULA: SAFE~~ PREPARATION, STORAGE AND FEEDING

I. PURPOSE

To describe the methodology to be used when preparing, storing and ~~initiating~~ formula feeding ~~of~~ a newborn.

II. REFERENCES~~:~~

American Academy of Pediatrics (AAP) Committee on Fetus and Newborn, American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice, and others. (2017). Chapter 10: Care of the newborn. In *Guidelines for perinatal care* (8th ed., pp. 347-408). Elk Grove Village, IL: AAP. (Level VII)

Stanzo, K. (2019). Chapter 22: Infant feeding. In S.S. Murray and others (Eds.), *Foundations of maternal-newborn and women's health nursing* (7th ed., pp. 606-632). St. Louis: Elsevier.~~American Academy of Pediatrics, and American College of Obstetricians and Gynecologists (1992) Guidelines for Perinatal Care. Washington D.C.: Author.~~

TJC, (202~~1+6~~), Standard PC.0~~3~~1.02.01, "*The hospital provides education and training based on each patient's needs and abilities.* ~~assesses and reassesses its patients.~~"

III. POLICY

Nursing staff will support the decision of a mother who wishes to ~~bottle~~ formula feed her newborn, ~~by offering instruction on method and infant safety.~~ Mothers that have decided not to breastfeed, "mixed-feed", or who require supplementation with formula for their newborns at the time of discharge, must receive written instruction and verbal information about safe preparation, storage and feeding of formula. ~~Staff should document completion of formula preparation instruction and feeding in the medical record.~~ The information should be given on an individual basis only.

IV. AUTHORITY/RESPONSIBILITY

Licensed nursing personnel

V. PROCEDURE

A. Review MD order for type of formula, amount and feeding method

~~A.~~ B. Evaluate suck-swallow coordination~~,~~

C. Feed babies ~~on demand or keep to a flexible schedule~~ on cue, frequent low volume feeds with paced technique unless the infant's condition or physician indicates otherwise.

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~~C.~~ D. Sterile caps should be kept on bottles and nipples until the baby is ready to feed. A sharp click is heard when the bottle is first opened.

~~D.~~ E. Instruct parents/caregivers on the ~~(reinforce)~~ use of bulb syringe (see patient teaching guidelines) and make sure ~~mother can reach~~ bulb syringe and ~~her~~ call light are within reach ~~button~~.

~~D.~~ F. Instruct mother on ~~Paced Bottle Feeding~~

~~2.~~ ~~Watch for baby~~ hunger cues:

1. ~~–~~Hands near the mouth

~~b.~~ 2. ~~-~~Arms and legs bending toward body

~~c.~~ 3. ~~–~~Sucking noises

~~d.~~ 4. ~~-~~Puckered lips

~~e.~~ 5. ~~–~~Rooting toward nipple

~~3.~~ G. Feeding ~~baby~~the newborn (Paced Feeding):

~~a.~~ 1. ~~–~~Hold the ~~baby~~ newborn upright

~~b.~~ 2. Eye to eye contact

~~c.~~ 3. ~~–~~Brush the bottle nipple across ~~baby's~~ newborn's upper lip and wait for mouth to open.

~~d.~~ 4. Hold the bottle in an almost flat position, so that the nipple is only partly full of formula. ~~an almost flat position. The nipple will be only partly full.~~

5. ~~–~~Let ~~baby~~ the newborn pause and take breaks every few sucks. The ~~baby~~ newborn will typically feed for about 15-20 minutes.

~~e.~~ 6. Burp newborn after feeds or as needed

H. ~~3.~~ Watch for signs of fullness:

~~a.~~ 1. ~~–~~Sucking slower or stops sucking

~~b.~~ 2. ~~-~~Relaxation of hands and arms

~~c.~~ 3. ~~–~~Turning/pushing away from nipple

4. Falls asleep

I. Regurgitation/Vomiting

1. If vomit is undigested or partially digested formula, wait 15 minutes then refeed volume-for-volume

2. Bilious (bright green or yellow) vomit may indicate an obstruction. Hold feedings.

3. Notify physician

J. Provide parent(s)/caregiver(s) with "Preparing Infant Formula" pamphlet, and education on the preparation, storage and feeding of formula.

K. Document all feedings, events and education provided in ccLink

~~d.~~

~~e. Letting a baby set the pace means less chance of overfeeding, gas, stomach discomfort, and spitting up.~~

~~E.~~A. ~~Have mother feed infant during waking hours unless otherwise ordered. Encourage mother to feed her infant during the night.~~

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~~Refeeding after regurgitation~~

~~2. Wait 15 minutes and refeed volume-for-volume with formula.~~

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~~F.~~B. ~~Vomiting~~

~~1. Document in notes~~

~~2. Notify Physician as condition warrants.~~

~~feedings. Notify physician.~~

~~3. Bilious vomiting means obstruction, until proven otherwise. Hold feedings. Notify physician.~~

~~G.~~C. ~~Record amount and time of all feedings, in the progress notes.~~

~~H.~~D. ~~Make frequent rounds to all mothers and babies to reinforce teaching and assure that fresh formula is available.~~

VI. ATTACHMENTS

Addendum ~~A.~~A: Formula Preparation Handout, English~~Preparing Infant Formula Pamphlet~~

Addendum B: Formula Preparation Handout, Spanish

VII. DOCUMENTATION:

~~VII.~~ ccLink

Newborn Nursery Care (MR540A)

Nursing Care Record (MR541)

Newborn Intensive Care Flow sheet (MR517-4)

~~VIII. REFERENCES:~~

~~American Academy of Pediatrics, and American College of Obstetricians and Gynecologists (1992) Guidelines for Perinatal Care. Washington D.C.: Author.~~

~~TJC 2016 Standard PC.01.02.01, "The hospital assesses and reassesses its patients."~~

APPROVED BY:

Pediatric Department: 11/2021

Clinical Practice Committee

Patient Care Policy and Procedure Committee:

Medical Executive Committee:

REVIEWED/REVISED:

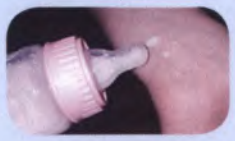
6/2007, 4/2010, 5/2017, 11/2021

General Guidelines for Preparing All Types of Formula

1. **Clean the surface** and equipment used to prepare formula.
2. **Wash your hands** with soap and water and dry with a clean towel.
3. **Use a safe water source.** Tap water is best in most areas. If you have any concerns, talk to your doctor about your water source.
4. **Before opening the container,** rinse and dry the top of the container. Check the expiration date.
5. **Read the directions** on the can for mixing the formula.

Adding too much formula or not enough formula can make your baby sick.

6. **Before you feed the baby, always test the temperature** of the formula. Shake a few drops of formula on your wrist. It should feel warm, not hot.



7. **To warm formula**, put the bottle in a ***small bowl of hot water***, and then shake the bottle to mix well. To cool the formula, put the bottle in a cup of cold water with ice.
   - Test the temperature again on your wrist before feeding the baby.

How Long Should You Keep Formula?	
Once you start to feed the baby	Discard after 1 hour
Prepared formula left unused at room temperature	Discard after 2 hours
Prepared formula in refrigerator (40 degrees F or less)	Discard after 24 hours

Do not heat the formula or bottle in the microwave.

Cleaning Equipment

1. **Wash your hands with soap and** water and dry with a clean towel.

2. **Wash all bottles and equipment** used to make formula in hot soapy water. Use a bottle and nipple brush to remove all formula from the previous feeding.

3. **Rinse the bottles, nipples and equipment with clean water.**
4. **Sterilize the bottles, nipples and equipment** by putting them in a pot of water and boiling them for one minute. Be sure the bottles, nipples and equipment are completely covered in the water.

5. **Keep the pot covered** until you need the bottles or put the nipples and caps on the bottles and store them in a clean area for later use.

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Powdered Formula

Powdered formula is not sterile and may have harmful bacteria in it. The water must be ***hot*** (greater than 158 degrees F) in order to kill bacteria in the powdered formula.

1. **Start with cold tap water.** Boil the water for 1 minute, then let it cool slightly, but no more than 30 minutes. The water must be hot enough to kill the bacteria.

2. **Pour the hot water into clean bottles,** Fill the bottles exactly to the 2 oz., 4 oz. or 6 oz. line on the bottle, depending on how much your baby eats at each feeding.

3. **Use the scoop in the formula container** to measure the formula. Fill the scoop up and level it off with a knife. **Do NOT** pack it down. Return the clean and dry scoop to the can.

How Much Formula?	
Water	**Powdered Formula**
2 oz.	Add 1 scoop
4 oz.	Add 2 scoops
6 oz.	Add 3 scoops

- Most newborn babies only eat two to four ounces per feeding. To make a three-ounce feeding, prepare a six-ounce bottle and divide it into two three-ounce bottles. ***Avoid using half-scoops*** of powder.

4. **Put the nipples and caps on the bottles**, shake well, and test the temperature on your wrist. It should feel warm not hot.

5. **Feed the baby or store** the bottle in the refrigerator for use within 24 hours.

Formula from Concentrate

When making formula from concentrate, add an equal amount of water and formula to make a feeding.

1. **Before opening the can**, wash and dry the top. Shake the can and open with a clean can opener.

2. **Pour the entire can of concentrate** into a pitcher. Using the same can, add a can of tap water. The water does not need to be boiled, unless advised by the doctor.

3. **Mix well and fill each bottle for one feeding**. Put the nipple and cap on the bottle.

4. **Test the temperature on your wrist** and feed the baby or store the bottle in the refrigerator for use within 24 hours.

STORING TIP:

Label the pitcher or bottles of formula with the date and time to avoid feeding your baby formula that has expired.

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1. **Shake the con formula well.**

2. **Pour enough bottles for eac** any other wat

3. **Put the nippl**

4. **Test the temp** on your wrist. hot. Feed the l in a refrigerato

Trave

What do I do wh

- Store the for before you le cold bottles c insulated bag the baby the warm the for hot water to

- Use single-p formula bott nipples and c when the bab

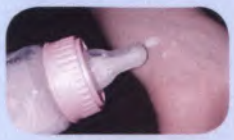
Pautas Generales para Preparar Todo Tipo de Formula

1. **Limpie la superficie** y los utensilios empleados para preparar la formula.
2. **Lávese las manos** con agua y jabón, y séquese con una toalla limpia.
3. **Use una fuente de agua segura. El agua de la llave es la mejor en la mayoría de las zonas.** Si tiene inquietudes, converse con su médico acerca de su fuente de agua.
4. **Antes de abrir el envase,** enjuague y seque la tapa del recipiente. Verifique la fecha de vencimiento.

5. **Lea las instrucciones** que figuran en la lata para mezclar la formula.

Si agrega una cantidad excesiva o insuficiente de fórmula, podría hacerle mal a su bebé.

6. **Antes de alimentar al bebé, compruebe siempre la temperatura** de la formula. Vierta algunas gotas de la leche sobre su muñeca. Debe estar tibia, no caliente.



7. **Para entibiar la formula,** coloque el biberón en un ***tazón pequeño de agua caliente,*** y luego agite el biberón para mezclar bien. Para enfriar la formula, coloque el biberón en una taza de agua fría con hielo.

- Vuelva a probar la temperatura en su muñeca antes de alimentar al bebé.

¿Cuánto Tiempo debe Conservar La Formula?	
Una vez que empiece a alimentar al bebé	Deseche al cabo de 1 hora
Formula preparada que le sobre sin utilizar a temperatura ambiente	Deseche al cabo de 2 horas
Formula preparada en el refrigerador (el refrigerador debe estar a 40° F o menos)	Deseche al cabo de 2 horas

NO caliente la formula /el biberón en el horno de microondas.

Utensilios de Limpieza

1. **Lávese las manos con agua** y jabón, y séquese con una toalla limpia

2. **Lave todos los biberones y los utensilios** empleados para preparar la formula con agua caliente jabonosa. Use un cepillo para biberón y tetina para eliminar toda la leche que haya quedado de comidas anteriores.

3. **Enjuague los biberones, las tetinas y los utensilios con agua limpia.**
4. **Esterilice los biberones, las tetinas y los utensilios** sumergiéndolos en una olla con agua y hiérvalos durante un minuto. Asegúrese de que los biberones, las tetinas y los utensilios estén completamente cubiertos por el agua.

5. **Mantenga la olla tapada** hasta que necesite los biberones o coloque la tetina y la tapa en los biberones y guárdelos en un lugar limpio para utilizarlos después.

Cór Fórmu

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Formula en Polvo

La fórmula en polvo no es estéril y puede contener bacterias perjudiciales. El agua debe estar CALIENTE (a más de 158° F) para eliminar las bacterias presentes en la formula en polvo.

1. **Comience con agua fría del de la llave.** Hierva el agua durante 1 minuto. Luego déjela enfriar un poco, pero no más de 30 minutos. El agua debe estar lo suficientemente caliente como para eliminar las bacterias.

2. **Vierta el agua caliente en biberones limpios,** según la cantidad que tome su bebé en cada comida. Asegúrese de llenar los biberones exactamente hasta la línea del biberón que marca 2 onzas, 4 onzas o 6 onzas.

3. **Use el medidor del envase de la fórmula** para medir la leche. Llene el medidor con la formula en polvo y quite el excedente con un cuchillo. **NO** presione la leche en polvo hacia abajo. Vuelva a colocar el medidor limpio y seco en la lata.

¿Qué cantidad de formula?	
Agua	**Formula en Polvo**
2 onzas	Agregue 1 copa medidora
4 onzas	Agregue 2 copa medidora
6 onzas	Agregue 3 copa medidora

- La mayoría de los recién nacidos toman solo de 2 a 4 onzas por alimento. Para elaborar un alimento de 3 onzas, prepare un biberón de 6 onzas y vierta la preparación en dos biberones de 3 onzas. ***Evite usar la mitad del medidor*** de polvo.

4. **Coloque las tetinas y las tapas en los biberones,** Agite bien y pruebe la temperatura de la leche sobre su muñeca. Debe estar tibia, no caliente.

5. **Alimente al bebé o guárdela en** el refrigerador para usar dentro de las próximas 24 horas.

Formula Concentrada

Al preparar formula con leche concentrada, deberá agregar agua. Añada una cantidad de agua equivalente a la cantidad de fórmula para preparar un alimento.

1. **Antes de abrir la lata,** lave y seque la parte superior. Agite la lata y ábrala con un abrelatas limpio.

2. **Vierta todo el contenido de la lata de leche concentrada en una jarra.** Con la misma lata, agregue una lata de agua de la llave. No es necesario que el agua esté hervida, a menos que lo indique el médico.

3. **Mezcle bien y llene cada biberón para un alimento.** Coloque la tetina y la tapa en el biberón.

4. **Coloque las tetinas y las tapas en los biberones,** agite bien y pruebe la temperatura de la leche sobre su muñeca. Debe estar tibia, no caliente.

5. **Alimente al bebé o guárdela en** el refrigerador para usar dentro de las próximas 24 horas.

SUGERENCIA DE CONSERVACIÓN:

Coloque una etiqueta sobre la jarra o los biberones de formula con la fecha y la hora para no darle a su bebé leche vencida.

Form

Est
y N

1. **Agite el envase**
2. **Vierta una can formula en bib cada comida.** N ningún otro líq
3. **Coloque la teti**
4. **Coloque las tet los biberones,** temperatura de Debe estar tibia
5. **Alimente al be** refrigerador pa próximas 24 ho

Cómo

¿Qué debo hacer

- Guarde la for antes de salir biberones frí bolso térmic hielo. Dele al ponga la lech caliente para

- **Use** biberone ***para usar*** de Lleve tetinas colocar en el esté listo par