Contra Costa
Regional Medical Center
& Health Centers
A Division of Contra Costa Health Services

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| To: | Joint Conference Committee Members | Date: | June 27, 2022 |
| From: | Supervisor John Gioia – District I<br>Supervisor Diane Burgis – District III | Subject: | Meeting Notice<br>Joint Conference Committee |
| By: | Samir Shah MD, Chief Executive Officer<br>Contra Costa Regional Medical Center | | |

**Due to the Shelter-in-Place Order, this meeting will not be held in person. You can access the meeting remotely by using the information on page 3 of this agenda.**

# JOINT CONFERENCE COMMITTEE

## VIA ZOOM WEBINAR-Instructions on Page Three of This Agenda

# AGENDA

**June 27, 2022, from 1:00 – 2:00 pm**

| AGENDA ITEM | RECOMMENDATION |
|---|---|
| I. **CALL TO ORDER and INTRODUCTIONS**<br>Meeting Chair- Supervisor John Gioia, District I | Inform |
| II. **APPROVAL OF MINUTES** – May 2, 2022<br>Supervisor Gioia | Inform/Action |
| III. **PUBLIC COMMENT**<br>Supervisor Gioia<br>*At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to two minutes or less. Under State law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration.* | Inform |
| IV. **ADMINISTRATIVE UPDATE**<br>Samir B. Shah, MD, Chief Executive Officer/Chief Medical Officer<br>A. Covid Update<br>Sergio Urcuyo, M.D., Hospital Medical Director<br>B. Measure X<br>C. Value Stream Mapping/Rapid Improvement Events | Inform |

| AGENDA ITEM | RECOMMENDATION |
|---|---|
| V. **MEDICAL STAFF UPDATE**<br>Sergio Urcuyo, M.D., Hospital Medical Director<br><br>A. Patient Care Policies for CCRMC/HCs | <br><br><br>Inform/Consent |
| VI. **SAFETY AND QUALITY UPDATES**<br>Courtney Beach, M.D., Chief, Hospital Medicine<br>A. PSPIC/Quality Update<br><br>B. Annual Quality Assurance/Performance Improvement report | <br><br>Inform<br><br>Inform/Consent |
| VII. **ADJOURN** | Inform |
| VIII. **NEXT MEETING**: Monday, September 26, 2022 | |

*Joint Conference Committee observes Ralph M. Brown Act open meeting law procedures. Reasonable accommodations will be provided for persons with disabilities planning to attend. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Joint Conference Committee prior to that meeting are available for public inspection at 2500 Alhambra Avenue during normal business hours. Public comment may also be submitted via electronic mail at least one full workday prior to the published meeting time. For information contact Karin Stryker – karin.stryker@cchealth.org, 925-234-1909.*

# Zoom Webinar

# Meeting Instructions

**Please click the link below to join the webinar**:

https://cccounty-us.zoom.us/j/82659445587?pwd=dDJYblh6VDd0UGNZSHhEMlVwTmtxdz09

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Contra Costa
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# JOINT CONFERENCE COMMITTEE

# MINUTES

**May 2, 2022, from 1:00 – 2:00 pm**

Due to the Shelter-in-Place Order, this meeting will not be held in person.

*VOTING MEMBERS PRESENT: Supervisor John Gioia, District I; Dr. Courtney Beach, Chair, Hospital Medicine; Supervisor Diane Burgis, District 3; Katherine Goheen; Ashley Porteous NON-VOTING MEMBERS PRESENT: Samir Shah MD, Chief Executive Officer/Chief Medical Officer; Kristin Moeller MD, Medical Staff President; Anna Roth, R.N. NON-VOTING MEMBERS ABSENT: None. GUESTS PRESENT: Jaspreet Benepal RN, Chief Nursing Officer; Sergio Urcuyo MD, Hospital Medical Director; Karin Stryker, Director of Safety and Performance Improvement; David Runt, Chief Operations Officer; Ira-Beda Sabio, Director of Inpatient Nursing; Gabriela Sullivan MD, Ambulatory and Specialty Medical Director; William Walker, Director of Health Services; Randy Sawyer, Health Services Deputy Director; Mary Campbell, Director of Safety and Performance Improvement; Will Harper, Community and Media Relations; Shannon Dickerson, Quality Management Program Coordinator; Shideh Ataii, Director of Pharmacy Services; David Twa, Contractor; Enid Mendoza, Chief Deputy Administrator; Nooshin Abtahi, Health Services Administrator; Jill Ray, Field Representative, Supervisor, Candance Anderson*

| AGENDA ITEM | RECOMMENDATION |
|---|---|
| I. **CALL TO ORDER and INTRODUCTIONS**<br>Meeting Chair- Supervisor John Gioia, District I | ***Inform*** |
| II. **APPROVAL OF MINUTES** – March 7, 2022<br>Supervisor Gioia<br><br>***In open session, voting members of Contra Costa Regional Medical Center Joint Conference Committee voted to accept the December 13, 2021, Joint Conference Committee minutes*** | ***Motion:***<br>***By Burgis***<br>***Seconded by Goheen***<br><br>***Ayes:***<br>***Gioia, Porteous***<br><br>***Absent: None***<br>***Abstain: None*** |
| III. **PUBLIC COMMENT**<br>Supervisor Gioia<br><br>***No public comment*** | ***Inform*** |
| **IV. ADMINISTRATIVE UPDATE**<br>Samir B. Shah, MD, Chief Executive Officer/Chief Medical Officer<br>A. Covid Update<br>Sergio Urcuyo, M.D., Hospital Medical Director<br><br>***Still seeing very low numbers in our institution and across the region. Due to the number of at-home tests being done, some of the publicly reported numbers are not fully indicative of what is going on in the community. Hospitalizations are low. Vaccination is still the most helpful thing we can do to prevent COVID-19 infections.***<br><br>***We are fully onboard with the program and are hoping to have zero COVID deaths if possible. Most of this is an outpatient program to meet patients where they are, providing them with medication and testing as quickly as possible. We will also be doing this in terms of the hospital, with ER visits and increased awareness that there are oral medications now that can help quite a bit.*** | ***Inform*** |

B. Measure X

***Went through a process with Public Works and the CAO's office to query the RFP's that we received for those interested in construction management for the Measure X projects on CCRMC campus. We have selected an individual construction management group that will hopefully be able to provide us the service we need throughout the process. Public Health is in the process of writing up a contract and making sure all the terms and agreements are appropriate for what we need. Once completed we will start with master planning.***

C. Appointment Unit Update

***In the early days of the COVID pandemic, emphasized some of the patient access challenges that the appointment unit and health centers were facing. In June 2020, we partnered with ECG Management Constants to identify areas to improve in the appointment unit operations.***

***Key areas of focus:***

- ***Improving operational KPI's***
- ***Streamlining the referral management and new patient scheduling processes***
- ***Increasing appointment unit staff productivity through a structured training program***
- ***Making assessments to the automated workflows within Epic***

***Four areas were identified as the primary areas of improvement:***

- ***Scheduling process within the appointment unit***
- ***Appointment unit staffing***
- ***Epic workflow optimization***
- ***Registration check-in***

***Key initiatives completed over this past year:***

- ***Simplifying the phone tree and greeting (major patient dissatisfier)***
- ***Optimizing the schedule workflows within Epic***
- ***Developed a standard training program for the appointment unit agents***
- ***Developed a weekly actionable dashboard with KPI's***
- ***Redesigned primary care provider templates***
- ***Placing a greater emphasis on patients being able to self-schedule through MyChart.***
    - ***In this past August, over 2500 new patient appointments have been scheduled through My Chart. The numbers continue to grow each month.***

***Work done this past year has resulted in operational improvements. Inbound calls are now down by 4%. Patient hold times have reduced. Clerks have been 7% more productive. Calla abandonment rates have decreased by 5%. As we fill the staffing vacancies, we expect to see service levels improve even more.***

***Primary care template optimizations are underway to enable flexible scheduling options, beginning with a pilot at Pittsburg Health Center. Over the next 6-months we will include the expansion on specialty template optimization and expansion of online scheduling to outpatient rehab services and other complex specialties.***

D. QIP Update
Nooshin Abtahi, QIP Lead

***The new Quality Incentive Project has been built upon prior value-based initiatives, Prime and QIP. They both ended in December 2020. This new project started January 2021 and is approved by CMS for three years. It will end December in December***

***2023.***

***We are required to have 40 quality metrics from both inpatient and outpatient settings. The selected measures evaluate the performance of different aspects of the health care delivery system. The funding for this project will be determined by DCHS after the conclusion of the measurement year. They will determine the funding based on the number of unduplicated managed care beneficiaries who had at least one service in our health care delivery system.***

***The total allocated budget for QIP PY4 is $1.8 billion statewide. Based on prior allocation history, we estimate that our share will be about $100 million. We are set to realize all the allocated fund for 2021.***

***2021 was a challenging year for population health improvement activities due to performance decline in 2020, frequent COVID shortages, staff shortage, competing priorities, massive backlog of services and patient hesitancy to come in for in-person visit. Despite all challenges, CCRMC achieved significant improvements in reaching out to patients and delivering the required services.***

***Preliminary date shared by Safety Net Institute reflects CCRMC was the best performing health entity in 2021. We were able to achieve all 40 measures and overperform in 18 measures.***

***Achievements:***

- ***Increased the Well Care Visits in child and adolescence by 11.5% in 2021 and reduced the disparity gap between the total and African American population from 10% to 6%***
- ***Significant improvement in Diabetes Eye Exam, Diabetes HBA1c Control, and Hypertension Control***
- ***Significant increase in Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening***

***Because of the significant improvement in the Calendar year 2021, CCRMC started the PY5 with a strong base and is on the path to realize all the QIP PY5 funding***

***Due to COVID and people holding back on preventative healthcare, Supervisor Burgis inquired if there was a comparison to 2019.***
***Per Dr. Shah, 2020 was a difficult year for us as there was a significant decrease in-person visits and screening. We ramped up our process towards the end of the year, which really helped with our numbers for 2021. We have the data for 2019 and will provide it.***

***Supervisor Burgis inquired if we are seeing as many people show up for the 2nd booster shot?***
***Per Dr. Shah, we are consistently boosting in our clinic site. Our daily booster numbers remain relatively stable. The number of new individuals coming in for their 2nd booster is lower than the number of people who received the 1st booster. The number of persons who received their 1st booster is lower than the number that received their 1st series if the vaccination.***
***In the clinics when patients are seeing providers or getting access to educational resource, we try to inform and offer the booster to them without the appointment if they are eligible. Public Health and other areas of the department have been doing lots of community outreach. The 1st two shots are still working very well, with the hospitalization numbers remining low.***

***Dr. Sullivan comments that the medical community is somewhat equivocal about the 2nd booster. In the press, the medical community is not being very aggressive with the messaging unless you are high risk. I believe this has affected the amount of people who have got their 2nd booster.***

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| ***Public Comment:***<br>***Anonymous caller proclaimed that the Brown Act was violated. She states that the administrative updates are not related, and public comment should have been allowed after each agenda item.***<br>***Caller expressed that the land callers were lied to when told that they can't participate. She states that if we provide an AT&T number with a code, callers can press *2 to participate.***<br>***Caller complains that there was a typo with the numerals on the agenda.***<br>***Caller directed a question to Dr. Urcuyo; There has been observation in Asian countries that the home test kits are not very accurate. If someone is suffering from allergic reaction from pollen this season, what is the likelihood that their test is a false positive?***<br>***Caller questioned what country the take-home-test kits given to the residents are made?***<br>***Caller expressed concern that there was no transparency in the Measure X update, as the amount spent was not reported.***<br><br>***Sergio states that as far as he is aware, seasonal allergies should not affect the sensitivity or specificity of the test kits. We are happy to supply the community with as many as we can and will continue to do so as aggressively as we can. Having test kits and knowing your status is the best way to prevent someone from getting sick.*** | |
| **V. MEDICAL STAFF UPDATE**<br>Kristin Moeller, M.D., Medical Staff President<br>A. Patient Care Policies for CCRMC/HCs, includes<br>- Policies, MEC approved, postponed from March 7 meeting (Attachment A)<br>- Policies, MEC approved for May 2 meeting (Attachment B)<br><br>***All policies have gone through their individual committees as well as the Medical Executive Committee for approval. They are all revisions of usual hospital and health center, ambulatory, and inpatient policies.*** | ***Motion:***<br>***By Goheen***<br>***Seconded by Porteous***<br><br>***Ayes:***<br>***Gioia, Burgis***<br><br>***Absent: None***<br>***Abstain: None*** |
| **VI. SAFETY AND QUALITY UPDATES**<br>Courtney Beach, M.D., Chief, Hospital Medicine<br>A. PSPIC/Quality Update<br><br>***Code Blue Committee gave report reflecting that they have a decreased number of code blues, increased survival rates, and a decrease in preventable codes. The following of ACLS guidelines were increased, specific to a newer standard in monitoring end-tidal CO2. They are at goal for monitoring end-tidal CO2.***<br><br>***We are meeting the collaborative alliance of nursing outcome measures for the goal prevalence rate of less than 1.75% for hospital acquired pressure injuries.***<br><br>***Perinatal health has met their quality incentive program measures in their departments. They are at or above target for exclusive breast milk feeding and low cesarean rate for first time deliveries and above target for timely prenatal and postpartum care. Perinatal health team is working on some measures that show more disparities in different groups. The most common factor for African Americans delivering elsewhere is due to lack of private rooms. Exclusive breast milk rates are lower in African American patients, so more predelivery and postpartum education and support.***<br><br>***Report of hospital acquired infections showed zero central line associated blood stream infections, zero CAUTI, zero infections from hysterectomy surgical sites, zero multiple drug resistance organisms' infections, one carbapenem resistant Enterobacteriaceae, and seven C. diff infections. We will work on our surgical site infections for colon surgery. There are plans underplay through Infection Control to work on the maintenance of hypothermia, the antibiotic administration and timing*** | ***Motion:***<br>***By Porteous***<br>***Seconded by Burgis***<br><br>***Ayes:***<br>***Gioia, Goheen***<br><br>***Absent: None***<br>***Abstain: None*** |

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| ***and to work on revitalizing our enhanced recovery after surgery program.***<br><br>***Public Comment:***<br>***Anonymous caller expressed concern that black mothers tend to be less likely to breastfeed. Breastfeeding takes a lot of time and if they are working, they may not have the time to keep their breast milk coming in. Appliances are sometimes needed to help pump the breast milk. We can maybe use Measure X or other funds that we have to intervene for black infants' nutrition up to 6-8 months. These infants are starving and there was no intervention report or proposal stated. Caller would like to see this on the agenda at a later time. Caller is also wondering if there is any plan to help educate the black mothers as they may just need help to learn how to lactate. If that concern is addressed, we should concentrate on nutritional intervention for the infants.***<br><br>***Addressing the callers' concerns, Dr. Beach states that in perinatal there has been more prepartum counseling for mothers that are in the group that don't tend to breastfeed as much. There have been group visits with breast feeding education, breastfeeding support when you're in the hospital and afterward, along with follow up with your provider postpartum for support.***<br><br>***Dr. Urcuyo added that being a baby friendly hospital, all of the providers who provide any of the care to potentially laboring patients goes through breast feeding training.***<br>***Dr. Goheen adds that breast pumps are covered by insurance. If patients need the higher level of breast pumps, those are available through our WIC program.***<br><br>B. Annual Medical Error Reduction Plan<br>Shideh Ataii, Director, Pharmacy Services<br><br>***The Medication Error Reduction Plan is drafted after thorough review and analysis of the annual medication errors. The philosophy of the plan is looking back at the patterns of medication errors and looking forward to preventatively reduce medication errors. Our harm index is zero, despite the medication errors reported. All medication errors are analyzed on an annual note and the plan is developed on a multi-disciplinary note. The 12-element plan is taken to the Medication Safety committee, Patient Care Policy and Evaluation committee, Patient Safety and Performance Improvement committee, as well as Medical Executive Committee. Once approved by those committees, all administrators get a copy of the documents, and the plan is approved by all administrators. We are now seeking approval from JCC.*** | |
| VII. **ADJOURN** | |
| VIII. **NEXT MEETING**: Monday, June 27, 2022 | |

**Minutes approved by Chair: Supervisor John Gioia, District I**

_____ _____

**Supervisor John Gioia** **Date**

***Minutes by Shanazz Ahmad***

CONTRA COSTA HEALTH SERVICES

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# MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
May 16, 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 April 18, 2022 Minutes | See attached Draft Minutes, April 18, 2022 | 2 min. |
| **Announcements (3 min)** | | |
| • **June 20. 2022 MEC meeting reports to Sue by June 9, 2022**<br>○ Contracted Services-Karin Stryker<br>○ Internal Medicine-Dr. Carcamo-Molina<br>○ Continuing Medical Education Committee-Drs. Hollandberry and Rodgers<br>Please use the standard SBAR form for your reports -You will be given 5 minutes in which to present your report. **PLEASE DATE YOUR REPORT AND NUMBER THE PAGES. Be sure to include your executive summary which can be added to the minutes. Next meeting June 20, 2022** | | |
| **ADMINISTRATIVE REPORTS** | | |
| Anna Roth, Health Services Director<br>Ori Tzvieli, Health Officer, Director of Public Health<br>Pat Godley, CFO for Health Services<br>Gilbert Salinas, Chief Equity Officer, HS<br>Jaspreet Benepal, RN, Chief Nursing Officer<br>Samir Shah, M.D., Chief Executive Officer/Chief Medical Officer<br>Vacant - Chief Quality Officer<br>David Runt - Chief Operations Officer | Rajiv Pramanik, M.D.- CMIO<br>Gabriela Sullivan, M.D.- Specialty/Ambulatory Medical Director<br>Sergio Urcuyo, M.D.- Hospital Medical Director<br>Sonia Sutherland, M.D.-Medical Director, Detention Health<br>Sharron Mackey, MHS, Chief Executive Officer CCHP<br>Dennis Hsieh, M.D., Medical Director/CMO CCHP | |
| **NEW BUSINESS** | | |
| **Medical Staff Funding Requests-Dr. Moeller** | Dr. Moeller | 5 min. |
| **OLD BUSINESS** | | |

CONTRA COSTA HEALTH SERVICES

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**MEDICAL EXECUTIVE COMMITTEE AGENDA**
CHAIR-KRISTIN MOELLER, M.D.
May 16, 2022
12 to 2:00p

| Agenda Topic | Status | Time |
|---|---|---|
| **Department Head Voting Results**<br>**Diagnostic Imaging Department-Dr. Hayashi**<br>**Surgery Department-Dr. Dosanjh** | Dr. Moeller | 3 min. |
| **Consent Agenda** | | |
| **Medication Safety Committee-Dr. Ataii** | Pend | 5 min. |
| **PCP&E-Dr. Forman**<br>**353, Standard Procedure for Rapid Response Team**<br>**Nursery Nursing Policies**<br>**3.146, Neonatal Intratracheal Surfactant**<br>**3.146 A , Neonatal Intratracheal Surfactant**<br>**3/146 B , Neonatal Intratracheal Surfactant**<br>**Infection Control**<br>**IC502, Sudden Influx Infectious Patients plan 2022-23**<br>**IC228, A How to remove PPE #1**<br>**IC110, Employee Education**<br>**IC210, Negative Pressure Isolation Rooms**<br>**IC228, B How to remove PPE #2**<br>**IC252, Temperature and humidity in the OR**<br>**IC253, Guidelines for Verification of Proper Operation of Airborne Infection Isolation Rooms at CCRMC**<br>**IC302, Transmission Based Isolation Precautions**<br>**IC420, Re-donning N95 masks** | See report | 5 min. |
| **COMMITTEE REPORTS** | | |
| **Credentials Committee- Dr. Mbanugo**<br>• List of Candidates - Vote needed | See report. | 3 min. |
| **Patient Safety and Performance Improvement Committee - Dr. Beach** | Pend | 3 min. |
| **APC - Dr. Pyrkova** | Pend | 3 min. |
| **Contra Costa Health Plan-Sharron Mackey** | Defer | 5 min. |

CONTRA COSTA
HEALTH SERVICES

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**MEDICAL EXECUTIVE COMMITTEE AGENDA**
CHAIR-KRISTIN MOELLER, M.D.
May 16, 2022
12 to 2:00p

| Agenda Topic | Status | Time |
|---|---|---|
| **Cancer Committee-Dr. Gynn** | See report | 5 min. |
| **Medical Staff Assistance Committee-Dr. Bhatt** | Defer to June | 5 min. |
| **Utilization Review Committee-Dr. Rael** | See report | 5 min. |
| **DEPARTMENT & DIVISION REPORTS** | | |
| **Critical Care-Dr. Forman** | Defer to June | 5 min. |
| **Pathology Department-Dr. Das** | Defer | 5 min. |
| **Department of Hospital Medicine-Dr. Beach** | See report | 5 min. |
| **Department of Family & Adult Medicine-Dr. Sandler** | See report | 5 min. |
| **ADJOURN TO CLOSED SESSION-VOTING MEMBERS ONLY** | | |
| **Adjournment. Next Meeting Date: June 20, 2022** | | |

**CLOSED SESSION**
**Review of credentialing process**
**DEIA work**
**Financial requests discussion if needed**

# STANDARD PROCEDURE FOR RAPID RESPONSE TEAM

## I. PURPOSE:

The Rapid Response Team (RRT) is designed to provide timely identification, intervention, and treatment of patients with early signs of deterioration before they require resuscitation.

## II. REFERENCES

Business and Profession Code, Nursing Practice Act (NPA) Section 2725
California Code of Regulation (CCR 1480)
Board of Registered Nursing, Title 16, CCR section 1474
The Joint Commission Standard PC.02.01.19, "The hospital recognizes and responds to changes in a patient's condition."
PI 03.01.01 The hospital improves performance on an ongoing basis. PI 03.01.01 The hospital improves performance on an ongoing basis.

## III. POLICY:

Any staff or family member who observes deterioration in the patient's clinical condition may call the RRT to assist with assessment, stabilization of patient and communication with medical staff. The team will consist of an RRT-trained RN, a Respiratory Therapist, ICU resident as well as the primary nurse of the patient. The RRT will cover adult inpatients.

## IV. AUTHORITY AND RESPONSIBILITY:

RRT-trained RNs, Respiratory Care Practitioners, Nursing staff, .

## V. PROCEDURE:

A. Criteria for calling the RRT:
   1. Staff or a family member is concerned about the patient's clinical condition.
   2. Any sudden abnormal or critical lab values. (For Example: Critical value of Lactic Acid equal to or greater than 4.)
   3. Any significant change in baseline lab values or vital signs.
   4. Respiratory rate less than 10 or greater than 28.
   5. Heart rate less than 45 or greater than 130.
   6. Altered level of consciousness.
   7. A sudden decrease in O2 Saturation below 90%, and an inability to increase above 90% with supplemental O2 therapy.
   8. SBP less than 90mm/Hg.
   9. Positive (+) Sepsis Screen.

   The primary nurse should have relevant information available (chart, MAR, lab results) and will become a key member of the team.

B. Rapid Response Team initiation process:
   1. The primary nurse dials 111 and tells the operator that RRT is needed and the location.
   2. The operator does a broadcast page on "195" that activates:

a. RRT-trained nurse/beeper/ICU Charge Nurse Code Blue beeper
b. Respiratory Therapist
c. Medical Center Supervisor (beeper #243)
d. The beeper message will include location of the call (Example: 5D-10 bed 1)

3. Operator will call 5666 to notify an RRT-trained RN of the RRT call and location.

RRT will respond within 5-10 minutes. Using the SBAR tool (Situation-Background-Assessment-Recommendation) they will assess the patient and gather appropriate information to communicate to the physician and make recommendations. If necessary, they will expedite and assist transfer of patient. If a physician is needed, the RRT nurse will page Doctor's first contact (information available from patient EMR in ccLink) RRT will collaborate with Doctor's first contact in consideration of transferring patient to higher acuity unit

C. Pending physician contact, the RRT may initiate the following interventions directly related to the immediate problem:
1. O2 via nasal cannula up to 6 LPM, via simple mask 6-10 LPM, or NRB mask, for signs of respiratory distress.
2. Nasotracheal suctioning in patients unable to clear their airway.
3. EKG.
4. Respiratory therapist draws arterial blood gas.
5. POCT glucose.
6. Blood cultures if appropriate.
7. Initiate inpatient sepsis nurse protocol; refer to Nursing Policy #126.
8. Initiate hypoglycemia protocol; refer to adult subcutaneous insulin orders for type 2 diabetes in ccLink.
9. Manage patient with chest pain as per Nursing Policy #200.
10. Initiate STEMI protocol; refer to Nursing Policy #200.
11. Follow tracheostomy occlusion and tracheostomy dislodgement algorithm; refer to Nursing Policy #403.
12. Administer Narcan for narcotic overdose after obtaining a physician's order or as per pain-controlled analgesia (PCA) orders.

D. The RRT will support and educate the primary nurse and provide feedback after the RRT call.
E. The RRT nurse document events in the patient chart using electronic 'Rapid Response Team Record' in ccLink, and interventions in the patient's progress notes.
F. When there is more than one RRT, call the ICU/IMCU NPM or medical center supervisor to find out who will be designated for RRT coverage.
G. The NPM/ MCS may choose to respond or may arrange or provide relief to one unit so that an RRT trained RN can respond.
1. The MCS may call in RRT trained staff.
2. The MCS may pull from within the RRT trained pool.
3. The MCS may delegate or perform the RRT function

H. Physician consultation is to be obtained as specified in the individual protocols and under the following circumstances:
1. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

2. Acute de-compensation of patient situation.
3. History, physical, or lab findings inconsistent with the clinical pictures.
4. Upon request of patient, family, nurse, or other disciplinary healthcare providers.

I. Educate patient and/or family about the immediate intervention and the plan of care including explanation of the event.

## VI. RRT NURSE COMPETENCY

- All RRT nurses are either CCU or IMCU nurses after successful completion of Rapid Response Team Nurse Training Curriculum.

1. -

## VII. ADDENDUM

Addendum A – Attachment 353 Intubation Criteria
Addendum B – Attachment 353 B Rapid Response Team Activation Algorithm

**FORMS USED:**
Rapid Response Team Record (Use the paper documentation form when ccLink is down)

**APPROVED BY:**
CCU Committee: 3/2014, 1/2022
Clinical Practice Committee: 3/2014, 11/2017, 3/2022
Patient Care Policy & Evaluation Committee: 3/5/2014, 12/2017, 3/2022
Medical Executive Committee: 1/2018, 05/2022
Joint Conference Committee:

**REVISED:**
5/2007 (new), 10/2012, 10/2013, 2/2014

**REVIEWED:**
12/2021, 3/2022

# NEONATAL INTRATRACHEAL SURFACTANT ADMINISTRATION

## I. PURPOSE:

To specify the nursing methodology for the care of newborns undergoing intratracheal suspension surfactant administration for the rescue treatment of Respiratory Distress Syndrome (RDS).

## II. REFERENCES:

*CUROSURF® (poractant Alfa): Dosing and administration*. Curosurf. (2021). https://curosurf.com/dosing-administration/?utm_source=bing&utm_medium=cpc&utm_campaign=Curosurf_Branded_Campaign_Refresh_Exact&utm_term=curosurf&utm_content=Curosurf_Brand.

Martin, R. (2021). *Prevention and treatment of respiratory distress syndrome in preterm infants*. Uptodate. https://www.uptodate.com/contents/prevention-and-treatment-of-respiratory-distress-syndrome-in-preterm-infants?search=surfactant+administration&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H4271638953.

TJC. 2021. MM.01.01.03. *The hospital safely manages high-alert and hazardous medications*. MM 06.01.05. *The hospital safely administers medications.*

## II. POLICY:

Newborns receiving surfactant will be safely cared for by a Nursery nurse in accordance with this policy.

Surfactant may be considered in:
Preterm newborns who have an FiO2 need > 30%. MD
Term newborns with severe pulmonary hypertension

Pediatrician to consult Neonatologist prior to administration.

## III. PROCEDURE:

A. Confirm provider's order and notify Respiratory Therapist for assistance
B. Assure proper placement and operation of CRM, pulse oximeter and T-piece resuscitator.
C. Verify endotracheal tube (ETT) position and size:

| Weight (grams) | ETT Size |
|---|---|
| <1000 grams or <28 weeks | 2.5 |
| 1000-2000 grams or 28-34 weeks | 3.0 |
| >2000 grams or >34 weeks | 3.5 |

D. Obtain blood gases as ordered by physician
E. Gather Supplies:
   1. 5 Fr. orogastric catheter
   2. Sterile scissors
   3. 3-mL or 5-mL syringe
   4. Large gauge needle (at least 20 gauge)
   5. Surfactant
      a. Before use, slowly warm surfactant vial to room temperature and gently turned upside down to obtain a uniform suspension. DO NOT SHAKE
      b. Unopened vials may be warmed to room temperature for up to 24 hours prior to use and may not be returned to the refrigerator more than once.
      d. Each single-use vial should be entered only once
      e. Vials with unused surfactant should be discarded after initial entry
F. Remove the rubber stopper from vial to extract contents using syringe and large gauge needle.
G. Attach the measured and cut orogastric catheter to the syringe and fill catheter with surfactant.
H. Discard excess surfactant through the catheter so that only the total dose to be given remains in the syringe.
I. Pre-oxygenate newborn to upper $SpO_2$ limit
J. While keeping the newborn in a neutral position (head and body in alignment without inclination), briefly disconnect the endotracheal tube from the oxygen source (ventilator, T-piece resuscitator). Suctioning of ETT may be done prior to surfactant instillation.
J. Insert the pre-cut 5 Fr. catheter into the endotracheal tube and instill the first aliquot.
K. The newborn should be positioned such that either the right or left side is dependent for this aliquot.
L. After the first aliquot is instilled, remove the catheter from the endotracheal tube and manually ventilate the newborn for 1 minute.
M. Reposition the newborn such that the other side is dependent and administer the remaining aliquot using the same procedure.
N. Place newborn in neutral position and monitor closely for signs of an adverse reaction:
   1. Bradycardia, apnea and/or desaturation associated with dosing
   2. Hypotension, hypertension
   3. ETT blockage
   4. Reflux
   5. Hypocarbia, hypercarbia

O. Do not suction airway for 1 hour post instillation unless signs of significant airway obstruction occur (rales and moist breath sounds can transiently occur after instillation).
P. Obtain blood gas approximately 30 minutes post-instillation and as needed

## IV. DOCUMENTATION:

MR727-4 during downtime
MR17-4 during downtime
ccLink

## V. ATTACHMENTS/ADDENDUMS:

Addendum A: CUROSURF® Dosing Instructions
Addendum B: CUROSURF® Dosing Chart

**APPROVED BY:**
Pediatric Department: 03/2022
Clinical Practice Committee: 03/2022
Patient Care Policy and Evaluation Committee: 03/2022
Medical Executive Committee: 05/2022
Joint Conference Committee:

**REVIEWED:**
4/2020, 5/2017, 03/2022

**REVISED:**
6/2007, 03/2022

# CUROSURF®

## How it is Supplied:


Each vial of CUROSURF has a color-coded cap that corresponds with the volume of surfactant supplied in each vial[1]:

- Green — 1.5 mL [120 mg poractant alfa (surfactant extract)] of suspension
- Blue — 3.0 mL [240 mg poractant alfa (surfactant extract)] of suspension

## Dosing Instructions:

**Initial recommended dose**
2.5 mL/kg birth weight

**Repeat Doses**
Up to two repeat doses of 1.25 mL/kg birth weight each may be administered at approximately 12-hour intervals in newborns who remain intubated and in whom RDS is considered responsible for their persisting or deteriorating respiratory status

**Maximum recommended total dosage** (sum of the initial and up to 2 repeat doses) = 5 mL/kg birth weight.

## ETT Reference Chart:

| Weight (grams) | DEPTH OF INSERTION[b] AT LIPS (cm) |
|---|---|
| 500-600 | 5.5 |
| 700-800 | 6.0 |
| 900-1000 | 6.5 |
| 1100-1400 | 7.0 |
| 1500-1800 | 7.5 |
| 1900-2400 | 8.0 |
| 2500-3100 | 8.5 |
| 3200-4200 | 9.0 |

| Weight (grams) | ET TUBE SIZE[c] (ID, mm) |
|---|---|
| <1000 g or <28 weeks | 2.5 |
| 1000-2000 g or 28-34 weeks | 3.0 |
| >2000 g or >34 weeks | 3.5 |

## CUROSURF® Dosing Chart

| WEIGHT (grams) | INITIAL DOSE 2.5 mL/kg 200 mg/kg EACH DOSE in mL (mg) | | REPEAT DOSE 1.25 mL/kg 100 mg/kg EACH DOSE in mL (mg) | |
|---|---|---|---|---|
| 600-650 | 1.60 | (128) | 0.80 | (64) |
| 651-700 | 1.70 | (136) | 0.85 | (68) |
| 701-750 | 1.80 | (144) | 0.90 | (72) |
| 751-800 | 2.00 | (160) | 1.00 | (80) |
| 801-850 | 2.10 | (168) | 1.05 | (84) |
| 851-900 | 2.20 | (176) | 1.10 | (88) |
| 901-950 | 2.30 | (184) | 1.15 | (92) |
| 951-1000 | 2.50 | (200) | 1.25 | (100) |
| 1001-1050 | 2.60 | (208) | 1.30 | (104) |
| 1051-1100 | 2.70 | (216) | 1.35 | (108) |
| 1101-1150 | 2.80 | (224) | 1.40 | (112) |
| 1151-1200 | 3.00 | (240) | 1.50 | (120) |
| 1201-1250 | 3.10 | (248) | 1.55 | (124) |
| 1251-1300 | 3.20 | (256) | 1.60 | (128) |
| 1301-1350 | 3.30 | (264) | 1.65 | (132) |
| 1351-1400 | 3.50 | (280) | 1.75 | (140) |
| 1401-1450 | 3.60 | (288) | 1.80 | (144) |
| 1451-1500 | 3.70 | (296) | 1.85 | (148) |
| 1501-1550 | 3.80 | (304) | 1.90 | (152) |
| 1551-1600 | 4.00 | (320) | 2.00 | (160) |
| 1601-1650 | 4.10 | (328) | 2.05 | (164) |
| 1651-1700 | 4.20 | (336) | 2.10 | (168) |
| 1701-1750 | 4.30 | (344) | 2.15 | (172) |
| 1751-1800 | 4.50 | (360) | 2.25 | (180) |
| 1801-1850 | 4.60 | (368) | 2.30 | (184) |
| 1851-1900 | 4.70 | (376) | 2.35 | (188) |
| 1901-1950 | 4.80 | (384) | 2.40 | (192) |
| 1951-2000 | 5.00 | (400) | 2.50 | (200) |

CONTRA COSTA REGIONAL MEDICAL CENTER
CONTRA COSTA HEALTH CENTERS

# SUDDEN INFLUX OF INFECTIOUS PATIENTS SURGE CAPACITY PLAN

2022 - 2023

Infection Prevention and Control Program

**Introduction**
The control of communicable disease outbreaks (natural or intentional) requires prompt identification and initiation of appropriate isolation and treatment guidelines. Such an outbreak may result in an influx of potentially infectious patients into the hospital or ambulatory care environment.

**Applicability**
This plan may be used for patients requiring Airborne or Droplet Isolation. Differences between these two isolation precautions will center on room ventilation and mask filtration ability. During a pandemic influenza situation, mask type may be driven by Centers Disease Control (CDC) or California Department of Public Health recommendations.

**Definition**
Surge capacity is defined as, "the ability to expand care capabilities in response to a sudden or more prolonged demand." – Surge capacity includes all aspects of providing care for patients and employees during this period of increased demand.

**Facility Overview**
Contra Costa Regional Medical Center is a 166-bed hospital located in Martinez (Contra Costa County), California. The hospital is a five-story building built in 1998. The average daily census is 117 (for calendar year 2021) Nursing units provide care to patients located on the following areas:

- ✓ Psychiatry Emergency Services
- ✓ Emergency Department
- ✓ Intensive Care Unit
- ✓ Intermediate Care Units
- ✓ Medical Surgical Nursing
- ✓ 5C/CP Postpartum
- ✓ Post Anesthesia Care Unit –
- ✓ Inpatient Psychiatry –

Services provided to patients include:

- ✓ Surgery and select invasive procedures.
- ✓ Diagnostic Imaging including CT and MRI
- ✓ Labor and Delivery Management
- ✓ Laboratory and blood bank services
- ✓ Respiratory treatments, diagnostics and ventilatory support
- ✓ Nutritional and dietary support
- ✓ Pharmacy
- ✓ Physical and Occupational Therapy
- ✓ Cardiopulmonary (Electrocardiograms, Stress Tests, Echocardiograms, Respiratory Therapy, blood gases etc.

Other support services include:

- ✓ Environmental Services (Housekeeping)
- ✓ Sterile Processing
- ✓ Materials Supply and Distribution

**Ambulatory Care**

Health Centers are located throughout Contra Costa County

- North Richmond Health Center
- West County Health Center
- Concord Health Center
- Baypoint Health Center
- Pittsburg Health Center
- Antioch Health Center
- Brentwood Health Center

Two of the Health Care Centers are located on the same campus as CCRMC

- Martinez Health Center
- Miller Wellness Center

The role that the individual Health Centers play during a surge or pandemic will be determined by CCRMC/ HC Leadership. Factors considered will include the needs of the patient population as well as the nature of the illness and extent of the surge and the pandemic.

**Integration with the Emergency Preparedness Mass Casualty Response Plan**
The management of an influx of potentially infectious patients will be conducted in accordance with the organization's mass casualty emergency response plan. Where differences exist due to the nature of an infectious process, the information contained below should be relied upon to provide guidance to organization leaders.

**Specific Response Guidelines**

***Incident Command Center***

Establish initial and ongoing contact with the following agencies to determine the specific nature and extent of the infectious issue:

- Public Health Department
- California Department of Health Services
- Emergency Management System
- Center for Disease Control
- Office of Homeland Security

**Infection Prevention and Control Program Participation**
This document is meant to serve as a guideline for the management of a large number of patients with airborne or droplet communicable illness. The goal is to minimize the transmission of illness from infected patients to non-infected healthcare workers and other patients.

- Based on information and recommendations from agencies listed above
    - Determine the type of isolation needed for incoming patients
    - Assist with appropriate room placement (type, location etc)
    - Participate in developing alternative patient housing plans if additional isolation beds are needed
    - Develop and distribute information and care guidelines specific to the illness involved.

- Institute additional isolation precautions if needed.

- For Ambulatory Care -determine the type of isolation precautions needed for building entry, waiting rooms and patient exam rooms.
- Communicate pertinent communicable disease information received from outside agencies to the Emergency Department and other appropriate clinical services.
- Assess patients in existing isolation to determine if isolation needed by these patients. Patients not requiring isolation will be transferred to a standard room. If Public Health approval needed for discharge, the Infection Prevention and Control Program Manager (IC Manager) will obtain the approval. The IC Manager will collaborate with the Medical Center Supervisor (MCS) on patient placement.
- Collaborate with Materials Management to address issues related to equipment needed to implement infection prevention guidelines (PPE- gowns, gloves, masks, eyewear, 95N masks, etc).
- Collaborate with Pharmacy Management to address issues related to vaccines or antibiotics (Bioterrorism, Influenza Pandemic, etc).
- Coordinate with Contra Costa Regional Medical Center Clinical Laboratory and the Contra Costa Public Health Department to provide guidelines and facilitate the collection and delivery of specimens related to potentially communicable illness (Bioterrorism, influenza pandemic, etc).
- Provide prophylaxis, vaccine and post exposure management for employees exposed to communicable illness (SARS, Influenza, and Avian Influenza) or to blood/body fluids during the emergency.
- Facilitate the administration of prophylaxis and vaccine to patients.
- Perform clinical duties as assigned.

**Infection Prevention and Control Fundamental Practices.**

The foundation for infection prevention and control practices aimed at limiting exposure/transmission to pandemic influenza are listed below.

- **Respiratory Etiquette**
  - ✓ Measures designed to limit the transmission of illness that is spread by the respiratory route.
    - Encourage patients to cover nose and mouth tissue or provide masks.
    - Provide disposal containers for used tissues and masks
    - Convenient placement of Alcohol gel dispensers
    - Signage reminders – cover cough and wash hands
- **Hand Hygiene**
  - ✓ No matter what type of Precautions is utilized, attention must be paid to hand hygiene. Alcohol based hand gels are appropriate whenever hands are not visibly soiled.
  - ✓ Soap and running water should be utilized when hands are soiled and there is potential for exposure to Norovirus or C. Difficile.

- **Standard Precautions**
  - ✓ Reduce of transmission of bloodborne pathogens. The precautions apply to blood and all body fluids except sweat regardless of whether or not they contain visible blood, non-intact skin, and mucous membranes.
  - ✓ Barriers (gowns, gloves, masks, eye protection) are used to protect the skin and mucous membranes of the healthcare worker from contact with the blood and/or body fluids of the patient. **TRANSMISSION BASED PRECAUTIONS**
  - ✓ Standard Precautions are to be observed in ***all*** patient care interactions.

- **Airborne Precautions**
  - ✓ Limit the spread of small (**5** µm or less) microorganisms that can remain in the air for long periods of time and be inhaled by someone in the same room - even after the patient has left the area.
  - ✓ Special ventilation and air handling are utilized in rooms where these patients are housed.
  - ✓ Respiratory protection used by personnel should be of the N95 respirator type. CAPRs may also be utilized when a higher level of protection is needed or by persons who cannot be successfully fit test for a 95N mask or if performing an aerosol generating procedure.

- **Contact Precautions**
  - ✓ Measures designed to limit the transmission of microorganisms spread by skin-to-skin contact or physical transfer of the microorganisms via unwashed hands or certain inanimate objects in the patient care environment.
  - ✓ Personal protective equipment utilized will include gloves, gowns for direct contact and additional personal protective equipment (PPE) as needed to observe standard precautions.

- **Droplet Precautions**
  - ✓ Measures designed to limit the transmission of illness caused by large droplets produced when an infected person coughs, sneezes, or talks. These droplets do not remain in the air long periods, travel short distances through the air and either land directly on the conjunctiva, nasal mucosa, or mouth of another person or on surfaces where they can contaminate the hands of another person. The unwashed contaminated hands will spread the pathogen when they touch the conjunctive, nasal mucosa, or mouth of another.
  - ✓ Special ventilation not required.
  - ✓ Standard surgical mask utilized; eye protection recommended. Other personal protective equipment (PPE) as needed to implement standard precautions.
- **Pandemic Viral Illness**
  - ✓ Implementation of transmission-based precautions as recommended by CDC, state, or local public health departments
  - ✓ PPE driven by recommendations.

**Critical Equipment/Supplies**
Ventilators. We currently own 19 ventilators. Emergency ventilators are available from state supply as needed.
Ventilator Circuits
Suction Catheters/kits
Intubation Tubes
Intubation Equipment
Antiviral and Antibacterial Medication as appropriate for pathogen involved. for treatment of secondary bacterial infections) Vaccine: appropriate to the viral illness
IV fluids
IV Administration and tubing sets.
Syringes and needles
Linen
N95 Respirators
Back-up CAPRs
CAPR DLCs
Isolation Gowns
Protective eye wear
Gloves (Latex free, all sizes)
Surgical masks
Alcohol based hand gels.
Face Shields

During a surge event, inventory tracking for critical supplies will be implemented. Command Center will assess this inventory daily. Existing processes for obtaining and managing supply delivery between sites will be maintained.

Additional items to be stockpiled will be determined based on illness.

**Personal Protective Equipment**
Must be used by all levels of employees. Those employees who have not been fit tested will either need to be fit tested or instructed on the use of CAPR's

- N95 Respirators
- Isolation Gowns
- Gloves
- Protective Eye wear
- CAPR(s) – DLC's head liners

**Limiting Access and Screening Prior to Entry**
If it is necessary to control access to CCRMC

- All doors will be secured.
- 2 entrances in and out of the facility will be designated and staffed for screening and security purposes
- Type of screening will be driven by the illness or by recommendations from local, state or CDC recommendations.

**In-Patient Housing**
The types of patient rooms needed will be guided by the nature of the communicable illness and recommended isolation precautions.

**Airborne Precautions** – Negative Pressure Ventilation – Tuberculosis, Measles, Chicken pox, Smallpox, Pneumonic Plague, SARS, MERS, SARSnCoV2 (COVID) Avian Influenza and possibly a pandemic influenza strain.

**Droplet Precautions** – private room or double room with blocked bed.

**Contact Precaution** – private room or double room with blocked bed.

**Patients with the same organism/diagnosis can be cohorted in one room with the approval of IC Manager.**

***Private Rooms – Nonnegative pressure***
At CCRMC private rooms are located in the following areas:

- Critical Care Unit 6 rooms
- Intermediate Care Unit 8 rooms
- 4A Telemetry 6 Rooms
- 4B 3 rooms
- 5A – All LDRP's are private
- 5D 3 rooms

***Double Rooms – Nonnegative pressure***
All other rooms on the inpatient units including Psychiatry are double occupancy.

***Negative Pressure Rooms – All are private rooms***
At CCRMC, negative pressure isolation rooms are located in the following areas:

- 4B Medical Unit Room16
- Newborn Nursery Isolation Room
- Screening Room 3 in ER (Room 17)
- PACU, Recovery 1
- 3E Intermediate Care Unit Rooms 6 and 8
- 3D Critical Care rooms 8 and10
- 5D Surgical Unit Room 16
- 5C Post-Partum Room 12

**Creating Additional Negative Pressure rooms**
Additional negative pressure rooms may be created through the use of free-standing HEPA filtration units that can be vented out of existing windows via replacing glass with plexiglass with cutout for exhaust tubing (or possibly attached to existing exhaust vents in individual patient rooms. If this method is utilized, rooms with two beds could be utilized to cohort patients with the same disease in negative pressure

At CCRMC, the following rooms are able to be adapted to provide negative pressure. The rooms are referred to as having enhanced airflow.

- 3D Rooms 14 and 16
- 3E Rooms 2, 4, 10 ,12, 14, 16, 18 and 20
- 4A Rooms 2, 4, 6, 8, 10, 12, 14 (2beds)

- 4B Rooms 20, 22
- 5A Rooms 00, 4, 18
- 5C MB Rooms 8, 10, 14
- 5D Room 10, 20

Created negative pressure rooms will not have annunciating alarms and must be tested for negative pressure by smoke or paper strip (toilet paper or thin strip of paper) that shows the direction of air flow testing. Will need to be done at a minimum daily and possibly each shift –consultation should be obtained from an engineer and the state.

***Emergency Department and PACU***

The Emergency Department has a total of 19 non-negative pressure beds and one negative pressure room. In ED two rooms have been converted to allow create negative pressure when a switch outside the room is activated.

- 3B 4 and 5

The PACU has 1 negative pressure room and 2 private rooms. Persons requiring droplet precautions may be housed in the private rooms.

Avoid using the private rooms to house a patient requiring Airborne or Enhanced Airborne precautions. If used, should be temporary and a portable HEPA unit should be placed at the head of the bed and at the room entrance.

The main part of PACU is a large room capable of housing up to 31 patients changes in air handling may not be possible

**Treatment**

Patients will be managed according to accepted treatment guidelines for the illness involved. Whenever possible care will be standardized based on current CDC, state, and local guidelines.

Standardized patient care plans, information and fact sheets and discharge instructions and home care instructions will be created and provided to persons seeking care.

**Medications and Vaccine**

When indicated and available anti-viral medication will be utilized. Vaccines if available will be administered to patients and staff.

**Emergency Department**

Patients presenting with respiratory symptoms -masked prior to building entry and screened for specifics of the illness causing the influx.

Efforts will be made to screen the patients in a timely manner and to isolate physically patients presenting with symptoms suspicious of the illness causing the influx.

Additional triage and treatment areas will be set up at the discretion of the Emergency Department Director and/or hospital administration.

**All Admitted Patients**
The illness responsible for the influx will determine the precautions to be used when caring for the patient. It is the responsibility of the IC Manager to review literature and recommendations to ensure that the appropriate precautions are in place.

Education will be provided to both patient and staff. The IC Manager will work with the nurse educators to develop the educational material. CDC and California Department of Public Health handouts will be used as appropriate.

If available, appropriate vaccines and medications will be provided to the patient.

**Specific Patient Populations**
**Obstetric**
Illness screening/testing at time of evaluation or admission will be implemented for patient presenting in labor The goal will be to protect as much as possible the neonate.

**Psychiatry**
Illness screening at time of admission will be implemented. Inpatient psychiatry is a community living situation and strategies used to prevent the spread of illness will include attention to basic health practices, covering coughs, hand hygiene and personal hygiene will be stressed.

**Ethical Guidance**
During a pandemic, shortages may exist in medications (vaccine and antivirals) critical care beds, durable equipment (ventilators, HFNC machines, CRRT machines etc.) and disposable medical equipment and supplies (IV fluids, masks, gowns, food, formula, water etc). Should rationing of care or equipment/supplies/medications become necessary, a representative of the Ethics Committee will be consulted as needed.

**Security**
The Contra Costa Sheriff's Department is contracted to provide hospital security at Contra Costa Regional Medical Center. The department is assigned the responsibility of maintaining hospital security and providing crowd control.

- The sheriff's deputy on duty will maintain communication with the command center and determine what access restrictions – if any – must be imposed to maintain hospital security.
- Assist with efforts to prevent potentially infectious individuals from entering the building before appropriate infection control precautions can be implemented.

If additional security (contracted outside agency) is utilized – they will need education, mask fit testing/training and be included in employee health program.

**Environmental Services**
The Environmental Services Department will maintain cleanliness. Non-essential cleaning services (cleaning offices etc) may be limited during the emergency. Extra linen, hampers, trash bins, and biohazard waste containers may be needed.

When necessary, the Infection Control Department will advise if a change in cleaning technique, equipment or solutions is required based on the disease(s) involved.

**Morgue Space**
The mortuary is located in the old laboratory building.

- Engineering, Housekeeping, Medical Center Supervisors (MCS) and Administration have the key to the locked room.
- The refrigerator space may be limited. If additional space is needed, a refrigerated truck may needed/utilized. **Contact Facilities Manager and Hospital Engineers if this is needed.**
- Body bags are located in Materials Management. Extra body bags may be found with the hospital disaster supplies.
- If an autopsy is needed, special safety precautions may be required consult with IC Manager and Public Health.
- The coroner may be reached at 313-2850 (information) 313-2888 (captain) or by fax 313-2886

**Surgery/PACU**
Should an infectious patient require surgery, the case should – whenever possible - be scheduled at the end of the day. The surgical suite should then be terminally cleaned.

If negative pressure isolation is required, the patient should be recovered in the negative pressure room that is located in the PACU.

**Pharmacy Services**
The pharmacy is responsible for ensuring that there is an adequate supply of critical medications during the emergency. Critical medications may include antibiotics, antivirals, vaccines, code blue drugs, sedation medication.

Pharmacist will evaluate the drug supply on hand. Should it be anticipated that supplies of drugs might be inadequate to last through the situation- follow pharmacy process to determine if additional supplies can be procured.

Pharmacy administration may be called upon to accept and store medications from the national stockpiles.

**CardioPulmonary**
This department is responsible for maintaining airway and ventilation support for new and existing patients. Evaluate the need for additional supplies and equipment – particularly to care for patients with a respiratory-based infectious process. If needed procure such supplies or equipment.

Respiratory Therapy staff will also be used as an education resource for training healthcare personnel on the use of the ventilators contained in the Emergency supplies.

**Patient Education**
It is recommended that a variety of patient education materials (flyers, handouts, brochures) be procured or developed on SARS, AVIAN Influenza, and Pandemic Influenza. These educational tools should be reviewed at least yearly to ensure that the information contained is up to date and in line with current state and federal disease information.

Home care and discharge instructions should also be developed and reviewed periodically to ensure currency.

**Employee Education**
Staff will receive education/training before assuming responsibility for providing care during the emergency:

- The specific nature of the infectious process
- The mode of transmission
- The clinical manifestation
- What precautions need to be implemented to prevent cross-contamination
- The location and use of appropriate protective equipment
    - Donning and Doffing Sequence

The IC Manager will work with the CCRMC Professional Development Department (PDD) to develop, teach, and disseminate information appropriate to the emergency. Attendance at teaching sessions will be documented.

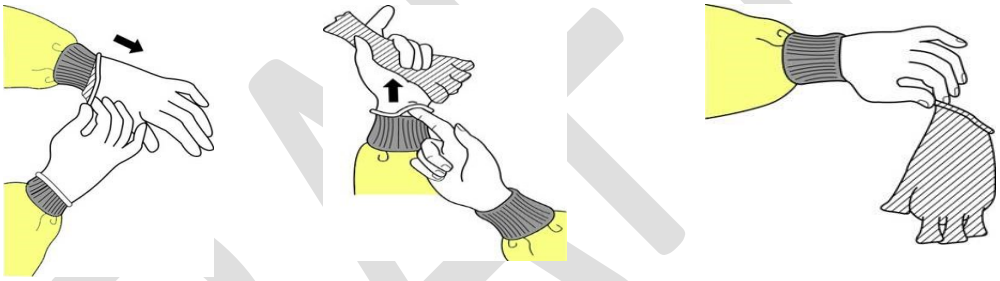
**Employee Health**
The Infection Prevention and Control Program in consultation with local, state, and federal Public Health officials will facilitate the appropriate administration of prophylaxis and vaccine to CCRMC and CCHC employees.

**APPROVED:**
MEC 5/16/22
JCC

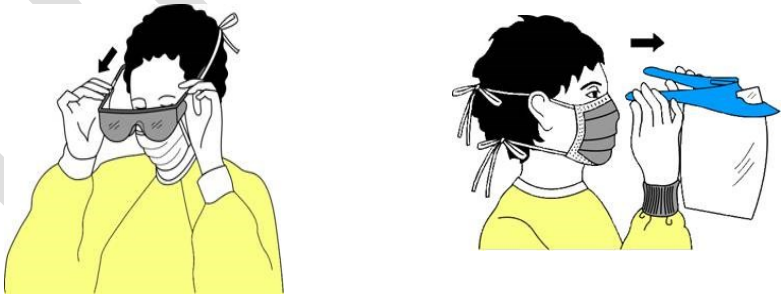
# HOW TO REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)
# EXAMPLE #1

**Doffing Sequence**

A. Gloves:
1. **Remember the outside of the glove is contaminated.**
2. Grasp the outside of the glove with other gloved hand, peel off the glove.
3. Hold removed glove in the palm of the gloved hand.
4. Slide the fingers of the ungloved hand under the wrist area of the remaining glove.
5. Peel glove off over the glove (in palm).
6. Discard gloves into the appropriate trash container.

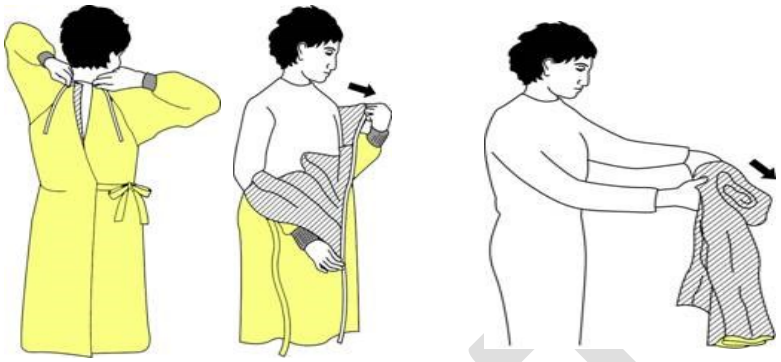


B. Eyewear /Goggles or Face shield:
1. **Outside of the eyewear/goggles or face shields is considered contaminated**.
2. To remove, handle by the earpieces or head band.
3. Place in designated receptacle for reprocessing or disposal.



C. Gown:
1. **Gown front and sleeves are contaminated**.
2. Unfasten the ties and the neck and waist.
3. Touching only the inside of the gown, pull it away from the neck and shoulders.
4. Turn gown inside out.

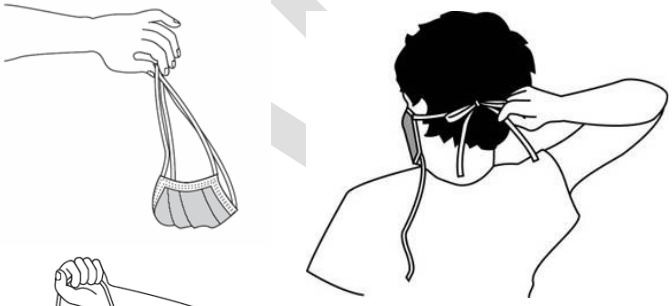
5. Fold or roll into a bundle and discard.



D. MASK / RESPIRATOR:

1. Front of mask or respirator is contaminated – **do not touch**!
2. Grasp bottom and then top ties or elastics and remove.
3. Discard in waste container.

Mask



Respirator

**Perform HAND HYGIENE IMMEDIATELY AFTER REMOVING PPE**. If hands not visibly soiled may use alcohol-based rub, if visibly soiled use soap and water.

**APPROVED:**
MEC 5/16/22
JCC

# INFECTION PREVENTION AND CONTROL EMPLOYEE EDUCATION

I. PURPOSE:

To outline the mechanism by which all employees receive initial and annual education in topics related to Infection Control.

II. REFERENCES:

The Joint Commission Hospital Accreditation Manual

Contra Costa Regional Medical Center, "Orientation, Continuing Education and Inservice Training for Employees", Hospital Policy Manual, Policy 247

Contra Costa Regional Medical Center, "Safety, Infection Control and Regulations Review", Hospital Policy Manual, Policy 267

III. POLICY:

All new hospital and clinic employees will either attend a training session or complete Safety, Infection Control and Regulations Review. Orientation sessions are held at regular intervals (monthly) and SICRR may be accessed either in print or via e learning.

Annually, employees will receive an infection control information update as part of SICRR (Safety, Infection Control and Regulations Review) and annual Aerosol Transmissible Disease (ATD) Review. Employees may meet this requirement by:

- Reading the newsletter entitled "SICRR Update" and then taking the post-test.
- Reading the on-line content and then taking the post test for each on-line module.
- Reading the on-line ATD content and taking the post-test.

It is the responsibility of the individual department manager to ensure that each employee fulfills the initial and annual review requirement.

The Infection Prevention and Control Program is responsible for developing and revising the content of the Infection Control portions of orientation and annual review programs. Infection Prevention and Control Program personnel are also available to prepare/present in services on topics identified either through needs assessments or by service, unit, or department request**.**

IV. AUTHORITY/RESPONSIBILITY:

Patient Services Managers (PSM)
Nursing Program Managers (NPM)
Infection Prevention and Control Program Staff

V. GUIDELINE:

**A. ORIENTATION**

1. Scheduled according to CCRMC and Health Centers Policy.
2. Infection Prevention and Control Program staff will review and update content
3. Documentation of attendance is maintained by the Professional Development Department.

**B. ANNUAL REVIEW / UPDATE**

1. Annual reviews/update is coordinated by the Professional Development Department.
2. Infection Prevention and Control Program staff will review and update content of all education programs.
3. Updates to education, regarding CalOSHA standards, will include revisions to CCRMC and Health Centers Plans.
4. Documentation of completion and test scores is maintained by the Professional Development Department.

VI. FORMS USED:

Orientation Handouts / Post Test
Documentation of Attendance
Skills Day Handouts / Post Test
Documentation of Skills Day Attendance
"SICRR Update" newsletter / Post Test
"SICRR Update" Sign-In Roster
ATD education/training

**APPROVED:**
Patient Care Policy and Evaluation Committee: 09/2017
MEC 5/16/22
JCC

**REVIEWED:** 08/17, 5/2021

**REVISED:** 07/12; 08/17, 5/21, 3/22

# NEGATIVE PRESSURE ISOLATION ROOMS

## I. POLICY:

Isolation rooms to be used for the care, housing, or treatment of patients with suspected or confirmed illness that is transmitted via the Airborne route will be maintained under negative pressure. These rooms are also called Airborne Infection Isolation (AII) rooms.

## II. AUTHORITY/RESPONSIBILITY

CCRMC Nursing Personnel
Medical Center Supervisor
Facilities Engineer
Infection Prevention and Control Program

## III. REFERENCES:

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee (HICPAC), "2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings". www.cdc.gov/ncidod/dhap/pdf/isolation 2007.pdf

Centers for Disease Control and Prevention, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings", MMWR, December 30, 2005, Vol. 54 No. RR-17

Tek-Air Systems, Inc., "ISO-TEK Space Pressurization Monitor, Installation, Operation and Maintenance Manual", Release 1.2, August 1995.

Cal OSHA, Aerosol Transmissible Disease Standard, Title 8 Section 5199

## IV. PROCEDURE:

A. Prior to entering the room to provide any care, the nurse should observe the alarm panel to verify that the light on the panel is in the green area.
- Light on the alarm panel will be in the green zone to indicate proper room function.
- Light on the alarm panel will be in the red zone to indicate that pressure in the room is outside of the acceptable range.
- There will be an audible and/or visual alert when the room door is left open for a period of >60 seconds or there is a loss of negative pressure in the room.

B. When the audible alarm sounds, the nurse should go to the isolation room and check to see if the room door is open or closed.
- If the door is open, upon closing the door the light on the alarm panel will go from red to green and audible alarm will turn off.

C. If room door is closed, and the alarm is still sounding and the light is red, the nurse will need to don the required respiratory protection and enter the rooms to

check for open window or a blocked vent. If the issue cannot be corrected, contact either Environmental Services or Facilities Maintenance. Close both the door to the patient's room **and** the anteroom door.

D. While waiting for either Environmental Services or Facilities Maintenance to respond, the nurse caring for the patient will:

- Obtain a HEPA filter.
- Don respiratory protection, enter patient's room and place the HEPA filter in the patient's room as close to the patient's head as possible. Plug in and turn the HEPA filter.
- If patient's respiratory status will not be compromised and it will take only a short time to fix the problem; place a standard surgical mask on the patient.
- Minimize trips into and out of the room. **The door to the patient's room and the anteroom door must remain closed until negative pressure has been restored**.
- Place a sign on the *anteroom* door advising that N95 Respirators are needed to enter beyond this door.
- When negative pressure has been restored within the room, wait approximately 40 minutes then remove the HEPA filter, unmask the patient, keep the anteroom door closed.

E. The charge nurse will notify the Medical Center Supervisor (MCS) of the disruption in the negative pressure.

- If the disruption will be prolonged, the MCS will notify the Infection Prevention and Control Program, Hospital Medical Director and Director of Inpatient Nursing Operations as needed.
- Medical Center Supervisor will move the patient to another appropriate room.

F. During a "shelter in place" or another situation requiring the shutdown of the ventilation (HVAC) system for any reason; staff will follow these guidelines for the duration of the shut down and for 1 hour after the ventilation system has been restored.

- The Manager of the Infection Prevention and Control Program or her designee will identify those patients for whom negative pressure isolation is indicated.
- A mask will be placed on these patients and the patient will remain in his/her isolation room.
- Access to the patient's room will be limited to essential purposes only. Nursing will be requested to group tasks or trips into the room thereby decreasing the opening and closing of the door.
- A portable HEPA FILTER will be placed in the room as close as possible to the patient's head.
- The anteroom/hall door will be kept closed at all times.

- All personnel will be required to wear an N95 respirator when entering the Anteroom.

**APPROVED BY:**
Infection Prevention and Control Committee: 4/21
Patient Care Policy & Evaluation Committee: 4/21
MEC 5/16/22
JCC

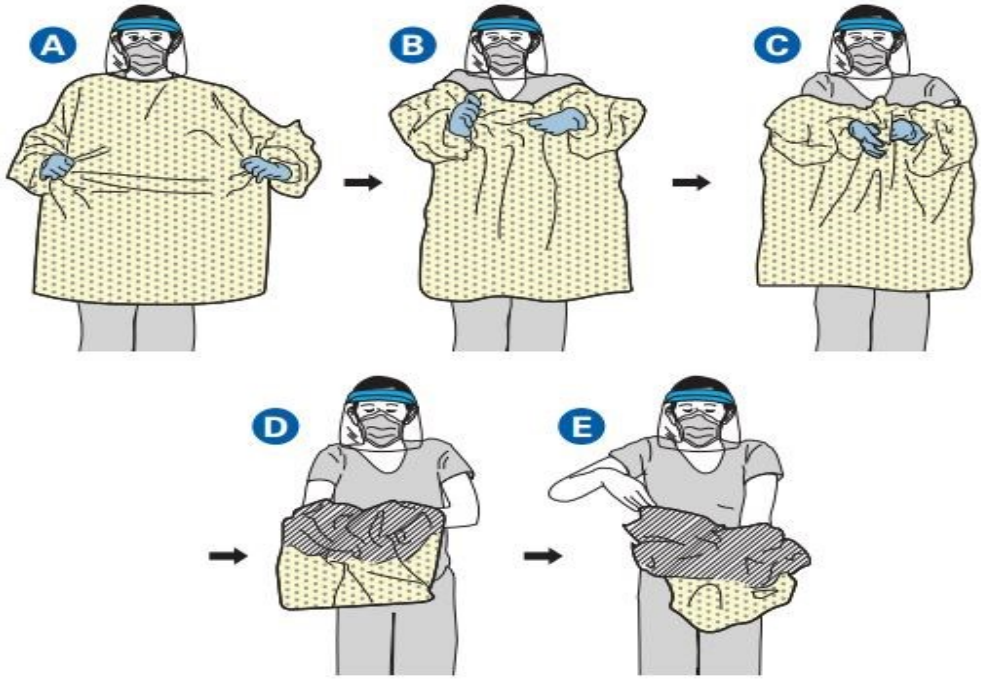
**REVIEWED:**
3/04 (new); 4/17, 4/21, 3/22

# HOW TO REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)
# EXAMPLE #2

**Doffing Sequence**

A. Gown and Gloves:

1. **Remember the gown front and sleeves and the outside of gloves are contaminated!**
2. If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
3. Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
4. While removing the gown, fold or roll the gown inside-out into a bundle
5. As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container




B. Eyewear /Goggles or Face shield:

1. **Outside of the eyewear/goggles or face shields is considered contaminated**.
2. If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
3. Remove eyewear, goggles, or face shield from the back by lifting head

band and without touching the front of the eyewear, goggles or face shield.

4. Place in designated receptacle for reprocessing or disposal.

C. MASK / RESPIRATOR:

1. Front of mask or respirator is contaminated – **do not touch**!
2. If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
3. Grasp bottom and then top ties or elastics and remove.
4. Discard in waste container.

Mask

Respirator

**Perform HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE**. If hands not visibly soiled may use alcohol-based rub, if visibly soiled use soap and water.

**APPROVED:**
MEC 5/16/22
JCC

# ENVIRONMENTAL CONTROL GUIDELINES AT CCRMC

## I. PURPOSE

Maintaining temperature, humidity and air flow direction (e.g., positive, negative) pressures within accepted ranges in critical patient care areas minimizes the risk of infection due to increased temperature and humidity and decrease the risk of fire due to humidity that is below acceptable range.

## II. REFERENCES

Joint Commission, EC.02.05.01 EP 15
American Association of Perioperative Nurses, Guideline for a Safe Environment of Care, part 2. In: Guidelines for Perioperative Practice. Denver, CO; AORN, Inc.
Centers for Medicare & Medicaid Services State Operations Manual Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Rev: 84.2013
CMC 2016 Table 4-A

## POLICY

Temperature, Humidity, and air flow (room pressure) will be maintained within the ranges listed below. However, if in the judgement of the operating team, in consultation with Plant Operations, they feel the temperature in the room should be lower than 68° for a specific case, engineering will be contacted to adjust the temperature.

As part of ~~in addition to~~ the centralized monitoring system, each operating room suite will have a temperature and humidity gauge installed.
Procedures for testing and managing out of range events are outlined within this policy

| Site | Department | Rooms | Pressure | Temp | RH | ACH |
|---|---|---|---|---|---|---|
| 2500 Alhambra Ave | Operating Rooms | OR1, OR2, OR3, OR4 | Pos | 68-75F | 30-60 | 12 |
| | Cystoscopy Rm | Cysto | Pos | 68-75F | 30-60 | 12 |
| | C Section Rms | C Section 1, C Section 2 | Pos | 68-75F | 30-60 | 20 |
| | Endoscopy | 2319, 2315, 2314 | Neg | 68-75F | 30-60 | 12 |
| | Negative Pressure Isolation Rms | PACU1, ED17, 3E06, 3E08, 3D08, 3D10, 4C02, 4B16, 5C12, 5D16, Nursery | Neg | 70-75F | <=60 | 12 |
| | SPD | Decontamination Room | Neg | 68-75F | N/R | 4 |
| | | Assembly Room | Pos | 68-75F | <=60 | 4 |
| | | Clean Work Area | Pos | 68-75F | <=60 | 4 |
| | | Sterile Holding | Pos | 68-75F | <=60 | 4 |
| | | | | | | |
| | | | | | | |

**RH = % Relative Humidity Ach = Minimum Air Changes per Hour**

## III. AUTHORITY/RESPONSIBILITY

Chief Quality Officer, Chief Operations Officer, Infection Prevention and Control Manager, Medical Center Supervisor, OR Nursing Manager, HSD Facilities Manager, PW Lead Engineer, PW Stationary Engineers, PW Supervisor, Director of Nursing Operations, Chief Nursing Officer

## IV. PROCEDURE

A. OPERATING ROOM STAFF

1. Prior to the start of the case, OR personnel staff should check the in-room temperature and humidity monitor. See chart under policy for accepted temperature and humidity levels. If the surgical team feels that the room should be less than 68°F, staff will contact the Medical Center Supervisor (MCS) who will request the engineer to adjust the temperature in the room for that particular case. These observations will not be logged.
2. If out temperature or humidity are out of range, the OR personnel will notify the Medical Center Supervisor who will contact the engineer immediately.
3. The engineer will investigate and if fault is found, the Medical Center Supervisor will be notified immediately.
4. The Medical Center Supervisor will consult with medical staff and infection control to determine if the case should be continued in that room.
5. The engineer will keep the Medical Center Supervisor informed of progress of any repair.
6. If at any time during the case, the operating team feels the room is too warm or if personnel are sweating excessively or condensation on equipment is noted, **the circulating nurse will check the in-room temperature/humidity monitor.** If either the temperature or humidity is out of accepted range, the Medical Center Supervisor will be contacted. Steps 2 through 5 above will be followed

B. STERILE PROCESSING PERSONNEL

1. Sterile processing staff should check the temperature and humidity in their work area prior to starting work.
2. If the temperature or humidity is out of range, SPD to notify the Medical Center Supervisor who will contact the engineer immediately.
3. The same process outlined in steps 3 through 5 will be followed.
4. If at any time during the work day, SPD personnel feel that room is uncomfortable and all parameters are within range, they should contact the Medical Center Supervisor who will contact the engineer who will lower the temperature to a more comfortable level.

C. FACILITIES MAINTENANCE

**Routine Maintenance and repair:**

1. Stationary engineers, using the Building Management System (BMS), record daily the pressure, temperature and relative humidity of the locations listed on the attached table.
    a. If out of range, the engineer shall notify the Medical Center Supervisor
    b. In consultation with medical staff, the Medical Center Supervisor shall decide whether to continue with the case.
    c. The engineer shall take corrective action to remedy any fault that is found. This may include an immediate repair by engineering staff or contacting an external vendor for an emergency repair.
2. An annual air balance shall be completed to ensure compliance with minimum air changes per hour and ensure negative or positive pressure. The Lead Engineer shall submit a copy of the annual report to the Health Services Department Facilities Manager. A copy of the report should also be forward to the Infection Prevention and Control Program.
3. Temperature and humidity calibration will be performed annually by outside vendor to ensure the accuracy of the central monitoring system
4. On a monthly basis, the stationary engineer will review all trend logs to identify any extended range excursions.
5. On a monthly basis, the Lead Engineer will provide a status report to the Health Services Facilities Manager regarding function and trends of the identified via the automated trend logs

**Management of out of range findings**

1. If extended out range excursion (>/= 60 minutes) noted in any parameter, the lead engineer will immediately notify the Medical Center Supervisor.
1. In consultation with medical staff the MCS shall decide on whether to continue with the case.
2. The engineer shall take corrective action to remedy any fault that is found. This may include an immediate repair by engineering staff or contacting an external vendor for an emergency repair.

Reviewed by:
EOC 7/11/2018
Infection Control 7/18/18

**ATTACHMENTS:**
IC 252a Temperature and Relative Humidity Management

**APPROVED BY:**
Infection Control Committee: 7/19/2017,
Patient Care Policy & Evaluation Committee: 8/2/2017
MEC 5/16/22
JCC

**REVISED:** May 2019

**REVIEWED:** 3/22

# GUIDELINE: VERIFICATION OF PROPER OPERATION OF AIRBORNE INFECTION ISOLATION ROOMS (AAIR) AT CCRMC

## I. PURPOSE:

To provide an overview of the Facilities Management process for ensuring appropriate operation of the negative pressure rooms.

## II. REFERENCES:

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee (HICPAC), "2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings." www.cdc.gov/ncidod/dhap/pdf/isolation 2007.pdf

Centers for Disease Control and Prevention, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings." MMWR, December 30, 2005, Vol. 54 No. RR-17

CAL OSHA, Title 8 Section 5199, Aerosol Transmissible Diseases July 2009

## III. POLICY:

Negative Pressure rooms will be tested and monitored as outlined in the procedure below.

## IV. AUTHORITY/RESPONSIBILITY:

Facilities Management
Infection Prevention and Control

## V. PROCEDURE:

A. Performed Annually – All Negative Pressure rooms:
   a. Calibration of the isolation room alarm
   b. Air balance test

B. Performed Daily – All rooms designated as Airborne Infection Isolation Rooms
   a. The pressure sensor alarm is tested.
      **Note:** If a negative pressure room is occupied by a patient with Airborne Precautions, the operation of the pressure sensor alarm will be completed only if it is safe to do so. Otherwise, pressure sensor alarm verification will be completed when the room is no longer occupied by an Airborne Precautions patient.
   b. Air pressure is verified as negative with a visual indicator, for example a smoke tube, flutter strip or a calibrated differential pressure device.

      The above testing is scheduled daily to ensure the readiness of the AAIR rooms for the placement of Airborne Precautions patients.

C. Failures/Alarm Conditions: Upon failure of the negative pressure system, including during routine testing or in response to alarm conditions as reported by Nursing:
   a. Corrective action to remedy the fault should be taken immediately, which may include an immediate or emergency repair by engineering or an external vendor.

b. The Medical Center Supervisor (MCS) and Infection Prevention and Control Manager should be notified so that immediate action to manage patient care can be taken if needed.

D. Reporting: The results of the annual and monthly testing, as well as alarm conditions and response, are provided to HSD Facilities Manager and the Infection Prevention and Control Program.

**APPROVED BY:**
Clinical Practice Committee: 6/2017
Infection Prevention & Control Committee: 6/2017
Quality/Regulatory: 6/2017
EOC Committee: 6/2017
Patient Care & Evaluation Committee: 8/2017
MEC 5/16/22
JCC

**REVIEWED:**
6/2017, 8/2017, 3/22

**REVISED:**
8/2017

# TRANSMISSION-BASED ISOLATION PRECAUTIONS

## I. POLICY:

In addition to Standard Precautions, Transmission-Based Isolation Precautions will be used to prevent the spread of communicable diseases. Transmission-Based Precautions are meant to stop spread based upon recognized routes of transmission for particular communicable diseases.

Appropriate isolation signage will be placed on the door of a patient in isolation precautions.

## II. AUTHORITY/RESPONSIBILITY:

All CCRMC personnel

## III. PROCEDURE:

### A. GENERAL GUIDELINES

During removal from a patient's body, bed or gurney, soiled linen is handled in a manner that prevents skin and mucous membrane contamination of clothing and transfer or microorganisms to other patients and to the environment.

Linen should not be shaken or manipulated in a way that might aerosolize lint.

a. Soiled linen will be place in covered hampers.
b. Environmental Services personnel will transport the linen hampers, remove the linen bags, and tie them. Bags are then placed into a laundry chute.
c. Doors to the laundry chutes will be kept locked. Keys will be kept by the Environmental Services workers.

Trash will be handled according to existing CCRMC policy.

### B. CONTACT PRECAUTIONS

These precautions are to be used to reduce the risk of transmission of resistant microorganisms by direct or indirect contact with a patient and/or patient's environment. Examples of these organisms are multiple drug-resistant organisms (MDROs) such as MRSA, VRE, or CRE.
Contact precautions should be used whenever a patient presents with excessive wound drainage, or other body discharges that can increase the risk of MDRO transmission.
**Colonization with MRSA does not require contact isolation, as Standard Precautions will be adequate.**

1. **Patient Placement:**

Place the patient in a private room. When a private room is not available, place the patient in a room with a patient who has active infection with the same microorganism, but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement.

a. Consultation with Infection Prevention is advised before patient placement.
b. Special air handling and ventilation are not necessary, and the door may remain open.
c. Colonized patients should either be in a private room or cohort with another colonized patient. If either option not possible, a colonized patient should be placed with a medical patient. Do not place a colonized patient in a room with a surgical or immunosuppressed patient.

2. **Personal Protective Equipment (PPE):**

Healthcare personnel should wear a gown and gloves when close interaction with the patient and/or environment is anticipated. Masks should be worn if patient care involves the possibility of splatter to the health care worker's mucous membranes.

a. All PPEs should be removed and discarded appropriately in the patient's room before exiting.
b. Hand hygiene should always be done before leaving the room, either with soap and water or alcohol-based hand rub.

3. **Patient Transport/Treatment and Ambulation Outside of Room**

Limit the movement and transport of the patient from the room to medically essential purposes only or with a physician order. If the patient is out of the room for any reason, precautions should be taken to ensure that the risk of transmission of microorganisms to other patients and the contamination of environmental surfaces or equipment is minimized.

a. All drainage and secretions are contained in dressing. Dressing clean, dry, and intact.
b. The patient is given a clean gown and covered with a clean sheet.
c. Assist patient with hand hygiene prior to exiting room.
d. If transport by bed or gurney; the rails and head/foot of the bed are wiped with disinfectant wipes
e. If transport by wheelchair, the chair should be appropriately covered.

f. PPE is **not worn** by transport staff unless performing direct patient care during transport.

4. **Visitors:**

When Contact Precautions are used for MRSA or VRE, visitors **are not required to wear barriers unless they wish to assist in patient care or are interacting with multiple patients.** If, however, visitors desire to wear barriers while at the bedside, they may do so. PPE if worn, must be removed prior to room exit.

a. In cases of *C. difficile*, Norovirus or extensively drug resistant gram-negative organisms, visitors should wear gowns and gloves.
b. Visitors with exposure to a symptomatic patient before hospitalization (parents/guardians/close family members) may be excluded from these precautions.
c. Visitors will be educated to perform hand hygiene when entering and prior to leaving the room.

5. ***Contact Plus Isolation Precautions for C. Difficile:***

a. Follow all guidelines under Contact Isolation with the following exceptions:
   1) EVS will disinfect the bathroom and high touch surfaces with hospital grade disinfectant and bleach.
   2) Bleach wipes will be provided in caddy for equipment.
   3) Hands must be washed with soap and water; alcohol hand gel is not an effective option.

## C. DROPLET ISOLATION PRECAUTIONS:

Droplet precautions are used to reduce transmission of infectious agents from close respiratory or mucous membrane contact, i.e., less than three (3) feet. *N. Meningitidis, B. Pertussis, and influenza* are a few of the infectious agents that are transmitted via large droplets.

1. **Patient Placement:**

Place the patient in a private room. When a private room is not available, place the patient in a room with a patient who has active infection with the same microorganism but with no other infection (cohorting) and consult with Infection Prevention for further patient placement.

a. When a private room is not available and cohorting is not achievable, consult with Infection Prevention and Control for appropriate room placement.
b. Special air handling and ventilation are not necessary, and the door may remain open.

2. **Personal Protective Equipment (PPE):**
   Wear a mask when entering a patient room.
   a. Masks should be disposed of in the patient's room at doorway just prior to exit.
   b. Hand hygiene should always be performed before leaving the patient's room.
3. **Patient Transport/Treatment and Ambulation Outside of Room**
   Limit the movement and transport of the patient from the room to medically essential purposes only.
   a. If transport of movement is necessary, minimize patient dispersal of droplets by masking the patient, if possible.
   b. Transport staff does not need to wear a mask or gloves.
4. **Visitors:**
   a. A regular mask is indicated. Don at entry, discard at exit.
   b. Instruct visitors to perform hand hygiene upon entering/leaving the room.

**D. AIRBORNE ISOLATION PRECAUTIONS:**

Airborne isolation precautions are intended to reduce the risk of airborne transmission of important and virulent infectious agents such as Rubeola Virus (measles), *Varicella Zoster,* and *M. Tuberculosis* and Disseminated Zoster.

1. **Patient Placement:**
   Place the patient in a private room (airborne) that has monitored negative air pressure in relation to the surrounding areas. Keep the room door closed and the patient in the room.
   a. When an airborne room is not available, consultation with Infection Prevention is advised before patient placement.
2. **Personal Protective Equipment/Respiratory Protection:**
   a. Wear a N95 or greater respiratory protection (PAPR, CAPR) when entering the room of a patient with known or suspected infectious pulmonary tuberculosis.
   b. Protection should be donned prior to room entry and discarded in anteroom area after door to room has been closed. If the room does not have an anteroom, discard respiratory protection outside of the room with the door closed.
   c. CAPR required for people present in room during aerosol generating procedures.
3. **Patient Transport:**

Limit the movement and transport of the patient from the room to medically essential purposes only. If transport or movement is necessary, minimize patient dispersal of infectious aerosols by placing a surgical mask on the patient, if possible.

4. **Visitors:**

Families and visitors should wear a respiratory protection, barriers needed if patient also on contact precautions if family will be assisting with physical care of the patient.

a. Regular mask is indicated.
b. Instruct visitors to perform hand hygiene upon entering/leaving the patient room.

## E. ENHANCED AIRBORNE PRECAUTIONS FOR COVID-19

a. Negative pressure or enhanced Ventilation Rooms- Door closed at all times
b. N95 Respirator or CAPR for room entry
c. CAPR for all participants in aerosol generating procedures
d. Gown and gloves, eye protection required for room entry. Remove prior to exit
    - Careful attention to donning and doffing sequence
e. Limit movement of patient in and out of room. Out of room for medically essential purposes only.
f. Limit use of shared equipment. Items taken into room must be cleaned with hospital grade FDA approved disinfectant prior to being removed from the room
g. Visitors allowed per CDC, CDPH and local public health department recommendations.

## F. NEUTROPENIC (PROTECTIVE ENVIRONMENT) PRECAUTIONS:

Protective precautions are used to protect severely immunocompromised patients (e.g., transplant patients, neutropenic patients) from the hospital environment.

1. **Patient Placement:**

Private room, preferably with the door closed. No live flowers or plants.

2. **Personal Protective Equipment:**

Patient should wear a mask when out of the room.

3. **Visitors:**

No one with an infection may visit.

**In outbreak situations or when novel potentially, virulent pathogens are suspected or identified (Ebola, MERS-CoV, SARS) isolation precautions should be enforced for all visitors. In addition, restricting visitors should be considered/necessary.**

## IV. DOCUMENTATION:

Patient progress notes in ccLink

## V. REFERENCES:

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Appendix A – "Type and duration of Precautions Recommended for Selected Infections and Conditions." 2007.

"Hospital Visitors and Isolation Precautions: Clearing Up the Confusion." Society for Healthcare Epidemiology of America (SHEA). April 29, 2016.

Department of Health and Human Services, Centers for Disease Control and Prevention, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings", MMWR, December 30, 2005, Vol. 54 No. RR-17

Cal OSHA, Aerosol Transmissible Disease Standard, Title 8 Section 5199

Cal OSHA "COVID-19 Prevention" Title 8 Division 1 Chapter 4 Subchapter 7 Section 3205.

Association for Professionals in Infection Control and Epidemiology, APIC Text of Infection Control and Epidemiology, online version downloaded 4/18/2017

Related Documents/signage

IC302a Type and Duration of Precautions recommended for selected infections
IC302b Airborne Precautions Sign
IC302c Droplet Precautions Sign
IC302d Contact Precautions Sign
IC302e Contact Plus Precautions Sign
IC302f Neutropenic Precautions Sign
IC302g Enhanced Airborne Precautions

**APPROVED:**
MEC 5/16/22
JCC

5/2017 (new)
CPC 5/15/2017
ICC 5/17/2017
PCP&E 6/7/2017

**REVISED**
9/10/21, 3/22

CONTRA COSTA REGIONAL MEDICAL CENTER POLICY IC420
CONTRA COSTA HEALTH CENTERS MARCH 2010

# RE-DONNING OF THE N95 Respirator

I. PURPOSE:

To provide guidelines for situations in which it may be necessary for an employee to re-don his/her fit test N95 Respirator.

II. REFERENCES:

CAL OSHA, Title 8 Section 5199, Aerosol Transmissible Diseases effective August 5, 2009.

CAL OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases) Issued October 22, 2009.

DEFINITION
Re-donning refers to the practice of reusing the N95 Respirator during the employee's 8-hour shift. **Re-donning may only be considered when the hospital is unable to obtain/maintain a sufficient supply of respirators for staff use.**

III. POLICY:

Contra Costa Regional Medical Center and Health Centers will make efforts to maintain an adequate supply of N95 Respirators for use by employees who are caring for persons with suspected or confirmed disease outlined in the California Airborne Transmissible Disease Standard.

During times of high use, a weekly inventory of available N95 Respirators by manufacturer and type will be conducted. The results of the inventory will be documented.

Efforts to obtain more of the masks commonly in use at the facility will also be documented on a weekly basis.

A mask should not be shared among employees. Each employee should have his/her own mask for that shift.

IV. AUTHORITY/RESPONSIBILITY:
Material Management
Infection Prevention and Control Program
Cardio-Pulmonary Department

Employees of Contra Costa Regional Medical Center and Health Centers.

V. PROCEDURE:

**A. TRACKING MASK INVENTORY AND DETERMINING SHORTAGE**

1. Materials Management personnel will conduct an inventory of N95 Respirators.

2. The inventory interval will be based on demand and availability of N95 Respirators.

3. A copy of the inventory will be sent to Hospital Administration and Infection Prevention and Control Program.

4. When supply falls to the point where only a 30-day supply of masks is available; the hospital will begin mask conservation efforts.

5. Staff will be notified by e-mail, signs and screen savers.

**B. REDONNING MASK GUIDELINES**

1. An employee may re-don his/her N95 Respirator during the shift **provided that it is not**
   - Wet
   - Dirty
   - Torn
   - Misshapen
   - Difficult to breathe through

   If any of the above conditions exist, the mask should be discarded even Even though the 8 hours has not been reached.

2. A N95 Respirator can be worn continuously between patients without removal without creating a hazard for either employees or patients so long as hand hygiene and other standard precautions are maintained.

3. A separate mask should be used (re-donned) for each patient whose care requires the use of a N95 Respirator. If not worn continuously but re-donned during a shift, a new mask should be worn when providing care for different patients.

4. Prior to entering the patient's room for the first time, label a brown paper

bag with your name and the date.

5. Between uses, the mask:
    - Should be placed in a brown paper bag labeled with the employee's name and date and left outside of the isolation room. (Follow removal process outlined below)
    - Masks should not be folded or crumpled or worn continuously around the neck between uses, as this will cause the mask to become misshapen or soiled.

6. A centralized location will be selected for the boxes of new masks. All Employees will be aware of the location of the masks.

7. When discarding the protective equipment used to care for this patient follow removal sequencing outlined in Policy #228.
    - Remove gloves
    - Wash Hands with either soap and water or an alcohol-based hand gel
    - Then remove the 95N respirator by lifting the straps from the back of the head
    - Touch mask as little as possible
    - Avoid touching the inside surfaces
    - Visually Inspect respirator and if not contaminated with blood or other body fluids, **soiled or misshapen then wash hands with either soap or alcohol-based hand gel. Do not save to re-don**
    - Label brown paper bag with the user's name and date
    - Place in a brown paper bag
    - leave outside of the isolation room

8. Wash hands with either soap and or alcohol-based hand gel.

VI. FORMS:

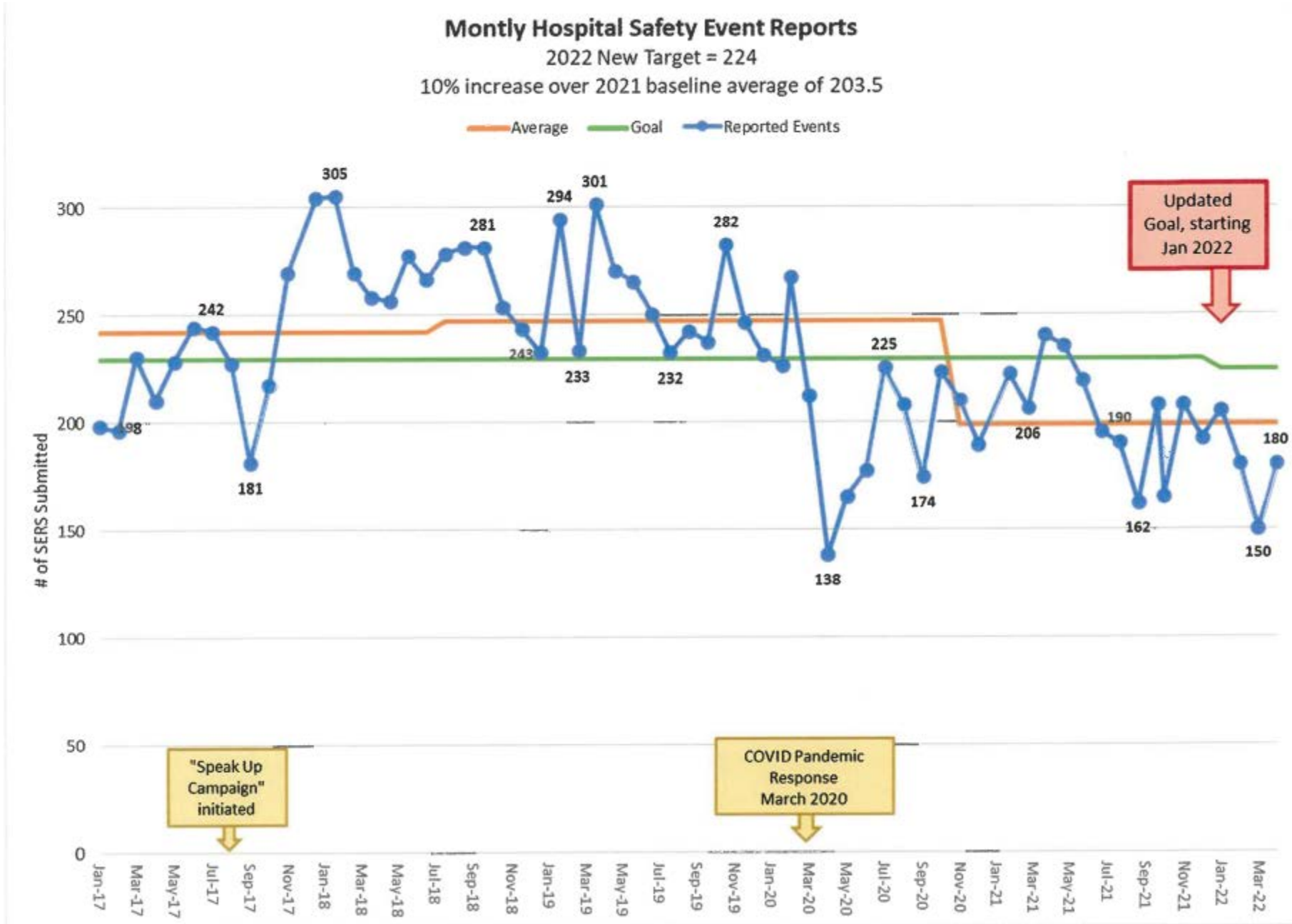
**APPROVED:**
MEC 5/16/22
JCC

**Review 3/11, 2/20**


Patient Safety and Performance Improvement Updates
May 2022
Contra Costa Regional Medical Center & Health Centers
A Division of Contra Costa Health Services

# Safety Event Reports

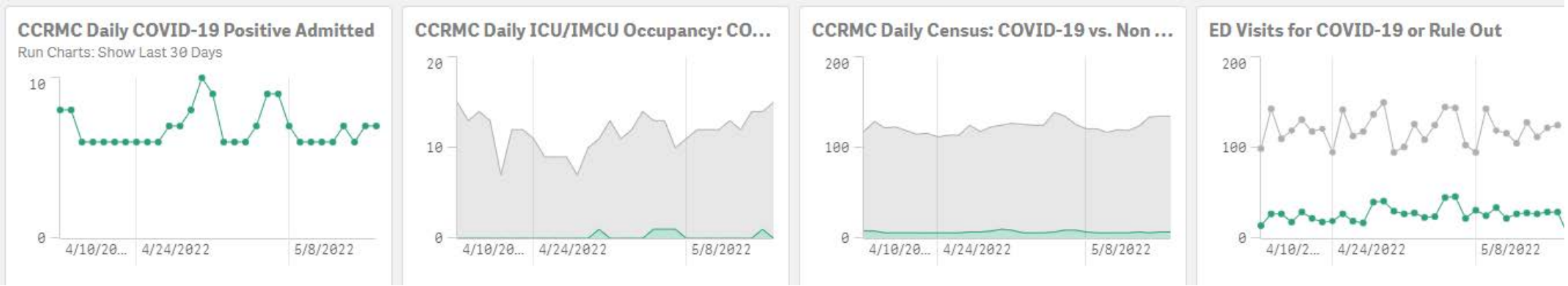
- **Beginning at the start of the pandemic, SERs have declined**
- **Goal – increase SERs by 10% from the current baseline in 2022**
- **Increase regular staff reminders about SERs, regular announcements and sharing of lessons learned to increase reporting**


Montly Hospital Safety Event Reports
2022 New Target = 224
10% increase over 2021 baseline average of 203.5
Average
Goal
Reported Events
# of SERS Submitted
300
250
200
150
100
50
0
305
301
294
281
282
242
243
233
232
225
198
181
138
174
206
190
162
150
180
Updated Goal, starting Jan 2022
"Speak Up Campaign" initiated
COVID Pandemic Response March 2020
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22

# Covid Command Center

# Covid Command Center

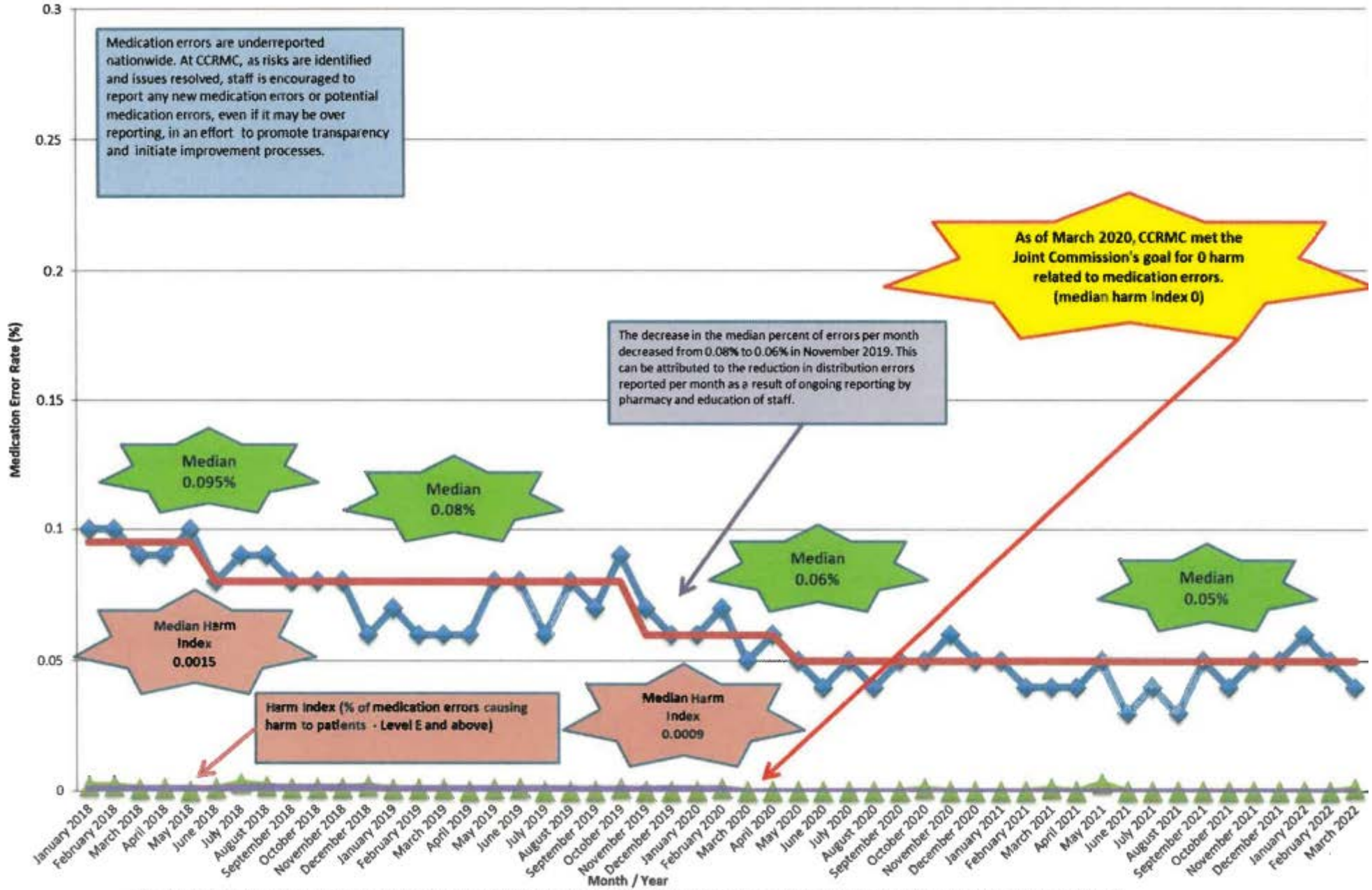
| Measures | Target | Current Data |
|---|---|---|
| Procure 120 days' supply on hand of all PPE. | 120 days | Goal met for all supplies |
| Maintain 30 days' supply on hand of all PPE. | 30 days | Goal met for all supplies |




*Dashboard data as of 5/17/22

# Medication Safety

## Percent Medication Error Rate: Number of Errors in CCRMC Hospital & Clinics / Total Number of Medication Doses Dispensed




**Note: As the Pharmacy Department learns more about the CPOE system, issues are reported via SERS to improve system workflow, and compliance with workflow.

# Upcoming Regulatory Visits

# Upcoming Regulatory Activity 2022

**CDPH General Acute Care Hospital Relicensing Survey (GACHRLS) and Medication Error Reduction Plan (MERP) Survey**

- Survey window: June 18 - September 2021

TJC Reaccreditation Survey – Hospital and Health Centers

- Survey window: Feb 23, 2021 – Aug 23, 2022

Board of Pharmacy

- Survey Window: March 2022 – August 2022

**Commission on Cancer**

- Survey window: April – June, 2022

TJC Reaccreditation Survey – Laboratory Services

- Survey Window: August 14 - November 14, 2022

CDPH Radiologic Services

- Survey Window: End of 2022

# Speak up for Patient Safety!


Patient Safety, Quality Assessment & Performance Improvement Program Evaluation
3Q-4Q21
Contra Costa Regional Medical Center & Health Centers
A Division of Contra Costa Health Services

# Highlights

- Improvement was seen in the majority of the individual metrics and our major quality programs (e.g., QIP).
- For the 56 individual metrics:
  - 52 reported data
    - 77% met target (40)
    - 23% did not meet target (12)
  - 4 did not report (Dietary, Nutrition Services, Organ Referral)
    - Performance data, analysis and action plan will be reported at the next PSPIC meeting
- No serious safety events

# QIP Program Year 4

- Began January 1, 2021, with a **new set of metrics**, including national HEDIS (managed care) and certain PRIME measures.
- Must **report at least 40** of 58 measures or lose funding.
  - 20 priority (must report all)
  - 38 elective
- New teams established and improvement work resumed.
- Due to continuing Covid emergency DHCS proposed to CMS **alternate funding and reporting structure** for 2021:
  - 50% based on Covid capacity building measures
  - 40% based on PY4 pay-for-performance on 10 measures
  - 10% based on PY4 pay-for-reporting of 30 measures

# Evaluation Highlights

- **Lessons Learned**
  - Cross divisional cooperation (CCHP, Public Health, EHSD) increases the likelihood of project success.
  - PRIME improvement work enabled us to pivot quickly during the Covid-19 pandemic to accommodate changes in staff workflows for telehealth, Covid-19 tent testing, and respiratory clinics.
- **Challenges**
  - Addressing patient population issues for those assigned, but not seen in our health system.
  - Improvement work interruptions during Covid surges.
- **Next Steps**
  - Address Covid-related issues affecting patient care outcomes.
  - Continue monitoring data and team improvement activities.

# Leapfrog

- Patient safety data and safety score are **published at least twice per year**, the latter in the form of a grade.

**Contra Costa Regional Medical Center (05-0276)**
2500 Alhambra Avenue, Martinez, CA 94553-3156

| My Score | My Letter Grade |
|---|---|
| 3.1333 | B |

- **Process and outcome** measures included
- **Earned a "B"** for Fall 2021 safety grade (5th consecutive)
- **Improvement opportunities**
  - Catheter-acquired urinary tract infection (CAUTI)
  - Falls/Trauma
  - HCAHPS: Communication, Medicine & Staff Responsiveness
  - Patient Safety Indicators composite score (PSI 90)

LEAPFROG HOSPITAL SAFETY GRADE

# Patient Safety

Safety Events:

- 188 SERS reported per month. SERS reporting has continued to fall over the last two years.
  - Health Risk Manager will support a campaign to promote SERS usage.
- No serious safety events/No RCAs required

Culture of Safety Survey:

- Surveys are done every 2 years; next one will be in 2022.

COVID Pandemic:

- Developing Aerosol Transmissible Diseases for Inpatient and Outpatient setting.

# Regulatory Compliance

- The Regulatory Work Group received and investigated:
  - Three Cal-OSHA citations received
  - Self-reported hospitalization of a staff member with COVID
- **Strength**: (1) System continues to engage and improve quality measurement design.
- **Weaknesses**: (1) Paper-based rounding system with simple tracking of findings and fixes. (2) Staff reporting to outside regulatory agencies continues to occur.
- **Opportunity**: (1) Build a rounding system that includes firm escalation process and follow through. (2) Health Risk Manager to explore opportunities to engage staff in SERS.
- **Threat**: Staff turn over and loss of system knowledge. Staffing issues.

# MERP

- The MERP Plan is evaluated every March per CDPH's calendar.

# Infection Prevention Plan

- The IP Plan is evaluated and reported separately.