IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD OF DIRECTORS

Katherine Burnworth, President | Laura Goodsell, Vice-President | Donald W. Medart Jr., Treasurer
Arturo Proctor, Secretary | Enola Berker, Director | Rodolfo Valdez, Director | James Garcia, Director

AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
THURSDAY, MAY 29, 2025, 5:00 P.M.*
NOTE, THIS START TIMEIS EALRIER THAN THE TYPICAL 6PM START TIME

601 Heber Ave., Calexico, CA. 92231

Join Microsoft Teams
Meeting ID: 247 036 201 983 1
Passcode: ha9Ja2pF

1. **Call to Order**

2. **Roll Call**

3. **Pledge of Allegiance**

4. **Approval of Request for Remote Appearance by Board Member(s)**, *if Applicable*

5. **Consider Approval of Agenda**
   In the case of an emergency, items may be added to the agenda by a majority vote of the Board of Directors. An emergency is defined as a work stoppage, a crippling disaster, or other activity that severely imperils public health, safety, or both. Items on the agenda may be taken out of sequential order as their priority is determined by the Board of Directors. The Board may take action on any item appearing on the agenda.

6. **Public Comments**
   At this time the Board will hear comments on any agenda item. If any person wishes to be heard, they shall stand; address the president, identify themself, and state the subject for comment. Time limit for each speaker is 3 minutes individually per item to address the Board. Individuals who wish to speak on multiple items will be allowed four (4) minutes in total. A total of 15 minutes shall be allocated for each item for all members of the public. The board may find it necessary to limit the total time allowable for all public comments on items not appearing on the agenda at anyone one meeting to one hour.

7. **Critical Elements of Effective Governance by Jeff Bills with Confidence Consulting (90 minutes) Part 2**

8. **Board Comments**

   Reports on meetings and events attended by Directors; Authorization for Director(s) attendance at upcoming meetings and/or events; Board of Directors comments.

   a. Brief reports by Directors on meetings and events attended
   b. Schedule of upcoming Board meetings and/or events
   c. Report by Education and Outreach Ad-Hoc Committee
   d. Report by AB 918 Negotiation Ad-Hoc Committee

9. **Consent Calendar**

   Any member of the Board may request that items for the Consent Calendar be removed for discussion. Items so removed shall be acted upon separately immediately following approval of items remaining on the Consent Calendar.

   a. Approve minutes for meetings of May 8, 2025
   b. Approve and file PMH Expenses/Financial Report for April 2025

10. **Action Items**

    a. Review and Authorize: IVHD Stop Loss Analysis Presentation

    b. MEDICAL STAFF REPORT – Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/ procedures/forms, or other related recommendations

    c. Policy and Procedure: Bioterrorism Management Plan

    d. Policy and Procedure: Child Care Disaster Plan

    e. Policy and Procedure: Code Silver – Active Shooter Situation Response

    f. Policy and Procedure: Earthquake Response Plan

    g. Policy and Procedure: Emergency Preparedness – House Supervisors Role

    h. Policy and Procedure: Code White - Hospital Evacuation Plan

    i. Policy and Procedure: Shelter in Place Plan

    j. Policy and Procedure: Workplace Violence Prevention Plan

    k. Policy and Procedure: Medical Equipment Management Plan

    l. Retire Policy and Procedure: Emergency Department (ED) Documentation Requirements

m. Policy and Procedure: Advance Directives

n. Authorize: Renewal of Workers' Compensation Coverage with BETA Risk Management Authority ("BETARMA") for coverage in the State of California.
Presented by: Carly Loper
Contract Value: $1,907,038 annual contribution (to be paid in monthly installments)
Contract Term: One year Term (July 1, 2025 – June 30, 2026)
Budgeted: Yes
Budgeted Classification: Workers' Compensation Insurance

o. Authorize: Renewal of Healthcare Entity Comprehensive Liability (HCL) Coverage, Directors & Officers Liability Coverage and Automobile Coverage with BETA Risk Management Authority ("BETARMA")
Presented by: Carly Loper
Contract Value: $1,880,387 net annual contribution
Contract Term: One year Term (July 1, 2025 – June 30, 2026)
Budgeted: Yes
Budgeted Classification: Liability Insurance

p. Review and Authorize: Property insurance coverage provided through broker, Alliant Insurance Services, Inc. ("Alliant"). Property insurance includes coverage for Property, Boiler & Machinery, Commercial Cyber Liability and Pollution. Other coverages include Cyber Breach Response Endorsement, Crime and the Deadly Weapon Response Program.
Presented by: Carly Loper
Contract Value: Total Premium $773,272 (HARPP + ADWRP, ACIP & BBR)
Contract Term: One year Term (July 1, 2025 – June 30, 2026)
Budgeted: Yes
Budgeted Classification: Insurance

11. **Management Reports**
    a. Finance: Carly C. Loper, MAcc – Chief Financial Officer
    b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer
    c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations
    d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918
    e. Executive: Christopher R. Bjornberg – Chief Executive Officer
    f. Legal: Adriana Ochoa – General Counsel

12. **Items for Future Agenda**
    This item is placed on the agenda to enable the Board to identify and schedule future items for discussion at upcoming meetings and/or identify press release opportunities.

13. **Closed Session**

    a. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
    Gov. Code Section 54956.9(d)(1))
    Name of Case:

1. Bradkowski v. PMHD
2. Garcia v. PMHD

b. CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: El Centro Regional Medical Center and Related Facilities 1415 Ross Ave, El Centro, CA 92243
Agency negotiators: AB 918 Ad Hoc Committee (Katherine Burnworth, James Garcia, Laura Goodsell), Christopher Bjornberg, Adriana Ochoa, Josh Schneiderman
Negotiating parties: City of El Centro
Under negotiation: Terms relating to acquisition of El Centro Regional Medical Center and related hospital facilities.

14. **Announcement of Closed Session Actions**

15. **Adjournment**
    a. The next regular meeting of the Board will be held on June 12, 2025, at 6:00 p.m.

POSTING STATEMENT

A copy of the agenda was posted May 23, 2025, at 601 Heber Avenue, Calexico, California 92231 at 10:30 p.m. and other locations throughout the IVHD pursuant to CA Government code 54957.5. Disclosable public records and writings related to an agenda item distributed to all or a majority of the Board, including such records and written distributed less than 72 hours prior to this meeting are available for public inspection at the District Administrative Office where the IVHD meeting will take place. The agenda package and material related to an agenda item submitted after the packets distribution to the Board is available for public review in the lobby of the office where the Board meeting will take place.

In compliance with the Americans with Disabilities Act, if any individuals request special accommodations to attend and/or participate in District Board meetings please contact the District at (760)970- 6046. Notification of 48 hours prior to the meeting will enable the District to make reasonable accommodations to ensure accessibility to this meeting [28 CFR 35.102-35.104 ADA title II].

MEETING MINUTES
May 8, 2025
REGULAR BOARD MEETING

THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 8th OF MAY 2025 AT 207 W. LEGION ROAD CITY OF BRAWLEY, CA. ON THE DATE, HOUR AND PLACE DULY ESTABLISHED OR THE HOLDING OF SAID MEETING.

1. **TO CALL ORDER:**
   The regular meeting was called to order at 6:09 pm by Katie Burnworth.

2. **ROLL CALL-DETERMINATION OF QUORUM:**

President	Katherine Burnworth
Vice-President	Laura Goodsell
Treasurer	Donald W. Medart Jr.
Secretary	Arturo Proctor
Trustee	Enola Berker
Trustee	Rodolfo Valdez
Trustee	James Garcia-online

GUESTS:
Adriana Ochoa – Legal/Snell & Wilmer
Christopher R. Bjornberg - Chief Executive Officer
Tomas Virgen - Support for IVHD (AB 918)

3. **PLEDGE OF ALLEGIANCE WAS LED BY DIRECTOR BURNWORTH.**

4. **APPROVAL OF REQUEST FOR REMOTE APPEARANCE BY BOARD MEMBER(S)**
   The directors accepted the request for remote appearance by Director James Garcia (see attached Request for Remote Appearance Form for basis).

5. **CONSIDER APPROVAL OF AGENDA:**
   Motion was made by Director Goodsell and second by Director Proctor to approve the agenda for the Regular and Special meeting agenda for May 8, 2025. Motion passed by the following vote wit:

   AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
   NOES: None

6. **PUBLIC COMMENT TIME:**
   Ron Rubin expressed his concerns and questioned how the financial report is supposed to be reviewed and approved under consent calendar. He feels the financial report should be reviewed, approved or not approved once the report has been given. He expressed his concerns on Strategic Planning and feels that this report could have been done three months ago and feels it does not say anything specific.

   Kevin Smith informed the board that we continue to be concerned about the financial situation and the El Centro Regional loss, and we add that up with Pioneers the numbers don't add up and the

numbers will never add up.

boards attention that there was an error on the minutes for April 10th that needed to be corrected.

7. **BOARD COMMENTS:**
   a. Brief reports by Directors on meetings and events attended. Schedule of upcoming Board meetings and events.

      Director Burnworth reported that she attended the Beckers Healthcare conference last week and it was very informative

   b. Report by Education and Outreach Ad-Hoc Committee

      Director Garcia commended our PR Team for sending out a nice article to Imperial Valley Press to celebrate National Nurses week and it was well done.

   c. Report by AB 918 Ad Hoc Negotiation Committee re AB 918

      Attorney Adiana reported that they continue having biweekly meetings with the ECRMC Team. They are meeting with the regulatory group to talk about regulatory licenses and approval that are necessary as we move forward with the deal. We have been having positive conversations with UCSD

8. **CONSENT CALENDAR:**
   Director Goodsell recommends pulling out item B, PMH Expenses/Financial Report to discuss further before approving.

   Motion was made by Director Goodsell and second by Director Berker to approve the consent calendar item A minutes for April 24, 2025. Motion passed by the following vote wit:

   AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
   NOES: None

   Carly Loper went over the financial report with board members and answered any questions the board had conceding the financial report.

   Motion was made by Director Berker and second by Director Goodsell to approve the consent calendar item B, PMH Expenses/Financial Report. Motion passed by the following vote wit:

   AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
   NOES: None

9. **ACTION ITEMS:**
   a. Policy and Procedure: Bioterrorism Management Plan

Director Proctor reminded the board that at our last meeting, it had some items that dealt with emergency services, emergency planning etc. and some of us had some questions and so we went them back so we can revisit the policies but after getting the copies Director Proctor still has some questions he would like to ask Jorge Mendoza and since Mr. Mendoza is not here to answer questions Director Proctor would like to table some of these item for a later meeting and have Jorge Mendoza attend a meeting to answer any questions.

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

b. Policy and Procedure: Child Care Disaster Plan

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

c. Policy and Procedure: Code Silver – Active Shooter Situation Response

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

d. Policy and Procedure: Earthquake Response Plan

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

e. Policy and Procedure: Emergency Preparedness – House Supervisors Role

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

f. Policy and Procedure: Code White - Hospital Evacuation Plan

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

g. Policy and Procedure: Infection Control Practices for Healthcare Personnel

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Infection Control Practices for Healthcare. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

h. Policy and Procedure: Shelter in Place Plan

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

i. Policy and Procedure: Value Analysis Committee

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Value Analysis Committee. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

j. Policy and Procedure: Workplace Violence Prevention Plan

Motion was made by Director Proctor and second by Director Medart Jr. to table this item for a later meeting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

k. Policy and Procedure: Financial Assistance Program (FAP), Charity Care Program

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Financial Assistance Program (FAP), Charity Care Program. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

l. Policy and Procedure: Billing and Collection

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Billing and Collection. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

m. Authorize: Renew contract with Canon Medical System Service Agreement
Presented by: Carly Zamora
Contract Value: Canon CT AQ64 Coverage: Monthly cost: $8,054.00,
Annual cost: $96,648.00, 4-Year total: $386,592.00
Contract Term: 4-years (06/08/2025 – 06/07/2029) Total $386,592.00
Budgeted: Yes
Budgeted Classification: Operation

Motion was made by Director Goodsell and second by Director Medart Jr. to the approve the Renew contract with Canon Medical System Service Agreement as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

n. Authorize: Renew contract with Canon MRI 3T Galan Service Agreement
Presented by: Carly Zamora
Contract Value: MRI 3T Service Coverage: Monthly cost: $9,396.52,
Annual cost: $112,758.24, 5-Year total: $563,791.20
Contract Term: 5 years (04/25/2025 – 04/24/2030) Total $563,791.20
4899-0142-1106
Budgeted: Yes
Budgeted Classification: Operation

Motion was made by Director Berker and second by Director Medart Jr. to approve the Renew contract with Canon MRI 3T Galan Service Agreement as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

o. Authorize: Oracle Cerner Changes related to IVHD
Presented by: Chris Bjornberg
Contract Value: $113,081.90
Contract Term: N/A
Budgeted: No
Budgeted Classification: Purchased Services

Motion was made by Director Goodsell and second by Director Medart Jr. to approve the Oracle Cerner Changes related to IVHD as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

p. Authorize: Firewall Upgrades
Presented by: Carly Loper
Contract Value: $80,982.16
Contract Term: Precision AI Network Security Subscription Bundle (Advanced Threat Prevention, Advanced URL Filtering, Advanced Wildfire, Advanced DNS Security and Advance SD-WAN), 3 years (36 months) term
Budgeted: Yes
Budgeted Classification: Maintenance

Motion was made by Director Medart Jr. and second by Director Berker to approve the Firewall Upgrades as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

q. Authorize the approval of the Engagement Letter and Professional Services Agreement between Moss Adams LLP and PMHD for financial audit services for fiscal year ending June 30, 2025
Presented by: Carly Loper
Contract Value: $150,000.00
Contract Term: One Year Agreement (audit for FY ending 06/30/2025)
Budgeted: Yes
Budgeted Classification: Purchased Services

Motion was made by Director Medart Jr. and second by Director Proctor to approve the Engagement Letter and Professional Services Agreement between Moss Adams LLP and PMHD for financial audit services for fiscal year ending June 30, 2025, subject to legal counsel approval. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

r. Discussion and Possible Action to Approve (1) Engagement Agreement for Special Counsel
Services with Procopio, Cory, Hargreaves & Savitch LLP for Bond and Financing Matters and
(2) Waiver Letter with US Bank Trust Company, National Association (Hourly Rate: $870).

Motion was made by Director Medart Jr. and second by Director Berker to approve the (1) Engagement Agreement for Special Counsel Services with Procopio, Cory, Hargreaves & Savitch LLP for Bond and Financing Matters and (2) Waiver Letter with US Bank Trust

Company, National Association (Hourly Rate: $870) as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

s. Joint CEO Presentation Regarding ECRMC Acquisition and Strategic Planning

Pablo Velez, ECRMC CEO gave a brief presentation on ECRMC Acquisition and Strategic Planning.

10. <u>MANAGEMENT REPORTS:</u>

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer

Carly gave a report under consent calendar.

b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer

Carol went over the CNO report and survey online.

c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations

Carly gave a brief report on the Clinic Operations.

d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918

Tomas reported that there was a meeting today held at the Calexico City Office. As he had reported at the last meeting, he had said that there were different opinions by different inspectors going to the Urgent Care site. Per our request they had meeting will all the parties involved and as of today they told us that we just need to put up three signs and that's a sign for each waiting room that say the maximum occupancy a sign by the expansive door on the back that says no exit on it. Those are going to be ordered and once those come in they are going to be doing a final inspection.

e. Executive: Christopher R. Bjornberg – Chief Executive Officer

Chris reported that they did have a meeting about the stop loss. They presented it to us and we are getting some finalized numbers from hem. We will come back with that to the next board meeting.

He also gave a brief report on the Beckers Conference he attended.

He informed the board that next week Hospital week and talked abut the events that will be going on during the week.

f. Legal: Adriana Ochoa – General Counsel

None.

IMPERIAL VALLEY HEALTHCARE DISTRICT

11. **ITEMS FOR FUTURE AGENDA:**
    Strategic Planning for June 12, 2025, meeting

BOARD ENTERED INTO CLOSED SESSION AT 8:49pm

12. **CLOSED SESSION:**
    a. **CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Gov. Code Section 54956.9(d)(2))**
    Government Names:
        1. **Adriana Pacheco**
        2. **Nicolas Magos**
        3. **Kevin Fernando Fernandez**
        4. **Stephany Rojas**

BOARD RECONVENED INTO OPEN SESSION AT 9:03PM

13. **REPORT OUT OF CLOSED SESSIONS ACTIONS:**

    The Board voted to reject the Government Claims presented by Adriana Pacheco, Nicolas Magos, Kevin Fernando Fernandez and Stephany Rojas.

    The Motion was made by Director Goodsell, Seconded by Director Proctor and the vote was 7-0.

    AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
    NOES: None

14. **ADJOURNMENT:**
    With no future business to discuss, Motion was made unanimously to adjourn meeting at 9:04 p.m.

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

To: Board of Directors

Katherine Burnworth, President

Laura Goodsell, Vice President

Arturo Proctor, Secretary

Donald W. Medart Jr., Treasurer

Enola Berker, Trustee

Rodolfo Valdez, Trustee

James Garcia, Trustee

Additional Distribution: N/A

From: Christopher R. Bjornberg, Chief Executive Officer

Financial Report – April 2025

Overview:

Financial operations for the month of April resulted in a profit of $280,798 against a budgeted profit of $19,647.

Patient Volumes:

For the month of April, inpatient admissions exceeded budget by 6.0% but fell below the prior month by (9.6%). For the year-to-date period, inpatient admissions are ahead of budget by 14.8% and ahead of the prior year by 14.7%. April inpatient days fell below budget by (32.3%) and fell below the prior month volumes by (17.8%). For the year-to-date period, inpatient days are below budget by (13.9%) and below the prior year by (13.2%).

Newborn deliveries in April exceeded March's deliveries by 49.4% and exceeded the monthly budget by 109.4%. April's ED visits fell below March's visits by (5.3%) but exceeded the budget for the month by 7.5%. Surgical case volumes fell below the prior month's volumes by (8.4%) and fell below the monthly budget by (38.1%).

Pioneers Health Center (PHC) visits in April fell below the prior month's visits by (3.2%) and fell below the monthly budget by (9.6%). The Calexico Health Center (CHC) volumes in April exceeded the prior month volumes by 9.3% and exceeded the monthly budget by 31.8%. The Pioneers Children's Health Center (PCHC) fell below the prior month's volumes by (13.8%) but exceeded the monthly budget by 3.7%.

Hospital outpatient volumes i.e., Lab, Imaging, Respiratory and other services exceeded March's volumes by less than 1.0% and exceeded the monthly budget by 36.2%.

For the month of April, Pioneers Memorial Skilled Nursing Center (PMSNC), *formerly Imperial Heights Health and Wellness Center*, inpatient days decreased from March's days by (7.3%) with 2,149 inpatient days in April compared to 2,317 inpatient days in March. PMSNC had an average daily census (ADC) of 71.6 for the month of April.

See Exhibit A (Key Volume Stats – Trend Analysis) for additional detail.

	Current Period			Year To Date		
	Act.	Bud	Prior Yr.	Act.	Bud	Prior Yr.
Deliveries	266	127	239	1,760	1,635	1,910
E/R Visits	3,839	3,570	3,996	38,706	38,527	38,963
Surgeries	277	412	299	3,356	3,920	2,953
GI Scopes	16	61	57	290	879	773
Calexico RHC	1,174	891	522	9,599	8,118	7,693
Pioneer Health	2,655	2,937	1,173	26,852	29,530	27,487
Children's RHC	728	702	275	7,518	7,879	7,251
O/P Visits	6,966	5,113	5,602	68,201	51,256	51,821

Gross Patient Revenues:

In April, gross inpatient revenues exceeded budget by 14.4% while outpatient revenues fell below budget by (5.2%).

Net operating revenues (Gross revenues less contractual deductions) exceeded the monthly budget by $496,225 or 3.9% but fell below the prior month's revenues by ($504,593) or (3.6%).

Operating Expenses:

In total, April operating expenses were over budget by ($167,586) or (1.3%). Staffing expenses, which include Salaries, Benefits and Contract Labor were over budget by ($147,860) or (2.0%). Non-salary expenses, which include Supplies, Professional Fees, Purchased Services and Other were just over budget by less than (1.0%).

Below is a summary table of expenses compared to budget.

Exp. Category	Actual	Budget	Var.	Comment
Salaries	6,237	6,028	-3.5%	Over Budget
Benefits	1,463	1,522	3.9%	Under Budget
Contract Labor	210	213	1.4%	On Budget
Pro Fees	1,490	1,243	-19.9%	Over Budget
Supplies	1,405	1,559	9.9%	Under Budget
Purchased Serv	459	636	27.8%	Under Budget
Other	785	779	-0.8%	On Budget

Bond Covenants:

As part of the Series 2017 Bond issue, the District is required to maintain certain covenants or "promises" to maintain liquidity (days cash on hand of 50 days) and profitability (debt service coverage ratio of 1.20). A violation of either will allow the Bond Trustee (US Bank) authorization to take certain steps to protect the interest of the individual Bond Holders.

Net Excess/(Deficit):

Fiscal year-to-date, District operations have resulted in a profit of $4,767,467 against a budgeted loss of ($39,199) which is less than the prior year-to-date profit of $7,908,686.

END OF REPORT

IMPERIAL VALLEY HEALTHCARE DISTRICT
STATEMENT OF REVENUE AND EXPENSE
FOR THE PERIOD ENDING APRIL 30, 2025

LAST MONTH ACTUAL MARCH	LAST YEAR ACTUAL APRIL	THIS MONTH ACTUAL APRIL	THIS MONTH BUDGET APRIL	% VAR		FYTD ACTUAL APRIL	FYTD BUDGET APRIL	% VAR	FYTD PRIOR YEAR APRIL	% VAR
3,264	3,866	2,707	4,489	-39.69%	ADJ PATIENT DAYS	32,259	44,718	-27.86%	43,304	-25.51%
1,350	1,486	1,110	1,640	-32.32%	INPATIENT DAYS	13,835	16,073	-13.92%	15,937	-13.19%
511	441	462	436	5.96%	IP ADMISSIONS	5,085	4,428	14.84%	4,433	14.71%
46	50	37	55	-32.32%	IP AVERAGE DAILY CENSUS	46	53	-13.92%	52	-13.19%
					GROSS PATIENT REVENUES					
4,460,991	4,476,718	4,502,920	7,071,961	-36.33%	DAILY HOSPITAL SERVICES	42,771,007	75,301,915	-43.20%	75,684,898	-43.49%
14,010,106	10,834,144	13,170,259	8,373,486	57.29%	INPATIENT ANCILLARY	149,871,034	77,590,229	93.16%	80,789,805	85.51%
26,191,988	24,524,724	25,433,294	26,831,100	-5.21%	OUTPATIENT ANCILLARY	256,543,474	272,477,273	-5.85%	268,699,695	-4.52%
44,663,085	39,835,586	43,106,473	42,276,547	1.96%	TOTAL PATIENT REVENUES	449,185,515	425,369,417	5.60%	425,174,398	5.65%
					REVENUE DEDUCTIONS					
11,713,712	9,191,349	10,228,981	9,258,997	-10.48%	MEDICARE CONTRACTUAL	107,972,248	93,160,260	-15.90%	94,349,870	-14.44%
12,785,203	13,814,652	13,643,163	12,101,267	-12.74%	MEDICAL CONTRACTUAL	136,465,716	121,758,025	-12.08%	127,344,446	-7.16%
-1,184,154	-1,423,762	-1,378,326	-1,359,079	-1.42%	SUPPLEMENTAL PAYMENTS	-13,526,326	-13,674,496	1.08%	-16,586,271	18.45%
-88,856	-11,210	-467,741	0	100.00%	PRIOR YEAR RECOVERIES	-2,497,742	0	100.00%	-3,557,517	
6,978,258	5,975,717	6,797,466	8,298,441	18.09%	OTHER DEDUCTIONS	72,953,858	83,495,542	12.63%	82,296,294	11.35%
0	211,042	8,600	154,910	94.45%	CHARITY WRITE OFFS	297,727	1,558,644	80.90%	1,585,277	81.22%
600,000	928,000	920,000	968,028	4.96%	BAD DEBT PROVISION	9,218,743	9,739,906	5.35%	10,044,405	8.22%
0	-4,167		-4,121	100.00%	INDIGENT CARE WRITE OFFS	-29,169	-41,466	29.66%	-41,667	-29.99%
30,804,163	28,681,622	29,752,144	29,418,443	-1.13%	TOTAL REVENUE DEDUCTIONS	310,855,056	295,996,415	-5.02%	295,434,837	-5.22%
13,858,922	11,153,964	13,354,329	12,858,104	3.86%	NET PATIENT REVENUES	138,330,459	129,373,002	6.92%	129,739,561	-6.62%
69.0%	72.0%	69.0%	69.6%			69.2%	69.6%		69%	
					OTHER OPERATING REVENUE					
0	0	0	0		GRANT REVENUES	0	0		580,000	-100.00%
535,886	630,641	372,539	384,748	-3.17%	OTHER	4,521,610	3,868,681	16.88%	4,185,614	8.03%
535,886	630,641	372,539	384,748	-3.17%	TOTAL OTHER REVENUE	4,521,610	3,868,681	16.88%	4,765,614	-5.12%
14,394,808	11,784,605	13,726,868	13,242,852	3.65%	TOTAL OPERATING REVENUE	142,852,069	133,241,683	7.21%	134,505,175	6.21%
					OPERATING EXPENSES					
6,268,879	5,558,720	6,237,213	6,027,615	-3.48%	SALARIES AND WAGES	63,384,210	60,972,517	-3.96%	56,029,196	-13.13%
1,816,690	1,393,022	1,462,931	1,522,353	3.90%	BENEFITS	16,466,467	15,223,530	-8.16%	14,786,773	-11.36%
180,983	156,732	210,277	212,592	1.09%	REGISTRY & CONTRACT	1,994,187	2,239,253	10.94%	2,773,300	28.09%
8,266,552	7,108,474	7,910,421	7,762,560	-1.90%	TOTAL STAFFING EXPENSE	81,844,864	78,435,300	-4.35%	73,589,269	-11.22%
1,463,172	1,174,225	1,490,185	1,242,802	-19.91%	PROFESSIONAL FEES	13,431,489	12,428,020	-8.07%	11,295,163	-18.91%
1,454,101	1,412,912	1,405,314	1,558,768	9.84%	SUPPLIES	16,323,081	15,778,809	-3.45%	15,363,569	-6.25%
684,894	778,764	459,333	635,697	27.74%	PURCHASED SERVICES	6,178,726	6,104,971	-1.21%	7,306,461	15.43%
723,397	642,261	662,344	580,089	-14.18%	REPAIR & MAINTENANCE	6,367,140	5,800,890	-9.76%	5,285,607	-20.46%
282,356	249,006	331,604	358,983	7.63%	DEPRECIATION & AMORT	3,027,937	3,637,695	16.76%	2,783,540	-8.78%
204,757	228,743	224,447	221,031	-1.55%	INSURANCE	2,302,966	2,382,928	3.36%	2,323,868	0.90%
249,017	302,635	244,297	206,321	-18.41%	HOSPITALIST PROGRAM	2,065,378	2,063,210	-0.11%	2,142,837	3.61%
786,002	1,165,304	784,905	779,013	-0.76%	OTHER	8,340,535	7,869,649	-5.98%	8,051,584	-3.59%
14,114,248	13,062,324	13,512,850	13,345,264	-1.26%	TOTAL OPERATING EXPENSES	139,882,116	134,501,472	-4.00%	128,141,898	-9.16%
280,560	-1,277,719	214,018	-102,412	308.98%	TOTAL OPERATING MARGIN	2,969,953	-1,259,789	-335.75%	6,363,277	53.33%
					NON OPER REVENUE(EXPENSE)					
114,595	98,665	344	60,744	-99.43%	OTHER NON-OP REV (EXP)	1,089,151	607,440	79.30%	732,657	48.66%
117,632	137,153	117,632	117,632	0.00%	DISTRICT TAX REVENUES	1,231,417	1,176,320	4.68%	1,371,530	-10.22%
-51,247	-54,098	-51,196	-56,317	9.09%	INTEREST EXPENSE	-523,054	-563,170	7.12%	-558,778	6.39%
0	0	0	0	0.00%	CARES HHS/ FEMA RELIEF FUNDING	0	0	0.00%	0	
180,980	181,720	66,780	122,059	-45.29%	TOTAL NON-OP REV (EXPENSE)	1,797,514	1,220,590	47.27%	1,545,409	16.31%
461,540	-1,095,999	280,798	19,647	-1329.22%	NET EXCESS / (DEFICIT)	4,767,467	-39,199	12262.22%	7,908,686	39.72%
1,106.21	914.92	964.28	917.10	-5.14%	TOTAL PAID FTE'S (Inc Reg & Cont.)	1,221.77	928.07	-31.65%	889.12	-37.41%
981.75	844.02	837.21	817.34	-2.43%	TOTAL WORKED FTE'S	1,010.21	833.25	-21.24%	792.18	-27.52%
20.84	16.25	21.15	15.43	-37.09%	TOTAL CONTRACT FTE'S	20.87	22.91	8.90%	20.63	-1.16%
914.42	794.45	803.19	772.43	-3.98%	PAID FTE'S - HOSPITAL	1,064.09	798.74	-33.22%	772.72	-37.71%
798.47	732.88	697.31	686.34	-1.60%	WORKED FTE'S - HOSPITAL	867.84	716.15	-21.18%	682.96	-27.07%
191.79	120.48	161.09	144.67	-11.35%	PAID FTE'S - SNF	157.68	129.33	-21.92%	116.40	100.00%
183.28	111.14	139.90	131.00	-6.79%	WORKED FTE'S - SNF	142.37	117.10	-21.58%	109.22	100.00%

IMPERIAL VALLEY HEALTHCARE DISTRICT
BALANCE SHEET AS OF APRIL 30, 2025

	MARCH 2025	APRIL 2025	APRIL 2024
ASSETS			
CURRENT ASSETS			
CASH	$32,548,213	$43,076,772	$39,425,666
CASH - NORIDIAN AAP FUNDS	$0	$0	$0
CASH - 3RD PRTY REPAYMENTS	$0	$0	$0
CDs - LAIF & CVB	$66,244	$66,244	$65,505
ACCOUNTS RECEIVABLE - PATIENTS	$93,968,163	$92,954,857	$100,467,483
LESS: ALLOWANCE FOR BAD DEBTS	-$3,293,239	-$2,655,434	-$7,921,462
LESS: ALLOWANCE FOR CONTRACTUALS	-$73,379,787	-$72,040,469	-$77,561,504
NET ACCTS RECEIVABLE	$17,295,137	$18,258,954	$14,984,517
	18.41%	19.64%	14.91%
ACCOUNTS RECEIVABLE - OTHER	$37,771,153	$27,649,375	$27,362,949
COST REPORT RECEIVABLES	$59,499	$59,499	$2,129,441
INVENTORIES - SUPPLIES	$3,069,724	$3,170,967	$3,296,406
PREPAID EXPENSES	$3,542,517	$2,558,343	$2,355,197
TOTAL CURRENT ASSETS	$94,352,487	$94,840,154	$89,619,681
OTHER ASSETS			
PROJECT FUND 2017 BONDS	$588,415	$616,332	$337,004
BOND RESERVE FUND 2017 BONDS	$968,353	$968,353	$968,316
LIMITED USE ASSETS	-$798,790	$10,198	$69,676
NORIDIAN AAP FUNDS	$0	$0	$0
GASB87 LEASES	$64,931,450	$64,931,450	$49,415,107
OTHER ASSETS PROPERTY TAX PROCEEDS	$269,688	$269,688	$505,438
OTHER INVESTMENTS	$420,000	$420,000	$0
UNAMORTIZED BOND ISSUE COSTS			
TOTAL OTHER ASSETS	$66,379,116	$67,216,021	$51,295,541
PROPERTY, PLANT AND EQUIPMENT			
LAND	$2,633,026	$2,633,026	$2,623,526
BUILDINGS & IMPROVEMENTS	$63,118,597	$63,118,597	$62,919,140
EQUIPMENT	$65,510,645	$66,017,727	$61,662,894
CONSTRUCTION IN PROGRESS	$107,758	$110,766	$1,586,602
LESS: ACCUMULATED DEPRECIATION	-$102,445,327	-$102,776,931	-$99,177,158
NET PROPERY, PLANT, AND EQUIPMENT	$28,924,699	$29,103,185	$29,615,003
TOTAL ASSETS	$189,656,302	$191,159,360	$170,530,225

IMPERIAL VALLEY HEALTHCARE DISTRICT
BALANCE SHEET AS OF APRIL 30, 2025

	MARCH 2025	APRIL 2025	APRIL 2024
LIABILITIES AND FUND BALANCES			
CURRENT LIABILITIES			
ACCOUNTS PAYABLE - CASH REQUIREMENTS	$3,645,266	$3,986,749	$3,676,871
ACCOUNTS PAYABLE - ACCRUALS	$9,080,736	$9,109,714	$9,442,614
PAYROLL & BENEFITS PAYABLE - ACCRUALS	$6,638,820	$7,092,710	$7,515,163
COST REPORT PAYABLES & RESERVES	$0	$0	$0
NORIDIAN AAP FUNDS	$0	$0	$0
CURR PORTION- GO BONDS PAYABLE	$0	$0	$230,000
CURR PORTION- 2017 REVENUE BONDS PAYABLE	$0	$0	$320,000
INTEREST PAYABLE- GO BONDS	$1,917	$1,917	$958
INTEREST PAYABLE- 2017 REVENUE BONDS	$321,254	$374,383	$59,942
OTHER - TAX ADVANCE IMPERIAL COUNTY	$0	$0	$0
DEFERRED HHS CARES RELIEF FUNDS	$0	$0	$0
CURR PORTION- LEASE LIABILITIES(GASB 87)	$3,756,205	$3,756,205	$1,722,161
SKILLED NURSING OVER COLLECTIONS	$1,846,445	$2,064,596	$0
CURR PORTION- SKILLED NURSING CTR ADVANCE	$0	$0	$0
CURRENT PORTION OF LONG-TERM DEBT	$1,056,440	$1,037,037	$185,895
TOTAL CURRENT LIABILITIES	$26,347,083	$27,423,311	$23,153,604
LONG TERM DEBT AND OTHER LIABILITIES			
PMH RETIREMENT FUND - ACCRUAL	$841,305	$991,305	$120,000
NOTES PAYABLE - EQUIPMENT PURCHASES	$0	$0	$43,566
LOANS PAYABLE - DISTRESSED HOSP. LOAN	$26,962,963	$26,962,963	$28,043,566
LOANS PAYABLE - CHFFA NDPH	$0	$0	$3,766,770
BONDS PAYABLE G.O BONDS	$0	$0	$0
BONDS PAYABLE 2017 SERIES	$14,469,988	$14,468,003	$14,491,826
LONG TERM LEASE LIABILITIES (GASB 87)	$62,267,845	$62,267,845	$48,170,072
DEFERRED REVENUE -CHW	$0	$0	$0
DEFERRED PROPERTY TAX REVENUE	$275,438	$275,438	$511,188
TOTAL LONG TERM DEBT	$104,817,539	$104,965,554	$95,146,988
FUND BALANCE AND DONATED CAPITAL	$54,003,028	$54,003,028	$44,264,668
NET SURPLUS (DEFICIT) CURRENT YEAR	$4,488,652	$4,767,467	$7,964,966
TOTAL FUND BALANCE	$58,491,680	$58,770,495	$52,229,634
TOTAL LIABILITIES AND FUND BALANCE	$189,656,302	$191,159,360	$170,530,225

IMPERIAL VALLEY HEALTHCARE DISTRICT
STATEMENT OF REVENUE AND EXPENSE - 12 Month Trend

	1	2	3	4	5	6	7	8	9	10	11	12	YTD
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Apr-25
ADJ PATIENT DAYS	3,358	3,210	3,336	3,200	2,948	3,036	3,243	3,868	3,776	2,876	3,264	2,707	38,827
INPATIENT DAYS	1,486	1,348	1,338	1,362	1,289	1,290	1,376	1,676	1,769	1,275	1,350	1,110	16,669
IP ADMISSIONS	441	461	486	487	495	479	501	591	585	488	511	462	5,987
IP AVERAGE DAILY CENSUS	48	45	43	44	43	42	46	54	57	46	44	37	46
GROSS PATIENT REVENUES													
DAILY HOSPITAL SERVICES	3,457,051	3,768,895	4,135,558	4,245,778	4,185,658	4,425,452	3,960,883	4,306,327	4,623,907	3,923,533	4,460,991	4,502,920	49,996,953
INPATIENT ANCILLARY	15,797,333	13,081,272	13,359,194	14,037,130	13,994,712	14,901,257	14,605,962	17,023,992	19,402,543	15,365,879	14,010,106	13,170,259	178,749,639
OUTPATIENT ANCILLARY	24,253,745	23,272,916	26,123,842	24,666,163	23,402,909	26,164,034	25,191,832	27,895,452	27,255,392	24,218,568	26,191,988	25,433,294	304,070,135
TOTAL PATIENT REVENUES	43,508,129	40,123,083	43,618,594	42,949,071	41,583,279	45,490,743	43,758,677	49,225,771	51,281,842	43,507,980	44,663,085	43,106,473	532,816,727
REVENUE DEDUCTIONS													
MEDICARE CONTRACTUAL	9,442,613	7,771,266	10,291,766	9,837,519	9,148,238	11,152,895	9,362,592	11,681,500	13,186,192	11,368,853	11,713,712	10,228,981	125,186,127
MEDICAL CONTRACTUAL	13,341,498	10,267,611	12,833,278	12,888,442	11,976,873	12,946,217	13,222,415	15,178,005	18,178,743	12,813,377	12,785,203	13,643,163	160,074,825
SUPPLEMENTAL PAYMENTS	-1,423,762	-1,335,395	-1,374,159	-1,336,399	-1,378,326	-1,374,159	-1,374,159	-1,374,159	-1,374,159	-1,378,326	-1,184,154	-1,378,326	-16,285,483
PRIOR YEAR RECOVERIES	-11,210	-424,603	0	0	0	0	0	-1,925,640	0	-15,505	-88,856	-467,741	-2,933,555
OTHER DEDUCTIONS	8,030,632	7,494,293	7,851,346	7,376,244	8,022,745	6,839,814	8,171,185	9,491,219	4,827,640	6,597,941	6,978,258	6,797,466	88,478,783
CHARITY WRITE OFFS	435,081	144,857	103,048	44,424	60,153	10,063	12,363	26,134	25,780	7,162	0	8,600	877,665
BAD DEBT PROVISION	928,000	966,744	937,839	920,000	1,030,122	1,020,000	920,000	1,171,548	749,234	950,000	600,000	920,000	11,113,487
INDIGENT CARE WRITE OFFS	-4,167	-3,450	-4,167	-4,167	-4,167	-4,167	-4,167	-4,167	-4,167	0	0	0	-36,785
TOTAL REVENUE DEDUCTIONS	30,738,685	24,881,323	30,638,952	29,726,063	28,855,638	30,590,663	30,310,229	34,244,440	35,589,263	30,343,502	30,804,163	29,752,143	366,475,064
NET PATIENT REVENUES	12,769,444	15,241,760	12,979,642	13,223,008	12,727,641	14,900,080	13,448,448	14,981,331	15,692,579	13,164,478	13,858,922	13,354,330	166,341,663
	70.65%	62.01%	70.24%	69.21%	69.39%	67.25%	69.27%	69.57%	69.40%	69.74%	68.97%	69.02%	68.78%
OTHER OPERATING REVENUE													
GRANT REVENUES	0	0	0	0	0	0	0	0	0	0	0	0	0
OTHER	1,211,651	581,000	273,801	307,025	728,012	296,651	392,693	909,432	343,185	362,386	535,886	372,539	6,314,261
TOTAL OTHER REVENUE	1,211,651	581,000	273,801	307,025	728,012	296,651	392,693	909,432	343,185	362,386	535,886	372,539	6,314,261
TOTAL OPERATING REVENUE	13,981,095	15,822,760	13,253,443	13,530,033	13,455,653	15,196,731	13,841,141	15,890,763	16,035,764	13,526,864	14,394,808	13,726,869	172,655,923
OPERATING EXPENSES													
SALARIES AND WAGES	5,928,983	5,967,105	5,849,650	5,850,323	6,387,066	6,843,129	6,700,034	6,537,237	6,670,775	6,039,904	6,268,879	6,237,213	75,280,298
BENEFITS	1,928,464	1,374,803	1,285,872	1,773,423	1,678,679	1,696,408	1,474,183	1,838,509	1,747,884	1,691,888	1,816,690	1,462,931	19,769,734
REGISTRY & CONTRACT	252,532	232,219	211,140	187,727	187,398	203,673	170,892	169,549	181,032	291,516	180,983	210,277	2,478,938
TOTAL STAFFING EXPENSE	8,109,979	7,574,127	7,346,662	7,811,473	8,253,143	8,743,210	8,345,109	8,545,295	8,599,691	8,023,308	8,266,552	7,910,421	97,528,970
PROFESSIONAL FEES	1,248,137	1,370,827	1,386,912	1,238,459	1,267,728	1,442,258	1,406,374	1,241,747	1,352,522	1,142,132	1,463,172	1,490,185	16,050,453
SUPPLIES	1,124,876	2,651,168	1,540,888	1,361,788	1,455,049	1,874,654	1,269,214	2,456,239	1,960,507	1,545,327	1,454,101	1,405,314	20,099,125
PURCHASED SERVICES	656,064	800,378	666,784	708,365	710,216	527,135	569,775	508,682	724,696	618,846	684,894	459,333	7,635,168
REPAIR & MAINTENANCE	439,958	661,148	461,240	445,422	675,929	847,788	668,786	795,518	820,025	266,691	723,397	662,344	7,468,246
DEPRECIATION & AMORT	293,150	278,685	286,396	287,071	288,299	288,299	288,299	293,647	399,610	282,356	282,356	331,604	3,599,772
INSURANCE	184,849	237,438	261,018	225,205	226,415	241,953	225,205	232,212	222,108	239,646	204,757	224,447	2,725,253
HOSPITALIST PROGRAM	263,626	223,290	239,321	245,047	259,019	272,176	122,990	0	266,507	167,004	249,017	244,297	2,552,294
OTHER	899,713	972,395	887,279	727,205	923,137	728,810	741,486	944,621	839,501	977,589	786,002	784,905	10,212,643
TOTAL OPERATING EXPENSES	13,220,352	14,769,456	13,076,501	13,050,035	14,058,935	14,966,283	13,637,238	15,017,961	15,185,167	13,262,899	14,114,248	13,512,850	167,871,925
TOTAL OPERATING MARGIN	760,743	1,053,304	176,942	479,998	-603,282	230,448	203,903	872,802	850,597	263,965	280,560	214,019	4,783,999
NON OPER REVENUE(EXPENSE)													
OTHER NON-OPS REVENUE	135,084	603,478	296,820	209,057	207,469	30,898	-2,357	-6,557	-6,426	245,308	114,595	344	1,827,713
CARES HHS RELIEF FUNDING	0	0	0	0	0	0	0	0	0	0	0	0	0
DISTRICT TAX REVENUES	117,632	117,632	117,632	117,632	117,632	117,632	117,632	117,632	172,729	117,632	117,632	117,632	1,466,681
INTEREST EXPENSE	-54,047	-53,997	-53,947	-53,896	-53,846	-51,503	-53,369	-51,401	-51,350	-51,299	-51,247	-51,196	-631,098
										0	0	0	
TOTAL NON-OPS REVENUE(EXPENSE)	198,669	667,113	360,505	272,793	271,255	97,027	61,906	59,674	114,953	311,641	180,980	66,780	2,663,296
NET EXCESS / (DEFICIT)	959,412	1,720,417	537,447	752,791	-332,027	327,475	265,809	932,476	965,550	575,606	461,540	280,799	7,447,295
TOTAL PAID FTE'S (Inc Reg & Cont.)	976.70	1,056.50	1,079.85	1,162.74	1,096.83	1,031.44	983.93	1,116.10	1,189.57	1,172.24	1,106.21	1,106.21	1,089.86
TOTAL WORKED FTE'S	892.08	929.50	935.01	1,045.12	770.43	748.59	748.38	948.70	993.61	1,051.28	981.75	981.75	918.85
TOTAL CONTRACT FTE'S	20.76	17.13	17.91	13.45	23.20	16.78	16.57	16.29	17.57	24.10	20.84	20.84	18.79
PAID FTE'S - HOSPITAL	852.00	948.45	938.27	1,020.05	981.91	927.71	880.21	964.18	1,040.82	1,008.51	914.42	914.42	949.25
WKD FTE'S - HOSPITAL	781.01	836.07	812.98	921.90	667.30	650.28	650.06	809.59	857.09	910.21	798.47	798.47	791.12
PAID FTE'S - SNF	124.69	108.06	141.57	142.68	114.92	103.73	103.73	151.92	148.75	163.74	191.79	191.79	140.61
WORKED FTE'S - SNF	111.08	93.43	122.03	123.23	103.13	98.32	98.32	139.11	136.53	141.07	183.28	183.28	127.73

Imperial Valley Healthcare District - Financial Indicators Report
(Based on Prior 12 Months Activities)
For The 12 Months Ending: April 30, 2025
excludes: GO bonds tax revenue, int exp and debt,

1. Debt Service Coverage Ratio

This ratio compares the total funds available to service debt compared to the debt plus interest due in a given year.

$$\text{Formula:} \quad \frac{\text{Cash Flow + Interest Expense}}{\text{Principal Payments Due + Interest}}$$

$$\text{DSCR} = \frac{\$10,975,991}{\$5,393,013} = \mathbf{2.04}$$

Recommendation: To maintain a debt service coverage of at least 1.20% x aggregate debt service per the 2017 Revenue Bonds covenant.

2. Days Cash on Hand Ratio

This ratio measures the number of days of average cash expenses that the hospital maintains in cash and marketable investments. (Note: The proformas ratios include long-term investments in this calculation:)

$$\text{Formula:} \quad \frac{\text{Cash + Marketable Securities}}{\dfrac{\text{Operating Expenses, Less Depreciation}}{365 \text{ Days}}}$$

$$\text{DCOHR} = \frac{\$43,143,016}{\dfrac{\$151,516,913}{365}} = \mathbf{103.9}$$

Recommendation: To maintain a days cash on hand ratio of at least 50 days per the 2017 Revenue Bonds covenant.

3. Long-Term Debt to Capitalization Ratio

This ratio compares long-term debt to the Hospital's long-term debt plus fund balances.

$$\text{Formula:} \quad \frac{\text{Long-term Debt}}{\text{Long-term Debt + Fund Balance (Total Capital)}}$$

$$\text{L.T.D.-C.R.} = \frac{\$108,492,053}{\$167,262,548} = \mathbf{64.9}$$

Recommendation: To maintain a long-term debt to capitalization ratio not to exceed 60.0%.

	Current Month 4/30/2025	Year-To-Date 0 4/30/2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income (Loss)	$280,796	$4,767,454
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	$331,604	$3,027,938
(Increase)/Decrease in Net Patient Accounts Receivable	($963,817)	($2,835,584)
(Increase)/Decrease in Other Receivables	$10,121,778	$3,152,339
(Increase)/Decrease in Inventories	($101,243)	($335,721)
(Increase)/Decrease in Pre-Paid Expenses	$984,174	($604,811)
(Increase)/Decrease in Other Current Assets	$0	$2,461,923
Increase/(Decrease) in Accounts Payable	$341,483	($1,473,337)
Increase/(Decrease) in Notes and Loans Payable	$28,978	($1,340,371)
Increase/(Decrease) in Accrued Payroll and Benefits	$451,907	$730,513
Increase/(Decrease) in Accrued Expenses	$0	$0
Increase/(Decrease) in Patient Refunds Payable	$0	$0
Increase/(Decrease) in Third Party Advances/Liabilities	$0	$0
Increase/(Decrease) in Other Current Liabilities	$33,726	($534,166)
Net Cash Provided by Operating Activities:	**$11,509,387**	**$7,016,177**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of property, plant and equipment	($510,089)	($2,367,828)
(Increase)/Decrease in Limited Use Cash and Investments	($808,988)	$30,760
(Increase)/Decrease in Other Limited Use Assets	($27,917)	($530,845)
(Increase)/Decrease in Other Assets	$0	$0
Net Cash Used by Investing Activities	**($1,346,994)**	**($2,867,912)**
CASH FLOWS FROM FINANCING ACTIVITIES:		
Increase/(Decrease) in Bond/Mortgage Debt	($1,985)	($19,853)
Increase/(Decrease) in Capital Lease Debt	$0	($3,766,770)
Increase/(Decrease) in Other Long Term Liabilities	$368,151	$2,750,383
Net Cash Used for Financing Activities	**$366,166**	**($1,036,239)**
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**$0**	**$0**
Net Increase/(Decrease) in Cash	**$10,528,559**	**$3,112,025**
Cash, Beginning of Period	$32,614,457	$40,030,991
Cash, End of Period	**$43,143,016**	**$43,143,016**

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Key Operating Indicators
April 2025

	Month			YTD		
	ACTUAL	BUDGET	PRIOR YR	ACTUAL	BUDGET	PRIOR YR
Volumes						
Admits	462	436	441	5,085	4,428	4,433
ICU	19	121	70	361	1,176	1,124
Med/Surgical	698	939	896	8,472	9,117	9,074
Newborn ICU	53	118	128	722	1,143	1,153
Pediatrics	91	72	62	861	694	703
Obstetrics	249	387	326	3,391	3,913	3,852
GYN	0	3	4	28	30	31
DOU	0	-	-	-	-	-
Total Patient Days	1,110	1,640	1,486	13,835	16,073	15,937
Adjusted Patient Days	2,707	4,489	3,866	32,259	44,718	43,304
Average Daily Census	37	55	50	46	53	52
Average Length of Stay	2.45	3.76	3.57	2.81	3.64	3.47
Deliveries	266	127	239	1,760	1,635	1,910
E/R Visits	3,839	3,570	3,996	38,706	38,527	38,963
Surgeries	277	412	299	3,356	3,920	2,953
GI Scopes	16	61	57	290	879	773
Vascular Access	50	64	50	526	638	624
Wound Care	292	267	262	2,940	3,409	3,218
Pioneers Health Center	2,655	2,937	1,173	26,852	29,530	27,487
Calexico Visits	1,174	891	522	9,599	8,118	7,693
Pioneers Children	728	702	275	7,518	7,879	7,251
Outpatients (non-ER/Clinics)	6,966	5,113	5,602	68,201	51,256	51,821
Surgical Health	58	39	28	539	556	549
Urology	315	285	171	3,417	3,024	3,109
WHAP	367	455	295	4,086	4,256	4,658
C-WHAP	419	426	255	3,663	3,340	3,669
CDLD	137	110	2	785	753	12
Skilled Nursing	2,149	2,435	2,324	21,951	24,349	24,471
FTE's						
Worked	837.21	817.34	844.02	1010.21	833.25	792.18
Paid	964.28	917.10	914.92	1221.77	928.07	889.12
Contract FTE's	21.15	15.43	16.25	20.87	22.91	20.63
FTE's APD (Worked)	9.28	5.46	6.55	9.52	5.66	5.58
FTE's APD (Paid)	10.68	6.13	7.10	11.51	6.31	6.26
Net Income						
Operating Revenues	$13,726,868	$13,242,852	$11,784,605	$142,852,069	$133,241,683	$134,505,175
Operating Margin	$214,018	-$102,412	-$1,277,719	$2,969,953	-$1,259,789	$6,363,277
Operating Margin %	1.6%	-0.8%	-10.8%	2.1%	-0.9%	4.7%
Total Margin	$280,798	$19,647	-$1,095,999	$4,767,467	-$39,199	$7,908,686
Total Margin %	2.0%	0.1%	-9.3%	3.3%	0.0%	5.9%

Exhibit A - April 2025

Key Volume Stats -Trend Analysis

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total	YTD
Deliveries														
Actual	152	167	184	159	167	170	148	169	178	266	0	0	1,760	1,760
Budget	153	127	185	173	176	157	181	160	196	127	159	177	1,972	1,635
Prior FY 2024	175	145	211	198	201	179	206	183	173	239	152	139	2,201	1,910
E/R Visits														
Actual	3,728	3,498	3,597	3,590	3,817	4,803	4,125	3,654	4,055	3,839	0	0	38,706	38,706
Budget	3,738	3,588	3,678	4,141	4,714	3,978	3,738	3,476	3,906	3,570	3,891	3,410	45,828	38,527
Prior FY 2024	3,500	3,614	3,500	3,985	3,867	4,467	3,931	4,071	4,032	3,996	4,101	-	43,064	38,963
Surgeries														
IP Actual	128	143	127	148	138	149	193	124	141	114	0	0	1,405	1,405
IP Budget	96	107	126	100	105	102	114	115	145	124	123	112	1,369	1,134
OP Actual	225	264	249	306	227	214	228	170	179	179	0	0	2,241	2,241
OP Budget	232	303	260	299	277	247	270	255	355	288	328	281	3,395	2,786
Total Actual	312	403	369	452	323	304	366	251	299	277	0	0	3,356	3,356
Total Budget	328	410	386	399	382	349	384	370	500	412	451	393	4,764	3,920
Prior FY 2024	303	316	289	324	272	273	290	296	291	299	281	276	3,510	2,953
GI Scopes														
Total Actual	41	4	7	2	42	59	55	43	21	16	0	0	290	290
Total Budget	29	110	97	119	84	90	109	92	88	61	23	66	968	879
Prior FY 2024	25	94	97	75	110	76	94	74	71	57	104	82	959	773
Vascular Access														
Actual	58	46	55	60	42	49	63	45	58	50	0	0	526	526
Budget	64	63	63	64	64	64	64	64	64	64	64	63	765	638
Prior FY 2024	54	75	60	69	67	37	72	64	76	50	52	60	736	624
Calexico														
Actual	621	675	829	915	1,119	1,232	1,012	948	1,074	1,174	0	0	9,599	9,599
Budget	696	926	844	792	731	793	816	769	860	891	896	824	9,838	8,118
Prior FY 2024	697	926	844	792	731	793	816	769	803	522	599	630	8,922	7,693
Pioneers Health Center														
Actual	1,937	2,115	2,308	2,688	3,473	3,496	2,856	2,580	2,744	2,655	0	0	26,852	26,852
Budget	1,943	3,774	2,818	2,955	2,954	3,016	3,094	2,890	3,149	2,937	3,800	2,862	36,192	29,530
Prior FY 2024	1,943	3,774	2,818	2,955	2,954	3,016	3,094	2,890	2,870	1,173	1,897	2,038	31,422	27,487
Pioneers Children														
Actual	358	376	765	841	1,009	984	878	734	845	728	0	0	7,518	7,518
Budget	776	959	719	939	835	671	767	713	798	702	861	735	9,475	7,879
Prior FY 2024	776	959	719	940	835	671	767	713	596	275	435	351	8,037	7,251
Outpatients														
Actual	6,314	6,270	6,378	6,780	6,531	7,619	7,471	6,911	6,961	6,966	0	0	68,201	68,201
Budget	5,158	5,407	5,487	5,913	4,848	4,269	4,886	4,640	5,535	5,113	5,359	5,520	62,135	51,256
Prior FY 2024	4,906	5,697	5,128	5,721	5,024	4,584	4,956	5,024	5,179	5,602	5,601	5,428	62,850	51,821
Wound Care														
Actual	270	327	332	326	251	258	293	304	287	292	0	0	2,940	2,940
Budget	311	415	366	357	285	364	370	341	333	267	270	262	3,941	3,409
Prior FY 2024	366	399	314	294	307	270	333	324	349	262	245	206	3,669	3,218
WHAP														
Actual	330	443	388	414	688	362	427	325	342	367	0	0	4,086	4,086
Budget	382	491	428	411	402	322	433	422	510	455	564	538	5,358	4,256
Prior FY 2024	430	520	477	512	436	348	631	533	476	295	604	543	5,805	4,658
C-WHAP														
Actual	131	95	365	403	552	400	425	441	432	419	0	0	3,663	3,663
Budget	303	341	308	325	358	310	301	330	338	426	478	377	4,195	3,340
Prior FY 2024	229	376	348	186	316	398	524	513	524	255	200	148	4,017	3,669

Stop Loss Analysis: IV-HD Board Presentation

Imperial Valley Healthcare District

May 29, 2025

Gallagher

Insurance | Risk Management | Consulting

Executive Summary

Recommendation: After careful evaluation, our recommendation is for IV-HD to consider raising the ISL to $250,000, provided the district can tolerate the additional potential risk. This adjustment would allow IV-HD to remain with Sun Life at a more favorable renewal rate, resulting in a 15.7% increase, estimated at $162,372 annually. This strategic decision balances risk management with cost containment, ensuring IV-HD continues to receive reliable coverage while mitigating the impact of large claim activities.

Market Analysis and Proposals: Gallagher conducted a comprehensive market analysis, seeking proposals for IV-HD's Stop Loss coverage from leading providers. Proposals were received from Sun Life, the incumbent carrier, HM, Voya, Optum, HCC and BCS. The most competitive proposals were provided by Sun Life and BCS. The current Individual Stop Loss (ISL) level is set at $225,000 on a Paid contract basis, with additional proposals requested at a $250,000 ISL level.

Renewal Insights: Sun Life's initial renewal proposal indicated a significant increase of 43%, translating to an additional $444,845 annually. This increase is primarily driven by substantial claim activity, including one cancer claimant nearing $1 million in claims in 9 months. Notably, two claimants have exceeded the current $225,000 Stop Loss level this year.

Gallagher is committed to supporting IV-HD in navigating the complexities of Stop Loss renewals. By adjusting the ISL level, IV-HD can achieve a more sustainable financial outcome while maintaining essential coverage.

Current Deductible Renewal and Options

ISL Deductible	Current Sun Life $225,000	Initial Renewal Sun Life $225,000	Renewal Sun Life $225,000	Option 1 BCS (24/12) $225,000
ADDITIONAL CLAIMS RISK				
Premium Total With Lasers and Agg Spec	$1,031,754	$1,476,598	$1,309,679	$1,455,914
Dollar Increase From Current	N/A	$444,845	$277,925	$424,160
Percentage Increase From Current	N/A	43.12%	26.94%	41.11%

Alternative Deductible Renewal and Options

Recommended

ISL Deductible	Current Sun Life $225,000	Alternate 1 Sun Life $250,000	Alternate 2 BCS (24/12) $250,000
ADDITIONAL CLAIMS RISK			
Annual Total With Lasers and Agg Spec	$1,031,754	$1,194,126	$1,331,066
Dollar Increase From Current	N/A	$162,372	$299,312
Percentage Increase From Current	N/A	15.74%	29.01%

*We would expect 3.5 claims at this deductible level. With $25K higher deductible we would expect between $75K and $100 additional risk for IV-HD. Note – the analysis assumes 679 lives. Rates are firm and expire by 6/1/2025. If needed, an extension can be requested.

Appendix

Stop Loss Deductible Breakeven Options

	2024/2025	2025/2026			
	SunLife Current	SunLife Renewal	Options		Proposed
			BCS	BCS	SunLife
Programs – Move to Aetna/Meritain at Renewal	No Plan Changes	No Plan Changes	No Plan Changes	No Plan Changes	No Plan Changes
Specific	$225,000	$225,000	$225,000	**$250,000**	**$250,000**
Specific Contract	Paid	Paid	24/12	24/12	24/12
Aggregate	125%	125%	125%	125%	125%
Total Employees	679	679	679	679	679
	Medical & Rx	Medical & Rx	Medical & Rx	Medical & Rx	Medical & Rx
Stoploss Premium Med & Rx	$225,000	$225,000	$225,000	$250,000	$250,000
Per Contract	$122.25	$156.36	$141.24	$128.96	$142.17
TOTAL	**$996,066**	**$1,273,991**	**$1,150,848**	**$1,050,756**	**$1,158,437**
Dollar Difference on Current		**$277,925**	**$154,782**	**$54,690**	**$162,372**
% Difference		**28%**	**16%**	**5%**	**16%**
Aggregate Premium Medical & Rx					
PEPM	$4.38	$4.38	$3.69	$1.63	$4.38
TOTAL	**$35,688**	**$35,688**	**$30,066**	**$30,311**	**$35,688**
Dollar Difference based on current		**$0**	**-$5,622**	**-$5,378**	**$0**
% Difference		**0%**	**-16%**	**-15%**	**0%**
Laser		0	$275,000	$250,000	0
Stoploss & Aggregate Premium + Laser Liability	**$1,031,754**	**$1,309,679**	**$1,455,914**	**$1,331,066**	**$1,194,126**
Dollar Difference based on current		$277,925	$424,160	$299,312	$162,372
% Difference	Claims	27%	41%	29%	**16%**
Additional Exposure	1			$25,000	$25,000
	2			$50,000	$50,000
3.5 Claims Expected at $250K	**3**			$75,000	$75,000
4.3 Claims Expected at $225K	**4**			$100,000	$100,000
	5			$125,000	$125,000
	6			$150,000	$150,000
	7			$175,000	$175,000
	8			$200,000	$200,000
	9			$225,000	$225,000
Claims + Premium	1	$1,309,679	$1,455,914	$1,356,066	$1,219,126
	2	$1,309,679	$1,455,914	$1,381,066	$1,244,126
Estimated Number of Claimants	**3**	$1,309,679	$1,455,914	**$1,406,066**	**$1,269,126**
	4	$1,309,679	$1,455,914	**$1,431,066**	**$1,294,126**
	5	$1,309,679	$1,455,914	$1,456,066	$1,319,126
	6	$1,309,679	$1,455,914	$1,481,066	$1,344,126
	7	$1,309,679	$1,455,914	$1,506,066	$1,369,126
	8	$1,309,679	$1,455,914	$1,531,066	$1,394,126
	9	$1,309,679	$1,455,914	$1,556,066	$1,419,126

Current Deductible Renewal and Options

	Current Sun Life $225,000	Initial Renewal Sun Life $225,000	Renewal Sun Life $225,000	Option 1 BCS (24/12) $225,000
ISL Deductible				
Additional Stop Loss Items				
Claim Accumulation Basis ISL	Per Member	Per Member	Per Member	Per Member
Claim Reimbursement Percentage	100% / 0%	100%	100%	100%
Retiree Coverage	No	No	No	No
Waive Actively at Work	Waived	Waived with large claim data	Waived with disclosure or acceptable claims data	Waived
ISL Advance Funding	Yes	Yes	Yes	No
Aggregate Accommodation	No	No	No	No
TLO-ISL	Not Included	Not Included	Not Included	Not Included
TLO-ASL	Not Included	Not Included	Not Included	Not Included
Cost of Mirroring	Included	Included	Included	Included
ISL Monthly Rate				
Employee	$58.70	$84.81	$75.08	$76.25
Employee + Spouse	$208.52	$301.27	$266.70	$229.48
Employee + Child(ren)	$208.52	$301.27	$266.70	$229.48
Family	$208.52	$301.27	$266.70	$229.48
Monthly ISL Premium	**$83,005**	**$119,926**	**$106,166**	**$95,904**
Annual ISL Premium	**$996,066**	**$1,439,118**	**$1,273,991**	**$1,150,848**
ASL Monthly Rate				
Employee	$4.38	$4.60	$4.38	$3.69
Employee + Spouse	$4.38	$4.60	$4.38	$3.69
Employee + Child(ren)	$4.38	$4.60	$4.38	$3.69
Family	$4.38	$4.60	$4.38	$3.69
Monthly ASL Premium	**$2,974**	**$3,123**	**$2,974**	**$2,506**
Annual ASL Premium	**$35,688**	**$37,481**	**$35,688**	**$30,066**
PREMIUM TOTALS				
Monthly Total	**$85,979**	**$123,050**	**$109,140**	**$98,410**
Annual Total	**$1,031,754**	**$1,476,598**	**$1,309,679**	**$1,180,914**
Dollar Increase From Current	**N/A**	**$444,845**	**$277,925**	**$149,160**
Percentage Increase From Current	**N/A**	**43.12%**	**26.94%**	**14.46%**
ADDITIONAL CLAIMS RISK				
Premium Total With Lasers and Agg Spec	**$1,031,754**	**$1,476,598**	**$1,309,679**	**$1,455,914**
Dollar Increase From Current	**N/A**	**$444,845**	**$277,925**	**$424,160**
Percentage Increase From Current	**N/A**	**43.12%**	**26.94%**	**41.11%**

Above assumes 679 lives. Rates are firm and expire by 6/1/2025. If needed, an extension can be requested.

Alternative Deductible Renewal and Options

	Current Sun Life $225,000	Alternate 1 Sun Life $250,000	Alternate 2 BCS (24/12) $250,000
ISL Deductible			
Additional Stop Loss Items			
Claim Accumulation Basis ISL	Per Member	Per Member	Per Member
Claim Reimbursement Percentage	100% / 0%	100%	100%
Retiree Coverage	No	No	No
Waive Actively at Work	Waived	Waived with disclosure or acceptable claims data	Waived
ISL Advance Funding	Yes	Yes	No
Aggregate Accommodation	No	No	No
TLO-ISL	Not Included	Not Included	Not Included
TLO-ASL	Not Included	Not Included	Not Included
Cost of Mirroring	Included	Included	Included
ISL Monthly Rate			
Employee	$58.70	$68.27	$69.59
Employee + Spouse	$208.52	$242.51	$209.56
Employee + Child(ren)	$208.52	$242.51	$209.56
Family	$208.52	$242.51	$209.56
Monthly ISL Premium	**$83,005**	**$96,536**	**$87,563**
Annual ISL Premium	**$996,066**	**$1,158,437**	**$1,050,756**
ASL Monthly Rate			
Employee	$4.38	$4.38	$3.72
Employee + Spouse	$4.38	$4.38	$3.72
Employee + Child(ren)	$4.38	$4.38	$3.72
Family	$4.38	$4.38	$3.72
Monthly ASL Premium	**$2,974**	**$2,974**	**$2,526**
Annual ASL Premium	**$35,688**	**$35,688**	**$30,311**
PREMIUM TOTALS			
Monthly Premium	**$85,979**	**$99,510**	**$90,089**
Annual Premium	**$1,031,754**	**$1,194,126**	**$1,081,066**
Dollar Increase From Current	**N/A**	**$162,372**	**$49,312**
Percentage Increase From Current	**N/A**	**15.74%**	**4.78%**
ADDITIONAL CLAIMS RISK			
Annual Total With Lasers and Agg Spec	**$1,031,754**	**$1,194,126**	**$1,331,066**
Dollar Increase From Current	**N/A**	**$162,372**	**$299,312**
Percentage Increase From Current	**N/A**	**15.74%**	**29.01%**

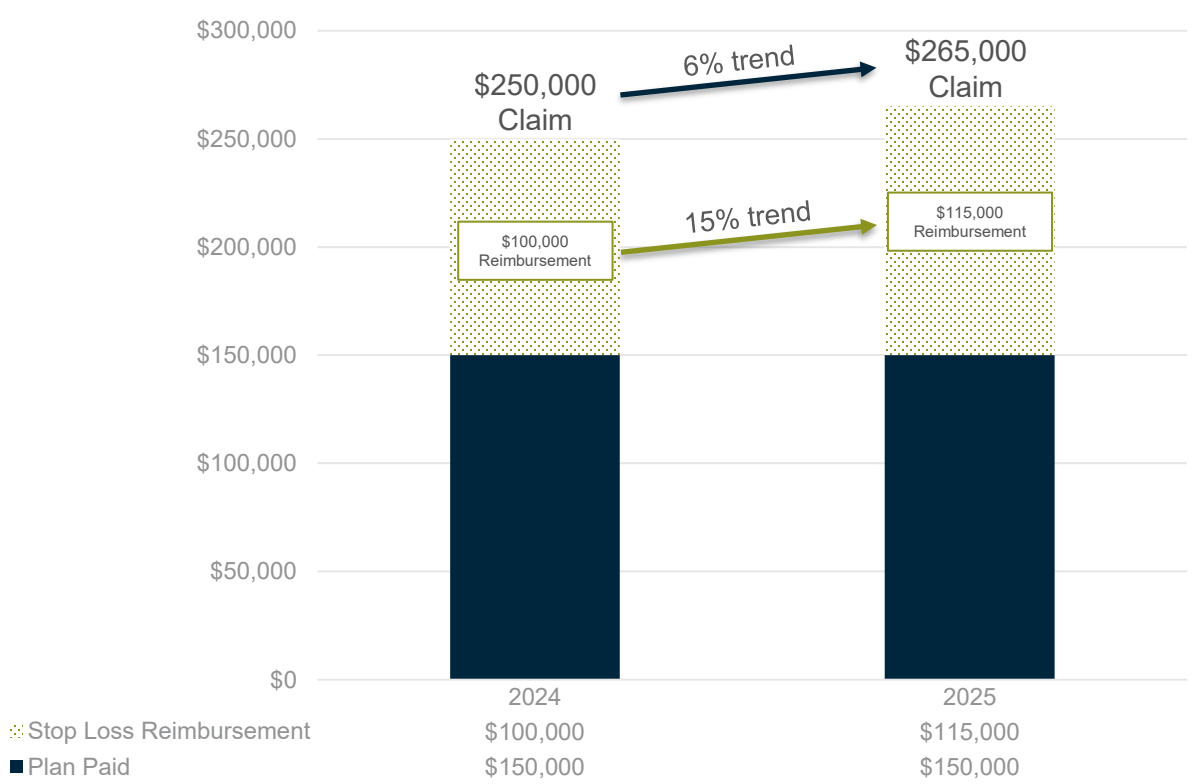
Above assumes 679 lives. Rates are firm and expire by 6/1/2025. If needed, an extension can be requested.

Claimants

High-Cost Claimants over 50% of the $225,000 Specific Deductible for claims paid from 7/1/2024 – 3/31/2025 (9 months)

Claimant	Diagnosis/Condition	
1	C649 Malig Neoplasm Kidney, Chemotherapy, R109 Abdominal Pain, M899 Disorder of Bone – Transplant List	$ 949,431
2	C9001 Multiple Myeloma in remission, Z5112 Antineoplastic Immunotherapy, Z1211 Malignant Neoplasm	$ 306,209
3 – *BCS Laser*	K5190 Ulcerative Colitis Uns, K644 Residual Hemorrhoidal Skin – CM Notes - bone metastasis authorization for ablation therapy to reduce tumors. Authorization 1.29 to 4.28.25 approved for J9299 nivolumab for cancer (size of tumor cannot be assessed).	$ 118,078
4	C538 Malignant Neoplasm Overlap Site Cervix	$ 115,352
5	Unspecified Cirrhosis of Liver, R188 Other Ascites (excess abdominal fluid)	$ 121,368
6	E1110 Type 2 DM Ketoacidosis without comorbidities, J121 RSV Pneumonia	$ 176,389

Leveraged Trend Example



$150,000 Stop Loss Deductible

6% Medical/Rx Trend

Results in 15% Stop Loss Reimbursement Trend

Historical Large Claimants

	07/01/2021 - 06/30/2022		07/01/2022 - 06/30/2023		07/01/2023 - 06/30/2024		07/01/2024 - (YTD)	
Individual Stop Loss Deductible	**$225,000**		**$225,000**		**$225,000**		**$225,000**	
Employees	**624**		**591**		**637**		**672**	
	Actual	**Expected**	**Actual**	**Expected**	**Actual**	**Expected**	**Actual**	**Expected**
Current ($225,000 ISL)	0	2 - 4	0	2 - 4	4	3 - 5	2	3 - 5
Alternate 1: Sun Life ($250,000 ISL)	0	2 - 3	0	2 - 3	3	2 - 4	2	3 - 4
Alternate 2: BCS (24/12) ($250,000 ISL)	0	2 - 3	0	2 - 3	3	2 - 4	2	3 - 4
Lowest Cost Alternative	SunLife ($250,000 ISL)		SunLife ($250,000 ISL)		SunLife ($250,000 ISL)		SunLife ($250,000 ISL)	

Aggregate Claims Liability

	Current Sun Life $225,000	Initial Renewal Sun Life $225,000	Renewal Sun Life $225,000	Option 1 BCS (24/12) $225,000
Corresponding ISL Deductible				
Aggregate Stop Loss				
Contract Basis	Paid	Paid	Paid	24/12
Contract Includes	Medical & Rx	Medical & Rx	Medical & Rx	Medical & Rx
Claim Corridor %	125%	125%	125%	125%
Maximum Aggregate Refund	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Run-in limit	No	No	No	No
Minimum Aggregate Annual Amt.	$10,977,719	$7,794,084	$6,321,749	$10,418,694
Aggregate Premium				
Composite Rate (PEPM)	**$4.38**	**$4.60**	**$4.38**	**$3.69**
MAX CLAIMS LIABILITY				
Composite Rate (PEPM)	**$1,347.29**	**$1,700.28**	**$1,379.09**	**$1,356.42**
Annual Aggregate Attachment Point	**$10,977,719**	**$13,853,881**	**$11,236,825**	**$11,052,108**
Dollar Increase From Current	**N/A**	**$2,876,163**	**$259,106**	**$74,389**
Percentage Increase From Current	**N/A**	**26.20%**	**2.36%**	**0.68%**

Individual and Aggregate Contract Details

	Current Sun Life	Alternate 1 Sun Life	Alternate 2 BCS (24/12)
Specific Individual Stop Loss			
Contract Basis	Paid	Paid	24/12
Run-in Limit	No	No	No
Contract Includes	Medical & Rx	Medical & Rx	Medical & Rx
Specific Deductible	$225,000	$250,000	$250,000
Renewal Rate Cap	50%	50%	50%
No New Laser	Yes	Yes	Yes
Proposed Lasers	No	No	Yes
Laser 1			$500,000
Specific Annual Maximum	Unlimited	Unlimited	Unlimited
Specific Lifetime Maximum Liability	Unlimited	Unlimited	Unlimited
Aggregating Specific Stop Loss ($)	$0	$0	$0

	Current Sun Life $225,000	Alternate 1 Sun Life $250,000	Alternate 2 BCS (24/12) $250,000
Corresponding ISL Deductible			
Aggregate Stop Loss			
Contract Basis	Paid	Paid	24/12
Contract Includes	Medical & Rx	Medical & Rx	Medical & Rx
Claim Corridor %	125%	125%	125%
Maximum Aggregate Refund	$1,000,000	$1,000,000	$1,000,000
Run-in limit	No	No	No

Stop Loss Marketing Activity Summary

Carrier Name & Contract Type	Line of Coverage	Response	Commission
Sun Life	Stop Loss	Renewal	11.0%
BCS (24/12)	Stop Loss	Quote Received	15.0%/11.0%
Voya (24/12)	Stop Loss	Quote Received	15.0%
Optum (24/12)	Stop Loss	Quote Received	15.0%
Declined to Quote	Line of Coverage	Reason for Decline (if applicable)	Commission
TM HCC	Stop Loss	Due to the size of this hospital and the level of tertiary care performed at this facility	
Symetra	Stop Loss	Uncompetitive	
HM	Stop Loss	Uncompetitive	
Wellpoint	Stop Loss	Uncompetitive	

* While Gallagher does not guarantee the financial viability of any health insurance carrier or market, it is an area we recommend that clients closely scrutinize when selecting a health insurance carrier. There are a number of rating agencies that can be referred to including, A.M. Best, Fitch, Moody's, Standard & Poor's, and Weiss Ratings (The Street.com). Generally, agencies that provide ratings of Health Insurers, including traditional insurance companies and other managed care organizations, reflect their opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. However, these ratings are not a warranty of an insurer's current or future ability to meet its contractual obligations.

Assumptions: Sun Life

Coverage Statement	The Sun Life mirroring endorsement covers claims paid in accordance with the terms of the plan that are incurred and paid during the Claims Basis, subject to certain limited exclusions generally involving plan administration expenses and expenses not payable under the plan.
Network and Third-Party Administrator	TPA: Meritain Health, Inc. Network: Aetna Choice POS II (ASO, Meritain)
Actively at Work	If a client acquires a new company during the contract year, will your organization agree to waive the actively at work, dependent non-confinement, and pre-existing condition limitation provisions for the newly acquired employees, their dependents, spouses, domestic partners, FMLA, retirees (if applicable), and COBRA beneficiaries? Disagree, in this case Sun Life would not waive the AAW provision. For an acquisition, underwriting would require an SRQ, census and claims data for the business being added. Typically based on the information provided, we are able to waive actively-at-work in this situation. Waive Active at Work: On new business and marketing/renewals for Gallagher prospects/clients, do you agree to waive actively at work for covered employees and dependents per the employer's plan document? Agreed, upon underwriter review and sign-off of the appropriate claims data. .
Plan Design	Advance Funding option This option enhances the cash flow of your self-funded plan by advancing the stop-loss funds to you or your administrator up front, before you pay the provider. Producer commissions Sun Life pays the following commission percent to the Stop-Loss producer: 11.0% Monthly Aggregate Accommodation is not included The following are not included in your policy Experience Rating Refund The following are not included in your policy Transplant Coverage This proposal assumes a fully insured transplant policy is in place. All transplants and transplant-related services are excluded from the stop loss coverage.
Retiree Coverage	The following are not included in your policy Retiree coverage
Lasered Claimant(s)	Specific Benefit Stop-Loss renewal acceptance Acceptance of your Specific Benefit Stop-Loss renewal by Sun Life is subject to timely receipt of a signed renewal proposal and contingent upon a review of large claims over $100,000 with diagnosis/prognosis for the period o July 1, 2024, through March 31, 2025, with accompanying required information. For large claims the required information includes paid claims, pending claims, and notification of known situations. Upon review of your large claims information, we reserve the right to recalculate quoted rates
No new Lasers	No New Laser Gene Therapy Enhancement: With this enhancement, we will not add a new laser, modify or increase the amount of an existing laser that was previously set for another treatment or condition, directly related to the cost of a gene therapy drug. We will continue to employ strategies to mitigate the impact of high-cost gene therapy claims, ensuring renewal stability. A gene therapy drug is a prescribed treatment that modifies a person's genes to treat or cure disease. Gene therapy drugs must be designated as a gene therapy and FDA approved. Existing individual Specific Benefit Deductibles applied to a specific Covered Person due to the member's underlying condition or other reasons will apply. View our Notice of Enhanced Business Practice here No New Lasers at Renewal option with Renewal Rate Cap of 50% This option prevents new lasers from being added to the new policy if it renews. The rate cap applies to Specific Benefit rates and the Aggregating Specific deductible (if applicable), and it assumes there are no material changes to the underlying plan, the Sun Life Stop-Loss policy, or the covered group
Renewal Rate Cap	No New Lasers at Renewal option with Renewal Rate Cap of 50% This option prevents new lasers from being added to the new policy if it renews. The rate cap applies to Specific Benefit rates and the Aggregating Specific deductible (if applicable), and it assumes there are no material changes to the underlying plan, the Sun Life Stop-Loss policy, or the covered group

Assumptions: Sun Life

Terminal Liability Coverage	The following are not included in your policy Terminal Liability option Terminal Liability option is not included.
Required Disclosure Statements	Disclosures 1. Sun Life 2023 book of business data. 2. For complete financial ratings, visit www.sunlife.com/financialratings. 3. Sun Life renewal statistics data from 2021 to 2023. 4. Health Research Institute Medical Trend “Behind The Numbers” report 2023. Producer licensing All Sun Life companies require producers using insurance quotes we issue for the purpose of soliciting, selling, or negotiating insurance to be licensed both by the state where the prospective client is located and by any state where the solicitation, sale, or negotiation of insurance occurs, if different. This requirement pertains to all forms of solicitation, sales or negotiation of insurance, including but not limited to solicitation, sale, or negotiation conducted in person, by telephone, by email, by fax, or otherwise. Producer compensation We encourage brokers and their clients to discuss what commission or other compensation may be paid in connection with the purchase of products and services from Sun Life companies. All Sun Life companies may pay the selling broker, agency, or third party administrator for the promotion, sale, and renewal of the products and services offered in this proposal. In addition to our standard compensation, we may make additional cash payments or reimbursements to selling brokers in recognition of their marketing and distribution activities, persistency levels, and volume of business. For New York situs business, we may pay reduced compensation where fewer services are offered and increased compensation where more services are provided. Producers must comply with the specific compensation disclosure requirements of New York Regulation 194. Plan and rates This renewal proposal is based on the employee census information that was provided. Acceptance of the group and final rates will be determined by the Sun Life home office in the United States based on actual enrollment and case experience, if required. Terms and conditions of any coverage under the policy will be determined by all necessary final data and by underwriting rules, policy requirements, and policy provisions in effect on the date coverage begins. Sun Life Companies The Sun Life group of companies operates under the "Sun Life" name. In the United States and elsewhere, insurance products are offered by members of the Sun Life group of companies that are insurance companies. Currently, group underwriting companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada. Sun Life Inc., the publicly traded holding company for the Sun Life group of companies, is not an insurance company and does not guarantee the obligations of these insurance companies. Each insurance company relies on its own financial strength and claims-paying ability. Group stop-loss insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 07-SL REV 7-12 and 22-SL. In New York, group stop-loss insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 07-NYSL REV 7-12 and 22-NYSL. Product offerings may not be available in all states and may vary depending on state laws and regulations. Stop-Loss information The following services are not insurance and carry a separate charge included with the price of coverage: Clinical 360, owned by Sun Life; SunElite℠, owned by Sun Life with services provided by The Phia Group, LLC. Information Issuance of a Stop Loss policy is dependent upon meeting underwriting guidelines and participation requirements.
Minimum Aggregate Attachment Calculation	Aggregate Stop-Loss renewal acceptance Renewal acceptance of Aggregate Benefit coverage by Sun Life is subject to timely receipt of a signed renewal proposal and contingent upon a review of monthly claims and lives, by line of coverage, for the period of July 1, 2024, through March 31, 2025. Upon review of that information, we reserve the right to recalculate the Aggregate Benefit Attachment Point $225,000 Deductible : $6,321,749 $250,000 Deductible : $6,446,296 $275,000 Deductible : $6,543,293
Prescription Drug Coverage	Rx claims are included and bundled with the administration (no carve-out PBM) This proposal assumes that your stop-loss insurance will include coverage for prescription drug claims and that the standard large claimant reporting from your medical administrator will include both medical and prescription drug claims. Based on the information provided, your PBM vendor is Express Scripts.

Assumptions: Sun Life

Plan Document Requirements	SunElite℠ medical document review service SunElite is a medical plan document review service for Sun Life Stop-Loss clients. Your custom SunElite report will analyze the plan's cost-containment, federal law compliance and discretionary authority. Sun Life Clinical 360 Sun Life Clinical 360 is a program utilizing clinical experts who act as a second set of eyes reviewing claim data to identify cost savings and care optimization opportunities. This program is automatically included for all Sun Life Stop-Loss clients
Other	Sun Life will not reimburse for claims expenses incurred outside the Policy Year parameters. Captive coverage Any Stop Loss policy issued to a policyholder that is part of a captive program, is excluded from any and al Sun Life incentive, bonus or override programs. Affordable Care Act accommodations This renewal proposal represents Sun Life's efforts to work with you to meet your requirements under the Affordable Care Act (ACA), including, but not limited to, the dependent age provisions of the ACA. It is the self-funded medical plan's responsibility to keep its census data up to date at all times. If the plan inadvertently does not remove a terminated participant, Sun Life may deny any claims from the participant However, in that situation, the self-funded medical plan is responsible for the claim

Assumptions: BCS (24/12)

Coverage Statement	BCS will agree to accept for claims reimbursement the employer's plan document.
Network and Third-Party Administrator	TPA: Meritain Network: Aetna
Actively at Work	If a client acquires a new company during the contract year, will your organization agree to waive the actively at work, dependent non-confinement, and pre-existing condition limitation provisions for the newly acquired employees, their dependents, spouses, domestic partners, FMLA, retirees (if applicable), and COBRA beneficiaries? Agree; When a group acquires a new company, BCS will need to be notified and approve in writing the acquisition for coverage under the stop loss insurance policy; BCS would request census, current benefit plan, monthly enrollment/paid claims, current large claim details, and if fully insured, the last renewal.. On new business and marketing/renewals for Gallagher prospects/clients, do you agree to waive actively at work for covered employees and dependents per the employer's plan document? Yes. BCS would agree to waive the actively-at-work provision for covered employees and dependents as per the employer's plan document.
Plan Design	If aggregate is included in this proposal, Claims up to the Specific Stop Loss deductible will be applied toward Aggregate Stop Loss coverage and the Monthly Aggregate Factor equals the Expected Losses adjusted by the corridor percentage. The rates and factors in this proposal are firm. A signed proposal acceptance must be received by the expiration date of this proposal. For new business quotes, a completed application and disclosure are required and BCS retains the right to re-underwrite the terms of this proposed policy and laser or exclude individuals from coverage based upon the new information received in the disclosure. This offer is subject to TPA approval. The network is Aetna. The claims administrator is Meritain. PBM is Alluma. Coverage applies to all active employees and their dependents; COBRA continuees and their dependents. This proposal assumes that the (current) Fully Insured Transplant policy remains inforce from 7/1/2025 through 6/30/2026. If the policy is not maintained, we reserve the right to re-price our proposal.
Retiree Coverage	Not Included
Conditions for Mid-Year Rate Changes	If the enrollment changes by 15% or more prior to the policy effective date, BCS has the right to re-rate, laser, and/or rescind this proposal. BCS reserves the right to modify or withdraw this proposal upon receipt of material information from whatever source.
Domestic Reimbursement	A listing of all Domestic Facilities will be required at point of sale.
Accuracy of Information Provided	This proposal is being provided to you in reliance upon the accuracy and completeness of the experience data provided to BCS by you, or on your behalf, when this proposal was requested. We may modify or withdraw this proposal, or declare the policy null and void, based upon incorrect, false or misleading information provided to us.
Lasered Claimant(s)	Claims incurred by Claimant 1 will be subject to a $500,000 individual specific deductible.
No new Lasers	At the group's 1st renewal with BCS, no new claimants will be lasered and specific rates will increase no more than 50% assuming the same contract type, same specific deductibles, same commission level, and same administrator. This NNL/Rate Cap option will not apply to any new acquisitions after the effective date of the group.
Renewal Rate Cap	At the group's 1st renewal with BCS, no new claimants will be lasered and specific rates will increase no more than 50% assuming the same contract type, same specific deductibles, same commission level, and same administrator. This NNL/Rate Cap option will not apply to any new acquisitions after the effective date of the group.
Terminal Liability Coverage	Terminal Liability Option: No

Assumptions: BCS (24/12)

Minimum Aggregate Attachment Calculation	Reinstating Attachment Point (incurred date) definition: A claim is considered to be incurred on the date that a service is rendered or a supply is delivered. In the case of a hospital claim, each day of a hospital stay is considered a separate incurred date. $225,000 Deductible : $10,418,694 $250,000 Deductible : $10,564,556 $275,000 Deductible : $10,699,999
Plan Document Requirements	Please acknowledge acceptance of the terms in this proposal by signing and returning by proposal expiration date or effective date, whichever is sooner. No signed proposal will be accepted after the effective date unless otherwise agreed by mutual agreement. Failure to remit the signed application and/or disclosure by the expiration date of this proposal will result in updated large claim data being required for our review. Please indicate which option is selected and whether aggregate is to be included. BCS will follow the group's Plan Document subject to the BCS stop loss policy exclusions and requirements. In most claim situations, BCS will agree with the standard third party reporting package as the basis for claim reimbursements however there may be claim submissions that will require additional information and that additional information may vary depending on the claim submission. For firm quotes, this proposal expires on the Expiration Date or the Proposal Effective Date whichever is sooner. However, this proposal expires immediately on the date you file a voluntary petition, or an involuntary petition is filed against you, that commences a Federal bankruptcy proceeding, or the date you become insolvent or unable to meet your debts as they become due. We recommend that the group maintain in-force coverage until written acceptance of replacement coverage is provided by us.
Other	BCS will follow all state mandates that pertain to stop loss policies.

Disclaimers

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Renewal / Financial Disclaimer

This analysis is for illustrative purposes only, and is not a proposal for coverage or a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. See your policy or contact us for specific information or further details in this regard.

Legal

The intent of this analysis is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject to change. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area.

Financial Solvency

While Gallagher does not guarantee the financial viability of any health insurance carrier or market, it is an area we recommend that clients closely scrutinize when selecting a health insurance carrier. There are a number of rating agencies that can be referred to including, A.M. Best, Fitch, Moody's, Standard & Poor's, and Weiss Ratings (The Street.com). Generally, agencies that provide ratings of Health Insurers, including traditional insurance companies and other managed care organizations, reflect their opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. However, these ratings are not a warranty of an insurer's current or future ability to meet its contractual obligations.

Supplemental Compensation

Gallagher may receive supplemental compensation from insurance carriers and vendors, normally calculated at the end of each calendar year, that are contingent on a number of factors including the overall number of employer plans represented, plan retention rates, and overall premium growth. Historically, supplemental compensation has ranged, on average, between 0-3% based on specific carrier programs. These plans have no effect on premiums. Further, Gallagher may receive non-cash compensation from plan vendors or service providers that are not in connection with any particular client. If you have any questions regarding direct or indirect compensation received by Gallagher, please contact your dedicated Gallagher advisor or refer to the Gallagher Global Standards of Business Conduct (https://www.ajg.com/us/about-us/global-standards).

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

DATE: May 21, 2025

TO: Imperial Valley Healthcare District Board of Directors

FROM: Ramaiah Indudhara, M.D; Chief of Staff, Pioneers Memorial Hospital

SUBJ: PMH Medical Staff Recommendations for Approval

ITEMS FOR CONSIDERATION: Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/procedures/forms or other related recommendations.

SUMMARY AND BACKGROUND: The Medical Executive Committee, upon the recommendations of the Credentials Committee and the respective clinical services and/or chiefs and based on the completed credential files, policies and procedures, recommends that medical staff membership and/or clinical privileges be granted as outlined below:

1. Recommendation for **Initial Appointment** to the **Provisional Staff effective June 1, 2025** for the following:
   - Batana, Jagadeesh, MD — Internal Medicine
   - El-Akkad, Samih, MD — Teleradiology
   - Fadeyi, Olaniyi, MD — Internal Medicine

2. Recommend **Reappointment** effective **June 1, 2025** for the following:
   - Aziz, Omar, MD — OB/GYN
   - Diaz, Olga, MD — Emergency Medicine
   - Klein, Michael, MD — Teleradiology
   - Palakodeti, Vachaspathi, MD — Cardiology (No Cardiac Cath pending documentaiton
   - Shahbazi, Nasim, MD — Nephrology
   - Crump, Amie, PA — Physician Assistant (No Central Lines)
   - Esparza, Noemi, FNP — Family Nurse Practitioner
   - McCarthy, Daniel, PA — Physician Assistant (No Central Lines)
   - Pritting, Rosanna, FNP — Family Nurse Practitioner
   - Scholl, Jacob, PA — Physician Assistant (No Central Lines)

3. Recommend **Release from Proctoring and/or Advancement** effective **June 1, 2025:**
   - Khan, Ibrahim, MD — Internal Medicine (Advancement)
   - Donahue, Rachael, PA — Physician Assistant

4. Recommend acceptance of the following **Resignations from Staff** effective **May 31, 2025** (unless otherwise noted)**:**
   - Ferguson, Brian, DO — Emergency Medicine
   - Frey, Joseph, MD — Teleradiology
   - Hamdy, Mostafa, MD — Gastroenterology
   - Jacoby, Richard, MD — Interventional Cardiology
   - Salahi, Maher, MD — Teleradiology
   - Yomogida, Grace, PA — Physician Assistant

5. Recommend Change in Telehealth Privilege Form (see attached) (***Sending back with corrections)***
   - Added Tele-Critical Care
     Added “Privileges to provide consultation by remote telehealth to include evaluate, diagnose and provide treatment recommendations, non-controlled substance prescriptions, referral recommendations and follow up.

6. Recommend acceptance of the following policies/forms:
   - Advance Directives (CLN-00610)
   - Bloodborne Pathogen Exposure Control Plan (CLN-02303)
   - Care of Patient with Poisoning (CLN-00949)
   - Clinical Service of Emergency Medicine Rules & Regulations (MS R & R)
   - Discharging a Patient from the Intermediate NICU – Procedure/Process (CLN-02531)
   - Emergency Department Diversion (CLN-01922)
   - Emergency Preparedness Communication Plan (EOC-00182)

- Employee Health Standing Orders Work Instruction (HRD-00120)
- Guidelines for Safe Discharge of Emergency (ED) Patients (CLN-00914)
- Hazardous Materials and Waste Management Plan (EOC-00111) **Compliance**
- Hepatitis B Vaccination Program (HRD-00109)
- Influenza Vaccination Program (HRD-00100)
- Neonatal Endotracheal Intubation Standard Procedure (CLN-00236)
- Neonatal Enteral Feeding & Tubing Management Feeding Tubes and Decompression Tubes in the NICU (CLN-01801)
- Neonatal Guidelines for Oxygen Administration (CLN-00246)
- Neonatal Thoracentesis/Needle Decompression Standard Procedure (CLN-02518)
- Neonatal Umbilical Vessel Catheterization Standard Procedure (CLN-00258)
- Pain Assessment and Management (CLN-00139)
- Postexposure Prophylaxis after Occupational Exposure to Blood or Body Fluids by Needle/Sharps Injury or Splashes (HRD-00127)
- Renal Dosing Pharmacy Protocol (CLN-02983)
- Skin to Skin in the Intermediate NICU (CLN-02519)

Note not all of these policies require Board approval. Only those requiring this approval will be forwarded to the Governing Body.

7. Providers discussed the consultation requests process and having clerks enter the order. Ms. Bojorquez will work with each department director to determine best communication practices between the providers and entering the orders in the system.

   In addition – the Cerner EHR systems in the 2 hospitals do not talk to each other – almost impossible to obtain patient info from each other when patients are seen in either hospital systems – lots of tests get repeated, delay in care etc.

8. There is a request to allow for a meeting with administration/management and all members of the Medical Staff be invited to ask questions and clarify any misunderstandings that there may be regarding the merging of the two facilities and the medical staff. In addition, members of the MEC would appreciate an opportunity to review the new JPA with UCSD prior to that meeting in order to ask meaningful questions about the document.

   Serious concerns were raised about the chart depiction of medical staff reporting to CMO.
   Lack of transparency and lack of consistency were evident in responses provided on several of the issues.

9. Mr. Bjornberg reported that the JPA should be discussed at the Board meeting on June 12th. Physicians are invited to attend and participate.

10. Ms. Loper stated that reports are not yet available for financial results for April.

11. Ms. Bojorquez reported that the ER had 11,986 visits, 2.8% of those patients required transfer to another facility. Most of the transfers were for GI, Cardio, Neurology, Neurosurgery and Pediatrics, higher level of care required. We are moving to Press Gainey for patient satisfaction scores. Our LeapFrog grade has moved from a “D” to “C.” Our CMS Hospital Compare star rating is Three Stars. Our BCMA for the first quarter is 82%.
    There was a luncheon for new nursing graduates which was attended by approximately 80 new nurses and the executive teams. Positive feedback was received per Ms. Bojorquez..

12. On an annual basis, all providers need to be Respiratory Mask Fit Tested per DNV. We have completed information on 81% of the Medical/Allied Health Staff. Reminders have been sent.

13. There were questions regarding the merging to one medical staff and how those elections for Clinical Service Chairmen and Vice Chairmen will be held. It was stated that this is still a work in progress to determine. The PMH Medical Staff requested input and involvement prior to decisions being made. They would like to be heard by the IVHD Board.

14. Clinical Service and Committee Reports:
    - Medicine – No meeting was held.
    - Emergency Medicine – No meeting was held.

- Surgery/Anesthesia/Pathology – No meeting was held. There were questions with regards to upcoming merger and the leadership selections process.
- OB/GYN – No meeting was held.
- Pediatrics – No meeting was held..
- Medical Imaging – Meeting was held. Current Nuc Med Tech is out. MRI tech is working two weekends per month currently. Policies discussed. Also there is discussion with regards to use of contrast material for Nephrology concerns.
- Ambulatory Services – No meeting.
- Credentials & Bylaws – As noted above.
- MSQC – Dr. Su presented information discussed at the meeting and approved policies as listed above.

- Utilization Management – The most current report was available and discussed.

RECOMMENDATION: That Imperial Valley Healthcare District Board of Directors approves each of the recommendations of the Medical Executive Committee for medical staff membership and clinical privileges as outlined above, policies and procedures as noted and authorizes the chief executive officer to sign any documents to implement the same.

Respectfully submitted,
Ramaiah Indudhara, MD, MBA, FACS
Chief of Staff, Pioneers Health Center.
RI/cb

POLICIES FOR APPROVAL AT IVHD BOARD

	Policy	Policy No.	Page #	Revisions (see policy for full description)
1.	Bloodborne Pathogen Exposure Control Plan	CLN-02303	• 1-5	• Annual Review; no changes to intent process. Updated from PMDH to IVHD, Dr. Al Jasim added as physician reviewer
2.	Clinical Service of Emergency Medicine Rules & Regulations	MS R&R	• 6-9	• Updated Logo
3.	Discharging a Patient from the Intermediate NICU – Procedure/Process	CLN-02531	• 10-11	• Updated References • Otherwise, reviewed and submitted without change
4.	Emergency Preparedness Communication Plan	EOC-00182	• 12-27	• Removed 5.1.2.2 which refers to Vesta, a mass notification system we no longer use. • Removed facsimile from external communications chart that we don't use. • Replaced PMHD to PMH on Section 5.1. • Changed section 5.1.4.1 "contact information maintained by Nursing Administration Staffing Coordinator" to "contact information maintained by Human Resources Recruiter coordinator".
5.	Employee Health Standing Orders Work Instruction	HRD-00120	• 28-31	• Added section 5.20 regarding COVID vaccine administration. • Added section 3.3 regarding testing for annual tb screening, post exposure testing, conversions. • Added vaccine documentation into CERNER for CAIR entry. • Dr. Al-Jasim added as physician reviewer • Updated from PMDH to IVHD
6.	Hazardous Materials and Waste Management Plan	EOC-00111	• 32-47	• Removed contact name and changed phone number 3.1.1 8.2 Changed PMHD to IVHD
7.	Hepatitis B Vaccination Program	HRD-00109	• 48-50	• Scheduled Revision; no changes to intent • Updated from PMHD to IVHD • Added Dr. Al-Jasim as physician reviewer

POLICIES FOR APPROVAL AT IVHD BOARD

8.	Influenza Vaccination Program	HRD-00100	• 51-54	• Annual review; no changes to intent • Updated from PMDH to IVHD • Added Dr. Al-Jasmin as physician reviewer
9	Neonatal Endotracheal Intubation Standard Procedure	CLN-00236	• 55-61	• Changed reference of ALS RN to Advanced NRP RN
10.	Neonatal Enteral Feeding & Tubing Management Feeding Tubes and Decompression Tubes in the NICU	CLN-01801	• 62-67	• Added Neonatal and in the NICU in the title • Otherwise, reviewed and submitted without change
11.	Neonatal Thoracentesis/Needle Decompression Standard Procedure	CLN-02518	• 68-72	• Changed term of ALS RN to Advanced NRP RN • Updated References
12.	Neonatal Umbilical Vessel Catheterization Standard Procedure	CLN-00258	• 73-79	• Reviewed and submitted without change
13.	Postexposure Prophylaxis after Occupational Exposure to Blood or Body Fluids by Needle/Sharps Injury or Splashes	HRD-00127	• 80-82	• Update section 3.0 to reflect ER no longer dispenses medication. • Removed reference to policy CLN-02881 Emergency Room Dispensing. Policy has been retired and ER no longer dispenses meds • Update 5.11.1 to reflect no dispensing of doses from the ER • Updated reference UCSF PEP Link

Imperial Valley Healthcare District

Title: **Bloodborne Pathogen Exposure Control Plan**	Policy No. CLN-02303
	Page 1 of 5
Current Author: Lizbette Cordova, RN	Effective: 04/21/2010
Latest Review/Revision Date:08/2024	Manual: Clinical – Infection Control

Collaborating Departments: Infection Control; Human Resource Department, Dr. Mohammed Al-Jasim	Keywords: Infectious Disease, Blood Exposure		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 12/2024		
Clinical Service _____	MSQC 3/2025	MEC 3/2025	BOD 3/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The purpose of the Bloodborne Pathogen Exposure Control Plan is to comply with Standard (Title 8, Chapter 4, Section 5193, http://www.dir.ca.gov/title8/5193html) and protect healthcare workers and employees from bloodborne infectious diseases by eliminating or reducing the risk of this type of exposure.

2.0 Scope: District wide

3.0 Policy:

3.1 IVHD is committed to providing a safe work environment for our entire staff. The following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens."

4.0 Definitions:

4.1 Blood – Human blood, human blood components, and products made from human blood.

4.2 Bloodborne Pathogens – Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

4.3 Contaminated – The presence or the reasonably anticipated presence of blood or other potentially infectious materials on a surface in or on an item.

4.4 Clinical Laboratory – A workplace where diagnostic or other screening procedures are performed on blood and other potentially infectious materials

4.5 Decontamination – The use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

4.6 Exposure Incident – A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIM) that result from the performance of an employee's duties.

4.7 EVS – Environmental Services

4.8 Hand Washing Facilities – Facilities providing adequate supplies of running potable water, soap, and single use towels or hot air dying machines and/or hand anti-microbial gel dispensers throughout the hospital.

4.9 HBV – Hepatitis B virus

4.10 HCV – Hepatitis C virus

4.11 HCW – Health Care Worker – Any employee, medical staff or other healthcares professional that has the potential for bloodborne or other exposures and works in our facility.

4.12 HIV – Human Immunodeficiency

4.13 Occupational Exposure – Reasonably anticipated skin, eye mucous membrane, or parenteral contact with blood or potentially infectious materials that may result from the performance of an employee's duties.

4.14 OPIM – Other Potentially Infectious Materials are as follows:

- 4.14.1 Human Body Fluids – semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, saliva in dental settings, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as emergency response.
- 4.14.2 Any unfixed tissue or organ (other than intact skin) from human (living or dead)
- 4.14.3 Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV
  - 4.14.3.1 Cell, tissue, or organ cultures from humans or experimental animals
  - 4.14.3.2 Blood, organs, or other tissues from experimental animals
  - 4.14.3.3 Culture medium or other solutions

4.15 Parental Contact – piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.

4.16 PPE – Personal Protective Equipment – Specialized clothing or equipment worn or used by HCW for protection against a hazard. General work clothes (e.g. uniforms, pants, shirts or blouses) not intended to function as protection against a hazard is not considered to be personal protective equipment. Personal protective equipment will be considered "appropriate only if it does not permit blood or OPIM to pass through to or reach the HCW's work clothes, street clothes, undergarments, skin, eye, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the PPE will be used.

4.17 Regulated Waste

- 4.17.1 Liquid or semi-liquid blood or OPIM
- 4.17.2 Contaminated items that:
  - 4.17.2.1 Contain liquid or semi-liquid blood, or are caked with dried blood or OPIM.
  - 4.17.2.2 Are capable of releasing these materials when handled or compressed
- 4.17.3 Contaminated sharps
- 4.17.4 Pathological and microbiological wastes containing blood or OPIM
- 4.17.5 Regulated waste includes "medical waste" regulated by Health and Safety Codes

4.18 Sharp – Any object used or encountered in the industries covered by subsection (a) that can be reasonably anticipated to penetrate the skin or/and other part of the body, and to result in an exposure incident, including, but not limited to, needle devices, scalpels, lancets, broken glass, and broken capillary tubes.

4.19 Standard Precautions – An approach to infection prevention. According to the concept of Standard Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

5.0 Procedure:

5.1 Employee Exposure Risk Determination

5.1.1 Category Risk I: Is a job classifications in which **all** employees have occupational exposure.

5.1.2 Category Risk II: Is a job classifications in which **some** employees have exposure.

5.2 Responsibilities:

5.2.1 Employee Health Services is responsible for coordinating the annual review and update of the Bloodborne Pathogen Exposure Control Plan. Employee Health provides the initial employee training of the Exposure Control Plan during general orientation and works with Infection Control Department to identify and select safety devices. They also serve as a resource for infection prevention and control information.

5.2.1.1 Employee Health Services is responsible for evaluating the circumstances surrounding exposure incidents, providing the hepatitis B vaccination for all employees who are at risk of occupational exposure to bloodborne pathogens, and for reporting safety-related incidents to the Safety Committee. Employee records for vaccinations, exposures and exposure follow-up, and confidential Sharp Injury Log are maintained by Employee Health Services.

5.2.2 The Safety Officer will assist Infection Control in overseeing the use of standard precautions by all HCW/personnel for Imperial Valley Healthcare District. The Safety Officer also provides input for review and update of the Exposure Control Plan as appropriate and reports safety-related incidents to the Safety Committee.

5.2.3 Human Resources is responsible for maintaining documentation of annual training.

5.2.4 Department Directors are responsible for:

5.2.4.1 Determining which employees have potential occupational exposure to bloodborne disease.

5.2.4.2 Ensuring that employees receive all required training and education

5.2.4.3 Ensuring that personal protective equipment is available for employee use

5.2.4.4 Ensuring that employees use safe practices and PPE when there is a potential of exposure to bloodborne pathogens

5.2.4.4.1 Monitoring employees for compliance with Standard Precautions and work practice controls
5.2.4.4.2 Maintaining current department-specific policies and procedures addressing engineering and work practice controls and PPE
5.2.4.4.3 Training and counseling employees who are not using safe practice while handling sharps and/or bloodborne pathogens

5.2.5 Employees are responsible for:
5.2.5.1 Knowing what tasks they perform that have potential for bloodborne exposure and using safe practices, PPE, and devices as appropriate.
5.2.5.2 Reviewing the Bloodborne Pathogens and associated policies as part of their annual review
5.2.5.3 Maintaining a clean and safe environment

5.3 Work Practice Controls and Procedures have been implemented to minimize exposure to bloodborne pathogens. Each Department Manager is responsible for implementing, evaluating, and monitoring compliance with work practices on an ongoing basis..
5.3.1 Engineering and work practice controls include: Needleless systems where applicable, use of needles with engineered safety devices, and disposal of sharps in sharp containers,

5.4 Standard precautions are used to prevent contact with blood or other potentially infectious materials and are to be applied to all patients. When necessary, transmission-based precautions are used in addition to standard precautions. (See policy CLN-02308; Isolation Guidelines)

5.5 Specimen Handling and Contact with Blood or Body Fluids:
5.5.1 Eating, drinking, applying cosmetics, or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of Occupational exposure to blood or body fluids.
5.5.1.1 Clinical departments may clearly identify areas of the department where bloodborne pathogens may be present, such as areas where clinical specimens' or blood glucose monitoring devices may be placed. Direct patient care areas are included in these designated areas.
5.5.1.2 Clinical departments may clearly identify areas of the department where items which may carry bloodborne pathogens may not be present, such as clean work areas or staff rest areas. Gloves should not be worn in these areas. Items which may carry bloodborne pathogens shall not be placed in theses identified areas.
5.5.1.3 Staff may drink liquids, while working as allowed by their director in designated clean department areas where bloodborne pathogens are not kept. Care should be taken to minimize the risk of spilling by covering liquid.
5.5.1.4 Staff food and drink are not allowed in patient refrigerators.
5.5.2 Food, drink, and oral medications will not be kept in refrigerators, freezers, shelves, cabinets, on countertops where blood or body fluids may be present.

5.5.3 Specimens' of blood or body fluids will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping.

5.5.4 If an exposure occurs, mucous membranes and eyes will be immediately flushed copiously with water following exposure to blood or body fluids (See policy HRD-00127; Postexposure prophylaxis after occupational exposure to blood & body fluids).

5.6 Housekeeping:

5.6.1 Environmental Services (EVS) is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning methods and schedules are appropriate. The Infection Control and Medical Staff Quality committee (MSQC) will review and approve all policies and procedures that address cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated.

6.0 References:

6.1 CAL/OSHA and NIOSH, Calif. Code of Regulations: Title 8, Division 1, Chpt. 4, Subchapter 7, Group 16, Art. 109, 5193, http://www.dir.ca.gov/title8/5193.html

7.0 Attachment List: None

8.0 Summary of Revisions:

8.1 Annual Review; no changes to intent process. Updated from PMDH to IVHD, Dr. Al-Jasim added as physician reviewer.

PIONEERS MEMORIAL ~~HEALTHCARE DISTRICT~~ HOSPITAL

CLINICAL SERVICE OF EMERGENCY MEDICINE

RULES AND REGULATIONS

(Revised March, 2025)

Table of Contents

PIONEERS MEMORIAL ~~HEALTHCARE DISTRICT~~Hospital
Imperial Valley Healthcare District
EMERGENCY MEDICINE SERVICE
RULES AND REGULATIONS

PHYSICIAN DIRECTOR

A member of the organized Active Medical Staff shall have overall responsibility for the Emergency Medicine Clinical Service. The Director or designee shall be responsible for:

1. Implementing established policies and procedures and providing overall direction in continuing operation of the Service.

2. Providing physician staffing for the emergency services 24 hours a day.

CRITERIA FOR GRANTING EMERGENCY MEDICINE PRIVILEGES

Board certified by the American Board of Emergency Medicine or its equivalent, or board eligibility due to training in an accredited residency in emergency medicine.

MEDICAL SCREENING EXAMINATIONS:

A medical screening examination will be performed on all patients presenting to the Emergency Department. This procedure may be initiated by the RN at triage and may be performed by the Physician Assistant or Nurse Practitioner. No patient will be discharged or transferred unless certified as Medically Stable on the Medical Record or until stabilized as much as possible given the resources available at this hospital. Telemedicine screenings will be permitted to the extent permitted by CMS.

EMERGENCY PHYSICIANS

Emergency Physician staffing will be available 24 hours a day. The degree of evaluation and treatment rendered to any patient who presents themselves or is brought to the Emergency Room is ultimately the responsibility of the Emergency Physician.

In the event of a disaster, the Emergency physician, with the assistance of the E. R. nurses, should activate the Disaster Plan and assess available help.

Emergency physicians will respond to any in house emergencies when requested.

REFERRAL OF PATIENTS

All physicians providing on-call services for the Emergency Medicine Clinical Service shall be members of the Medical Staff.

Patients who require follow-up care after having been seen in our Department, and who do not currently have a primary or specialist physician shall be given either:

1. A referral to an appropriate primary physician

2. A referral to an appropriate specialist if needed.

These patients will be instructed to return to our Emergency Room should they be unable to get an appointment with a primary care or specialty physician.

MOONLIGHTING FOR RESIDENTS

Fourth year residents in an Emergency Medicine Training Program will be allowed to moonlight and become members of the Medical Staff at Pioneers following the same procedure as all other Medical Staff members. These individuals will be allowed to work under the supervision of a physician member of the medical staff in the Emergency Department until completion of their training program.

Imperial Valley Healthcare District

Title: **Discharging a Patient from the Intermediate NICU – Procedure and Process**	Policy No. CLN-02531
	Page 1 of 2
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 11/2018
Latest Review/Revision Date: 02/20/2025	Manual: Clinical

Collaborating Departments: Neonatal Dr Alshareef, NICU Manager	Keywords: Discharge Process for NICU		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Pediatrics 4/2025	MSQC 5/2025	MEC 5/2025	BOD 6/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish guidelines for discharging a patient from the NICU.

2.0 Scope:

2.1 Neonatal Staff

3.0 Policy:

3.1 Discharge will be initiated by the Attending Physicians order.
3.2 Discharge medications are ordered by the physician prior to the discharge day.
3.3 Prescriptions will be provided to the patients' family and filled at their preferred pharmacy.
3.4 A copy of the discharge summary and medication list is sent electronically to the Primary Care Provider.
3.5 Verify patient instructions have been completed.
3.6 Follow-up appointments are made prior to discharge in collaboration with parents and health care team. All appointments are documented in the electronic medical record.
3.7 The complete after visit summary is reviewed with parents by the RN before discharge.
3.8 Parents will be encouraged to view Infant CPR video and attend a CPR Certification Course.
3.9 For non-English/Spanish speaking families, provide instruction in the appropriate language. Arrangements are made 24-48 hours in advance.

4.0 Definitions:

4.1 CSTS – Car Seat Tolerance Screening
4.2 CCHD – Critical Congenital Heart Disease
4.3 Pre-ductal – relating to the part of the aorta proximal to the aortic opening of the arterial canal
4.4 Post-ductal – relating to that part of the aorta distal to the aortic opening of the ductus arteriosus

5.0 Procedure:

5.1 Process prior to release of infant to be discharged home:
5.1.1 See "Admission, Transfer and Discharge Criteria policy, CLN – 02513 for listing of criteria.

5.1.2 Car seat tolerance screening (CSTS) has been successfully completed, if indicated. See "Car Seat Challenge policy, CLN-02523

5.1.3 Critical Congenital Heart Disease (CCHD) screening successfully completed. See "Newborn Critical Congenital Heart Disease (CCHD) Screening policy, CLN-00267

5.2 Preparation for discharge

5.2.1 Obtain discharge order from physician.

5.2.2 Notify appropriate departments or facility as necessary (i.e., Discharge Planning/Case Management, Social Services, Dietitian, Home Health).

5.2.3 Discuss discharge time with parents prior to day of discharge.

5.2.4 Discuss with the parents appropriate clothes needed for infant and need for a car seat. Coordinate anticipated time of parent's arrival to receive infant.

5.2.5 Obtain and complete all discharge forms prior to the anticipated time of discharge.

5.2.6 Review discharge medication with family, if applicable. (education prior to day of discharge is encouraged)

5.2.7 Review formula recipe, if applicable. (education prior to day of discharge is encouraged)

5.2.8 Assure that the family's questions have been answered.

5.2.9 Review information on discharge instruction sheet with parents, have them sign and give them a copy. Reinforce teaching as necessary.

5.2.10 Document teaching in the electronic medical record.

6.0 References:

6.1 Gardner, S., Carter, B., et al. (2021). Merenstein & Gardner's Handbook of Neonatal Intensive Care 9th ed. St Louis, Mo. Elsevier.

6.2 Verklan, M., Terese & Walden, Marlene (2020). Discharge Planning and Transition to Home Care. Core Curriculum for Neonatal Intensive Care Nursing 6th Ed.

6.3 Hospital Discharge of the High-Risk Neonate: American Academy of Pediatrics Policy Statement. Committee on Fetus and Newborn (2008) Pediatrics

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Updated References

8.2 Otherwise, reviewed and submitted without change

Imperial Valley HealthCare District **ANNUAL REVIEW**

Title: **Emergency Preparedness Communications Plan**	Policy No. EOC-00182
	Page 1 of 5
Current Author: Jorge Mendoza	Effective: 9/1/1995
Latest Review/Revision Date: 3/2025	Manual: EOC / Emergency Management

Approval Route: List all required approval				
MARCC 9/14/2021	PSQC	Other: Safety Committee 10/2021		
Clinical Service _____		MSQC 11/2021	MEC 11/2021	BOD 11/2021

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To ensure that Pioneers Memorial hospital (PMH) will be able to communicate with all employees, physicians, volunteers, other key community agencies during an emergency/disaster.

1.2 To establish guidelines that will ensure communication equipment remains efficient, reliable, and properly maintained to function during an emergency/disaster.

1.3 To ensure proper release of protected health information during emergency/disaster events, including events that may warrant evacuation of the facility.

2.0 Scope: District wide

3.0 Policy:

3.1 The Emergency Preparedness Manager in coordination with the Biomedical and Information Systems Departments are responsible for maintaining Emergency/Disaster Communication equipment

3.2 The PMH Communication Center is located in the Hospital Command Center (HCC) located in the classroom

3.3 PMH recognizes the importance of redundant communications and has established primary and alternate methods of communication with all employees, physicians, volunteers, other key community agencies during an emergency/disaster.

3.4 The hospital's telephone system must be safeguarded for overloading during a disaster

3.5 All incoming and outgoing messages will be routed through the HCC

3.6 External communication will be chiefly with the Medical Health Operational Area Coordinator (MHOAC), the City of Brawley Emergency Operations Center (EOC) and the Imperial County EOC

3.7 All internal and external communications both incoming and outgoing will be documented by the HCC using Hospital Incident Command System (HICS) Form 205 (Internal & External)

3.8 PMH will maintain the ability to share information and medical documentation of patients with other healthcare providers to maintain continuity of care during an incident.

3.9 During an emergency incident that may require evacuation of the facility patient information will be released in accordance with policy DPS-00358 "Emergency Release of Patient Medical Information"

3.10 During an emergency/disaster the Incident Commander will appoint a Public Information Officer (PIO)

4.0 Definitions:

4.1 Public Information Officer (PIO) – Assigned by the Incident Commander to disseminate all approved information to the public and the media.

4.2 Joint Information Center (JIC) – A centralized facility where organizations responding to an emergency coordinate the release of accurate and timely information to the public and the media.

5.0 Procedure:

5.1 Internal Notification – Following an emergency/disaster response and activation of PMH's Emergency Operation's Plan (EOP) the appropriate stakeholders, which may include all or select groups, will be notified as soon as possible. PMH will maintain contact information for all employees, physicians, volunteers and those contracted to work at PMH facilities.

5.1.1 Employees

5.1.1.1 All current employees will maintain current contact information, including phone number, on file with the Human Resources Department in accordance with policy # HRD-00076.

5.1.2 Physicians

5.1.2.1 Physician contact information is maintained by the medical staff office and can be found within the physician credential files as well as a backup binder.

5.1.3 Volunteers

5.1.3.1 Volunteers provide their contact information upon application with the Volunteer Coordinator. Contact information for all active volunteers is maintained on a file in the Volunteer Coordinators Office

5.1.3.2 While in the facility volunteers are required to check in and out via an electronic system. In the event of an emergency/disaster, pending the system is operational there is ability to track which volunteers are actively volunteering.

5.1.4 Contracts

5.1.4.1 Travel Nurses – contact information maintained by Human Resources Recruiter coordinator.

5.1.4.2 Security – Maintained by contracted company. A 24/7 dispatch number has been provided to PMHs Safety Officer. Through the company's dispatch center contracted staff can be contacted in the event of an emergency/disaster response.

5.1.4.3 All other contract contact information is maintained by Human Resources

5.2 Notifying External Agencies – Appropriate notifications to cooperating agencies must be made at the initiation of any emergency/disaster response. Notifications to local emergency response agencies may be made via telephone or the 800 MHz system. These notifications include but are not limited to:

5.2.1 Imperial County Medical Health Operational Area Coordinator (MHOAC) (760) 791-7521; if unavailable the alternate MHOAC or Imperial County Public

Health Department Duty Officer may be notified, contact information available on Attachment A.

5.2.2 911 communications center, this will include Brawley Police and Fire Departments; utilize business line for notification (760) 344-2111. Additional contact numbers for the City of Brawley EOC if activated can be found in Attachment A.

5.2.3 California Department of Public Health – Licensing and Certification Office: (866) 706-0759 immediately upon being notified of the intent of discontinuance or disruption of services or upon threat of a walkout of substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

5.2.4 Imperial County Office of Emergency Services if necessary

5.3 Incident specific notifications may be required based on the type of incident. Additional notification requirements will be included in the Incident Specific Emergency/Disaster Response Plans.

5.4 PMHD will have available redundant communication methods to be used to communicate internally as well as with area hospitals, emergency response vehicles, and City/County Emergency Operations Centers (EOCs).

Internal Communication Methods	External Communication Methods
Telephone	Telephone
Ascom Phones	Cellular Phones (personal or provided)
PBX Overhead Speakers	Electronic Mail
VHF Radios	800 MHz Radios
Electronic Mail	Satellite Phones
800 MHz Radios (conventional mode)	REDDINET
Cellular Telephones (personal or provided)	

5.5 In the absence of a radio system or other forms of communications, arrangements must be made with the City of Brawley EOC and Imperial County EOC to utilize land runners for external and internal communication

5.6 REDDINET carries critical data and communications for daily operations and crises

5.6.1 An individual trained in using the REDDINET System will be assigned in the HCC by the Incident Commander to coordinate REDDINET communications.

5.6.2 Emergency Medical Communication connecting all hospitals, agencies, and service providers within regional healthcare systems, REDDINET optimizes timely, accurate communication and coordination

5.6.3 REDDINET displays real-time, regional and inter-regional diversion data and available resources

5.6.4 Special screens allow for data input on patient capacity, victim identification, and dispatch information to evenly and accurately distribute patients to waiting hospitals

5.6.5 REDDINET serves as a virtual command and control center for managing emergency transport locations, resource location, victim identification and evacuation

5.7 Communication will be limited to messages essential to the disaster operation

5.8 When telephone extensions to the HCC are tied up, incoming calls will be switched to messenger personnel who will copy the messages and route to the HCC

5.9 All messenger-borne and radio-transmitted messages sent to the HCC will be on letter-sized paper or laptop computer showing

5.9.1 The date and time sent or received

5.9.2 The names and title of the addressee and the sender

5.10 The HICS 205A and 213 Forms will be utilized to log all communication in the HCC by a clerk

5.11 The PIO will establish a system for providing timely and accurate information to the public during a crisis or emergency situation. This system will include “many voices” and create “one message” that will be sent out the public. During an event the PIO will handle:

5.11.1 Media and public inquiries

5.11.2 Emergency public information and warnings

5.11.3 Rumor monitoring and response

5.11.4 Media monitoring

5.11.5 Other functions required for coordinating, clearing with authorities, and disseminating accurate timely information related to the incident, particularly regarding information on public health and safety and protection

5.12 A public information system is comprised of a Joint Information System (JIS) and a Joint Information Center (JIC). The JIS provides an organized, integrated, and coordinated mechanism to ensure delivery of understandable, timely, accurate, and consistent information to the public. The JIC is a physical location where public information professionals from all organizations involved in incident management activities can co-locate to perform their duties. The hospital PIO may be located at the HCC, local EOC, or the JIC.

6.0 References:

6.1 Imperial County Operational Area Medical Health Branch Disaster Plan

6.2 California Code of Regulations Title 22, 70741 Disaster and Mass Casualty Program

6.3 California EMSA, HICS Implementation Guide

6.4 California Emergency Management Agency Department of Health, California Emergency Medical Mutual Aid Plan

6.5 CMS CoP §482.15 Condition of participation: Emergency Preparedness

7.0 Attachment List:

7.1 Attachment A – Community Emergency Contact List

7.2 Attachment B – PMHD HCC Contact Info

7.3 Attachment C – Imperial County 800MHz Radio Fleet Map

7.4 Attachment D – HICS Form 205A

7.5 Attachment E – HICS Form 213

8.0 Summary of Revisions:

8.1 Removed 5.1.2.2 which refers to Vesta, a mass notification system we no longer use.
8.2 Removed facsimile from external communications chart that we don't use.
8.3 Replaced PMHD to PMH on Section 5.1.
8.4 Changed section 5.1.4.1 "contact information maintained by Nursing Administration Staffing Coordinator" to "contact information maintained by Human Resources Recruiter coordinator".

COMMUNITY EMERGENCY CONTACT LIST

STATE AGENCIES	TELEPHONE NUMBERS
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH – LICENSING & CERTIFICATION REPORTING/COMPLAINT LINE	**(866) 706-0759**
COUNTY AGENCIES	**TELEPHONE NUMBERS**
IMPERIAL COUNTY MEDICAL HEALTH OPERATIONAL AREA COORDINATOR (MHOAC)/IMPERIAL COUNTY EMS AGENCY – CHRIS HERRING, EMS MANAGER	**OFFICE – (442) 265-1364** **CELL – (760) 791-7521** **800 MHZ IMA TAC #2**
IMPERIAL COUNTY MEDICAL HEALTH OPERATIONAL AREA COORDINATOR (MHOAC) ALTERNATE – JAMES PINTUS	**CONTACT DUTY OFFICER # (760) 455-4083**
Imperial County Public Health Department ICPHD Lab – Call Duty Officer #	Main # – (442) 265-1444 **DUTY OFFICER 24/7 – (760) 455-4083** **DEPARTMENT OPERATIONS CENTER – (442) 265-6727**
Imperial County Public Health Department – Robin Hodgkin, Department Director	Office – (442) 265-1337
IMPERIAL COUNTY OFFICE OF EMERGENCY SERVICES – ALFREDO ESTRADA JR., COORDINATOR/IMPERIAL COUNTY FIRE CHIEF	**OFFICE – (442) 265-6011**
IMPERIAL COUNTY OFFICE OF EMERGENCY SERVICES – DEPUTY COORDINATOR	**OFFICE - (442) 265-6012** **CELL – (760) 427-4865**
Imperial County Division of Environmental Health Control – Jeff Lamoure, Deputy Director	Office – (442) 265-1894 24/7 – (442) 265-1900
Imperial County Sheriff's Office Dispatch Center	(442) 265-2021
CITY OF BRAWLEY	**TELEPHONE NUMBERS**
BRAWLEY POLICE DEPARTMENT DISPATCH CENTER (POLICE & FIRE)	**(760) 344-2111**
Brawley Fire Department (Non-Emergency #'s)	Station 1 – (760) 344-1234 Station 2 (Admin) – (760) 351-9110 Fax (Admin) – (760) 351-9456
UTILITIES	**TELEPHONE NUMBERS**
City of Brawley Water	(760) 344-5800 After Hours Emergency – (760) 344-2111
Imperial Irrigation District – Electricity	(760) 335-3640 – #2 After Hours Emergency – (760) 339-0510
Southern California Gas Company	(800) 427-2000
Alfords Distributing (bottled water)	(760) 427-3920 – 24/7 cell
Sparkletts Water (Potable)	(760) 344-2075
D & M Water (Potable bulk)	(760) 344-2100
Mann Co. (Fuel)	(760) 344-1313 Steve Cochran – Manager 24Hrs – (760) 455-7287
CONVALESCENT CARE FACILITIES	**TELEPHONE NUMBERS**
Imperial Heights Healthcare (Brawley)	(760) 344-5431
Valley Inn Blossom (Holtville)	(760) 356-1262
Valley Convalescent (El Centro)	(760) 352-8471

COMMUNITY EMERGENCY CONTACT LIST

AMBULANCE SERVICES	TELEPHONE NUMBERS
AMR Ambulance Service	(760) 550-4369
REACH Air Medical Dispatch Brandon Walls – General Manager	(800) 338-4045 Cell – (858) 492-8111
Mercy Air Ambulance Dispatch	(800) 222-3456
United Ambulance (BLS capability)	(858) 277-0300
OTHER LAW ENFORCEMENT/FIRE DEPT.	**TELEPHONE NUMBERS**
California Highway Patrol	Office – (760) 352-6136 Dispatch – (760) 482-2550
Imperial County Fire Department (Non – Emergency)	(442) 265-6000
Imperial County Sheriff's Department Coroner	(442) 265-2021
Calipatria State Prison	(760) 348-7000 Watch Commander – Ext.# 5302
Centinela State Prison	(760) 337-7900 Watch Commander – Ext.# 7612
EL CENTRO REGIONAL MEDICAL CENTER	**TELEPHONE NUMBERS**
HOSPITAL COMMAND CENTER	**INCIDENT COMMAND – (760) 339-7152** **IC SATELLITE PHONE – (254) 219-8502** **LOGISTICS – (760) 339-7174** **OPERATIONS – (760) 339-3712** **OPERATIONS SATELLITE PHONE – (254) 219-8509** **FINANCE – (760) 339-3558**
EMERGENCY DEPARTMENT	**(760) 339-7254**
Base Hospital/Trauma Coordinator – Danielle Walls	(760) 482-5134
OUT OF COUNTY HOSPITALS	**TELEPHONE NUMBERS**
UCSD Medical Center	Trauma Center – (619) 543-7428 Transfer Center – (619) 543-5709 Burn Center – (619) 543-6502
Palomar Hospital	(760) 739-3000
Scripps Memorial Hospital	(858) 554-9100 (858) 626-6140
Children's Hospital San Diego	(858) 576-1700
Yuma Regional Medical Center	(928) 344-2000
JFK Memorial Hospital (Indio)	(760) 347-6191
Eisenhower Medical Center (Rancho Mirage)	(760) 340-3911
Desert Regional Medical Center (Palm Springs)	(760) 323-6511
Loma Linda University Medical Center	(909) 558-4000
CLINICAS DE SALUD DEL PUEBLO	**TELEPHONE NUMBERS**
Corporate Office/Command Center	(760) 344-9951 Administration – ext. 10101 Emergency Preparedness – ext. 10158 Chief Medical Officer – ext. 10153
Brawley Open Access Center	(760) 351-2000

COMMUNITY EMERGENCY CONTACT LIST

Brawley Health Clinic/ Women's Center/ Behavioral Health (alternate command center)	(760) 344-6471
Niland Health Center	(760) 359-0110
West Shores Health Clinic	(760) 394-4338
El Centro Health Clinic	(760) 352-4579
Calexico Health Clinic	(760) 357-2020
Winterhaven Health Clinic	(760) 538-3073
MEDICAL/SURGICAL SUPPLIES	**TELEPHONE NUMBERS**
Medline Customer Service (24 hrs)	(800) 633-5463 (563) 589-7977 Alternate
Cardinal Health District	(800) 964-5227
DRUG SUPPLY	**TELEPHONE NUMBERS**
Cardinal Health District	(800) 688-8764
BLOOD SUPPLY	**TELEPHONE NUMBERS**
San Diego Blood Bank	(800) 479-3902
OTHER AGENCIES/COMPANIES	**TELEPHONE NUMBERS**
POISON CONTROL	**(800) 222-1222**
Safety Kleen (HazMat Clean-up)	(619) 401-3120 (619) 401-3132 24 Hrs. (800) 468-1760
SYSCO Foods	(760) 562-6271
Waxie	(760) 352-4691
Trident	(800) 424-9300 24/7 (619) 688-9600 24/7 (619) 572-4407
Elms Equipment Rental	(760) 344-3780
Supreme Electric (Electric Supplies)	(760) 352-4840
Kone (Montgomery Elevator)	(858) 679-2400
Angelica Textile Services (Housekeeping/Linens)	(800) 464-6671 Colton - (909) 825-2292
Sierra Air (HVAC System)	(760) 352-2767
AMSCO/Steris (Sterilizers)	(800) 333-8838
Global Power Solutions (Generators)	(619) 579-1221
Mann Co. (Generators)	(760) 344-1313
Simplex Grinnell (Fire Extinguishers)	(858) 633-9100
LABORATORY SERVICES	**TELEPHONE NUMBERS**
SUPPLIES	
Beckman	(800) 854-3633
Cardinal Supplies	(800) 964-5227
CMS/Fisher	(800) 640-0640
Dade-Micro Scan	(800) 677-7226
REPAIR	
Beckman	(800) 854-3633
Abbott	(800) 235-5396
Siemens Health Care Diagnostic	(877) 229-3711

COMMUNITY EMERGENCY CONTACT LIST

ALARM COMPANIES	TELEPHONE NUMBERS
Jade Security	(760) 337-2100
A & S Security	(760) 352-4371
Central Monitoring (Hospital)	(760) 352-8725 acct # 1067-977
Central Monitoring (PMC)	(760) 352-4371 acct # 1067-465
NUCLEAR MEDICINE	**TELEPHONE NUMBERS**
QA Services – Russ Deacon, Radiation Safety Officer	Office – (619) 482-1003 Cell – (619) 339-7669
Nuclear Medicine Technologist – Ruben Gomez	Cell – (760) 550-3026
Department Head – Dr. Shahrouz Tahvilian	Cell – (760) 848-8176
Shelley Becker – QA Services Health Physicist	Office – (626) 616-5135 Cell – (760) 536-3144

Pioneers Memorial Healthcare District Hospital Command Center Communications	
Landline #1	760-351-3912
Landline #2	760-351-3913
Landline #3	760-351-3914
Landline #4/fax	760-351-3915
Satellite Phone #1	254-219-7679
Satellite Phone #2	254-219-7675

Hospital Incident Command System (HICS) Leaders Electronic Mail Addresses	
Role	**Email**
Incident Commander	hicscommand@pmhd.org
Public Information Officer	hicspublicinfo@pmhd.org
Safety Officer	hicssafety@pmhd.org
Planning Section Chief	hicsplanning@pmhd.org
Finance Section Chief	hicsfinance@pmhd.org
Operations Section Chief	hicsoperations@pmhd.org

IMPERIAL COUNTY EMS

1-May-14

Radios: All Units

(EMS Mode 3, 4, 5 on IMA) | EMS Mode 6 & 7 need function to page hospitals | (EMS Mode 13 & 14 on IFM) | (EMS Mode 15 & 16 on RMA)

	ZONE	MODE 1	MODE 2	MODE 3	MODE 4	MODE 5	MODE 6	MODE 7	MODE 8	MODE 9	MODE 10	MODE 11	MODE 12	MODE 13	MODE14	MODE 15	MODE 16
1	EMS	CMD	TAC	ICOCAL	ICOTC1	ICOTC2	ELCTR	PION	ICS1	ICS2	ICS3	IM M/AIR	SD M/AIR	IFM CMD1	IFM TAC1	RCOCAL	RCOTC1
2	BLS	ELCTR	PION	TRI	SLJ	PAL	UCSD	MERCY	SHRP	GRSMT	SCHV	ALVR	MEDG				
3	MT1	POM	FALB	SENC	CMPPEN	MBAY	VET	THRNTN	NAVY	VILV	CABR	KAISER	PARD	CRD	SHCV	SEAST	REWARD
4	ALS	ELCTR	TRI	SLJ	PAL	UCSD	MERCY	SHRP	GRSMT	SCV	CHLD	SD F/AIR	IM F/AIR	SD L/AIR	SD M/AIR		
	AIR	IM M/AIR	IM F/AIR	IM L/AIR	SD M/AIR	SD F/AIR	SD L/AIR	ICOCALL	ICOTAC 1	ICOTAC 2	ICOTAC 3	ICOTAC 4	I ICS 1	MVU DIS	MVU CMD1	MVU TAC1	MVU TAC2
5	IFM	CALL	CMD1	TAC1	TAC2	CMD2	TAC3	TAC4	CMD3	TAC5	TAC6	CMD4	TAC7	TAC8	CMD5	TAC9	TAC10
6	IMA	COCAL	COTC1	COTC2	COTC3	COTC4	ICS1	ICS2	ICS3	ICS4	ICS5	ICS6	ICS7	EMER1	EMER2	EMER3	EMER4
7	EMA	CMD1	TAC1	TAC2	CMD2	TAC3	TAC4	CMD3	TAC5	TAC6	CMD4	TAC7	TAC8	CMD5	TAC9	TAC10	TAC11
8	RMA	COCAL	COTC1	COTC2	COTC3	COTC4	ICS1	ICS2	ICS3	ICS4	ICS5	ICS6	ICS7	EMER1	EMER2	EMER3	EMER4
9	TRF	CMD1	TAC1	CMD2	TAC2	CMD3	TAC3	CMD4	TAC4	CMD5	TAC5	CMD6	TAC6	TAC7	TAC8	TAC9	TAC10
10	CNV	FMAR	ISERV	CLMRS	SDMAR	CARS1	CARS2	CARS3	CARS4	ICALL	ITAC1	ITAC2	ITAC3	ITAC4			

Green-RCS Analog Talkgroups
Blue-Transportable Radio Facility
Red-800mhz Conventional Channels

ZONES:
EMS-Imperial County EMS zone
BLS-Basic Life Support Hospital zone
MT1-Medical Transport(Hospital) zone
ALS-Advanced Life Support Hospital zone
IFM-Imperial County Fire Mutual Aid Talkgroups
IMA-Imperial County Mutual Aid zone
EMA-San Diego County EAST Fire Mutual Aid zone
RMA-San Diego County Mutual Aid zone
TRF-Transportable Radio Facility
CNV-800mhz Conventional Channels zone

DEK

1	2	3	4	5	6	7	8
Ems Cmd	ELCTR	PION	ICOCall	IMP M/Air	SD M/Air	IFM Cmd1	SD Cocall

printed 12/12/2014

HICS 205A - COMMUNICATIONS LIST

1. Incident Name	2. Operational Period (#)
	DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____

3. Internal Contacts

ASSIGNMENT / NAME	RADIO CH # / FREQUENCY	PHONE	FAX	EMAIL	MOBILE PHONE	PAGER	IDENTIFICATION NUMBER OF DEVICE ISSUED / COMMENTS

4. Special Instructions

HOSPITAL INCIDENT COMMAND SYSTEM

Purpose: Provides information on all communication devices assigned
Origination: Communications Unit Leader
Copies to: Command Staff, Section Chiefs, and Documentation Unit Leader

HICS 205A - COMMUNICATIONS LIST

5. External Contacts

AGENCY / ASSIGNMENT / NAME	RADIO CH # / FREQUENCY	TELEPHONE	FAX	EMAIL	MOBILE PHONE	PAGER	IDENTIFICATION NUMBER OF DEVICE ISSUED / COMMENTS

6. Special Instructions

7. Prepared by
Communications Unit Leader

PRINT NAME: _____ SIGNATURE: _____

DATE/TIME: _____ FACILITY: _____

HOSPITAL INCIDENT COMMAND SYSTEM

Purpose: Provides information on all communication devices assigned
Origination: Communications Unit Leader
Copies to: Command Staff, Section Chiefs, and Documentation Unit Leader

HICS 205A - COMMUNICATIONS LIST

PURPOSE: The HICS 205A - Communications List provides information on all radio frequencies, telephone, and other communication assignments for each operational period.

ORIGINATION: Prepared by the Logistics Section Communications Unit Leader and given to the Planning Section Chief for inclusion in the Incident Action Plan (IAP).

COPIES TO: Duplicate and provide to all recipients as part of the IAP. All completed original forms must be given to the Documentation Unit Leader. Information from the HICS 205A can be placed on the Organization Assignment List (HICS 203).

NOTES: If additional pages are needed, use a blank HICS 205A and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period**	Enter the start date (m/d/y) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Internal Contacts**	Enter the appropriate contact information for internal contacts, hospital personnel, those in an activated Hospital Incident Management Team (HIMT) position, and other key staff.
4	**Special Instructions**	Enter any special instructions (e.g., using repeaters, secure-voice, private line [PL] tones, etc.) or other emergency communications. If needed, also include any special instructions for alternate communication plans.
5	**External Contacts**	Enter the appropriate contact information for external agencies, organizations, key contacts.
6	**Special Instructions**	Enter any special instructions (e.g., using repeaters, secure-voice, private line [PL] tones, etc.) or other emergency communications. If needed, also include any special instructions for alternate communication plans.
7	**Prepared by Communications Unit Leader**	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

HICS 213 - GENERAL MESSAGE FORM

1. Incident Name

2. To

PRINT NAME: _____ POSITION: _____

3. From

PRINT NAME: _____ POSITION: _____

4. Subject	**5. Date**	**6. Time**

7. Priority ☐ URGENT - HIGH ☐ NON URGENT - MEDIUM ☐ INFORMATIONAL - LOW

8. Message ☐ RESPONSE REQUIRED

9. Approved by PRINT NAME: _____ SIGNATURE: _____

10. Reply / Action Taken

11. Replied by

PRINT NAME: _____ SIGNATURE: _____

POSITION: _____ FACILITY: _____

DATE/TIME: _____

HOSPITAL INCIDENT COMMAND SYSTEM

Purpose: Used to transmit messages regarding resources requested, status information, and other coordination issues
Origination: Any personnel
Copies to: Documentation Unit Leader

HICS 213 - GENERAL MESSAGE FORM

PURPOSE: The HICS 213 - General Message Form is used to record incoming messages that cannot be orally transmitted to the intended recipients. The HICS 213 is also used to transmit messages (resource order, status information, other coordination issues, etc.). This form is used to send any message or notification to incident personnel that require hard-copy delivery.

ORIGINATION: Initiated by any person on an incident.

COPIES TO: Upon completion, the HICS 213 is delivered to the original sender.

NOTES: The HICS 213 is composed of three steps:

- The message (Section 8) is completed by sender
- The message is replied to in Section 10
- After noting action taken, message form is returned to original sender

NUMBER	TITLE	INSTRUCTIONS
1	**Incident Name**	Enter the name assigned to the incident.
2	**To**	Enter the name and position for whom the message is intended. For all individuals, use at least the first initial and last name. For Unified Command, include agency names.
3	**From**	Enter the name and position of the individual sending the General Message. For all individuals, use at least the first initial and last name. For Unified Command, include agency names.
4	**Subject**	Enter the subject of the message.
5	**Date**	Enter the date (m/d/y) of the message.
6	**Time**	Enter the time (24-hour clock) of the message.
7	**Priority**	Enter the priority of the message or request.
8	**Message**	Enter the content of the message.
9	**Approved by**	Enter the name and signature of the person approving the message, if necessary.
10	**Reply / Action Taken**	The intended recipient will enter a reply and/or action taken to the message and return it to the originator.
11	**Replied by**	Enter the name, signature of the person replying to the message, and Hospital Incident Management Team (HIMT) position. Enter date (m/d/y), time prepared (24-hour clock), and facility.

Imperial Valley Healthcare District

Title: **Employee Health Standing Orders – Work Instruction**	Policy No. HRD-00120
	Page 1 of 4
Current Author: Lizbette Cordova RN	Effective: 2/1994
Latest Review/Revision Date: 09/01/2024	Manual: Human Resources

Collaborating Departments: Infection Control, Pharmacy, Dr. Mohammed Al-Jasim		Keywords: Guidelines		
Approval Route: List all required approval				
	PSQC	Other: Safety Committee 12/2024		
Clinical Service _____		MSQC 03/2025	MEC 03/2025	BOD 03/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The purpose of the standing orders is to assist the Health Nurse and/or designee to provide screenings, vaccinations, limited treatment and advise employees who become sick or injured on duty.

2.0 Scope: Employee Health and/or Designee

3.0 Policy:

3.1 Employee Health nurse is able to provide first aid as indicated in policy, if necessary to IVHD employees.

3.2 Employee Health nurse may order follow-up testing as needed for bloodborne pathogen exposures.

3.3 Employee Health nurse may order follow-up testing as needed for annual tuberculosis screening and any conversions.

3.4 Employee Health nurse may administer employee vaccines and appropriate antibody testing follow-up.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 Abrasions/Lacerations: Cleanse area with soap and water. Apply dressing. Assess immunization status for tetanus. If required, administer tetanus-diphtheria toxoid (TD) 0.5 mL IM. Refer to physician if wound involves:

5.1.1 >2 cm (0.8 inch) in length or is deep (0.6 cm / 0.25 inch)
5.1.2 Gaping or jagged edges
5.1.3 Embedded material
5.1.4 A cut producing a flap
5.1.5 A serious cut to fingers, hands, toes, feet or is over joints (exposes fat, muscle, tendon or bone)
5.1.6 Human / animal bite
5.1.7 Facial laceration
5.1.8 Functional disturbance
5.1.9 Uncontrolled bleeding
5.1.10 Gross contamination

5.2 Anaphylactic Shock: Call a Code Blue; Perform CPR if necessary. Transfer to Emergency Department immediately.
- 5.2.1 Outpatient clinics: Notify PA/NP or physician. Call 911 for hospital transfer.

5.3 Asthmatic Reaction: Help employee take own medication, if available. Significant ongoing symptoms or status asthmaticus evident refer for medical evaluation.

5.4 Bloodborne Pathogen Exposure: Needlestick/sharp injury or exposed to blood or other body fluid, the following steps should be taken:
- 5.4.1 Wash needlestick and cuts with soap and water
- 5.4.2 Flush splashes to the nose, mouth, or skin with water
- 5.4.3 Irrigate eyes with clean water, saline, or sterile irrigates
- 5.4.4 Refer to Emergency Department immediately for assessment of the injury, exposure risk and need for chemo-prophylaxis. Hepatitis Panel, Hepatitis B Surface Antibody Quantitative, and HIV antibody status (baseline testing) should be established. Employee should be retested six (6) weeks, three (3) months and six (6) months post exposure to determine if transmission has occurred if source status is unknown or positive.

5.5 Chronic Low Back Pain: Advise of over the counter (OTC) anti-inflammatory drugs. Apply heat. Medical evaluation for any changes or increase in pain.

5.6 Cumulative Trauma Disorder (CTD): Apply hot soaks for 10 – 15 minutes four times a day as needed. Apply bandage or splint. Advise of OTC anti-inflammatory drugs. Refer to physician if symptoms continue after 3 days, continual pain or limited movement.

5.7 Contusion: Elevate affected part. Apply cold compresses to area for 10 minutes, remove for 5 minutes, the reapply 3 – 4 times to reduce edema formation. Apply elastic pressure bandage to reduce edema formation. Advise OTC analgesic. Advise warm moist heat after swelling is reduced; usually after 48 hours. Refer to physician for persistent soreness or disability.

5.8 Dermatitis: Mild cases; cool wet compresses. Advise of OTC topical medications. Refer to physician for acute, severe persistent or recurrent dermatitis, or infection.

5.9 Headache: Advise of OTC analgesics. Encourage rest in a darkened quiet room. Refer to physician for severe complaints not relieved with treatment.

5.10 Hepatitis A Vaccination: Administer Hepatitis A Vaccine, Havrix 1440 IU (VAQTA 50 units) IM deltoid to employees at risk of exposure and others as per policy. Two (2) doses are required; second dose to be given six (6) months after the first. Document in CERNER for CAIR entry.

5.11 Hepatitis B Vaccination: Administer Hepatitis B Vaccine (recombinant) 20 mcg IM deltoid to employees at risk for bloodborne pathogen exposure and other as per policy. Three (3) doses required: second dose 1 month after first and third dose 6 months after first. . Document in CERNER for CAIR entry.
- 5.11.1 Test for hepatitis B surface antibody (anti-HBs) to document immunity 1 – 2 months after third dose. If anti-HBs is at least 10 mIU/mL (positive), the employee is immune. No further serologic testing or vaccination is recommended.

5.11.2 If anti-HBs is less than 10 mIU/mL (negative), the employee is unprotected. Revaccinate with a 3-dose series. Retest anti-HBs 1 -2 months after dose #3. If anti-HBs is negative after 6 doses of vaccine, employee is a non-responder.

5.12 Influenza: Advise of OTC drugs; to increase fluid intake and rest. Should stay at home at least 24 hours after fever is gone. Refer to physician if bacterial infection suspected, severely ill, debilitated or pregnant. . Document in CERNER for CAIR entry.

5.13 Influenza Virus Vaccination: Administer Influenza Virus Vaccine (Inactivated) 0.5mL IM deltoid to Employees, Women's Auxiliary, Adult Volunteers, Contract Employees, Nursing Instructors and Students as it becomes available. Administer vaccine annually as recommended by the Center for Disease Control and the Health Department.

5.14 Insect Sting: Assess employee for mild or severe allergy. Remove stinger, cleanse site. Apply ice to limit swelling, elevate limb. Assess immunization status for tetanus; if required, administer tetanus-diphtheria toxoid (Td) 0.5 mL. Refer to physician if severe reaction, previous history or evidence of allergic sensitivity, general allergic response, or stings around mouth or throat or multiple stings.

5.15 Measles, Mumps, Rubella Vaccination: May administer 2 doses of Measles, Mumps, Rubella Virus vaccine (MMR) 0.5 mL SQ, 4 weeks apart to employees found not to have immunity. . Document in CERNER for CAIR entry.

5.16 Pharyngitis: Advise of OTC analgesics, decongestant if needed. Advise rest, increase fluid intake. Employees with temperature >101 F should be sent home. Refer to physician if antibiotic treatment needed or temperature greater than 101 F.

5.17 Sprain: Rest injured part. Ice to affected part for 15 minutes 4 times a day for 48 hours. Compress injury with dressing to control swelling. Elevate affected part. Advise of OTC anti-inflammatory drugs. Refer to physician if persistent soreness or disability.

5.18 Tetanus, Diphtheria and Pertussis (Tdap) Vaccination: Administer Tdap vaccine, 0.5 mL IM deltoid to employees who have not or unsure if they have previously received a dose of Tdap (one-time dose), as soon as feasible, without regard to the interval since the previous dose of Tdap. Then, should receive Tdap booster every 10 years thereafter. . Document in CERNER for CAIR entry.

5.19 Upper Respiratory Infection (Common cold): Advise of OTC decongestants, analgesics. Advise to increase fluid intake and rest. Employee with temperature >101 F should be sent home. Refer to physician for moderate amounts of purulent sputum, pleuritic chest pain, indications of lower respiratory involvement, severe and/or persistent cold symptoms.

5.20 COVID Vaccine: If available, administer COVID vaccine per CDC recommendations and according to last dose received. If receiving primary series, two doses recommended 0.3mL, 3 weeks apart. If employee has not received 2024-2025 dose, give 1 dose at least 8 weeks after the previous dose. Employees may be reimbursed for COVID vaccine administered elsewhere, if vaccine is not available through IVHD.

6.0 References:

6.1 Clinician Consultation Center. http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide/

6.2 Aerosol Transmission Plan (ATP) CLN-02378
6.3 National Institute for Occupational Safety and Health (NIOSH)
6.4 Treatment of Allergic Reactions 01860-CLN

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

Added section 5.20 regarding COVID vaccine administration.
Added section 3.3 regarding testing for annual tb screening, post exposure testing, conversions.
Added vaccine documentation into CERNER for CAIR entry.
Dr. Al-Jasim added as physician reviewer
Updated from PMDH to IVHD

Imperial Valley Healthcare District

Title: **Hazardous Materials and Waste Management Plan**	Policy No. EOC-00111
	Page 1 of 13
Current Author: Carlos Espinoza	Effective: 8/25/1997
Latest Review/Revision Date: 4/2024	Manual: Hazardous Materials and Waste

Collaborating Departments: Risk/Quality; Human Resource; Safety Officer; Pharmacy		Keywords: Hazardous Materials and Waste Management System	
Approval Route: List all required approval			
	PSQC	Other: Safety Committee	
Clinical Service Radiology 7/2024	MSQC 7/2024	MEC 7/2024	BOD 7/2024

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish, implement, monitor, and document evidence of an ongoing program for the management of hazardous materials and waste.

1.2 To ensure that there is minimal risk to patients, personnel, visitors, and the community environment within the confines of IVHD

2.0 Scope: District wide

3.0 Policy:

3.1 The program describes the responsibilities, functions, and mechanisms the hospital carries out to provide for protection of patient, staff and visitors from all materials, and waste that require specials handling.

3.1.1 The person responsible for implementing this plan is the Environmental Services Manager, (760) 351-4644 at 207 West Legion Road, Brawley, CA 92227.

3.1.2 The Hazardous Materials and Waste Management System consist of these overlapping programs and functions:

3.1.2.1 Risk Management Program
3.1.2.2 Employee Orientation Program
3.1.2.3 Education Program
3.1.2.4 Safety Plan
3.1.2.5 Quality Resources
3.1.2.6 Emergency Management Plan
3.1.2.7 Life Safety Plan
3.1.2.8 Safety Committee
3.1.2.9 Notification Requirements

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 The Hazardous Materials and Waste Management System is implemented by creating, maintaining, evaluating, and improving policies and procedures for managing environmental hazards.

5.2 The process for creating these actions is through the Safety Committee.

5.2.1 To develop a system that addresses the identification of hazardous waste and material from the point of entry into the facility to the point of final disposal.
5.2.2 To develop a system for managing hazardous materials and waste safely
5.2.3 To ensure the policies and procedures related to the various hazardous materials and waste are reviewed, revised, and approved at least annually by the appropriate committees.
5.2.4 To provide adequate supervision of hospital personnel
5.2.5 To enhance coordination and communication among departments, services, and committee of the hospital

5.3 Types of Bio Hazardous Waste generated
5.3.1 Blood or Body Fluids: Liquid blood elements or other regulated body fluids, or articles contaminated with bloody or body fluids.
5.3.2 Sharps: syringes, needles, blades, broken glass
5.3.3 Isolation Waste: Waste contaminated with excretion, exudates, or secretions from humans who are isolated due to highly communicable disease.
5.3.3.1 Pathological Waste
5.3.3.2 Chemo Waste
5.3.3.3 Pharmaceutical Waste
5.3.4 Each of the following classes of waste is separated at the time of generation and placed in the appropriately labeled containers
5.3.4.1 General Waste is all non-hazardous waste that cannot be classified in any other category. It is placed in brown-bagged waste receptacles and transported by the housekeeping department to the compactor. The city garbage company transports this material to the landfill. The environmental services staff is responsible for delivery of all solid waste to the hospital compactor and for delivering all red bagged waste to the holding area.
5.3.4.2 Biohazardous Waste is waste contaminated (soiled) by body fluid or infections' materials placed in red bags and transported in containers to a locked hazardous waste compound.
5.3.4.2.1 Container and Labeling Requirements
5.3.4.2.1.1 Initially in red biohazard bag, labeled with the words Bio Hazardous Waste" or with biohazard symbol and the work "BIOHAZARD"
5.3.4.2.1.2 Secondarily in rigid, leak resistance container with tight fittings lids of any color, labeled with "Biohazardous Waste" or biohazard symbol and the

word “Biohazard” on the lid and sides so as to be visible from any lateral direction.

5.3.4.2.1.3 What can go in the container

5.3.4.2.1.3.1 Cultures and stocks of infections agents

5.3.4.2.1.3.2 Items soaked or caked with blood or other infectious materials

5.3.4.2.1.3.3 Suction canisters

5.3.4.2.1.3.4 ET tubes

5.3.4.2.1.3.5 Culture plates

5.3.4.2.1.3.6 Bloody disposable gowns/gloves

5.3.4.2.2 Storage Requirements: May not be stored longer than 7 days

5.3.4.3 Sharps Waste (needles, syringes, and other sharp implements) are immediately placed in puncture proof disposal containers. When the containers are 2/3 full they are sealed and placed in biohazardous bag infectious waste trash and taken to storage are for biohazard waste pick up.

5.3.4.3.1 Container and Labeling Requirements:

5.3.4.3.1.1 Rigid puncture resistant container that, when sealed, is leak resistant and cannot be opened without great difficulty

5.3.4.3.1.2 Containers should be labeled with the words “sharps waste” or with the biohazard symbol and the word “BIOHAZARD”.

5.3.4.3.1.3 What can go in the container

5.3.4.3.1.3.1 Devices and implements that could potentially puncture or cut the skin, and/or otherwise cause percutaneous injury, e.g.

5.3.4.3.1.3.2 Sharps with or without engineered injury protection

5.3.4.3.1.3.3 All disposable needles

5.3.4.3.1.3.4 All disposable syringes with needles

5.3.4.3.1.3.5 Scalpels/blades

5.3.4.3.1.4 Storage Requirement: May not be stored longer than 7 days.

5.3.4.4 Trace Chemo is disposed of in yellow containers marked Chemotherapy waste. Empty vials, empty IV tubing, gowns, or gloved contaminated from chemo administration.

5.3.4.4.1 The disposal of antineoplastic waste is the joint responsibility of pharmacy, nursing, and environmental services. Pharmacy and nursing personnel are responsible for placing all antineoplastic waste, all trace contaminated (e.g., vials, ampules, IV bottles/gas, tubing and sharps) in the specially marked, yellow collection container labeled with chemotherapy waste hazard

labels. When the container is full, without compacting the locking lid is placed on top and secured. Gowns, gloves, and other non-sharp object may also be deposited in the container. These containers are picked up for transport to an approved Incineration Facility where biohazardous waste is treated. Sharps chemo must be segregated in separate containers from non-sharps to minimize the risk of needle stick.

5.3.4.4.2 Container and Labeling Requirements:

5.3.4.4.2.1 Yellow BD Chemo/Sharps container marked “Chemotherapy Waste”, “CHEMO”. Or other label approved by the CDPH on the lid and sides.

5.3.4.4.3 What can go in the container

5.3.4.4.3.1 Empty vials, empty IV tubing from chemo administration

5.3.4.4.3.2 Gowns and gloves contaminated from chemo administration

5.3.4.4.3.3 Sharps chemo must be segregated in separate container from non-sharps to minimize risk of needle stick

5.3.4.4.4 Storage Requirements: May not be stored longer than 7 days.

5.3.4.5 Pathology Waste including surgery specimens or tissues, limbs labeled pathological waste or pathological containers. These are sealed and collected by housekeeping personnel and taken to storage area for biohazard waste and transported for Incineration Only.

5.3.4.5.1 Container and Labeling Requirements:

5.3.4.5.2 Rigid, leak resistant container with tight fitting lids of any color. Labeled with the words “Pathology Waste”. “PATH” or other label approved by the CDPH on lid and sides so as to be visible from any lateral direction.

5.3.4.5.2.1 What can do in the container

5.3.4.5.2.1.1 Surgery specimens or tissues which have been fixed in formalin or other fixatives. Fixatives must be decanted off prior to disposal.

5.3.4.5.2.1.2 Fetal remains cannot go in these containers. They must be placed in zip lock or sealable plastic containers for disposal to crematorium.

5.3.4.5.2.2 Storage Requirement: May not be stored longer than 7 days.

5.3.4.5.3 For purposes of this subdivision, a container, or inner liner removed from a container, which previously contained a chemotherapeutic agent, is empty if the container or inner liner removed from the container has been emptied by the generator as much as possible using methods commonly employed to

remove water or material from containers or liners, so that the following conditions are met:

5.3.4.5.4 If the material which the container or inner liner held is pourable, no material can be poured or drained from the container or inner level when held in any orientation, including, but not limited to, when tilted or inverted.

5.3.4.5.5 If the material which the container or inner liner held is not pourable, no material or waste remains in the container or inner liner that can feasibly be removed by scraping.

5.3.4.6 Controlled Substances

5.3.4.6.1 Regulatory Reference: California Earthquake Authority, Resource Conservation and Recovery Act (RCRA) and California Medical Waste Mgt. Act

5.3.4.6.2 Container and Labeling Requirements:

5.3.4.6.3 Depends on classification of controlled substances. For the majority that are California only hazardous pharmaceutical wastes, "Incineration Only" or other label approved by the DHS on lid and sides so as to be visible from any lateral direction. *NOTE*: Pharmacy Container not approved for sharp's waste.

5.3.4.6.3.1 What can go in the container

5.3.4.6.3.1.1 DEA Schedule 2-5 narcotics. Most diluted injectable classified as pharmacy waste and must be sent for incineration. Some solids are P & U listed and must be sent as RCRA wastes.

5.3.4.6.3.1.2 Storage Requirements: ON-site for no longer than 90 days. Once the container is ready for disposal, must be emptied at least once per year.

5.3.4.6.3.1.3 Returned of expired medication is sent to Inmar EXP Healthcare, 48021 Warm Spring Blvd, Fremont, CA 94539

5.3.4.7 Pharmaceutical Non-Sharps waste narcotics are put in a container that is labeled incinerate only. They are removed by security and transported to an incinerator site.

5.3.4.7.1 Container and Labeling Requirements:

5.3.4.7.1.1 Rigid, leak resistant container with the tight fitting lid of any color

5.3.4.7.1.1.1 Labeled with the words "Incineration Only" or other label approved by the CDPH on lid and sides so as to be visible from any lateral direction. Waste narcotics are the responsibility of the department generating the waste. Each

department has a sharps container marked (Incinerator only). Waste narcotics, including syringes will be wasted in the container and pills will be grounded up to make them non retrievable. They will be placed in this container and are periodically shipped via medical waste hauler to be incinerated. *NOTE*: Container not approved for sharp's waste.

5.3.4.7.1.2 What can go in the container

5.3.4.7.1.2.1 All non-RCRA pharmaceuticals except list of 24 tested by Kaiser and found to not be California Haz Waste. Contact local Publicly Owned Treatment Works (POTW) to receive approval for sewerage.

5.3.4.7.1.2.2 Partial vials and IV bags containing medications

5.3.4.7.1.2.3 Sharps go in red sharps container.

5.3.4.7.1.2.4 Live and attenuated vaccines

5.3.4.7.1.3 Storage Requirements: On-Site for no longer than 90 days. If <10 lbs/yr can store for 1 year

5.3.4.8 Hazardous Waste chemicals, liquid, dry powder, etc. must be stored in leak proof containers compatible with the waste. Hazardous waste label stating chemical hazard with start date and origin data

5.3.4.8.1 Container and Labeling Requirement

5.3.4.8.1.1 Vary by waste type and volume but must be leak proof and compatible with the waste.

5.3.4.8.1.2 "Hazardous Waste" labels stating chemical hazard, "Accumulation Star Date" and Facility/Department generating waste.

5.3.4.8.2 What can go in the container

5.3.4.8.2.1 All chemical wastes that are characteristically hazardous or listed

5.3.4.8.2.2 All RCRA P&U listed Bulk Chemotherapy Dry Powders (list of 19)

5.3.4.8.2.3 All pharmaceuticals that are RCRA Characteristic or listed waste (see Attachment A-RCRA Table)

5.3.4.8.3 Storage Requirements: Storage time limits vary with generators status and TSDF distance. The responsibility of disposing of

chemical waste rests with engineering under the coordination of Safety Manager.

5.3.4.9 Universal Waste included batteries, mercury thermometers, lamps, fluorescent, neon, sodium vapor, halide, electrical devices, TV sets, telephone, etc.

5.3.4.9.1 Container and Labeling Requirements: vary by waste type.

5.3.4.9.2 What can go in the container

5.3.4.9.2.1 Batteries except Lead Acid, which are hazardous waste, must have accumulation date.

5.3.4.9.2.2 Mercury containing thermostats switches (including motor vehicle light switches), thermometers, dental amalgam, pressure or vacuum gauges, GL dilators, gas, gas flow regulators and more, must have accumulation date.

5.3.4.9.2.3 Lamps, (including all fluorescent), neon, high intensity discharge, sodium vapor and metal halide, must have accumulation date.

5.3.4.9.2.4 Consumer electronic devices including Cathode Ray Tube, TVs, computers, telephones, answering machines, etc. These items must have accumulation date. Imperial Valley Resource Management Agency accepts small quantity e-waste and all documents are collected and filed in the Facilities Office.

5.3.4.9.3 Storage Requirements: not to exceed 12 months from accumulation date.

5.3.4.10 Radiological Waste is the responsibility of the nuclear medicine department and is disposed of in accordance with the Nuclear Regulatory Commission and State of California rules and regulations.

5.3.4.10.1 Liquid radioactive waste will be disposed of in accordance with Section 20.303 of 10 codes of Federal Regulations Part 20. Liquid medical waste is diluted 100 parts water to 1 part waste and flushed to sewer system, only if the waste does not constitute bio hazardous laboratory waste or microbiological specimens as defined in MWMA and (B) discharge is consistent requirements established by the California Regional Water Quality Control Board.

5.3.4.10.2 Waste gases are the responsibility of anesthesia and central supply, who have written procedures for disposal of their waste gases.

5.3.4.10.3 Medical waste is removed from the hospital premises by a licensed Medical Waste Hauler, Thermal Combustion Innovators, Inc., 241 W. Laurel Street, Colton, CA 92324, (909) 370-0730 and transported to an approved incineration facility

where the waste is treated. TCI has an agreement with Healthcare Environmental in Fargo, North Dakota to provide emergency-backup contingency treatment services, along with treatment facilities in Ventura and Los Angeles Counties and in the State of Utah. In case of additional transportation being required, TCI can engage contingency transportation assistance from Black Gold Industries, 527 North Rice Avenue, Oxnard, CA 93030, (805) 981-4616, Aipura LLC, 7106 Marcella Street, Paramount, CA 90723, (213) 814-3644, and other licensed transporters. The monthly averages for the following medical waste hauled are as follows:

5.3.4.10.3.1 Bio-Sharp 6817.1lbs.
5.3.4.10.3.2 Path 174.5 lbs.
5.3.4.10.3.3 Chemo 104.5 lbs.
5.3.4.10.3.4 Pharm 678.9 lbs.

5.3.5 The control of all hazardous materials and waste in the institution will be done by one of the following methods:

5.3.5.1 Containment
5.3.5.2 Dilution
5.3.5.3 Disinfection
5.3.5.4 General Housekeeping
5.3.5.5 Isolation
5.3.5.6 Neutralizing
5.3.5.7 Segregation
5.3.5.8 Substitution
5.3.5.9 Ventilation
5.3.5.10 Wetting

5.3.5.10.1 All of PMHD clinics generate biohazardous waste. A current Limited Quantity Hauling Exemption is maintained for each site. Waste is delivered by designated personnel to PMHD Biohazardous Waste Storage Facility then transported to a licensed treatment facility.

5.3.5.10.2 The hospital will not accept Biohazardous waste from any other facility not covered under The Limited Quantity Hauling Exemption.

5.3.6 Bio hazardous Waste is contained separately from other wastes at the point of generation. In non-patient areas, solid waste is not to be disposed of in biohazardous waste containment devices. When cleaning patient care areas, Environmental Services will placed all biohazardous waste into RED biohazard bags labeled with the words, “Biohazard”. These bags are to be impervious to moisture and have strength sufficient to preclude ripping, tearing, or bursting under normal use and handling. The biohazard bag used must be constructed of material that will pass the 165 gram dropped dart impact resistance test as

required by Standard D of the ASTM documentation from the manufacturer of compliance with these minimum construction standards will be kept on file in the safety office. All waste placed in a red biohazardous bag will be considered to be biohazardous waste. The bags will be carefully tied to prevent spillage in the event the bag is dumped upside down. All sharps will be placed in a sharps container labeled with the works “SHARPS WASTE” or with the international biohazard symbol and the word “Biohazard”. Sharp container will be in rigid puncture proof containers that when sealed is leak resistant and cannot be reopened without great difficulty. Sharps containers shall be considered “full” when they reach 2/3 capacity or the manufacturers full line. Lids on filled sharps containers must be snapped closed, taped, or otherwise sealed to prevent loss of contents prior to disposal. Bio Hazardous waste will be stored and transported in rigid containers to the biohazardous waste storage area. The containers will be labeled with the words “Biohazardous Waste”, or the word “Biohazard”, and the international biohazard symbol. This storage area will be locked at all times. Access will be limited to environmental services and engineering department personnel and the key will be available only from the environmental services office.

5.3.6.1 Waste consisting of medical and non-medical waste will be handled as biohazardous waste except as follows:

5.3.6.1.1.1 Bio hazardous waste mixed with hazardous waste will be treated as hazardous waste.

5.3.6.1.1.2 Bio hazardous waste mixed with radioactive waste will be treated as radioactive waste.

5.3.6.1.1.3 Bio Hazardous waste mixed with hazardous and radioactive waste will be treated as radioactive waste.

5.3.7 All biohazardous waste will be collected and stored in the locked biohazardous waste storage area until transported by the bio hazardous waste hauler. All biohazardous waste shall be stored handled or transported in containers that are leak resistant, have tight fitting covers, and are kept clean and in good repair. This area shall be marked with warning signs saying in English, “CAUTION BIOHAZARDOUS WASTE STORAGE AREA – UNAUTHORIZED PERSONS KEEP OUT,” and in Spanish, “CUIDADO – ZONA DE RESIDUOS BIOLOGICOS PELIGROSOS – PROHIBIDA LA ENTRADA A PERSONSA NO AUTHORIZADA”. Biohazard bags and filled sharps containers shall not be stored for more than 7 days at a temperature above 32 degrees Fahrenheit. This 7-day period begins when any waste has been placed in the bag container. All reusable rigid containers that are used for accumulation, transportation, and storage of biohazardous waste shall be washed and decontaminated after a maximum of 7 days or less if visibly soiled. The approved method for decontamination at this hospital is the use of a bleach solution diluted 1:10. The solution should be

allowed contact with the surface for a minimum of 3 minutes. The amount of solution mixed will be no more than can be used at any one time.

5.3.8 Records of biohazardous waste will be kept in the facilities office and retained for a minimum of seven years.

5.4 Emergency Response Procedure

5.4.1 Please refer to Policy # DPS-00534, Emergency Action Plan for Cleanup of Medical Waste Spills for details.

5.4.2 The manager of the hazardous materials and waste management system components develop and maintain emergency procedures and controls designed to assure rapid, effective response to spills and releases of or exposures

5.4.3 The emergency procedures and controls are designed to evaluate spills to determine if outside assistance is necessary. Incidental spills are managed by staff with training appropriate to the type of spill. All spills are documented as incidents.

5.4.4 Spills exceeding the capability of the trained staff of PMHD to neutralize the hazard and to manage the cleanup and disposal of the waste generated require implementation of the emergency response plan. In all such cases, the Incident Commander assigns qualified staff to assess the area affected to determine if evacuation, ventilation, isolation, or other actions are required to manage the hazards until a commercial or fire department HAZMAT team arrives on site. The PMHD Incident Commander works with the outside Incident Commander to coordinates the procedures for neutralizing and cleaning up the spill in a manner that minimizes human and environmental impact.

5.4.5 The incident commander and the safety officer prepare and file appropriate QRR incident reports with the risk manager and with outside regulatory agencies as required.

5.4.6 If spill kits, personal protective equipment, or other equipment and supplies were expended during the management of a spill, the safety officer is responsible for acquiring and stocking replacements to appropriate areas.

5.4.7 Safety Monitoring

5.4.7.1 Area monitoring, and staff monitoring, for dangerous levels of hazardous materials and waste are done individually in the applicable departments according to all applicable laws and regulations. Finding from these reports are submitted to the Patient Safety Quality Council.

5.4.8 Alcohol Based Hand Cleaners

5.4.8.1 Notwithstanding any provisions of the 2012 edition of the Life Safety Code to the contrary, a hospital may install alcohol-based hand rub dispensers in its facility if:

5.4.8.1.1 Use of alcohol-based hand rub dispensers does not conflict with any state or local codes that prohibit or otherwise restrict the

placement of alcohol-based hand rub dispensers in health care facilities;

5.4.8.1.1.1 The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

5.4.8.1.1.2 The dispensers are installed in a manner that adequately protects against inappropriate access;

5.4.8.1.1.3 The dispensers are maintained in accordance with dispenser manufacturer guidelines;

5.4.8.1.1.4 If dispensers are stored in corridors, the corridor must be a minimum of 72 inches;

5.4.8.1.1.5 The maximum individual dispenser fluid capacity shall be:

5.4.8.1.1.5.1 1.2 liters (0.3 gallons) for dispensers in rooms, corridors, and areas open to corridors.

5.4.8.1.1.5.2 2.0 liters (0.5 gallons) for dispensers in suites of rooms

5.4.8.1.1.6 The dispensers shall have a minimum horizontal spacing of 4 ft. (1.2m) from each other.

5.4.8.1.1.7 Not more than an aggregate 37.8 liters (10 gallons) of alcohol base hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet.

5.4.8.1.1.8 Storage of quantities greater than 18.9 liters (5 gallons) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.

5.4.8.1.1.9 The dispensers shall not be installed over or directly adjacent to an ignition source;

5.4.8.1.1.10 In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.

5.4.8.1.1.11 Where minimum corridor width is 72 inches (1830 mm), projections of maximum 6 inches (152 mm) from the corridor wall, above the handrail, shall be

permitted for the installation of hand-rub dispensing units.

5.5 In anesthetizing locations, which use alcohol-based skin preparations, have implemented effective fire risk reductions measures which include:

5.6 The use of unit dose skin prep solutions;

5.7 Application of skin prep follows manufacture/supplier instructions and warnings;

5.8 Sterile towels are used to absorb drips and runs during the application and then removed from the anesthetizing location prior to draping;

5.9 Verifying that all of the above has occurred prior to initiating the surgical procedure

5.10 Nonflammable medical gas located outside of an enclosure, in use for patients, does not exceed 300 cubic feet per smoke compartment.

5.11 Enforcement is necessary for the safe day-to-day operation, management, and coordination of a Hazardous Materials and Waste Management System. Enforcement is not an end unto itself, rather a means to achieve a goal of lessening and/or abating the hazardous materials and waste generated within the hospital. The principal ingredients of enforcement of this plan will be:

5.12 The Hazardous Material and Waste Management Plan of PMHD is reviewed annually by the following committees:

- 5.12.1 Safety Committee for chemical waste and physical hazards
- 5.12.2 Radiation Safety Committee for radioactive waste hazards.
- 5.12.3 The Annual Report will be presented to the Board of Directors for approval.
- 5.12.4 Departmental policies and procedures are reviewed and revised annually.
- 5.12.5 The Environmental Services Manager will be the liaison between the staff, department, administration, and outside agencies.
- 5.12.6 Coordinated enforcement with outside agencies, such as Emergency Water Plan, Fire Plan, and Community Disaster Plan, etc
- 5.12.7 Review and evaluation of individual case reports of incidents/and or accidents.
- 5.12.8 Establishment and maintenance of a record-keeping system, i.e. Safety Data Sheet (SDS), etc
- 5.12.9 Implementation of all measures outlined in this plan
- 5.12.10 Systematic monitoring to assure compliance with the different segments of the plan.

5.13 Emergency Action Plan

- 5.13.1 While it is highly unlikely that our waste management service would experience a shutdown of operations, contingencies includes use of an alternate hauler or retention of the medical waste for no more than 7 days. Another contingency for less well-defined emergency situations would be to contact the Department of Public Health Medical Waste Program for guidance.
- 5.13.2 Our Medical Waste Management Company has agreed to assist PMHD in the event of a natural disaster to handle bio-hazardous waste. In order to prevent

interruption of services in the event of an emergency, PMHD has on file a backup waste management service.

6.0 References:

6.1 Medical Waste Management Act (H&S Code 11760-118360)
6.2 CEA, RCRA and California Medical Waste Management Act
6.3 Title 40, Code of Federal Regulations and Title 22, California Code Regs
6.4 California Health & Safety Code 25150.6
6.5 NFPA 30 “Flammable and Combustible Liquids Code”
6.6 OSHA 29 CFR 1910
6.7 EPA
6.8 USP 797 – Pharmacy Compounding
6.9 NRC – Nuclear Regulatory Commission
6.10 CMS CoP – Centers for Medicaid and Medicare Services Conditions of Participation
6.11 DNV NIAHO National Integrated Accreditation for Healthcare Organizations – Physical Environment Chapter – PE.5, SR.1, SR.2, SR.3, SR.4, SR.5, SR.6, SR.7,

7.0 Attachment List:

7.1 Attachment A – RCRA P and U

8.0 Summary of Revisions:

8.1 Removed contact name and changed phone number 3.1.1
8.2 Changed PMHD to IVHD

I declare under penalty of law that to the best of my knowledge and belief that the statements made herein is complete and accurate.

Signature/Title: _____ Date: _____
Manager of Environmental Services

Signature/Title: _____ Date: _____
Chief Executive Officer

RCRA P-Listed Waste Codes		
Note: must contain constituent as sole-active ingredient and be unused or discarded		
Waste Code	**Constituent of Concern**	**Product Name Examples:**
P001	Warfarin & salts (concentration > 0.3%)	Coumadin; Warfarin
P012	Arsenic trioxide	Trisenox
P042	Epinephrine	Adrenalin; EpiPen; Eppy/N; Epifrin; Epinal; Anaphalaxis kit; Epinephrine (inhalants, injectibles, kits); Racepinephrine; Racord; Primatene aerosol inhaler
P046	Phentermine	Phentermine (CIV)
P075	Nicotine & salts	Nicotine patches; Habitrol; Nicoderm; Nicorette; Nicotrol; Tetrahydronicotyrine
P188	Physostigmine salicylate	aka Eserine salicylate
P204	Physostigmine	aka Eserine

RCRA U-Listed Waste Codes		
Note: must contain constituent as sole-active ingredient and be unused or discarded		
Waste Code	**Constituent of Concern**	**Product Name Examples:**
U010	Mitomycin C	Mitomycin; Mitomycin C; Mutamycin; Mutamycin VHA Plus
U015	Azaserine	Chemotherapy for leukemia
U034	Chloral / Chloral hydrate	Chloral hydrate (CIV)
U035	Chlorambucil	Leukeran
U044	*Chloroform*	*Not commonly seen*
U058	Cyclophosphamide	CTX; Cytoxan injection, Lycophilized/VHA Plus; Neosar; Procytox
U059	Daunomycin	Daunorubicin, Cerubidin, DaunoXome, Rubidomycin; Liposomal; Idarubicin/Idamycin; Daunomycin
U075	Dichlorodifluoromethane	Dichlorodifluoromethane
U089	Diethylstilbesterol	Diethylstilbestrol, DES (synthetic estrogen), Stilphostrol
U121	Trichloromonofluromethane	Trichlorofluoromethane
U129	Lindane	G-Well shampoo; Kwell; shampoo
U132	Hexachlorophene	Phisohex disinfectant
U150	Melphalan	Alkeran; L-PAM; Melphalan
U151	Mercury	Mercurochrome; Mercury iodide; Mercury chloride; Mercury sulfate

U182	Paraldehyde	Paral; Paraldehyde (CIV)
U187	Phenacetin	Acetophenetidin; typically veterinary
U188	Phenol	Phenol; Liquified phenol
U200	Reserpine	Resperine
U201	Resorcinol	Resorcinol
U205	Selenium sulfide	Exsel shampoo; selenium sulfide; Selsun
U206	Streptozotocin	Streptozotocin; Streptozocin; Zanosar
U237	*Uracil mustard*	*Not commonly seen: Uracil mustard; Uramustine*
U248	Warfarin & salts (concentration ≤ 0.3%)	Warfarin

Imperial Valley Healthcare District

Title: **Hepatitis B Vaccination Program**	Policy No. HRD-00109 Page 1 of 2
Current Author: Lizbette Cordova, RN	Effective: 11/1/1993
Latest Review/Revision Date: 08/2024	Manual: HR / Employee Health

Collaborating Departments: Infection Control, Pharmacy, Dr. Mohammed Al-Jasim	Keywords: Hepatitis, Exposure		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 12/2024		
Clinical Service _____	MSQC 3/2025	MEC 3/2025	BOD 3/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 For the protection of employees against the Hepatitis B virus (HBV)

2.0 Scope:

2.1 Employees at risk for occupational exposure to blood or other potentially infectious body fluids/material. The program is also open to physicians.

3.0 Policy:

3.1 Vaccine shall be offered at no cost to employees identified to be at risk for occupational exposure to blood or other potentially infectious body fluids/material. Refusal to be immunized will be documented. Employee may change their mind and be immunized.

3.2 High-risk areas are considered to be Emergency Department, Surgery, all nursing units, including clinics, Laboratory, Radiology, Cardio-Pulmonary, Environmental Services, Bio-Med, Security, and Engineering.

3.3 Human Resources and the Employee Health Nurse will coordinate the program. Records will be maintained by Employee Health/Human Resources.

4.0 Definitions:

4.1 Hepatitis B is a virus infection of the liver caused by Hepatitis B Virus (HBV). Body substances capable of transmitting HBV include: blood and blood products; cerebrospinal fluid; peritoneal, pleural, pericardial and synovial fluid; amniotic fluid; semen and vaginal secretion, and other body fluid containing blood. Transmission occurs by percutaneous, (Intravenous, intramuscular, subcutaneous, or intradermal) and permucosal exposure to infective body fluids.

5.0 Procedure:

5.1 During the hiring process, immunity status will be obtained by a blood test.

5.2 All employees shall be informed of the vaccination program at the time of hire and as part of the orientation program/physical.

5.3 If employees do not have proof of immunity by either a blood test or proof of previously received vaccine series, they must either receive or decline the vaccine. If the employee declines the vaccine, they may change their mind and receive it, in the future.

5.4 Employees will receive the vaccination during the new hire physical or contact the Employee Health Nurse in the Human Resources Department to arrange vaccination.

5.5 Three doses of the vaccine are required to achieve immunity; at 1 and 6 months from first dose.

5.6 Antibody testing may be done 1 to 2 months after the 3rd dose.
5.7 If antibody level is less than 10, the vaccination series will be repeated one time.

6.0 References:

6.1 Cal/OHSA – http://www.dir.ca.gov/title8/5193.html
6.2 Centers for Disease Control
6.3 Immunization Action Coalition
6.4 Occupation Safety and Health Administration – https://www.osha.gov/OshDoc/data_BloodborneFacts/bbfact05.html

7.0 Attachment List:

7.1 Attachment A – Informed Consent for Hepatitis B Vaccine

8.0 Summary of Revisions:

8.1 Scheduled Revision; no changes to intent
8.2 Updated from PMHD to IVHD
8.3 Added Dr. Al-Jasim as physician reviewer

tis B Vaccination Consent Form

Name:	Date of Birth:
Department:	Position/Title:

Hepatitis B is a virus infection of the liver caused by Hepatitis B Virus (HBV). Most people with Hepatitis recover completely, but approximately 5-10% becomes chronic carriers of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis; HVB also appears to be a causative factor in the development of liver cancer. Thus, immunization against Hepatitis B can prevent acute hepatitis and reduce sickness and death from chronic active hepatitis, cirrhosis, and liver disease.

ENGERIX B is a non-infectious viral vaccine produced in yeast cells. It is manufactured synthetically and free of association with human blood or blood products. No substances of human origin are used in its manufacture. It is supplied as a sterile solution for intramuscular injection in the deltoid (arm) muscle. Possible Side Effects: No serious side effects have been reported with the vaccine. There may be tenderness and redness at the site of injection.

Contraindications

Persons who should not receive Hepatitis B Vaccine are:

- Allergic to Yeast,
- Pregnant – studies have not been conducted to its safe use.
- Nursing Mothers – it is not known if it is excreted in milk.

CONSENT

I have read the information and have the opportunity to ask questions. I understand the benefits and risk of Hepatitis B Vaccination. I understood that I must have three (3) doses of vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from it. I request that it be given to me.

Print Name: _____

Signature: _____ Date: _____

Date Vaccinated	Site	Manufacturer	Lot Number/Expiration Date	Administered by
#1				
#2				
#3				
Antibody Testing (To be done one (1) month after the third (3rd) dose). Result:				

DECLINATION:

I decline to receive the Hepatitis B Vaccine and understand that I may be at risk of acquiring the Hepatitis B Virus. If I change my mind at a later date, I will still be able to receive the Hepatitis B Vaccine at no charge to me. Reason for declining vaccination:_____

Print Name _____ Signature _____ Date _____

Imperial Valley Healthcare District

Title: **Influenza Vaccination Program**	Policy No. HRD-00100
	Page 1 of 2
Current Author: Lizbette Cordova, MSN	Effective: 3/5/2008
Latest Review/Revision Date: 07/12/2024	Manual: HR / Employee Health

Collaborating Departments: Infection Control, Employee Health, Pharmacy, Dr. Mohammed Al-Jasim	Keywords: Flu shots		
Approval Route: List all required approval			
	PSQC	Other: Safety Committee	
Clinical Service _____	MSQC 03/2025	MEC 03/2025	BOD 03/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 Minimizing the transmission of influenza between healthcare workers and patients is a major component of patient and healthcare worker safety. To help protect staff, non-employees, patients, and families of Imperial Valley Healthcare District from acquiring seasonal influenza and to help prevent the unnecessary spread of the influenza virus between employees, non-employees, patients, and families the influenza vaccination is offered annually. The virus is spread from person to person through coughing and sneezing.

2.0 Scope:

2.1 The program is available to all District Employees, Physicians, Adult Volunteers, Contract Employees, Students, Job Shadows, Nursing Instructors, and Board of Directors.

3.0 Policy:

3.1 Immunization against influenza is offered at no cost.

3.2 Healthcare Workers (HCW) are offered the influenza (flu) vaccine each year. The program will generally begin in the fall and extend through the winter, prior to the expected "flu season".

3.3 Employees must consent or decline to influenza vaccine each year.

3.4 All staff (employees, contracted employees and volunteers) who refuse or are not able to take the flu vaccination will be required to wear a mask (regardless of reason) while working in the organization, with the exception of restrooms, staff lounges (while on a designated break), cafeteria and all off-site non-clinical buildings.

3.5 A legible, written record of current flu vaccination from outside providers will be accepted as proof of vaccination.

3.6 Acceptable proof of vaccination (from another facility) for medical staff, is either a signed IVHD consent form (checking the box stating that this year's flu vaccine was already received), written record of current flu vaccination from outside providers or a signed letter stating that they have completed the flu shot requirement, elsewhere.

3.7 Staff without documentation of the flu vaccination will be required to wear a mask during the influenza season to be determined by the Centers of Disease Control, the California Department of Public Health and/or the Infectious Disease Physician.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 The program will be coordinated by the Human Resources/Employee Health and Infection Control Departments.

5.2 Administration of the vaccine will begin each year as recommended by the Centers of Disease Control and the California Department of Public Health.

5.3 Administration of vaccinations will be coordinated by Employee Health and Infection Control.

5.4 Vaccination administration schedules will be announced by department managers, IVHD e-mail and posted flyers.

5.5 HCWs who receive the flu vaccine will receive a sticker for their name badge.

5.6 HCWs who do not receive the flu vaccine and who do not wear a mask while working in the acute care environment will be considered non-compliant and will be removed from duty without pay until they comply with these requirements.

6.0 References:

6.1 Aerosol Transmission Plan (Employee Health Services: 5199 ATD (h) page 8)

6.2 Aerosol Transmissible Disease Standard

6.3 California Department of Public Health

6.4 American Hospital Association Quality Advisory – July, 2011

7.0 Attachment List:

7.1 Attachment A – Consent Mandatory Decline Influenza

8.0 Summary of Revisions

8.1 Annual review; no changes to intent

8.2 Updated from PMDH to IVHD

8.3 Added Dr. Al-Jasmin as physician reviewer

Declination of Influenza Vaccination 2024-2025

Name:	**Date of Birth:**
Department:	**Position/Title:**
□ Hospital □ SNF □ Physician/Midlevel Provider □ Student □ Volunteer □ Traveler/Contract	

My employer or affiliated health facility, **Imperial Valley Healthcare District**, has recommended that I receive influenza vaccination to protect the patients I serve.
I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
  - all patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

If NO, please check all the following that apply:

☐ a. Fear of injection (sore arm, tenderness)

☐ b. Fear of getting influenza from the vaccine

☐ d. Medical Contraindication

☐ e. Other, specify:

_____

_____

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring **seasonal influenza**. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring **influenza.** If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.. **I also understand that if I decline to receive the influenza vaccine (regardless of the reason) that I will be required to wear a mask while working in the organization, with the exception of restrooms, staff lounges (while on a designated break), and the cafeteria.**
I have read and fully understand the information on this declination form.

Signature: _____

Date: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—

Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

www.immunize.org/catg.d/p4068.pdf • Item #P4068 (10/11)

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011.
Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

2024-2025 Influenza Vaccine Consent

(Please Print Clearly)

Return form to Employee Health

Name:	**Date of Birth:**
Department:	**Position/Title:**
□ Hospital □ SNF □ Physician, NP, PA, Midwife (APP-Medical Staff) □ Student □ Volunteer □ Traveler/Contract	

Yes	**No**	**(Permanent Contra-indications)**
☐	☐	1. Have you ever had Guillian-Barre Syndrome?
☐	☐	2. Have you ever had an anaphylactic reaction to the influenza vaccine?

☐ **Yes, I would like to have the influenza vaccination given to me**

☐ *I have had the flu shot already this year.* (Must provide proof)*

☐ I am not able to receive the flu shot due to permanent contraindication 1 – 2 above.

*****Cerner registration is required for CAIR vaccine data submission******

X _____

Signature **Date**

For Healthcare Provider Use Only

Vaccine Manufacturer: Lot #: Expires:

Site: ☐ Left deltoid ☐ Right deltoid Dose: 0.5ml VIS: 08/06/2021

Signature: (**RN / LVN**) Date:

Imperial Valley Healthcare District ***REVIEWED ANNUALLY***

Title: **Standardized Procedure for Registered Nurses: Neonatal Endotracheal Intubation**	Policy No. CLN-00236 Page 1 of 7
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 11/1/1995
Latest Review/Revision Date: 02/20/2025	Manual: Clinical / Nursery/NICU

Collaborating Departments: Perinatal; Neonatal Dr Alshareef, NICU Manager	Keywords: Intubation, Neonatal Intubation		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Credentials 3/2025 OB/Peds 4/2025	MSQC 5/2025	MEC 5/2025	BOD 6/2025

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
CHIEF EXECUTIVE OFFICER		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

NOTE: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This standardized procedure is designed to establish guidelines that allow the Neonatal Advanced NRP RN to perform neonatal endotracheal intubation.

2.0 Scope: Neonatal Advanced NRP RN only

3.0 Policy:

3.1 Only approved RNs may function under any Standardized Procedure. The Advanced NRP RN may perform endotracheal intubation on neonates as outlined in procedure.

3.2 Circumstances under which the competency validated Advanced NRP RN may perform endotracheal intubation:

3.2.1 In the Perinatal/Neonatal Department of Pioneers Memorial Hospital

3.2.2 In the Emergency Department of Pioneers Memorial Hospital

3.3 When possible, the physician should be contacted before the procedure. In all emergencies, the primary physician will be notified as soon as possible while advanced life support is being initiated.

3.4 Scope of Supervision – The competency validated Advanced NRP RN will receive:

3.4.1 Indirect supervision by the attending physician

3.4.2 A physician will be available at all times for consultation

3.5 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.

3.6 RN Requirements

3.6.1 Education/Training/Experience
- 3.6.1.1 The Advanced NRP RN will have been a Registered Nurse for a minimum of 3 years with at least 3 years of Neonatal Nursery experience
- 3.6.1.2 The RN will be certified in all aspects of NRP

3.6.2 Initial and Ongoing Competency Evaluation
- 3.6.2.1 Initial competency will be validated by the physician or experienced Advanced NRP RN
- 3.6.2.2 The Advanced NRP RN will successfully complete three (3) endotracheal intubations under direct supervision of the physician or experienced Advanced NRP RN before being allowed to perform the procedure without direct supervision

3.6.3 Annual Competency Assessment
- 3.6.3.1 Complete three (3) successful endotracheal intubations supervised by a physician or experienced Advanced NRP RN
- 3.6.3.2 If minimum number of annual procedures is not obtained, the following are options for competency maintenance:
  - 3.6.3.2.1 Attend skills lab offered biannually (procedure review & simulation)
  - 3.6.3.2.2 Competency validation test and demonstration of skill

3.6.4 This Standardized Procedure will be subject to periodic review by the appropriate interdisciplinary committees

4.0 Definitions:

4.1 Endotracheal Intubation – The placement of a flexible plastic tube into the trachea to maintain an open airway or to serve as a conduit through which certain drugs may be administered
4.2 CO2 – Carbon dioxide
4.3 LMA – Laryngeal Mask Airway
4.4 NRP – Neonatal Resuscitation Program
4.5 Competency Validation – Has completed required education, demonstrated competency and completes ongoing competency validation as required
4.6 EMR – Electronic Medical Record
4.7 RSI – Rapid Sequence Intubation

5.0 Procedure:

5.1 Database

5.1.1 Subjective
- 5.1.1.1 Historical information relevant to present illness

5.1.2 Objective
- 5.1.2.1 Physical examination with focus on pulmonary and cardiovascular systems

5.1.3 Assessment

5.1.3.1 Decision for endotracheal intubation will be based upon subjective and objective data and in collaboration with the attending physician when not an emergent life-saving maneuver

5.1.4 Plan

5.1.4.1 Parents/primary caregivers will be provided with the appropriate information prior to initiation of the endotracheal intubation procedure if not an emergent lifesaving procedure, and obtain consent as per hospital protocol

5.1.4.2 A chest x-ray will be obtained upon completion of the procedure

5.1.4.3 Inability to intubate the trachea

5.1.4.4 Inability to oxygenate or ventilate effectively

5.1.4.5 Trauma, including tracheal or hypoxemia, bradycardia, cardiac arrest

5.1.4.6 If the patient's condition is unstable

5.1.4.7 If there are any complications or unexpected outcomes from the procedure

5.2 Indications

5.2.1 When continued positive pressure ventilation or mechanical ventilation is required

5.2.2 To resolve a critical upper airway obstruction or protect airway due to the inability to clear secretions

5.2.3 To provide selective bronchial ventilation

5.2.4 To obtain a sterile specimen for tracheal culture

5.2.5 To provide ventilation for suspected congenital diaphragmatic hernia

5.2.6 To administer surfactant therapy

5.3 Contraindications

5.3.1 In the neonatal population, there is not conclusive contraindication for intubation. Cervical injuries would be contraindication for use of a laryngoscope; however injuries of this type are infrequent in this patient population.

5.4 Equipment

5.4.1 Select appropriate size of endotracheal tube

5.4.1.1 2.5 for infant less than 1000 grams

5.4.1.2 3.0 for infant 1001-2000 grams

5.4.1.3 3.5 for infant 2001-3700 grams

5.4.1.4 3.5-4.0 for infant 3701-4500 grams

5.4.2 Sterile stylet (optional)

5.4.3 Laryngoscope – blades for term and preterm infants

5.4.3.1 #0 blade for preterm infants

5.4.3.2 #1 blade for full term infants

5.4.4 Positive pressure device – resuscitation bag/mask, manometer and oxygen/air source with blander and analyzer, oxygen tubing

5.4.5 Wall suction and 6fr, 8fr and 10fr suction catheters

5.4.6 Stethoscope

5.4.7 Carbon dioxide (CO_2) detector

5.4.8 Pulse oximeter with neonatal probe
5.4.9 Personal protective equipment such as gloves
5.4.10 Adhesive tape or endotracheal intubation securing device

5.5 Considerations
5.5.1 Prepare equipment prior to starting the procedure. Keep equipment ready and available near bedside of patients that will likely require intubation
5.5.2 Use appropriate sized tubes for the patient to minimize airway trauma
5.5.3 Each intubation attempt should be limited to 30 seconds to minimize hypoxia of patient
5.5.4 Interrupt an unsuccessful attempt with bag and mask ventilation. The one exception is a diagnosed or suspected diaphragmatic hernia
5.5.4.1 If the patient has a known congenital diaphragmatic hernia, try to avoid bag and mask ventilation prior to intubation
5.5.5 Ensure the visualization of the larynx. Have an assistant maintain good position of the patient without hyperextending or rotating the neck
5.5.6 Do not use pressure or force that may cause trauma. Avoid using a rocking motion with the laryngoscope, using extensive pressure on the external trachea, or pushing the tube against any obstruction.
5.5.7 Make sure all attachments are secure and in a careful position to avoid dislodging, kinking or moving the endotracheal tube.
5.5.8 Avoid pushing the endotracheal tube in too far to avoid right main stem bronchus intubation.
5.5.9 Recognize factors that may lead to spontaneous extubation, such as increased oral secretions, infant activity, frequent repositioning, tube slippage
5.5.10 RSI when in the presence of a physician
5.5.10.1 RSI in the neonate has been shown to reduce the number of intubation attempts and decrease the amount of time needed for neonatal intubation. RSI should be strongly considered prior to intubation, except for emergent intubation during resuscitation or in the delivery room. Medications with rapid onset and short duration of action are preferred. Preferred medications include analgesic agents or anesthetic dose of a hypnotic drug, vagolytic agents and rapid-onset muscle relaxants.

5.6 Guidelines for Procedure/Practice:
5.6.1 Prior to procedure, perform “Time Out” Universal Protocol according to hospital policy
5.6.2 Proceed with RSI if clinically indicated and/or appropriate
5.6.3 Choose the appropriate sized tube based on weight or gestational age. Stylet is optional. While maintaining aseptic technique, thread sterile stylet inside endotracheal tube being careful to not advance the stylet beyond the end of the tube.
5.6.4 Choose appropriately sized blade, Open blade and ensure working light. Hold blade in left hand with thumb and first three fingers with blade directed at patient.

5.6.5 Clear oropharynx with gentle suctioning using suction catheter
5.6.6 Empty stomach
5.6.7 Pre-oxygenate infant with bag and mask ventilation as indicated. Follow heart rate and oxygenation on monitor.
5.6.8 Position and stabilize infant with head midline and neck slightly extended in the sniffing position. It may be helpful to place a roll underneath the patient's shoulders.
5.6.9 Open a sterile towel to place equipment on (blade and ETT) between attempts
5.6.10 Open infant's mouth with right index finger, depress and move tongue towards the left side of the mouth. Do not use the laryngoscope to open mouth.
5.6.11 Insert laryngoscope blade into the mouth sliding the blade along the tongue until the tip is resting in the vallecula (area between base of tongue and epiglottis). In extremely premature infant, it may be appropriate to use the blade tip to lift epiglottis.
5.6.12 Lift the laryngoscope blade slightly, lifting the tongue out of the way to expose the pharyngeal area allowing visualization of the epiglottis and glottis. Lift the entire blade with one motion. Do not use a rocking motion.
5.6.13 Suction if necessary
5.6.14 Identify marks. It may be helpful to have an assistant apply gentle pressure on eternal trachea to bring the glottis into view.
5.6.15 Once vocal cords and trachea are visualized, with the endotracheal tube in the right hand, introduce it to the right side of the mouth to maintain direct visualization of the glottis. When the vocal cords are apart, place the tube through the cords approximately 2 cms, or until the vocal cord guide is at the level of the cords.
5.6.16 If the cords are together, wait for them to open. Do not touch the cords with the tube. Do not force the tube between closed cords. If the cords do not open in seconds, stop and ventilate with bag and mask.
5.6.17 Try to limit the intubation attempt to 30 seconds. If infant's vital signs become unstable or if the endotracheal tube is thought to be misplaced in the esophagus, remove tube and administer positive pressure ventilation. Place endotracheal tube on sterile towel to maintain sterile/clean equipment before next intubation attempt.
5.6.18 Once the tube has passed through vocal cords, stabilize the tube and carefully remove the laryngoscope. Continue to stabilize the tube and carefully remove the stylet, if used.
5.6.19 Confirm placement by placing a CO2 detector on end of tube, attach a ventilation bag and assess for color change when giving positive pressure ventilation. Have assistant listen to chest to ensure equal breath sounds and chest rise bilaterally. No breath sounds should be heard over the stomach.
5.6.20 Verify tube depth. Once verified, secure the tube to the infant's face using adhesive tape or other endotracheal tube securing device.

Weight (kg)	Depth of insertion

	(cm mark at upper lip)
Babies less than 750 grams	5.5-6
1	7
2	8
3	9
4	10

5.6.21 Obtain chest x-ray to verify correct placement (tip of endotracheal tube at T2-3)

5.7 Documentation

5.7.1 A written consent per hospital protocol will be obtained and placed in the patient's medical record prior to the procedure if not a lifesaving procedure. If consent is not obtained in advance, the parent/guardian is to be notified as soon as possible after procedure.

5.8 Laryngeal Mask Airway application

5.8.1 LMA's may be utilized for resuscitation in neonates over 1500gms. Size 1

5.8.2 Using clean technique, removed the device from the sterile package

5.8.3 Deflate the cuff following manufactures recommendations

5.8.4 Stand at the baby's head and position the infant in a sniffing position

5.8.5 Hold the device along the airway tube with the closed bottom if the mask facing the baby's palate and the open bowl of the mask facing towards the baby's chin

5.8.6 Open the baby's mouth by pressing gently downward on the baby's chin

5.8.7 Insert the leading tip of the mask into the baby's mouth, on top of the tongue, with the bottom of the mask pressed against the baby's palate

5.8.8 Glide the device downward and backward, following the contour of the palate, with a continuous but gentle push until you feel definitive resistance

5.8.9 Holding the tube in place, attach a CO2 detector and PPV device.

5.8.10 Begin PPV and secure the device following the manufactures recommendation for cuff inflation

5.8.11 If the LMA is correctly inserted and you are providing ventilation that inflates the lungs, you should detect exhaled CO2 within 8-10 positive pressure breaths. You should see synchronized chest wall movement and hear equal breath sounds when you listen with a stethoscope. You should not hear a large leak of air coming from the mouth or see a growing bulge in the baby's neck.

5.8.12 Babies can breathe spontaneously through the device, crying and grunting sounds may be audible

5.8.13 Removing the LMA:

5.8.13.1 The airway can be removed when the baby establishes effective spontaneous respirations and the device is no longer needed or when an endotracheal tube can be inserted successfully.

5.8.13.2 When the device is to be removed, suction secretions from the mouth and throat before you remove the device.

5.8.13.3 Deflate the cuff before removal of the LMA

6.0 References:

6.1 American Academy of Pediatrics, American Heart Association, Neonatal Resuscitation Textbook 8th edition (2021)

6.2 Trevisanutp, D. MD, et al "The Laryngeal Mask Airway: Potential Applications in Neonates" (2022) https://fn.bmj.com/content/89/6/F485

6.3 University of California, San Francisco Medical Center, Standardized Procedure (2008) http://www.ucsfmedicalcenter.org/medstaffoffice/Standardized_Procedures/Neonatal%20Intubation.pdf

6.4 Rady Children's Hospital Standardized Procedure SP 2-01 "Neonatal Endotracheal Intubation" (2017)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Changed reference of ALS RN to Advanced NRP RN

Imperial Valley Healthcare District

Title: **Neonatal Enteral Feeding & Tube Management Feeding Tubes and Decompression Tubes in the NICU**	Policy No. CLN-01801
	Page 1 of 6
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 8/2018
Latest Review/Revision Date: 02/20/2025	Manual: Clinical / Nursery/NICU

Collaborating Departments: Perinatal/Neonatal Dr Alshareef	Keywords: Enteral Tube, Tube Feedings		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Peds 04/09/2025	MSQC 05/13/2025	MEC 05/20/2025	BOD 06/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish a policy and procedure for the care and maintenance of enteral tubes

2.0 Scope: Perinatal and Neonatal Staff

3.0 Policy:

3.1 Enteral tube placement requires a physician order.

3.2 Management of enteral tubes is performed by a competency validated nurse.

3.3 Nutrition, hydration and medications that are delivered through an enteral appliance (i.e., naso-gastric tube) will utilize ENFit connectors in order to prevent tubing misconnections.

3.4 ENFit enabled transition connectors, enteral syringes, pump sets, extension sets, feeding tubes, and access devices are to be used throughout the entire path of the enteral tube for nutrition, fluid, hydration or medication. Utilize ENFit connectors and ports from the start of the nutrition, fluid, hydration, or medication preparation to the finish of the product's administration.

3.5 All enteral feeding tubes (NG, OG):

3.5.1 Placement is verified initially and prior to the start of any feeding or medication administration.

3.5.2 Enteral feedings and medications require a medical order specifying the type, amount and concentration, frequency and route.

3.5.3 The attending physician is notified for any signs and symptoms of feeding intolerance.

3.5.4 Enteral feeding pumps and/or syringe pumps dedicated to enteral feedings are utilized for continuous feedings and/or bolus feedings given over a set amount of time.

3.5.5 Enteral feedings are not to be administered using IV infusion pumps.

3.5.6 Enteral formulas/breast milk is prepped in a clean environment using aseptic technique.

3.5.7 Gloves are worn for prepping, hanging, and rinsing/flushing enteral feeds.

3.5.8 Enteral feeding tubes are cleated with a small amount of air to clear the tube after every bolus feed and every 4 hours for continuous feeding.

3.5.9 The enteral only extension set (with syringe) is changed with each feeding or every 4 hours. Syringes used for venting are changed every 24 hours.

3.6 For open feeding administration sets:
- 3.6.1 No more than 4 hours' worth of formula feeding is hung at any one time.
- 3.6.2 A new syringe is used every 4 hours.
- 3.6.3 The feeding administration set is changed every 24 hours and labeled with expiration time and date.

3.7 NG/OG tubes:
- 3.7.1 For feedings: Proper placement is confirmed before administering any feedings/medications through an NG/OT tube.
- 3.7.2 For decompression – Salem sump tubes are not to be used for enteral feedings and/or medications
- 3.7.3 A provider order is required to administer feedings and/or medications

4.0 Definitions:

4.1 Competency Validated – Has completed required education, demonstrated competency and completes ongoing competency validation as required.

4.2 ENFit Connectors/Adaptors – FDA approved materials required to minimize the risk of tubing misconnections.

4.3 Nasogastric (NG) or Orogastric (OG) tubes – Includes any enteral tube placed via the nose or mouth into the stomach. Tubes are placed for either decompression (suction/gravity) or feeding.

4.4 Decompression tubes (Salem-sump/Replogle) – Dual lumen tubes placed specifically for temporary decompression of the stomach. Eyelet holes prevent tube from adhering to the stomach lining.

4.5 Feeding tubes – weighted or non-weighted soft tubes with a single hole placed for feeding into the stomach.

5.0 Procedure:

5.1 NG/OG Tube – equipment and supplies:
- 5.1.1 Appropriate size and type of tube (decompression or feeding)
- 5.1.2 Clean gloves
- 5.1.3 Lubricant
- 5.1.4 Tape or sharpie for marking tube
- 5.1.5 Transparent dressing for securement – cut to appropriate size for patient's face
- 5.1.6 Scissors
- 5.1.7 Functioning bedside suctions equipment
- 5.1.8 ENFit connector pieces, as needed
- 5.1.9 Additional supplies for decompression tubes
- 5.1.10 Gastric drainage collection device with tubing
- 5.1.11 Irrigation solution, syringes, as needed
- 5.1.12 Pump (Enteral only syringe pump) ENFit Feeding syringe and tubing, ENFit transition connector piece (if needed)

5.2 NG/OG tube insertion:
- 5.2.1 Keep feeding tube in sterile packaging until removed for measurement and

insertion

5.2.2 Perform hand hygiene and don clean gloves

5.2.3 Measure from tip of the nose to the earlobe; then from the earlobe to the mid-way point between the xiphoid process and umbilicus. Clearly mark the tube at the correct length for patient with tape or sharpie

5.2.4 Place patient supine with head slightly elevated, infant may be swaddled for comfort

5.2.5 Lubricate the tip of the enteral tube (use sterile water for lubrication)

5.2.6 Offer infant a pacifier during tube insertion

5.2.7 For an oral tube (OG) – place the tip of the feeding tube on the anterior surface of the tongue and gently, steadily advance the tube past the oropharynx

5.2.8 For a nasogastric tube (NG) – gently, steadily thread the tube through the nare (alternate nares as needed to minimize irritation). Aim the tube posterior and parallel to the nasal septum to avoid trauma. Continue to advance the tube until the measurement mark is reached

5.2.9 If there appears to be resistance, do not force. Try rolling the enteral tube gently. If still unable to pass the enteral tube, remove it and try the other nostril

5.2.10 Remove enteral tube at once if there are signs of distress, coughing, gasping, apnea, bradycardia or cyanosis allow the patient to stabilize and resume insertion procedure.

5.3 Securing the NG/OG tube

5.3.1 Secure the tube in such a way that there is no tension on the tube or the nares

5.3.2 Place hydrocolloid dressing on cheek (pre-cut to appropriate size for patient)

5.3.3 Position tube over hydrocolloid dressing (ensure no pressure/pulling on nares or surrounding skin) secure tube to hydrocolloid dressing with transparent tape

5.3.4 Verify securement tape does not surpass perimeter of hydrocolloid dressing *NOTE: repeated removal of hydrocolloid dressing increases the risk for skin breakdown*

5.4 Verifying NG/OG tube placement

5.4.1 Proper placement is assessed both at the time of placement, and before each feeding if left indwelling by confirming centimeter measurement and the presence of gastric aspirate before the administration of medications or feedings. If unable to obtain gastric aspirate, and tube placement has not been verified by x-ray observe infant closely for first 15 minutes of feeding for any signs of distress

5.4.2 Evaluate tube placement whenever an x-ray (chest or abdominal) is taken to confirm proper location of the tip of the tube

5.4.3 Verify tube placement by physical assessment, gastric/intestinal content aspiration, and air bolus auscultation

5.5 Physical assessment:

5.5.1 Verify placement by checking the measurement (confirm with initial placement measurement), verify measurement marker is in the correct position directly outside the nare

5.5.2 Inspect patient's mouth for signs of the tube

5.5.3 Assess for any signs of tube dislocation (visible displacement from original tube position/marking, pain, continuous coughing, respiratory changes, feeding intolerance)

5.6 Gastric/intestinal content aspiration:
- 5.6.1 Draw small volume of air into an ENFit syringe
- 5.6.2 Connect to feeding tube (with ENFit connector/reverse connector, as needed)
- 5.6.3 Flush tube with air and pull back slowly to aspirate gastric contents
- 5.6.4 Aspirate air/fluid. Check for negative pressure while attempting to withdraw fluid from the tube
  - 5.6.4.1 If the tube is in the small intestine you will not be able to aspirate air. Negative pressure is more likely to be felt from tubes in the small intestine

5.7 Assess aspirate:
- 5.7.1 Gastric aspirate may appear grassy green, yellow, brown, or clear and colorless, with off-white to tan shreds of mucus. Aspirates of continuously fed patients have the appearance of curdled enteral formula
- 5.7.2 Air bolus auscultation (cannot reliably differentiate between gastric and respiratory placement) – Draw small volume of air into an ENFit syringe and connect to feeding tube (with ENFit connector/reverse connector, as needed)
- 5.7.3 Place stethoscope over patient's abdomen
- 5.7.4 Flush tube with air and auscultate for whooshing air sound

5.8 Connecting NG decompression tube to suction device:
- 5.8.1 Perform hand hygiene and don clean gloves
- 5.8.2 Connect the suction tubing to the decompression tube and connect other end to the "patient" port on the suction canister
- 5.8.3 Connect another suction tubing to the "suction" port of the suction canister and the other end to wall suction
- 5.8.4 Turn on suction source to the ordered level and frequency of suction (e.g., Low continuous or low intermittent – standard is 30-40 mmHg)
- 5.8.5 Ensure the suction canister is stabilized in an upright position and all connections are secure
- 5.8.6 Ensure that the vent/sump lumen (blue pigtail) is above the level of the patient's stomach (to minimize the risk of gastric secretions refluxing into vent/sump lumen)

5.9 Irrigating an NG/OG decompression tube
- 5.9.1 Perform hand hygiene and don clean gloves
- 5.9.2 Irrigation is only to keep the tube patent. Pull appropriate volume of irrigation solution into a syringe. Disconnect decompression tube from suction, flush irrigation solution into decompression tube, reconnect decompression tube to suction
- 5.9.3 Pull a small volume of air into a syringe, then inject air into the vent/sump lumen (blue pigtail)
- 5.9.4 Inject air into blue pigtail after every irrigation and PRN (if tube is "whistling")

5.10 NG/OG Assessing face and nare for evidence of skin breakdown:
- 5.10.1 Check nares where tubing contacts for skin breakdown and moisture
- 5.10.2 Check where tubing is secured for skin breakdown
- 5.10.3 Check any other tubing contact points (ears, neck, etc.) for slim breakdown

5.11 Gravity gavage feeding:
- 5.11.1 Perform hand hygiene and don clean gloves
- 5.11.2 Check tube placement
- 5.11.3 Attach and prime ENFit tubing with appropriate enteral feeding solution
- 5.11.4 Hold syringe above stomach level and allow feed to flow in by gravity

5.12 Connecting feeding tube to feeding device: Open system
- 5.12.1 Perform hand hygiene and don clean cloves. Use aseptic technique for handling (prepping/administering) all formula/feeds
- 5.12.2 Max hang time for open system is 4 hours. Place appropriate volume of ordered feed into bag/syringe
- 5.12.3 Prime the ENFit feeding tubing
- 5.12.4 Program feeding pump/enteral feeding pump according to manufacturer's guidelines
- 5.12.5 Connect ENFit feeding tube to ENFit feeding device, ensure all connections are secure prior to starting feed

5.13 Venting feeding tubes
- 5.13.1 Perform hand hygiene and don clean gloves
- 5.13.2 Venting with a syringe
  - 5.13.2.1 Remove plunger from back of appropriate size ENFit syringe
  - 5.13.2.2 Connect syringe to feeding tube (ensure connection is secure)
  - 5.13.2.3 Place syringe above the level of the stomach, allow air to escape until stomach is soft
- 5.13.3 For continuous venting:
  - 5.13.3.1 Secure the syringe appropriately to avoid spilling

5.14 Documentation:
- 5.14.1 Size and type of feeding tube
- 5.14.2 Amount and type of feeding
- 5.14.3 Site assessment
- 5.14.4 Centimeter marking at insertion site
- 5.14.5 How patient tolerated procedure

6.0 References:

6.1 Gardner, Carter et al. (2021)Merenstein & Gardner's Handbook of Neonatal Intensive Care 9th ed.. St Louis, MO: Mosby Elsevier.

6.2 Replogle Tube Management (2016) Clinical Guidelines, The Royal Children's Hospital Melbourne https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Replogle_tube_management/

6.3 Rady Children's Hospital San Diego, PM 6-4. (2017). "Enteral Feeding &

Decompression Tube Management"

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Added Neonatal and in the NICU in the title

8.2 Otherwise, reviewed and submitted without change

Title: **Standardized Procedure for Registered Nurses: Neonatal Thoracentesis/Needle Decompression**	Policy No. CLN-02518 Page 1 of 5
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 4/19/2018
Latest Review/Revision Date: 02/20/2025	Manual: Clinical / Nursery/NICU

Collaborating Departments: Neonatal, Dr Alsharee NICU Manager	Keywords: Neonate Thoracentesis, Needle decompression

Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Pediatrics 4/2025	MSQC 5/2025	MEC 5/2025	BOD 5/2025

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
CHIEF EXECUTIVE OFFICER		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This standardized procedure is designed to establish guidelines that allow the Neonatal Advanced NRP RN to perform neonatal emergency thoracentesis.

2.0 Scope: Neonatal Advanced NRP RN

3.0 Policy:

3.1 Only approved RNs may function under any Standardized Procedure. The Advanced NRP RN may perform thoracentesis on neonates as outlined in the procedure.

3.2 Circumstances under which the competency validated Advanced NRP RN may perform thoracentesis:

3.2.1 In the Perinatal/Neonatal Department of Pioneers Memorial Hospital

3.2.2 In the Emergency Department of Pioneers Memorial Hospital.

3.3 When possible, the physician should be contacted before the procedure. In all emergencies, the primary physician will be notified as soon as possible while advanced life support is being initiated.

3.4 Scope of Supervision – The competency validated Advanced NRP RN will receive:

3.4.1 Indirect supervision by the attending physician

3.4.2 A physician will be available at all times for consultation.

3.5 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.

3.6 RN requirements:
- 3.6.1 Education/Training/Experience – below will be documented and maintained in the employee file:
  - 3.6.1.1 The Advanced NRP RN will have been an RN for a minimum of three (3) years with at least three (3) years of Neonatal Nursery experience.
  - 3.6.1.2 The RN will be certified in all aspects of NRP.
  - 3.6.1.3 The Advanced NRP RN will demonstrate competencies in skills lab that will be held biannually
- 3.6.2 Initial and Ongoing Competency Evaluation:
  - 3.6.2.1 Initial competency will be validated by the physician or experienced Advanced NRP RN
- 3.6.3 Annual Competency Assessment:
  - 3.6.3.1 Completed three (3) successful thoracentesis supervised by a physician or experienced Advanced NRP RN
  - 3.6.3.2 If minimum number of annual procedures are not obtained, the following are options for competency maintenance:
    - 3.6.3.2.1 Attend skills lab offered biannually (procedure review & simulation)
    - 3.6.3.2.2 Competency validation test and demonstration of skill
- 3.6.4 This standardized procedure will be subject to periodic review by the appropriate interdisciplinary committees.

4.0 Definitions:

4.1 Thoracentesis – (closed chest needle aspiration) to remove air or fluid from the pleural space.

4.2 Competency Validation – Has completed required education, demonstrated competency and completes ongoing competency validation as required.

4.3 NRP – Neonatal Resuscitation Program Certification

5.0 Procedure:

5.1 Database:
- 5.1.1 Subjective:
  - 5.1.1.1 Historical information relevant to present illness
- 5.1.2 Objective:
  - 5.1.2.1 Physical examination with focus on pulmonary, cardiovascular and neurological systems.
    - 5.1.2.1.1 Symptoms may vary from irritability and restlessness to apneic spells, tachypnea, grunting and retractions and in severe cases, bradycardia, cyanosis and shock. A tension pneumothorax must be diagnosed and treated promptly.
    - 5.1.2.1.2 Clinical signs of a tension pneumothorax include:
      - 5.1.2.1.2.1 Abrupt worsening of the respiratory or circulatory status
      - 5.1.2.1.2.2 Hypertension followed by hypotension with decreased

pulse pressure.
5.1.2.1.2.3 Tachycardia followed by bradycardia
5.1.2.1.2.4 Absent or decreased breath sounds on affected side.

5.1.3 Assessment:
5.1.3.1 Decision for needle thoracentesis will be based upon subjective and objective data and in collaboration with attending physician prior to the initiation of the procedure when not an emergent/lifesaving procedure.

5.1.4 Plan:
5.1.4.1 Parents/primary caregivers will be provided with the appropriate information prior to initiation of the thoracentesis procedure if not an emergent lifesaving procedure, and obtain consent as per hospital protocol.
5.1.4.2 A chest x-ray will be obtained upon completion of procedure.
5.1.4.3 Documentation of the procedure performed, outcome and any complications will be recorded in the electronic medical record.

5.2 Indication:
5.2.1 Symptomatic treatment of air or fluid accumulation in the pleural space

5.3 Contraindications
5.3.1 Confirmed/suspicion of diaphragmatic hernia.
5.3.2 Small air or fluid collection without significant hemodynamic symptoms.
5.3.3 Spontaneous pneumothorax that, in the absence of lung disease, is likely to resolve without intervention.

5.4 Equipment:
5.4.1 Cardio/respiratory and pulse oximeter in place with alarms on.
5.4.2 Transilluminator
5.4.3 Sterile gloves and gown
5.4.4 Non-sterile hat and mask
5.4.5 Thoracentesis insertion kit, including:
5.4.5.1 Chlorhexidine antiseptic solution (Povodine if infant less than 1000gms).
5.4.5.2 Sterile towels/drape
5.4.5.3 Three-way stopcock
5.4.5.4 20 ml syringe
5.4.5.5 2 x 2 sterile gauze pads
5.4.5.6 Transparent dressing and tape
5.4.5.7 IV extension tubing
5.4.5.8 23 gauge butterfly

5.5 Guidelines for procedure/practice – Thoracentesis
5.5.1 Prior to the procedure, analgesia will be administered prophylactically as/if needed in accordance with the “Pain Management” policy CLN-00223.
5.5.2 Gather equipment
5.5.3 Connect the 3-way stopcock and syringe to IV extension tubing.
5.5.4 Turn the stopcock “off” to the remaining outlet (off to atmosphere)
5.5.5 Sterile technique is required throughout the procedure.

5.5.6 Have an assistant position the infant appropriately. The most preferred position is supine with affected side slightly elevated. Restrain the infant's arms and legs.
5.5.7 Identify entry site. Use second or third intercostal space along the midclavicular line.
5.5.8 Prep skin with antiseptic solution.
5.5.9 Puncture skin at a 45ϖ angle, angling over the third or fourth rib, and advance needle at a 90ϖ angle. Inserting the needle over the top of the rib will avoid blood vessels and nerves that run along the bottom of the rib.
5.5.10 As needle enters pleural space, decrease angle to approximately 15ϖ horizontal.
5.5.11 Attach the butterfly to the stopcock and syringe. The stopcock allows for aspiration of free air or fluid into the syringe and emptying of the syringe while maintaining a closed system.
5.5.12 Aspirate air into syringe attached to 3-way stopcock and evacuate via open position. When free air of fluid is obtained, stabilize the catheter and continue to aspirate until preparation for chest tube insertion is complete, or until the air leak or fluid accumulation is evacuated. Continue intermittently as patient's condition warrants.
5.5.13 Removed butterfly needle once air evacuation is compete.
5.5.14 Cleanse site and apply sterile dressing over site using 2x2 gauze and transparent dressing.
5.5.15 Monitor closely for signs of re-accumulation of pleural air.
5.5.16 Assess, treat and reassess pain according to "Pain Management' policy.

5.6 Complications:
5.6.1 Hemorrhage.
5.6.2 Infection.
5.6.3 Needle injury to lung or adjacent structures.
5.6.4 Damage to breast tissue.
5.6.5 Pain.

5.7 Documentation:
5.7.1 A written consent per hospital protocol will be obtained and placed in the patient's medical record prior to procedure if not a lifesaving procedure. If consent is not obtained in advance, the parent/guardian is to be notified as soon as possible after procedure.
5.7.2 Document according to the hospital policy: date, time, butterfly size, location, amount of air/fluid evacuated, patient's tolerance of procedure and any medications used.
5.7.3 A procedure note will be added to the electronic medical record.

6.0 References:

6.1 Verklan, M. T., Walden, M.et al, Core Curriculum for Neonatal Intensive Care Nursing, 6th Ed. (2020). Elsevier
6.2 Gardner, S.L, Carter, B.S. et al, Merenstein & Gardner's Handbook of Neonatal intensive Care, 9th ed (2021). Elsevier

6.3 Neonatal Thoracentesis policy SP 2-06 & SP 3-06, Rady Children's Hospital, San Diego (2016 & 2017)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Changed term of ALS RN to Advanced NRP RN
8.2 Updated References

Imperial Valley Healthcare District ***ANNUAL REVIEW***

Title: **Standardized Procedure for Registered Nurses: Neonatal Umbilical Vessel Catheterization**	Policy No. CLN-00258
	Page: 1 of 7
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 11/1/1995
Last Review/Revision Date: 02/20/2025	Manual: Clinical / OB

Collaborating Departments: Neonatal, Pharmacy, Dr Alshareef, NICU Manager	Keywords: Umbilical Catheterization		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Credentials/Peds/OB 3/2025, 4/2025	MSQC 5/2025	MEC 5/2025	BOD 6/2025

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
CHIEF EXECUTIVE OFFICER		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

NOTE: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This standardized procedure is designed to establish guidelines that allow the Neonatal Advanced Life Support (ALS) Registered Nurse (RN) to perform umbilical vessel catheterization (arterial and venous).

1.2 The purpose of umbilical catheterization is to obtain direct access to arterial circulation with placement of a sterile radiopaque catheter into the aorta via an umbilical artery to provide a means of obtaining arterial blood gases and for continuous monitoring of blood pressure. In addition, umbilical artery catheterization may be a means for fluid/electrolyte balance and pharmacologic support and treatment. The purpose of umbilical venous catheterization is to establish a route for emergency administration of IV fluids and medications, to provide nutrition and to provide venous access for IV fluids and medication.

2.0 Scope: Neonatal ALS RN only

3.0 Policy:

3.1 Standardized Procedure Function – patients requiring umbilical vessel catheterization

3.2 Only approved RNs may function under any Standardized Procedure. The ALS RN may perform umbilical vessel catheterization on neonates as outlined in the procedure.

3.3 Circumstances under which the RN may perform Umbilical Vessel Catheterization:

3.3.1 Setting – The competency validated ALS RN may perform umbilical vessel catheterization in the Perinatal Unit or impatient area, including the Emergency Department of PMHD.

3.3.2 Scope of Supervision – The competency validated ALS RN will receive:
- 3.3.2.1 Indirect supervision by the attending Pediatrician/Neonatologist
- 3.3.2.2 A Pediatrician/Neonatologist will be available at all times for consultation.
- 3.3.2.3 In the event that this procedure is altered via a physician's written or verbal order, the ALS RN will inform the physician that he/she is not verified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.

3.3.3 Patient conditions to notify physician:
- 3.3.3.1 In all emergencies, the attending Pediatrician/Neonatologist will be notified as soon as practical while advanced life support is being initiated.
- 3.3.3.2 The attending Pediatrician/Neonatologist will be notified immediately if any of the following complications occur:
  - 3.3.3.2.1 Severe uncontrolled bleeding from the umbilical stump
  - 3.3.3.2.2 Blanching/cyanosis of the skin, loss of femoral pulses or other evidence of emboli
  - 3.3.3.2.3 Inability to obtain blood after insertion of catheter despite traction and/or tension
  - 3.3.3.2.4 Catheter malposition
  - 3.3.3.2.5 Vasospasm
  - 3.3.3.2.6 Thrombus
  - 3.3.3.2.7 Hypertension
  - 3.3.3.2.8 Unstable patient
  - 3.3.3.2.9 Unsuccessful procedure
  - 3.3.3.2.10 Any complications or unexpected outcomes of the procedure

3.3.4 Rn requirements
- 3.3.4.1 Education/Training/Experience:
  - 3.3.4.1.1 The ALS nurse will have been a RN for a minimum of 3 years with at least 3 years of Neonatal Nursery experience.
  - 3.3.4.1.2 The ALS RN will attend the Advanced Life Support didactic classes (minimum of 24 hours) held at Rady Children's Hospital, San Diego or a comparable training facility. All quizzes and tests administered in the classes with an 80% pass rate.
- 3.3.4.2 Initial and Ongoing Competency Evaluation:
  - 3.3.4.2.1 Initial competency will be validated by the physician or experienced ALS RN.
  - 3.3.4.2.2 The ALS RN will successfully complete three (3) umbilical vessel catheterizations under direct supervision of the physician or experienced ALS RN before being allowed to perform the procedure without direct supervision.
- 3.3.4.3 Annual competency assessment:
  - 3.3.4.3.1 Complete 3 successful umbilical vessel catheterizations supervised by a physician or experienced ALS RN.

3.3.4.3.2 If minimum number of annual procedures is not obtained, the following are options for competency maintenance:
3.3.4.3.2.1 Attend skills lab offered biannually (procedure review & simulation)
3.3.4.3.2.2 Competency validation test and demonstration of skill

3.3.4.4 RNs authorized to perform standardized procedure function – a written record of initial and ongoing competency will be maintained in the employee file in the Perinatal Department and a roster of RN competency validation will be set to the Education Department annually.

3.3.4.5 This Standardized Procedure will be subject to periodic review by the appropriate interdisciplinary committees not to exceed every 2 years.

4.0 Definitions:

4.1 PMHD – Pioneers Memorial Healthcare District
4.2 UAC – Umbilical Artery Catheter
4.3 UVC – Umbilical Venous Catheter
4.4 EMR – Electronic Medical Record

5.0 Procedure:

5.1 Database
5.1.1 Subjective:
5.1.1.1 Historical information relevant to present illness
5.1.1.2 History including reactions/allergies to medications
5.1.2 Objective:
5.1.2.1 Physical examination with focus on pulmonary, cardiovascular and neurological systems
5.1.3 Assessment:
5.1.3.1 Decision for umbilical vessel catheterization will be based upon subjective and objective data and in collaboration with attending physician prior to the initiation of the procedure when not an emergent, lifesaving procedure.
5.1.4 Plan:
5.1.4.1 Patients and families will be provided with the appropriate information prior to initiation of the umbilical vessel catheterization if not an emergent/lifesaving procedure, and obtain consent as per hospital protocol.

5.2 Indication:
5.2.1 Primary
5.2.1.1 Emergency vascular (venous catheter) access for fluid and medication infusion and for blood drawing, central venous pressure monitoring (if the catheter crosses the ductus venosus)
5.2.1.2 Exchange Transfusion
5.2.2 Secondary

5.2.2.1 Long-term central venous access

5.3 Contraindications:
- 5.3.1 Omphalitis
- 5.3.2 Omphalocele
- 5.3.3 Necrotizing enterocolitis or intestinal hypoperfusion
- 5.3.4 Peritonitis
- 5.3.5 Evidence of vascular compromise in lower extremities
- 5.3.6 Acute abdomen etiology

5.4 Equipment:
- 5.4.1 Umbilical catheter tray
- 5.4.2 Appropriate size umbilical catheter, either single or double lumen
- 5.4.3 Sterile gown and gloves
- 5.4.4 Hat and mask
- 5.4.5 Povidone-iodine solution for infants less than 1000 grams
- 5.4.6 Chlorhexidine prep solution for infants over 1000 grams unless contraindicated due to allergy or patient condition, then Povidone-iodine and saline will be used
- 5.4.7 Heparinized flush
  - 5.4.7.1 Infants ≤ 1500 grams, mix at concentration of 0.5 units heparin to 1 ml normal saline
  - 5.4.7.2 Infants > 1500 grams, mix at concentration of 1 unit heparin to 1 ml normal saline
  - 5.4.7.3 3-0 silk suture
  - 5.4.7.4 IV solution as ordered
  - 5.4.7.5 Light and heat source
  - 5.4.7.6 Cardiac monitor

5.5 Essential steps in procedure:
- 5.5.1 Perform Universal Protocol “time out” according to hospital policy, prior to procedure.
- 5.5.2 Make necessary measurements to determine length of catheter to be inserted, adding length of umbilical stump.
- 5.5.3 Explain procedure to parent(s), if available.
- 5.5.4 Open the umbilical tray, maintaining sterility and adding needed items not included in the tray.
- 5.5.5 Generally infants weighing <1500 grams will have a 3.5 Fr catheter placed in the umbilical artery. A 5.0 Fr catheter may be utilized for umbilical venous catheterization.
- 5.5.6 Have assistant hold appropriately prepared heparinized flush. Leave flush syringe attached to 3-way stopcock on your tray.
- 5.5.7 Attach umbilical catheter to 3-way stopcock.
- 5.5.8 Flush stopcock and umbilical catheter with heparinized flush. Leave flush syringe attached to 3-way stopcock.
- 5.5.9 Have assistant hold umbilical cord up and away from the infant’s abdomen. Cleanse the umbilical cord stump and adjacent skin with proper solution as listed in 5.4.5 and 5.4.6. Beginning at the base of the cord and working in a circular

motion outward on the skin to about 2 inches. Cleanse the cord clamp of present.

5.5.9.1 When using Povidone-iodine solution, allow to dry for 30 seconds and then remove with saline wipe.

5.5.9.2 When using Chlorhexidine, allow to dry for 30 seconds prior to procedure.

5.5.10 Place sterile drape on the infant with an open hole over the prepped cord.

5.5.11 Place sterile umbilical tape around the cord stump with a loose tie.

5.5.11.1 Tighten only enough to prevent bleeding and place, if possible, around Wharton's jelly rather than skin.

5.5.11.2 It may be necessary to loosen the tie when inserting the catheter.

5.5.12 Using sterile scalpel, cut off the cord stump approximately 0.5-1.5cms above the skin. Avoid "sawing" of the cord. The umbilical tape may be pulled snug to prevent bleeding when the cord is cut.

5.5.13 Locate the umbilical vessels, 2 arteries and a vein. The umbilical arteries will have a thick wall while the umbilical vein will have a thinner wall.

5.5.14 Using hemostats, clamp the Wharton's jelly on either side of the cord. Apply tension and expose the vessels.

5.5.15 For UAC:

5.5.15.1 Using the points of the curved iris forceps or vein introducer, gently dilate the lumen of the artery by inserting the device to the depth of approximately 0.5cm. Repeat this several times until the lumen is dilated. Use an up and down motion. Do not pull or twist.

5.5.15.2 When the vessel is dilated, insert the fluid filled catheter into the lumen of the artery. Use a downwards approach and advance gently. Advance the catheter to the appropriate distance. Slight obstructions or resistance at the junction of the umbilical artery and fascial plane may be relieved by gently upwards traction on the cord stump and/or applying steady gently pressure on the catheter for 15-30 seconds.

5.5.15.3 Using attached syringe, aspirate. There should be free flow of blood.

5.5.15.4 If no blood is obtained, remove the catheter and try advancing one more time.

5.5.15.5 The catheter should be advanced to the appropriate tip placement.

5.5.15.5.1 For high UAC tip placement, the appropriate length can be obtained by multiplying the infant's weight (kg) by 3, then adding 9. [Kg x 3 +9]

5.5.15.5.1.1 This will give a UAC placement between T6 and T10.

5.5.15.5.2 For low UAC tip placement, the tip should be between L3 and L4. Length can be calculated by measuring the distance from the shoulder to the umbilicus.

5.5.16 For UVC:

5.5.16.1 Identify thin walled vein, close to periphery of umbilical stump.

5.5.16.2 Grasp cord stump with toothed forceps.

5.5.16.3 Gently insert tips of iris forceps into lumen of vein and remove any clots.

5.5.16.4 Introduce fluid filled catheter, attached to the stopcock and syringe, approximately 2 to 3cms into vein (measuring from anterior wall).
5.5.16.5 Apply gentle suction to syringe.
5.5.16.6 If there is not easy blood return, catheter may have a clot in tip. Withdraw catheter while maintaining gently suction. Removed clot and reinsert catheter.
5.5.16.7 If there is smooth blood return, continue to insert catheter for full estimated distance.
5.5.16.7.1 Appropriate UVC length can be calculated by multiplying the infant's weight (kg) by 3, then, adding 9, then dividing by 2 and adding 1. [(kg x3 + 9) /2+1]
5.5.16.7.2 The tip of the UVC should be at the junction of the inferior vena cava and the right atrium, projecting just above the diaphragm on x-ray.
5.5.16.8 If the catheter meets any obstruction prior to measured distance:
5.5.16.8.1 It has, most commonly, entered the portal system, or
5.5.16.8.2 Wedged in the intrahepatic branch of the umbilical vein
5.5.16.9 Withdraw catheter 2 to 3cms, gently rotate and reinsert in an attempt to get tip through the ductus venosus
5.5.16.10 If the catheter is in the portal circulation, leave the misdirected catheter in its place. Pass a new 5 Fr catheter into the same vessel. Once the catheter is in good position, remove the misdirected catheter. This procedure has a success rate of 50%.
5.5.17 In the event the catheter cannot be advanced, or no blood can be obtained, remove the catheter and notify the Pediatrician/Neonatologist for further orders.
5.5.18 When the catheter has been advanced to the appropriate length and blood can be aspirated, note the centimeter mark at the level of the skin.
5.5.19 With a needle holder, secure sutures to the stump using a purse string closure. After x-ray for catheter placement confirms proper placement, using the same suture, tie around catheter to hold in place. Temporarily tape catheter(s) in place until x-ray is completed.
5.5.20 Obtain a chest x-ray immediately after line placement to verify proper location of tip.
5.5.21 If the line needs adjustment, the line may be withdrawn to the appropriate level but cannot be advanced once the sterile field has been disassembled.
5.5.22 In the delivery room, when emergency vascular access is needed, the umbilical catheter will be flushed with saline and attached to a 3-way stopcock.
5.5.22.1 Don sterile gloves
5.5.22.2 Prep the cord with Povidone-iodine solution or chlorhexidine solution as appropriate.
5.5.22.3 Tie umbilical tape around the base of the cord.
5.5.22.4 Cut cord 1-2cms above the base.
5.5.22.5 Place a 5 Fr umbilical catheter into the vein until a blood return is obtained. This should be 3-5cms. If the catheter is inserted further,

there is a risk of infusing hypertonic solution into the liver and causing damage to the liver.

5.5.22.6 Secure the catheter by taping firmly to the infant's abdomen.

5.5.22.7 When the resuscitation is completed, remove the catheter.

5.6 Documentation:

5.6.1 Document procedure in the nurse's notes of the EMR

5.6.1.1 Time of procedure

5.6.1.2 Reason(s) for procedure

5.6.1.3 Size of catheter(s) length of insertion

5.6.1.4 X-ray placement of catheter

5.6.1.5 Circulation of buttocks, legs, toes, strength of femoral pulses before and after catheter placement

5.6.1.6 Infant's tolerance to procedure

5.6.2 A written consent per hospital protocol is obtained and placed in the infant's medical record prior to procedure if not a lifesaving procedure. If consent is not obtained in advance, parent/guardian is to be notified as soon as possible after procedure.

5.6.3 Utilize the "Special Care Nursery Procedure Note" to record the procedures performed by the ALS RN. One copy will be placed in the individuals' personal file in the Intermediate NICU.

6.0 References:

6.1 Magnan, J.P., Kulkami, M., Umbilical Vein Catheterization (2022) https://emedicine.medscape.com/article/80469-overview

6.2 Sawyer, T., Kulkami, M., Umbilical Artery Catheterization (2022) https://emedicine.medscape.com/article/1348931-overview

6.3 University of California, San Francisco – Standardized Procedure Neonatal Umbilical Vessel Catheterization (2008) http://www.ucsfmedicalcenter.org/medstaffioffice/Standardized_Procedure/Neonatal%20Umbilical%20Vessel%20Catheterization.pdf

6.4 Rady Children's Hospital, San Diego (2017) Neonatal Umbilical Vessel Catheterization, Standardized Procedure SP 2-02

7.0 Attachment: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Imperial Valley Healthcare District

Title: Postexposure Prophylaxis after Occupational Exposure to Blood or Body Fluids by needle/sharps injury and/or splashes Protocol	Policy No. HRD-00127 Page 1 of 3
Current Author: Lizbette Cordova, RN	Effective: 01/28/2002
Latest Review/Revision Date: 06/2024	Manual: Human Resource

Collaborating Departments: Pharmacy, Infection Control, Dr. Mohammed Al-Jasim	Keywords: employee, needle stick, blood borne		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 12/2024		
Clinical Service _____	MSQC 3/2025	MEC 3/2025	BOD 3/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To provide prophylaxis treatment within 1 to 2 hours of exposure to contaminated blood/body fluid (sharp injury), in order to lower the risk of virus transmission.

1.2 To establish procedures for treatment/follow up of health care workers accidentally exposed to blood or body fluids through:

1.2.1 Parenteral exposure (accidental needle stick/sharp injury). Needles are considered to be "contaminated" after penetration.

1.2.2 Oral ingestion

1.2.3 Direct mucous membrane contact – eye/mouth splash

1.2.4 Non-intact skin

1.2.5 One must always consider the potential risks of exposure to Hepatitis B, Hepatitis C, tetanus, HIV/AIDS, and/or wound infection.

1.3 To comply with Public Health Service and CDC recommendations for chemoprophylaxis after occupational exposure to HIV by type of exposure and source material.

2.0 Scope: District-wide

3.0 Policy:

3.1 This facility will treat employees and non-employees with prophylaxis treatment if there is a recognized risk of exposure. Initial dose will be given through Emergency Department to start immediately. The employee will be instructed to follow-up with the Employee Health Nurse for scheduling of further follow up and counseling through the designated occupational medicine clinic. It will be the determination of the Occupational Medicine Physician if the employee needs further treatment. The non-employee (physician, volunteer, contracted employees) will be instructed to follow up with their primary care physician to determine if the 4 week regimen is necessary.

4.0 Definitions:

4.1 Prophylaxis – Measures taken for the prevention of a disease or condition.

4.2 CDC- Center for Disease Control

4.3 HIV – Human Immunodeficiency Virus.

4.4 PEP – Post Exposure Prophylaxis

4.5 PCP – Primary Care Physician

5.0 Procedure:

5.1 After exposure to potentially infected blood, body fluid, and/or needle/sharps injury employee and non-employee should control bleeding or other first aid measures must be established initially. Immediate and thorough cleaning of exposed skin surfaces by washing with soap and water or irrigating mucous membranes with water or saline solution as soon as possible.

5.2 Employees are responsible for reporting the accident to his/her manager and for completing an Employee Injury/Accident form, including explanation of how exposure occurred as well as the MR# of the source patient. If exposure is due to sharp injury, Sharp Injury Log Form must be completed. The employee will report to ER department as soon as possible for evaluation of injury and treatment (if indicated).

5.3 Non-employees should report to the emergency Department to be evaluated by the ER Physician (not covered by IVHD Work Compensation Insurance for non-employees).

5.4 Status of the employee/ non-employee's blood that has been exposed must be established (Hepatitis Evaluation/testing and HIV antibody testing).

5.5 The ER physician will treat the exposure site, assess the risk of infection, determining the need for prophylaxis and inform the non-employee that follow-up monitoring will need to be assessed by their PCP.

5.6 The exposed employee should follow up with Employee Health for referral to Occupational Medicine for further evaluation and testing needs.

5.7 Status of the patient's (source) blood that the employee (or non-employee) was exposed to must be established. Complete Hepatitis Panel (patient should not be charged) and HIV antibody testing (rapid HIV). If the source patient has evidence of infection, declines testing, has a positive test or is unknown, the exposed healthcare-worker should be evaluated clinically as soon as possible after the exposure.

5.8 The Emergency Department Physician shall be responsible for:

- 5.8.1 Obtaining informed consent from employee/non-employee
- 5.8.2 Maintaining employee/non-employee confidentially
- 5.8.3 Following HIV/HBV/HCV antibody testing protocol.
- 5.8.4 Following existing recommendations for Hepatitis B and HIV exposure prophylaxis.

5.9 Employee Health will provide the employee with necessary lab results, for follow up and counseling through the Occupational Medicine Clinic. The employee is responsible for attending his/her follow-up appointments.

5.10 The non-employee shall follow up with his/her PCP.

5.11 Prophylaxis Treatment:

5.11.1 The Pharmacy Department will stock the IVHD Emergency Department Automated Dispensing Machine with medications using the regimens recommended by the CDC.

5.11.1.1 Recommended Regimen: Truvada (Tenofovir DF 300mg + emtricitabine 200mg) once daily **and** Isentress (raltegravir 400mg) twice daily.

5.11.1.2 Truvada™ 1 tablet by mouth once daily [co-formulated Tenofovir DF (Viread®; TDF) 300mg + emtricitabine (Emtriva™; FTC) 200mg]

PLUS

Raltegravir (Isentress®; RAL) 400mg by mouth twice daily

or

Dolutegravir (Tivicay™; DTG) 50mg by mouth once daily

6.0 References:

6.1 The Clinician Consultation Center University of California, San Francisco. Available at http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide/ Updated: 2024

7.0 Attachement List: Not Applicable

8.0 Summary of Revisions:

8.1 Update section 3.0 to reflect ER no longer dispenses medication.

8.2 Removed reference to policy CLN-02881 Emegency Room Dispensing. Policy has been retired and ER no longer dispenses meds

8.3 Update 5.11.1 to reflect no dispensing of doses from the ER

8.4 Updated reference UCSF PEP Link

Imperial Valley Healthcare District

Title: **Bioterrorism Management Plan**	Policy No. EOC-00060
	Page 1 of 27
Current Author: Jorge Mendoza	Effective: 10/01/2001
Latest Review/Revision Date: 1/2025	Manual: EOC / Emergency Management

Collaborating Departments: Infection Control; Pharmacy	Keywords: Bioterrorism		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This plan is intended to serve as a tool to guide the response to a bioterrorist attack on the hospital or surrounding communities.

2.0 Scope: District wide

3.0 Policy:

3.1 Pioneers Memorial Hospital (PMH) recognizes the importance of awareness and preparation for Bioterrorism events affecting the hospital. The components of the plan are incorporated in the overall PMH Emergency Preparedness Program. These components range from notification of Local Emergency Networks to transfer of patients to appropriate care facilities. The Hospital Incident Command System / Emergency Operations Plan have policies in place to rapidly implement prevention and control measures to respond to a suspected outbreak.

4.0 Definitions:

4.1 Bioterrorism is terrorism involving the intentional release or dissemination of biological agents. These agents are bacteria, viruses, or toxins, and may be in a naturally occurring or a human-modified form.

4.2 Syndrome, as it is used in medicine, is the association of several clinically recognizable features, signs (observed by someone other than the patient), symptoms (reported by the patient), phenomena or characteristics that often occur together, so that the presence of one or more features alerts the healthcare provider to the possible presence of the others.

4.3 Epidemiology is the study of the distribution and patterns of health-events, health-characteristics and their causes or influences in well-defined populations.

5.0 Procedure:

5.1 General Categorical Recommendation for Any Suspected Bioterrorism Event

5.1.1 Reporting Requirements and Contact Information

5.1.1.1 Healthcare facilities may be the initial site of recognition and response to a bioterrorism event. If a bioterrorism event is suspected, local emergency response systems should be activated. Notification should immediately include local infection control personnel and the healthcare facility administration, and prompt communication with the

local and state health departments, FBI field office, local police, Centers for Disease Control (CDC), and emergency medical services. Each health care facility should include a list containing the following telephone notification numbers in its readiness plan:

5.1.1.1.1 Internal Contacts**:**
Infection Control: 760-351-3525
Administration: 760-351-3250

5.1.1.1.2 External Contacts:
Local Public Health Department: 442-265-1444 and
Duty Officer: 760-455-4083
State Health Department: 916-328-9025 and
Duty Officer: 916-328-3605
Centers for Disease Control and Prevention: 800-232-4636
FBI Field Office: 760-355-0397

5.1.2 Potential Agents

5.1.2.1 Four diseases with recognized bioterrorism potential (anthrax, botulism, plague, and smallpox) and the agents responsible for them are described in Section II of this document. The CDC does not prioritize these agents in any order of importance or likelihood of use. The CDC also recognizes tularemia, brucellosis, Q fever, viral hemorrhage fevers, viral encephalitis, and disease associated with staphylococcal enterotoxin B as agents with bioterrorism potential; however these agents will not be covered in this policy. For additional information on these agents see *Attachment A – Terrorism Agent Information and Treatment Guidelines for Clinicians and Hospitals*.

5.1.3 Detection of Outbreaks Caused by Agents of Bioterrorism

5.1.3.1 Bioterrorism may occur as covert events, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms. Bioterrorism may also occur as announced events, in which persons are warned that an exposure has occurred. The possibility of a bioterrorism event should be ruled out with the assistance of the FBI and state health officials.

5.1.3.2 Syndrome-Based Criteria

5.1.3.2.1 Rapid response to a bioterrorism-related outbreak requires prompt identification of its onset. Because of the rapid progression to illness and potential for dissemination of some of these agents, it may not be practical to await diagnostic laboratory confirmation. Instead, it will be necessary to initiate a response based on the recognition of high-risk syndromes. Each of the agent-specific plans in Section II includes a syndrome description (i.e., typical combination of clinical features of the illness at presentation), that should alert healthcare practitioners to the possibility of a bioterrorism-related outbreak.

5.1.3.3 Epidemiologic Features

5.1.3.3.1 Epidemiologic principles must be used to assess whether a patient's presentation is typical of an endemic disease or is an unusual event that should raise concern. Features that should alert healthcare providers to the possibility of a bioterrorism-related outbreak include:

5.1.3.3.1.1 A rapidly increasing disease incidence (e.g., within hours or days) in a normally healthy population

5.1.3.3.1.2 An epidemic curve that rises and falls during a short period of time

5.1.3.3.1.3 An unusual increase in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints

5.1.3.3.1.4 An epidemic disease rapidly emerging at an uncharacteristic time or in unusual pattern

5.1.3.3.1.5 Lower attack rates among people who had been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outdoors

5.1.3.3.1.6 Clusters of patients arriving from a single locale

5.1.3.3.1.7 Large numbers of rapidly fatal cases

5.1.3.3.1.8 Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential (e.g., pulmonary anthrax, tularemia, or plague)

5.1.4 Infection Control Practices for Patient Management

5.1.4.1 The Management of patients following suspected or confirmed bioterrorism events must be well organized and rehearsed. Strong leadership and effective communication are paramount.

5.1.4.1.1 Isolation precautions

5.1.4.1.1.1 Agents of bioterrorism are generally not transmitted from person to person; re-aerosolization of these agents is unlikely. All patients in healthcare facilities, including symptomatic patients with suspected or confirmed bioterrorism-related illnesses should be managed utilizing Standard Precautions. Standard Precautions are designed to reduce transmission for both recognized and unrecognized sources of infection in healthcare facilities, and are recommended for all patients receiving care, regardless of their diagnosis or presumed infection status. For certain diseases or syndromes (e.g., smallpox and pneumonic plague), additional precautions may be needed to reduce the likelihood for transmission. See Section 5.2 for specific diseases

and requirements for additional isolation precautions.

5.1.4.1.1.2 Standard Precautions prevent direct contact with all body fluids (including blood), secretions, excretions, non-intact skin (including rashers), and mucous membranes. Standard Precautions routinely practiced by healthcare providers include:

5.1.4.1.1.2.1 Hand washing

5.1.4.1.1.2.1.1 Hands are washed after touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids, whether or not gloves are worn. Hands are washed immediately after gloves are removed, between patient contacts, and as appropriate to avoid transfer of microorganisms to other patients and the environment. Either plain or antimicrobial-containing soaps may be used according to facility policy.

5.1.4.1.1.2.2 Gloves

5.1.4.1.1.2.2.1 Clean, non-sterile gloves are worn when touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids. Clean gloves are put on just before touching mucous membranes and non-intact skin. Gloves are changed between tasks and between procedures on the same patient if contact occurs with contaminated material. Hands are washed promptly after removing gloves and before leaving a patient care area.

5.1.4.1.1.2.3 Masks/Eye Protection or Face Shields

5.1.4.1.1.2.3.1 A mask and eye protection (or face shield) are worn to protect the mucous membranes of the eyes, nose, and mouth while performing procedures and patient care activities that may cause splashes of blood, body fluids, excretions, or secretions.

5.1.4.1.1.2.4 Gowns

5.1.4.1.1.2.4.1 A gown is worn to protect skin and

prevent soiling of clothing during procedures and patient-care activities that are too likely to cause splashes or sprays of blood, body fluids, excretions, or secretions. Selection of gowns and gown materials should be suitable for the activity and amount of body fluid likely to be encountered, soiled gowns are removed promptly and hands are washed to avoid transfer of microorganisms to other patients and environments.

5.1.4.2 Patient Placement

5.1.4.2.1 In small-scale events, routine facility patient placement and infection control practices should be followed. However, when the number of patients presenting to a healthcare facility is too large to allow routine triage and isolation strategies (if required), it will be necessary to apply practical alternatives. These may include cohorting patients who present with similar syndromes, i.e., grouping affected patients into a designated section of a clinic or emergency department, or a designated ward or floor of a facility, or even setting up a response center at a separate building. Designated cohorting sites should be chosen by infection control in consultation with facility engineering staff, based on patterns of airflow and ventilation, availability of adequate plumbing and waste disposal, and capacity to safely hold potentially large numbers of patients. The triage or cohort site should have controlled entry to minimize the possibility for transmission to other patients at the facility and to staff members not directly involved in managing the outbreak. At the same time, reasonable access to vital diagnostic services, e.g., radiography departments should be maintained.

5.1.4.3 Patient Transport

5.1.4.3.1 Most infections associated with bioterrorism agents cannot be transmitted from patient-to-patient. Patient transport requirements for specific potential agents of bioterrorism are listed in Section 5.2. In general, the transport and movement of patients with bioterrorism-related infections, as for patient with any epidemiologically important infections (e.g., pulmonary tuberculosis, chickenpox, measles), should be limited to movement that is essential to provide patient care, thus reducing the opportunities for transmission of microorganisms within healthcare facilities.

5.1.4.4 Cleaning, disinfection, and sterilization of equipment and environment

5.1.4.4.1 Principles of Standard Precautions should be generally applied for the management of patient-care equipment and environmental control.

5.1.4.4.1.1 Each facility should have in place adequate procedures for the routine care, cleaning and disinfection of environmental surfaces, beds, bedrails, beside equipment, and other frequently touched surfaces and equipment, and should ensure that these procedures are being followed.

5.1.4.4.1.2 Facility-approved germicidal cleaning agents should be available in patient care areas to use for cleaning spills of contaminated material and disinfecting non-critical equipment.

5.1.4.4.1.3 Used patient-care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions should be handled in a manner that prevents exposures to skin and mucous membranes, avoids contamination of clothing, and minimizes the likelihood of transfer of microbes to other patients and environments.

5.1.4.4.1.4 Sterilization is required for all instruments or equipment that enter normally sterile tissues or through which blood flows.

5.1.4.4.1.5 Rooms and bedside equipment of patients with bioterrorism-related infections should be cleaned using the same procedures that are used for all patients as a component of Standard Precautions, unless the infecting microorganism and the amount of environmental contamination indicates special cleaning. In addition to adequate cleaning, thorough disinfection of bedside equipment and environmental surfaces may be indicated for certain organisms that can survive in the inanimate environment for extended periods of time. The methods and frequency of cleaning and the products used are determined by facility policy.

5.1.4.4.1.6 Patient linen should be handled in accordance with Standard Precautions. Although linen may be contaminated, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to other patients, personnel and environments. Facility policy and local/state regulations should determine

the methods for handling, transporting, and laundering soiled linen.

5.1.4.4.1.7 Contaminated waste should be sorted and discarded in accordance with federal, state and local regulations.

5.1.4.4.1.8 Refer to PMH policies *CLN–02303; Bloodborne Pathogen Exposure Control Plan* and *HRD-00101; Bloodborne Pathogen Exposure Protocol* for guidelines on preventing and treating occupational injuries related to the exposure of bloodborne pathogens.

5.1.4.5 Discharge Management

5.1.4.5.1 Ideally, patients with bioterrorism-related infections will not be discharged from the facility until they are deemed noninfectious. However, consideration should be given to developing home-care instructions in the event that large numbers of persons exposed may preclude admission of all infected patients. Depending on the exposure and illness, home care instructions may include recommendations for the use of appropriate barrier precautions, hand washing, waste management, and cleaning and disinfection of the environment and patient care items.

5.1.4.6 Post-mortem Care

5.1.4.6.1 Pathology departments and clinical laboratories should be informed of a potentially infectious outbreak prior to submitting any specimens for examination or disposal. Standard precautions will be maintained during any post-mortem care. Notification to the appropriate responding agency (i.e. Imperial County Sheriff's Office Coroner or funeral home) that the patient was potentially infected with a bioterrorism agent will be given during the initial telephone. This will allow the responding agency adequate notice if additional Personal Protective Equipment (PPE) needs to be obtained prior to picking up the decedent.

5.1.5 Post Exposure Management

5.1.5.1 Decontamination of Patients and Environment

5.1.5.1.1 The need for decontamination depends on the suspected exposure and in most cases will not be necessary. The goal of decontamination after a potential exposure to a bioterrorism agent is to reduce the extent of external contamination of the patient and contain the contamination to prevent further spread. Decontamination should only be considered in instances of gross contamination. Decisions regarding the need for decontamination should be made in consultation with state and local health departments. Decontamination of exposed

individuals prior to receiving them in the healthcare facility may be necessary to ensure the safety of patients and staff while providing care. When developing Bioterrorism Readiness Plans, facilities should consider available locations and procedures for patient decontamination prior to facility entry.

5.1.5.1.2 Depending on the agent, the likelihood for re-aerosolization, or a risk associated with cutaneous exposure. Clothing of exposed persons may need to be removed. After removal of contaminated clothing, patients should be instructed (or assisted if necessary) to immediately shower with soap and water. Potentially harmful practices, such as bathing patients with bleach solutions, are unnecessary and should be avoided. Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes. If indicated, after removal at the decontamination site, patient clothing should be handled only by personnel wearing appropriate personal protective equipment, and placed in an impervious bag to prevent further environmental contamination. Decontamination requirements for specific potential agents of bioterrorism are listed in Section II.

5.1.5.1.3 The FBI may require collection of exposed clothing and other potential evidence for submission to FBI or Department of Defense laboratories to assist in exposure investigations.

5.1.5.2 Prophylaxis and post-exposure immunization

5.1.5.2.1 Recommendations for prophylaxis are subject to change. Current recommendations for post-exposure prophylaxis and immunization are provided in Section II for relevant potential bioterrorism agents. However, up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure to potentially exposed healthcare workers.

5.1.5.3 Triage and management of large scale exposures and suspected exposures:

5.1.5.3.1 In the event of a large scale exposure or suspected exposure, policy *EOC-00213; Emergency Operations Plan* may be placed into effect. Triage of incoming patients will utilize the processes outlined in policy *EOC-00180; Emergency Preparedness Medical Surge Registration and Triage*.

5.1.5.4 Psychological aspects of bioterrorism:

5.1.5.4.1 Following a bioterrorism-related event, fear and panic can be expected from both patients and healthcare providers. Psychological responses following a bioterrorism event may include horror, anger, and panic, unrealistic concerns about

infection, fear of contagion, paranoia, social isolation, or demoralization.

5.1.5.4.1.1 Minimize panic by clearly explaining risks, offering careful but rapid medical evaluation/treatment, and avoiding unnecessary isolation or quarantine.

5.1.5.4.1.2 Treat anxiety in unexposed persons who are experiencing somatic symptoms (e.g., with reassurance, or diazepam-like anxiolytics as indicated for acute relief of those who do not respond to reassurance).

5.1.5.4.1.3 Consider the following to address healthcare worker fears:

5.1.5.4.1.3.1 Provide bioterrorism readiness education, including frank discussions of potential risks and plans for protecting healthcare providers.

5.1.5.4.1.3.2 Fearful or anxious healthcare workers may benefit from their usual sources of social support, or by being asked to fulfill a useful role (e.g., as a volunteer at the triage site).

5.1.6 Laboratory Support and Confirmation

5.1.6.1 Facilities should work with local, state and federal public health services to tailor diagnostic strategies to specific events.

5.1.6.2 Obtaining diagnostic samples

5.1.6.2.1 See specific recommendations for diagnostics sampling for each agent. Sampling should be performed in accordance with Standard Precautions. In all cases of suspected bioterrorism, collect an acute phase serum sample to be analyzed, divided, and saved for comparison to a later convalescent serum sample.

5.1.6.3 Laboratory criteria for processing potential bioterrorism agents:

5.1.6.3.1 To evaluate laboratory capacity in the United States, a proposal is being made to group laboratories into one of four levels, according to their ability to support the diagnostic needs presented by an event. The proposed laboratory levels in the planning stages are:

5.1.6.3.2 Level A – Clinical laboratories – minimal identification of agents

5.1.6.3.3 Level B – County/State/other laboratories – identification, confirmation, susceptibility testing
Level C – State and other large facility laboratories with advanced capacity for testing – some molecular technologies

5.1.6.3.4 Level D – CDC or select Department of Defense laboratories, such as U.S. Army Medical Research Institute of Infectious Diseases (USARMIID) – Bio Safety Level (BSL) 3 and 4 labs with special surge capacity and advances molecular typing

techniques

5.1.6.4 Transport Requirements

5.1.6.4.1 Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. *For specific instructions, contact the Bioterrorism Emergency Number at the CDC Emergency Response Office*, ***770-488-7100***. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

5.1.7 Patient, Visitor, and Public Information

5.1.7.1 Clear, consistent, understandable information should be provided (e.g., via fact sheets) to patients, visitors, and the general public. During bioterrorism-related outbreaks, visitors may be strictly limited.

5.1.7.2 Failure to provide a public forum for information exchange may increase anxiety and misunderstanding, increasing fear among individuals who attribute non-specific symptoms to exposure to the bioterrorism agent.

5.2 Agent-Specific Recommendations

5.2.1 **Anthrax**

5.2.1.1 Anthrax is an acute infectious disease caused by *Bacillus anthracis*, a spore forming, and gram-positive bacillus. Associated disease occurs most frequently in sheep, goats, and cattle, which acquire spores through ingestion of contaminated soil. Humans can become infected through skin contact, ingestion, or inhalation of *B. anthracis* spores from infected animals or anima products (as in “woolsorter’s disease” from exposure to goat hair). Person-to-person transmission of inhalational disease does not occur. Direct exposure to vesicle secretions of cutaneous anthrax lesions may result in secondary cutaneous infection.

5.2.1.2 Clinical features

5.2.1.2.1 Human anthrax infection can occur in three forms: pulmonary, cutaneous, or gastrointestinal, depending on the route of exposure. Of these forms, pulmonary anthrax is associated with bioterrorism exposure to aerosolized spores. Clinical features for each form of anthrax include:

5.2.1.2.1.1 <u>Pulmonary</u>

5.2.1.2.1.1.1 Non-specific prodrome of flu-like symptoms follows inhalation of infectious spores.

5.2.1.2.1.1.2 Possible brief interim improvement.

5.2.1.2.1.1.3 Two to four days after initial symptoms, abrupt onset of respiratory failure and hemodynamic collapse, possible accompanied by thoracic

edema and a widened mediastinum on chest radiograph suggestive of mediastinal lymphadenopathy and hemorrhagic mediastinitis.

5.2.1.2.1.1.4 Gram-positive bacilli on blood culture, usually after the first two or three days of illness.

5.2.1.2.1.1.5 Treatable in early prodromal stage. Mortality remains extremely high despite antibiotic treatment if it is initiated after onset of respiratory symptoms.

5.2.1.2.1.2 Cutaneous

5.2.1.2.1.2.1 Local skin involvement after direct contact with spores or bacilli.

5.2.1.2.1.2.2 Commonly seen on the head, forearms or hands.

5.2.1.2.1.2.3 Localized itching, followed by a papular lesion that turns vesicular, and within 2-6 days develops into a depressed black eschar.

5.2.1.2.1.2.4 Usually non-fatal if treated with antibiotics.

5.2.1.2.1.3 Gastro-Intestinal

5.2.1.2.1.3.1 Abdominal pain, nausea, vomiting, and fever following ingestion of contaminated food, usually meat.

5.2.1.2.1.3.2 Bloody diarrhea, hematemesis.

5.2.1.2.1.3.3 Gram-positive bacilli on blood culture, usually after the first two or three days of illness.

5.2.1.2.1.3.4 Usually fatal after progression to toxemia and sepsis.

5.2.1.2.1.4 Modes of transmission:

5.2.1.2.1.4.1 The spore form of *B. anthracis* is durable. As a bioterrorism agent, it could be delivered as an aerosol. The modes of transmission for anthrax include:

5.2.1.2.1.4.1.1 Inhalation of spores.

5.2.1.2.1.4.1.2 Cutaneous contact with spores or spore-contaminated materials.

5.2.1.2.1.4.2 Ingestion of contaminated food.

5.2.1.2.2 Incubation Period:

5.2.1.2.2.1 The incubation period following exposure to *B. anthracis* ranges from 1 day to 8 weeks (average 5 days), depending on the exposure route and dose:

- 2-60 days following pulmonary exposure.
- 1-7 days following cutaneous exposure.
- 1-7 days following ingestion.

5.2.1.2.3 Period of communicability

5.2.1.2.3.1 Transmission of anthrax infections from person to person is unlikely. Airborne transmission does not occur, but direct contact with skin lesions may result in cutaneous infection.

5.2.1.3 Preventive Measures

5.2.1.3.1 Vaccine availability

5.2.1.3.1.1 Inactivated, cell-free anthrax vaccine (Bioport Corporation **517-327-1500**, formerly Michigan Biologic Products Institute) – limited availability.

5.2.1.3.2 Immunization recommendations

5.2.1.3.2.1 Routinely administered to military personnel. Routine vaccination of civilian populations not recommended.

5.2.1.3.2.2 Infection Control Practices for Patient Management:

5.2.1.3.2.2.1 Symptomatic patients with suspected or confirmed infections with *B. anthracis* should be managed according to current guidelines specific to their disease state. Recommendations for chemotherapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact the local and state health department.

5.2.1.4 Infection Control Practices for Patient Management

5.2.1.4.1 Isolation precautions

5.2.1.4.1.1 Standard Precautions are used for the care of patients with infections associated with *B. anthracis.* Standard Precautions include the routine use of gloves for contact with non-intact skin, including rashes and skin lesions.

5.2.1.4.2 Patient placement

5.2.1.4.2.1 Private room placement for patients with anthrax is <u>not</u> necessary. Airborne transmission of anthrax does not occur. Skin lesions may be infectious, but requires direct skin contact only.

5.2.1.4.3 Patient transport

5.2.1.4.3.1 Standard Precautions should be used for transport and movement of patients with *B. anthracis* infections.

5.2.1.4.4 Cleaning, disinfection, and sterilization of equipment and environment

5.2.1.4.4.1 Principles of Standard Precautions should be generally applied for the management of patient-care equipment and for environmental control (see Section I for more detail).

5.2.1.4.5 Discharge management

5.2.1.4.5.1 No special discharge instructions are indicated. Home care providers should be taught to use Standard Precautions for all patient care (e.g., dressing changes).

5.2.1.4.6 Post-mortem care

5.2.1.4.6.1 Standard Precautions should be used for post-mortem care. Standard Precautions include wearing appropriate personal protective equipment, including masks and eye protection, when generation of aerosols or splatter of body fluids is anticipated.

5.2.1.5 Post Exposure Management

5.2.1.5.1 Decontamination of patients/environment – The risk for re-aerosolization of *B. anthracis* spores appears to be extremely low in settings where spores were released intentionally or were present at low or high levels. In situations where the threat of gross exposure to *B. anthracis* spores exists, cleansing of skin and potentially contaminated fomites (e. g. clothing or environmental surfaces) may be considered to reduce the risk of cutaneous and gastrointestinal forms of disease. The plan for decontaminating patients exposed to anthrax may include the following:

5.2.1.5.1.1 Instructing patients to remove contaminated clothing and store in labeled, plastic bags.

5.2.1.5.1.2 Handling clothing minimally to avoid agitation.

5.2.1.5.1.3 Instructing patients to shower thoroughly with soap and water (and providing assistance if necessary).

5.2.1.5.1.4 Instructing personnel regarding Standard Precautions and wearing appropriate barriers (e.g. gloves, gown, and respiratory protection) when handling contaminated clothing or other contaminated fomites.

5.2.1.5.1.5 Decontaminating environmental surfaces using an EPA-registered, facility-approved sporicidal/germicidal agent or 0.5% hypochlorite solution (one part household bleach added to nine parts water).

5.2.1.5.2 Prophylaxis and post-exposure immunization

5.2.1.5.2.1 Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Prophylaxis should be initiated upon confirmation of an anthrax exposure (Table 1).

Table 1: Recommended post-exposure prophylaxis for exposure to Bacillus anthracis

Antimicrobial Agent	Adults	Children§
Oral Fluoroquinolones One of the following:		
Ciprofloxacin	500 mg twice daily	20-30 mg per kg of body mass daily, divided into two doses
Levofloxacin	500 mg once daily	Not recommended
Ofloxacin	400 mg twice daily	Not recommended
If flouroquinolones are not available or are contraindicated Doxycycline	100 mg twice daily	5 mg per kg of body mass per day divided into two doses

§ Pediatric use of flouroquinolones and tetracyclines is associated with adverse effects that must be weighed against the risk of developing a lethal disease. If *B. anthracis* exposure is confirmed, the organism must be tested for penicillin susceptibility. If susceptible, exposed children may be treated with oral amoxicillin 40 mg per kg of body mass per divided every 8 hours (not to exceed 500 mg, three times daily)

5.2.1.5.3 Prophylaxis should continue until *B. anthracis* exposure has been excluded. If exposure is confirmed, prophylaxis should continue for 8 weeks. In addition to prophylaxis, post-exposure immunization with an inactivated, cell-free anthrax vaccine is also indicated following anthrax exposure. If available, post-exposure vaccination consists of three doses of vaccine at 0, 2 and 4 weeks after exposure. With vaccination, post-exposure antimicrobial prophylaxis can be reduced to 4 weeks.

5.2.1.6 Laboratory Support and Confirmation

5.2.1.6.1 Diagnosis of anthrax is confirmed by aerobic culture performed in a BSL-2 Laboratory.

5.2.1.6.1.1 Diagnostic samples to obtain include:

5.2.1.6.1.1.1 Blood Cultures.

5.2.1.6.1.1.2 Acute serum for frozen storage.

5.2.1.6.1.1.3 Stool culture if gastrointestinal disease is suspected.

5.2.1.6.2 Laboratory Section – Handling of clinical specimens should be coordinated with local and state health departments and undertaken in BSL –2 or –3 laboratories. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI

or Department of Defense Laboratories.

5.2.1.6.3 Transport requirements – Specimen packaging and transport must be coordinated with local and state health departments and the FBI. A chain of custody document should accompany the specimen from the moment of collection.
For specific instructions, contact the CDC National Center for Environmental Health and Agency for Toxic Substances and Disease Registry at ***770-488-7100***.
Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

5.2.1.7 Patient, Visitors, and Public Information

5.2.1.7.1 Fact sheets for distribution should be prepared, including explanation that people recently exposed to *B. anthraces* are not contagious, and antibiotics are available for prophylactic therapy along with the anthrax vaccine. Dosing information and potential side effects should be explained clearly. Decontamination procedures, i.e., showering thoroughly with soap and water; and environmental cleaning, i.e., with 0.5% hypochlorite solution (one part household bleach added to nine parts water), can be described.

5.2.2 **Botulism**

5.2.2.1 *Clostridium botulinum* is an anaerobic gram-positive bacillus that produces a potent neurotoxin, botulinum toxin. In humans, botulinum toxin inhibits the release of acetylcholine, resulting in characteristic flaccid paralysis. *C. botulinum* produces spores that are present in soil and marine sediment throughout the world. Foodborne botulism is the most common form of disease in adults. An inhalational form of botulism is also possible. Botulinum toxin exposure may occur in both forms as agents of bioterrorism.

5.2.2.2 Clinical features – Foodborne botulism is accompanied by gastrointestinal symptoms. Inhalational botulism and foodborne botulism are likely to share other symptoms including:

5.2.2.2.1 Responsive patient with absence of fever.

5.2.2.2.2 Symmetric cranial neuropathies (drooping eyelids, weakened jaw clench, difficulty swallowing or speaking).

5.2.2.2.3 Blurred vision and diplopia due to extra-ocular muscle palsies.

5.2.2.2.4 Symmetric descending weakness in a proximal to distal pattern (paralysis of arms first, followed by respiratory muscles, then legs).

5.2.2.2.5 Respiratory dysfunction from respiratory muscle paralysis or upper airway obstruction due to weakened glottis.

5.2.2.2.6 No sensory deficits.

5.2.2.3 Mode of Transmission – Botulinum toxin is generally transmitted by

ingestion of toxin-contaminated food. Aerosolization of botulinum has been described and may be a mechanism for bioterrorism exposure.

5.2.2.4 Incubation Period

5.2.2.4.1 Neurologic symptoms of foodborne botulism begin 12-36 hours after ingestion.

5.2.2.4.2 Neurologic symptoms of inhalational botulism begin 24-72 hours after aerosol exposure.

5.2.2.5 Period of Communicability – Botulism is not transmitted from person to person.

5.2.2.6 Preventive Measures

5.2.2.6.1 Vaccine availability – A pentavalent toxoid vaccine has been developed by the Department of Defense. Completion of a recommended schedule (0, 2, 12 weeks) has been shown to induce protective antitoxin levels detectable at 1-year post vaccination.

5.2.2.6.2 Immunization Recommendations – Routine immunization of the public, including healthcare workers, is not recommended.

5.2.2.7 Infection Control Practices for Patient Management – Symptomatic patients with suspected or confirmed botulism should be managed according to current guidelines. Recommendations for therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact CDC or state health department

5.2.2.8 Isolation precautions – Standard Precautions are used for the care of patients with botulism.

5.2.2.9 Patient placement – Patient-to-patient transmission of botulism does not occur. Patient room selection and care should be consistent with facility policy.

5.2.2.10 Patient transport – Standard Precautions should be used for transport and movement of patients with botulism.

5.2.2.11 Cleaning, disinfection, and sterilization of equipment and environment. Principles of Standard Precautions should be generally applied to the management of patient-care equipment and environmental control (see Section I for more detail).

5.2.2.12 Discharge management – No special discharge instructions are indicated.

5.2.2.13 Post-mortem care – Standard Precautions should be used for post-mortem care.

5.2.2.14 Post Exposure Management – Suspicion of even single cases of botulism should immediately raise concerns of an outbreak potentially associated with shared contaminated food. In collaboration with CDC and local/state health departments, attempts should be made to locate the contaminated food source and identify other persons who may have been exposed. Any individuals suspected to have been exposed to botulism toxin should be carefully monitored for evidence of

respiratory compromise.

5.2.2.14.1 Decontamination of patients/environment

5.2.2.14.1.1 Contamination with botulinum toxin does not place persons at risk for dermal exposure or risk associated with re-aerosolization. Therefore, decontamination of patients is not required.

5.2.2.14.2 Prophylaxis and post-exposure immunization

5.2.2.14.2.1 Trivalent botulinum antitoxin is available by contacting state health department. This horse serum product has a <9% of hypersensitivity reactions. Skin testing should be performed according to the package insert prior to administration.

5.2.2.14.3 Triage and management of large scale exposures/potential exposures.

5.2.2.14.3.1 Patients affected by botulinum toxin are at risk for respiratory dysfunction that may necessitate mechanical ventilation. Ventilatory support is required, on average, for 2 to 3 months before neuromuscular recovery allows unassisted breathing. Large-scale exposures to botulinum toxin may overwhelm an institution's available resources for mechanical ventilation. Sources of auxiliary support and means to transport patients to auxiliary sites, if necessary should be planned in advance with coordination among neighboring facilities.

5.2.2.15 Laboratory Support and Confirmation

5.2.2.15.1 Obtaining diagnostic samples – Routine laboratory tests are of limited value in the diagnosis of botulism. Detection of toxin is possible from serum, stool samples, or gastric secretions. For advice regarding the appropriate diagnostic specimens to obtain, contact state health.

5.2.2.15.2 Laboratory selection – Handling of clinical specimens should be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

5.2.2.16 Patient, Visitor, and Public Information

5.2.2.16.1 Fact sheets for distribution should be prepared, including explanation that people exposed to botulinum toxin are <u>not</u> contagious. A clear description of symptoms including blurred vision, drooping eyelids, and shortness of breath should be provided with instructions to report for evaluation and care if

such symptoms develop.

5.2.3 **Plague**

5.2.3.1 Plague is an acute bacterial disease caused by the gram-negative bacillus *Yersinia pestis,* which is usually transmitted by infected fleas, resulting in lymphatic and blood infections (bubonic and septicemia plague). A bioterrorism-related outbreak may be expected to be airborne, causing a pulmonary variant, pneumonic plague.

5.2.3.2 Clinical features of pneumonic plague include:

5.2.3.2.1 Fever, cough, chest pain.

5.2.3.2.2 Hemoptysis.

5.2.3.2.3 Muco-purulent or watery sputum with gram-negative rods on gram stain.

5.2.3.2.4 Radiographic evidence of bronchopneumonia.

5.2.3.3 Modes of transmission

5.2.3.3.1 Plague is normally transmitted from an infected rodent to maybe infected fleas.

5.2.3.3.2 Bioterrorism-related outbreaks are like to be transmitted through dispersion of an aerosol.

5.2.3.3.3 Person-to-person transmission of pneumonic plague is possible via large aerosol droplets.

5.2.3.4 Incubation period – The incubation period for plague is normally 2 – 8 days if due to fleaborne transmission. The incubation period may be shorter for pulmonary exposure (1-3 days).

5.2.3.5 Period of communicability – Patients with pneumonic plague may have coughs productive of infectious particle droplets. Droplet precautions, including the use of a mask for patient care, should be implemented until the patient has completed 72 hours of antimicrobial therapy.

5.2.3.6 Preventive Measures

5.2.3.6.1 Vaccine availability – Formalin-killed vaccine exists for bubonic plague, but has not been proven to be effective for pneumonic plague. It is currently available in the United States.

5.2.3.6.2 Immunization recommendations – Routine vaccination requires multiple doses given over several weeks and is not recommended for the general population. Post-exposure immunization has no utility.

5.2.3.7 Infection Control Practices for Patient Management – Symptomatic patients with suspected or confirmed plague should be managed according to current guidelines. Recommendations for specific therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact CDC or state health department.

5.2.3.7.1 Isolation precautions – For pneumonic plague, Droplet Precautions should be used in addition to Standard Precautions.

5.2.3.7.1.1 Droplet Precautions are used for patients known or suspected to be infected with microorganisms

transmitted by large particle droplets, generally larger than 5µ in size, that can be generated by the infected patient during coughing, sneezing, talking, or during respiratory-care procedures.

5.2.3.7.1.2 Droplet Precautions require healthcare providers and others to wear a surgical-type mask when within 3 feet of the infected patient. Based on local policy, some healthcare facilities require a mask be worn to enter the room of a patient on Droplet Precautions.

5.2.3.7.1.3 Droplet Precautions should be maintained until patient has completed 72 hours of antimicrobial therapy.

5.2.3.7.2 Patient placement – Patients suspected or confirmed to have pneumonic plague require Droplet Precautions. Patient placement recommendations for Droplet Precautions include:

5.2.3.7.2.1 Placing infected patient in a private room.

5.2.3.7.2.2 Cohort in symptomatic patients with similar symptoms and the same presumptive diagnosis (i.e. pneumonic plague) when private rooms are not available.

5.2.3.7.2.3 Maintaining spatial separation of at least 3 feet between infected patients and others when cohorting is not achievable.

5.2.3.7.2.4 Avoiding placement of patient requiring Droplet Precautions in the same room with an immunocompromised patient.

5.2.3.7.2.5 Special air handling is not necessary and doors may remain open.

5.2.3.7.3 Patient transport

5.2.3.7.3.1 Limit the movement and transport of patients on Droplet Precautions to essential medical purposes only.

5.2.3.7.3.2 Minimize dispersal of droplets by placing a surgical-type mask on the patient when transport is necessary.

5.2.3.7.4 Cleaning, disinfection, and sterilization of equipment and environment

5.2.3.7.4.1 Principles of Standard Precautions should be generally applied to the management of patient-care equipment and for environmental control (see Section I for more detail).

5.2.3.7.5 Discharge management – Generally, patients with pneumonic plague would not be discharged from a healthcare facility until no longer infectious (completion of 72 hours of antimicrobial therapy) and would require no special discharge instructions. In the event of a large bioterrorism exposure with patients receiving care in their homes, home care providers should be

taught to use Standard and Droplet Precautions for all patient care.

5.2.3.7.6 Post-mortem care – Standard Precautions and Droplet Precautions should be used for post-mortem care.

5.2.3.8 Post Exposure Management

5.2.3.8.1 Decontamination of patients/environment

5.2.3.8.1.1 The risk of re-aerosolization of *Y. pestis* from the contaminated clothing of exposed persons is low. In situations where there may have been gross exposure to *Y. pestis*, decontamination of skin and potentially contaminated fomites (e.g. clothing or environmental surfaces) may be considered to reduce the risk of cutaneous or bubonic forms of the disease. The plan for decontaminating patients may include:

5.2.3.8.1.1.1 Instructing patients to remove contaminated clothing and storing in labeled, plastic bags.

5.2.3.8.1.1.2 Handling clothing minimally to avoid agitation.

5.2.3.8.1.1.3 Instruction to patients to shower thoroughly with soap and water (and providing assistance if necessary).

5.2.3.8.1.1.4 Instructing personnel regarding Standard Precautions and wearing appropriate barriers (e.g. gloves, gown, face shield) when handling contaminated clothing or other contaminated fomites.

5.2.3.8.1.1.5 Performing environmental surface decontamination using an EPA-registered, facility-approved sporicidal/germicidal agent or 0.5% hypochlorite solution (one part household bleach added to nine parts water).

5.2.3.9 Prophylaxis

5.2.3.9.1 Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

5.2.3.9.2 Post-exposure prophylaxis should be initiated following confirmed or suspected bioterrorism *Y. pestis* exposure, and for post-exposure management of healthcare workers and others who had unprotected face-to-face contact with symptomatic patients (Table 2).

Table 2. Recommended post-exposure prophylaxis for exposure to *Yersinia pestis.*

Antimicrobial Agent	Adults	Children§
First Choice Doxycycline	100 mg twice daily	5 mg per kg of body mass per day divided into two doses
Second Choice Ciprofloxacin	500 mg twice daily	20-0 mg per kg of body mass daily, divided into two doses
§Pediatric use of tetracyclines and flouroquinolones is associated with adverse effects that must be weighed against the risk of developing a lethal disease.		
Prophylaxis should continue for 7 days after last known or suspected *Y. pestis* exposure has been excluded.		

5.2.3.10 Triage and management of large scale exposures/potential exposures.

5.2.3.10.1 Advance planning should include identification of sources for appropriate masks to facilitate adherence to Droplet Precautions for potentially large numbers of patients and staff. Instruction and reiteration of requirements for Droplet Precautions (as opposed to Airborne Precautions) will be necessary to promote compliance and minimize fear and panic related to an aerosol exposure.

5.2.3.11 Laboratory Support and Confirmation

5.2.3.11.1 Laboratory confirmation of plague is by standard microbiologic culture, but slow growth and misidentification in automated systems are likely to delay diagnosis. For decisions regarding obtaining and processing diagnostic specimens, contact state laboratory authorities or CDC.

5.2.3.12 Diagnostic samples to obtain include:

5.2.3.12.1 Serum for capsular antigen testing.

5.2.3.12.2 Blood cultures.

5.2.3.12.3 Sputum or tracheal aspirates for Gram's, Wayson's, and fluorescent antibody staining.

5.2.3.12.4 Sputum or tracheal aspirates for culture.

5.2.3.13 Laboratory selection – Handling of clinical specimens should be coordinated with local and state health departments, and undertaken in Bio-Safety Level (BSL) – 2 or – 3 laboratories. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

5.2.3.14 Transport requirements – Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection.

For specific instructions, contact the Bioterrorism Emergency Number

*at the CDC Emergency Response Office, **770-488-7100***.
Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

5.2.3.15 Patient, Visitor, and Public Information – Fact sheets for distribution should be prepared, including a clear description of Droplet Precautions, symptoms of plague, and instructions to report for evaluation and care if such symptoms are recognized. The difference between prophylactic antimicrobial therapy and treatment of an actual infection should be clarified. Decontamination by showering thoroughly with soap and water can be recommended.

5.2.4 **Smallpox**

5.2.4.1 Smallpox is an acute viral illness caused by the variola virus. Smallpox is a bioterrorism threat due to its potential to cause severe morbidity in a nonimmune population and because it can be transmitted via the airborne route. A single case is considered a public health emergency.

5.2.4.2 Clinical Features – Acute clinical symptoms of smallpox resemble other acute viral illnesses, such as influenza. Skin lesions appear, quickly progressing from macules to papules to vesicles. Other clinical symptoms to aid in identification of smallpox vehicle:

5.2.4.2.1 Non-specific prodrome of fever, myalagias, 2-4 day

5.2.4.2.2 Rash most prominent on face and extremities (including palms and soles) in contrast to the truncal distribution of varicella

5.2.4.2.3 Rash scabs over in 1-2 weeks

5.2.4.2.4 In contrast to the rash of varicella, which arises in “crops” variola rash has a synchronous onset

5.2.4.3 Mode of transmission – Smallpox is transmitted via both large and small respiratory droplets. Patient-to-patient transmission is likely from airborne and droplet exposure, and by contact with skin lesions or secretions. Patients are considered more infectious if coughing or if they have a hemorrhagic form of smallpox.

5.2.4.4 Incubation period – The incubation period for smallpox is 7-17 days; the average is 12 days.

5.2.4.5 Period of communicability – Unlike varicella, which is contagious before the rash is apparent, patients with smallpox become infectious at the onset of the rash and remain infectious until their scabs separate (approximately 3 weeks)

5.2.4.6 Preventive Measures

5.2.4.6.1 Vaccine Availability – A live-virus intradermal vaccination is available for the prevention of smallpox.

5.2.4.6.2 Immunization recommendations – Since the last naturally acquired case of smallpox in the world occurred more than 20 years ago, routine public vaccination has not been recommended. Vaccination against smallpox does not reliably

confer lifelong immunity. Even previously vaccinated persons should be considered susceptible to smallpox.

5.2.4.7 Infection Control Practices for Patient Management

5.2.4.7.1 Symptomatic patients with suspected or confirmed smallpox should be managed according to current guidelines. Recommendations for specific therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact the CDC or state health department.

5.2.4.7.2 Isolation precautions – For patients with suspected or confirmed smallpox, both Airborne and Contact Precautions should be used in addition to Standard Precautions.

5.2.4.7.2.1 Airborne Precautions are used for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small particle residue, 5μ or smaller in size) of evaporated droplets containing microorganisms that can remain suspended in air and can be widely dispersed by air currents.

5.2.4.7.2.2 Airborne Precautions require healthcare providers and others to wear respiratory protection when entering the patient room. (Appropriate respiratory protection is based on facility selection policy; must meet the minimal NIOSH standard for particulate respirators, N95).

5.2.4.7.2.3 Contact Precautions are used for patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient or indirect contact with potentially contaminated surfaces in the patient's care area.

5.2.4.7.2.4 Contact precautions require healthcare providers and others to:

5.2.4.7.2.4.1 Wear clean gloves upon entry into patient room.

5.2.4.7.2.4.2 Wear gown for all patient contact and for all contact with the patient's environment. Based on local policy, some healthcare facilities require a gown be worn to enter the room of patient on Contact Precautions. Gown must be removed before leaving the patient's room.

5.2.4.7.2.5 Wash hands using an antimicrobial agent.

5.2.4.8 Patient placement – Patients suspected or confirmed with smallpox require placement in rooms that meet the ventilation and engineering

requirements for Airborne Precautions, which include:

5.2.4.8.1 Monitored negative air pressure in relation to the corridor and surrounding areas.

5.2.4.8.2 6 – 12 air exchanges per hour.

5.2.4.8.3 Appropriate discharge of air to the outdoors, or monitored high efficiency filtration of air prior to circulation to other areas in the healthcare facility.

5.2.4.8.4 A door must remain closed.

5.2.4.8.5 Healthcare facilities without patient rooms appropriate for the isolation and care required for Airborne Precautions should have a plan for transfer of suspected or confirmed smallpox patients to neighboring facilities with appropriate isolation rooms.

5.2.4.8.6 Patient placement in a private room is preferred. However, in the event of a large outbreak, patients who have active infections with the same disease (i.e., smallpox) may be cohorted in rooms that meet appropriate ventilation and airflow requirements for Airborne Precautions.

5.2.4.9 Patient transport

5.2.4.9.1 Limit the movement and transport of patients with suspected or confirmed smallpox to essential medical purposes only.

5.2.4.9.2 When transport is necessary, minimize the dispersal of respiratory droplets by placing a mask on the patient, if possible.

5.2.4.10 Cleaning, disinfection, and sterilization of equipment and environment.

5.2.4.10.1 A component of Contact Precautions is careful management of potentially contaminated equipment and environmental surfaces.

5.2.4.10.1.1 When possible, noncritical patient care equipment should be dedicated to a single patient (or cohort of patients with the same illness).

5.2.4.10.1.2 If use of common items in unavoidable, all potentially contaminated, reusable equipment should not be used for the care of another patient until it has been appropriately cleaned and reprocessed. Policies should be in place and monitored for compliance.

5.2.4.11 Discharge management – In general, patients with smallpox will not be discharged from a healthcare facility until determined they are no longer infectious. Therefore, no special discharge instructions are required.

5.2.4.12 Post-mortem care – Airborne and Contact Precautions should be used for post-mortem care.

5.2.4.13 Post Exposure Management

5.2.4.13.1 Decontamination of patients/environment

5.2.4.13.2 Patient decontamination after exposure to smallpox is not

indicated.

5.2.4.13.3 Items potentially contaminated by infectious lesions should be handled using Contact Precautions.

5.2.4.14 Prophylaxis and post-exposure immunization

5.2.4.14.1 Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

5.2.4.14.2 Post-exposure immunization with smallpox vaccine (vaccinia virus) is available and effective. Vaccination alone is recommended if given within 3 days of exposure. Passive immunization is also available in the form of vaccinia immune-globulin (VIG) (0.6ml/kg IM). If greater than 3 days has elapsed since exposure, both vaccination and VIG are recommended.

5.2.4.14.3 Vaccination is generally contraindicated in pregnant women, and persons with immunosuppression, HIV-infection, and eczema, who are at risk for disseminated vaccinia disease. However, the risk of smallpox vaccination should be weighed against the likelihood for developing smallpox following a known exposure. VIG should be given concomitantly with vaccination in these patients.

5.2.4.14.4 Following prophylactic care, exposed individuals should be instructed to monitor themselves for development of flu-like symptoms or rash during the incubation period (i.e., for 7 to 17 days after exposure) and immediately report to designated care sites selected to minimize to risk of exposure to others.

5.2.4.14.5 Facilities should ensure that policies are in place to identify and manage health care workers exposed to infectious patients. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.

5.2.4.15 Triage and management of large scale exposures/potential exposures.

5.2.4.15.1 Advance planning must involve IC professionals in cooperation with building engineering staff, to identify sites within the facility that can provide necessary parameters for Airborne Precautions. See Section I for additional general details regarding planning for large-scale patient management.

5.2.4.16 Laboratory Support and Confirmation

5.2.4.16.1 Diagnostic samples to obtain

5.2.4.16.1.1 For decisions regarding obtaining and processing diagnostic specimens, contact state laboratory authorities or CDC.

5.2.4.16.2 Laboratory selection

5.2.4.16.2.1 Handling of clinical specimens must be coordinated with state health departments, CDC, and USAMRIID.

Testing can be performed only in BSL – 4 laboratories. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

5.2.4.16.3 Transport requirements

5.2.4.16.3.1 Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. *For specific instructions, contact the Bioterrorism Emergency Number at the CDC Emergency Response Office*, ***770-488-7100***. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

5.2.4.16.4 Patient, Visitor, and Public Information

5.2.4.16.4.1 Fact sheets for distribution should be prepared, including a clear description of symptoms and where to report for evaluation and care if such symptoms are recognized. Details about the type and duration of isolation should be provided. Vaccination information that detail who should receive the vaccine and possible side effects should be provided. Extreme measures such as burning or boiling potentially exposed materials should be discouraged.

5.3 The preceding bioterrorism agents are considered the most likely threats according to the CDC. For information regarding other potential bioterrorism agents refer to Attachment A – Terrorism Agent Information and Treatment Guidelines for Clinicians and Hospitals (also known as The Zebra Book). The Zebra Book covers the following additional bioterrorism agents:

5.3.1 Tularemia
5.3.2 Viral Hemorrhagic Fevers
5.3.3 Brucellosis
5.3.4 Glanders and Melioidosis
5.3.5 Q Fever
5.3.6 Ricin

5.4 If bioterrorism is suspected the *PMH Emergency Operations Plan <EOC – 00213>* should be implemented. Hospital Incident Command System (HICS) Incident Response Guides (IRG) that would be appropriate for this scenario includes Infectious Disease IRG and the Mass Casualty IRG, see attachments.

6.0 References:

6.1 Imperial County Medical/Health Branch Plan

6.2 Centers for Disease Control (http://www.bt.cdc.gov/bioterrorism/)
6.3 PMH policy EOC-00213; Emergency Operations Plan
6.4 PMH policy CLN-02355; Plan to Manage Influx of Potentially Infectious Disease Patients
6.5 PMH policy CLN-02341; Infection Control Program
6.6 PMH policy CLN-02303; Infection Control – Bloodborne Pathogen Control Plan
6.7 PMH policy HRD-00101; Bloodborne Pathogen Exposure Protocol

7.0 Attachment List:

7.1 Attachment A – Terrorism Agent Information and Treatment Guidelines for Clinicians and Hospitals (also known as The Zebra Book)
7.2 Attachment B – HICS Infectious Disease Incident Response Guide
7.3 Attachment C – HICS Mass Casualty Incident Response Guide
7.4 Attachment D – Bioterrorism Syndrome Quick Reference

8.0 Summary of Revisions:

8.1 Updated PMHD to PMH

HICS 258 - HOSPITAL RESOURCE DIRECTORY

1. Incident Name	2. Operational Period (#)
	DATE: FROM: _____ TO: _____
	TIME: FROM: _____ TO: _____

3. Contact Information

COMPANY / AGENCY	COMPANY / AGENCY / NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	EMAIL	FAX	RADIO
Agency for Toxic Substances and Disease Registry (ATSDR)						
Air transport: helicopter or fixed wing						
Ambulance, hospital-based						
Ambulance, private						
Ambulance, public safety						
American Red Cross						
Automated Teller Machine (ATM) (Onsite)						
Biohazard/Waste company						
Buses						
Cab (Taxi)						
Centers for Disease Control and Prevention (CDC)						
Clinics						
Coroner/Medical Examiner						
Dispatcher, 911						
Emergency Management Agency						
EMS Agency/Authority						
Emergency Operations Center (EOC), Local						
Emergency Operations Center (EOC), State						

HICS 258 - HOSPITAL RESOURCE DIRECTORY

COMPANY / AGENCY	COMPANY / AGENCY / NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	EMAIL	FAX	RADIO
Engineers: HVAC						
Engineers: mechanical						
Engineers: seismic						
Engineers: structural						
Environmental Protection Agency (EPA)						
Epidemiologist						
Federal Bureau of Investigation (FBI)						
Fire Department						
Food service (Note if vendor, onsite, or emergency)						
Fuel distributor						
Fuel trucks						
Funeral homes/mortuary services						
Generators						
HazMat Team						
Health department, local						
Health department, state						
Heavy equipment (e.g., backhoes, snowplow, etc.)						
Home health service						
Home repair/construction supplies						
1.						
2.						

HICS 258 - HOSPITAL RESOURCE DIRECTORY

COMPANY / AGENCY	COMPANY / AGENCY / NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	EMAIL	FAX	RADIO
Hospice						
Hospitals						
1.						
2.						
3.						
4.						
Hotel/motel						
Housing, temporary						
Ice, commercial						
Laboratory Response Network						
Laundry/linen service						
Law Enforcement						
Lighting						
Long term care facilities						
1.						
2.						
3.						
Media: print						
Media: print						
Media: radio						
Media: radio						

HICS 258 - HOSPITAL RESOURCE DIRECTORY

COMPANY / AGENCY	COMPANY / AGENCY / NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	EMAIL	FAX	RADIO
Media: TV						
Media: TV						
Media: TV						
Medical gases						
Medical supply						
1.						
2.						
Medication, distributor						
1.						
2.						
Pharmacy, commercial						
1.						
2.						
3.						
Poison Control Center						
Portable toilets						
Radios: amateur radio						
Radios: satellite						
Radios: handheld or 2-way						
Regional Medical Health Coordinator						

HICS 258 - HOSPITAL RESOURCE DIRECTORY

COMPANY / AGENCY	COMPANY / AGENCY / NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	EMAIL	FAX	RADIO
Repair Services						
Beds						
Biomedical devices						
Elevators						
Gardeners/landscapers						
Glass						
Medical equipment						
Oxygen devices						
Radios						
Roadways/sidewalks						
Salvation Army						
Shelter Sites						
Surge Facilities						
Traffic Control/Department of Transportation						
Trucks						
Refrigeration						
Towing						
Moving						
Utilities						
Gas						

HICS 258 - HOSPITAL RESOURCE DIRECTORY

COMPANY / AGENCY	COMPANY / AGENCY / NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	EMAIL	FAX	RADIO
Utilities						
Gas/Electricity						
Sewage						
Telephone						
Water, municipal						
Vending Machines						
Ventilators						
Water: non-potable						
Water: potable						
Other						
Other						
Other						
Other						

4. Date Last Updated _____

5. Prepared by

PRINT NAME: _____ SIGNATURE: _____

DATE/TIME: _____ FACILITY: _____

HICS 258 - HOSPITAL RESOURCE DIRECTORY

PURPOSE: The HICS 258 - Hospital Resource Directory lists all methods of contact for hospital resources for an incident.

ORIGINATION: Completed by the Planning Section Resources Unit Leader **prior** to an incident (when possible) or at the incident onset, and continually updated throughout an incident.

COPIES TO: Distributed to the Command and General staff including the Documentation Unit Leader, and posted as necessary.

NOTES: If this form contains sensitive information such as cell phone numbers, it should be clearly marked in the header that it contains sensitive information and is not for public release.If additional pages are needed, use a blank HICS 258 and repaginate as needed. Additions and deletions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period**	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	**Contact Information**	
	Company / Agency	Type of company or agency.
	Company / Agency / Name	List the name of the company/agency. List the name of the point of contact if available.
	Telephone	Enter the telephone number.
	Alternate Telephone	Enter the alternate telephone number.
	Email	Enter the email, if available.
	Fax	Enter the fax number.
	Radio	Enter the radio frequency if appropriate.
4	**Date Last Updated**	If the document is completed prior to an incident, the last update should be entered (m/d/y). The directory should be updated at least annually.
5	**Prepared by**	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

Incident Response Guide: Mass Casualty Incident

Mission

To ensure a safe environment for staff, patients, visitors, and the facility when the number of patients severely challenges or exceeds the capability and capacity of the hospital.

Directions

Read this entire response guide and review the Hospital Incident Management Team Activation chart. Use this response guide as a checklist to ensure all tasks are addressed and completed.

Objectives

- ☐ Identify, triage, and treat patients
- ☐ Provide safe and appropriate patient care, based on scope of response
- ☐ Maintain patient tracking
- ☐ Provide continuity of care for non-incident patients
- ☐ Maintain communications with healthcare and public safety response partners

Immediate Response (0 – 2 hours)				
Section	**Officer**	**Time**	**Action**	**Initials**
Command	**Incident Commander**		Activate Emergency Operations Plan, Mass Casualty Incident Plan, Hospital Incident Management Team, and Hospital Command Center.	
			Establish operational periods, objectives, and regular briefing schedule. Consider use of Incident Action Plan Quick Start for initial documentation of the incident.	
			Notify hospital Chief Executive Officer, Board of Directors, and other appropriate internal and external officials of situation status.	
	Public Information Officer		Conduct media briefings and situation updates, in conjunction with Incident Commander.	
			Maintain communication with patients, staff, and families regarding current situation and what's being done to address the situation.	
			Monitor media outlets for updates on the incident and possible impacts on the hospital. Communicate information via regular briefings to Section Chiefs and Incident Commander.	
	Liaison Officer		Notify community partners in accordance with local policies and procedures (e.g., consider local Emergency Operations Center, other area healthcare facilities, local emergency medical services, and healthcare coalition coordinator), to determine incident details, community status, estimates of casualties, and establish contacts for requesting supplies, equipment, or personnel not available in the facility.	
			Communicate with local emergency medical services for local, regional, and state bed availability.	
	Safety Officer		Complete HICS 215A to assign, direct, and ensure safety actions are adhered to and completed.	
			If nontraditional areas are used for patient care and other services, ensure they follow health and safety standards.	

			Direct implementation of safety practices (e.g., sharps disposal, linen control, trash control, biohazard materials control, electrical safety, water, temperature, etc.) in nontraditional areas.	

Immediate Response (0 – 2 hours)				
Section	**Branch/Unit**	**Time**	**Action**	**Initials**
Operations	**Section Chief**		Refer to Job Action Sheet for appropriate tasks.	
	Medical Care Branch Director		Review hospital census and determine if patient discharges and appointment cancellations are required.	
			Establish a staffing plan for medical direction and nursing care in alternate care sites or nontraditional patient care areas.	
			Identify inpatients for immediate discharge or transfer to other facilities and direct staff to expedite patient discharges.	
			Establish a patient discharge area to free beds until patients can be discharged or transferred and transported.	
			Provide for the rapid clearing and turnover of patient care beds and areas to expedite patient discharge and admission.	
			Consider extending outpatient hours to accommodate additional patient visits.	
			Consider cancellation of all planned surgeries and outpatient procedures.	
			Prepare for fatalities in conjunction with Medical Examiner or Coroner and local emergency medical services.	
	Security Branch Director		Consider use of facility lockdown to restrict access.	
			Consider establishing alternate traffic routing to facilitate triage and arrival of multiple victims.	

Planning	Section Chief		Assess, in collaboration with Operations Section, current staffing and project staffing needs or shortages for the next operational period.	
			Establish operational periods, incident objectives, and the Incident Action Plan in collaboration with Incident Commander.	
			In conjunction with Operations Section, review all surgeries, outpatient appointments, and procedures for cancellation or rescheduling, and make recommendations to Incident Commander.	
	Resources Unit Leader		Initiate personnel and materiel tracking.	
	Situation Unit Leader		Initiate patient and bed tracking in collaboration with Operations Section (HICS 254–Disaster Victim/Patient Tracking).	
			Gather situational assessment and response data from internal and external sources.	
			Collect and collate patient, bed, personnel, and materiel tracking status and project future resource needs.	
Logistics	Section Chief		Coordinate with Planning and Operations Sections to determine, obtain, and transport additional supplies, equipment, medications, and personnel as required.	
	Support Branch Director		Establish Labor Pool and Credentialing Unit if needed.	
			Register, credential, assign, and mobilize solicited and unsolicited volunteers per Volunteer Utilization Plan.	
			Assist the Operations Section with establishing alternate care or nontraditional care sites.	

Intermediate Response (2 – 12 hours)				
Section	**Officer**	**Time**	**Action**	**Initials**
Command	Incident Commander		Update hospital Chief Executive Officer, Board of Directors, and other appropriate internal and external officials of situation status.	
			Monitor and ensure that communications and decision-making are coordinated with external agencies and healthcare facilities, as appropriate.	
			Establish a schedule to regularly update and revise	

			the initial Incident Action Plan, in collaboration with the Planning Section.	
	Public Information Officer		Continue to provide information to patients, staff, visitors, families, and media regarding situation status and facility measures taken to meet demand.	
			Coordinate information release with the Joint Information Center.	
	Liaison Officer		Continue to communicate with local emergency medical services regarding local, regional, and state bed availability and updating on hospital situation status and critical issues or needs.	
	Safety Officer		Continue to implement and maintain safety and personal protective measures to protect patients, staff, visitors, and the facility.	

Intermediate Response (2 – 12 hours)				
Section	**Branch/Unit**	**Time**	**Action**	**Initials**
Operations	**Section Chief**		Refer to Job Action Sheet for appropriate tasks.	
	Medical Care Branch Director		Continue patient care and management activities. ☐ Provide re-triage and observation of all patients waiting for further care ☐ Provide crisis standards of care guidelines, if necessary, and prioritization of resources (coordinate with Planning Section)	
			Expedite patient discharge medication processing and dispensing.	
	Patient Family Assistance Branch Director		Establish a family reunification area and provide support staff to facilitate the flow of information.	
			Consider activating a patient information center.	
Planning	**Section Chief**		Update and revise the Incident Action Plan, and distribute to Command Staff and Section Chiefs.	
			Coordinate with Operations Section for continued consideration of canceling or rescheduling surgeries and elective procedures.	
	Resources Unit Leader		Continue staff and equipment tracking.	

	Situation Unit Leader		Continue patient and bed equipment tracking.	
	Demobilization Unit Leader		Begin planning for demobilization and system recovery.	
Logistics	**Section Chief**		Refer to Job Action Sheet for appropriate tasks.	
	Support Branch Director		Continue to call in additional staff to supplement operations, as directed.	
			Coordinate the transportation services (ambulance, air medical services, and other transportation) with the Operations Section (Medical Care Branch) to ensure safe patient relocation, if necessary.	
			Obtain needed supplies, equipment, and medications to support patient care activities.	
			Establish an employee dependent care area, as appropriate.	
			Rapidly investigate and document injuries or employees exposed to illness; provide appropriate follow-up.	
Finance/ Administration	**Section Chief**		Implement procedures to authorize expedited procurement of emergent supplies, equipment, and medications to meet patient care and facility needs.	
			Track all costs and expenditures of response and estimate lost revenues due to canceled procedures and surgeries and other services.	
	Time Unit Leader		Track hours associated with the emergency response.	

Extended Response (greater than 12 hours)				
Section	**Officer**	**Time**	**Action**	**Initials**
Command	**Incident Commander**		Establish priorities for restoring normal operations using the facility's Business Continuity Plan.	
	Public Information Officer		Conduct briefings for media, in cooperation with the Joint Information Center.	
			Address social media issues as warranted; use social media for messaging as situation dictates.	

	Liaison Officer		Communicate facility status, report of patient conditions and location to emergency medical services.	

Extended Response (greater than 12 hours)				
Section	**Branch/Unit**	**Time**	**Action**	**Initials**
Operations	**Section Chief**		Refer to Job Action Sheet for appropriate tasks.	
	Medical Care Branch Director		Review current patient census, capability to continue services, and timeframe to return to normal operations. Provide recommendations to Incident Commander.	
	Patient Family Assistance Branch Director		Provide behavioral health support and community services information for patients and families.	
Planning	**Section Chief**		Ensure that updated information and intelligence is incorporated into the Incident Action Plan. Ensure the Demobilization Plan is being readied.	
	Documentation Unit Leader		Collect, organize, secure, and file incident documentation.	
Logistics	**Section Chief**		Refer to Job Action Sheet for appropriate tasks.	
	Support Branch Director		Monitor health status of staff, and provide appropriate medical and behavioral health follow-up.	
			Collect unused supplies distributed to alternate care and non-traditional care sites. Restock and redistribute all supplies and medications.	
Finance/ Administration	**Section Chief**		Continue to track all costs and expenditures of response and estimate lost revenues due to canceled procedures and surgeries and other services.	
	Time Unit Leader		Continue to track hours associated with the emergency response.	

Demobilization/System Recovery				
Section	**Officer**	**Time**	**Action**	**Initials**
Command	**Incident Commander**		Approve the Demobilization Plan.	
	Public Information Officer		Conduct final briefings for media, in cooperation with the Joint Information Center.	

			Close the patient information center, if activated.	
	Liaison Officer		Communicate facility status, final report of patient condition and location to local emergency medical services	

Demobilization/System Recovery				
Section	**Branch/Unit**	**Time**	**Action**	**Initials**
Operations	**Section Chief**		Refer to Job Action Sheet for appropriate tasks.	
	Medical Care Branch Director		Deactivate alternate care sites and nontraditional patient care areas and safely close.	
			Reschedule canceled surgeries, procedures, and outpatient appointments.	
			Repatriate transferred patients, if applicable.	
	Business Continuity Branch Director		If record keeping included use of paper-based records, ensure all clinical information is entered into electronic medical records.	
Planning	**Section Chief**		Finalize and distribute the Demobilization Plan.	
			Conduct debriefings and hotwash with: ☐ Command Staff and section personnel ☐ Administrative personnel ☐ All staff ☐ All volunteers	
			Write an After Action Report and Corrective Action and Improvement Plan that includes: ☐ Summary of the incident ☐ Summary of actions taken ☐ Actions that went well ☐ Actions that could be improved ☐ Recommendations for future response actions	
	Documentation Unit Leader		Collect, organize, secure, and file incident documentation.	
			Prepare summary of the status and location of all incident patients, staff, and equipment. After approval by Incident Commander, distribute to appropriate external agencies.	

Logistics	**Section Chief**		Inventory all Hospital Command Center and hospital supplies and replenish as necessary, appropriate, and available.	
Finance/ Administration	**Section Chief**		Compile summary of final response and recovery cost and expenditures, and estimated lost revenues.	

Documents and Tools

Emergency Operations Plan, including:

- ☐ Mass Casualty Incident Plan
- ☐ Triage Plan
- ☐ Patient, staff, and equipment tracking procedures
- ☐ Business Continuity Plan
- ☐ Behavioral Health Support Plan
- ☐ Alternate Care Site Plan
- ☐ Security Plan
- ☐ Lockdown Plan
- ☐ Fatality Management Plan
- ☐ Volunteer Utilization Plan
- ☐ Emergency Patient Registration Plan
- ☐ Risk Communication Plan
- ☐ Demobilization Plan

Forms, including:

- ☐ HICS Incident Action Plan (IAP) Quick Start
- ☐ HICS 200 – Incident Action Plan (IAP) Cover Sheet
- ☐ HICS 201 – Incident Briefing
- ☐ HICS 202 – Incident Objectives
- ☐ HICS 203 – Organization Assignment List
- ☐ HICS 205A – Communications List
- ☐ HICS 214 – Activity Log
- ☐ HICS 215A – Incident Action Plan (IAP) Safety Analysis
- ☐ HICS 221 – Demobilization Check-Out
- ☐ HICS 251 – Facility System Status Report
- ☐ HICS 253 – Volunteer Registration
- ☐ HICS 254 – Disaster Victim/Patient Tracking
- ☐ HICS 255 – Master Patient Evacuation Tracking

Job Action Sheets

Access to hospital organization chart

Television/radio/internet to monitor news

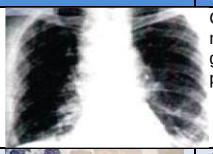
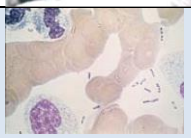
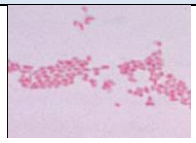
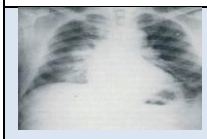
Telephone/cell phone/satellite phone/internet/amateur radio/2-way radio for communication

Hospital Incident Management Team Activation: Mass Casualty Incident

Position	Immediate	Intermediate	Extended	Recovery
Incident Commander	X	X	X	X
Public Information Officer	X	X	X	X
Liaison Officer	X	X	X	X
Safety Officer	X	X	X	X
Operations Section Chief	X	X	X	X
Medical Care Branch Director	X	X	X	X
Security Branch Director	X	X	X	X
Business Continuity Branch Director				X
Patient Family Assistance Branch Dir.		X	X	X
Planning Section Chief	X	X	X	X
Resources Unit Leader	X	X	X	X
Situation Unit Leader	X	X	X	X
Documentation Unit Leader			X	X
Demobilization Unit Leader		X	X	X
Logistics Section Chief	X	X	X	X
Support Branch Director	X	X	X	X
Finance /Administration Section Chief		X	X	X
Time Unit Leader		X	X	X

BIOTERRORISM SYNDROMES

If you suspect disease from a potential bioterrorism event, call the Imperial County Public Health Department at 760-482-4438

Syndrome	Bioterrorism Threat Disease Description	Differential Diagnosis	Picture	Initial Laboratory & other diagnostic test results	Immediate Public Health & Infection control actions
Acute Respiratory Distress with Fever	**Inhalational Anthrax** Abrupt onset of fever, chest pain, respiratory distress without radiographic findings of pneumonia, no history of trauma or chronic disease, progression to shock and death within 24-36 hours.	Dissecting aortic aneurysm, pulmonary embolism, influenza, community acquired pneumonia		Chest x-ray with widened mediastinum; pleural effusion; gram-positive bacilli in blood or pleural fluid;	Call ICPHD Alert your laboratory to possibility of anthrax. No person-to-person transmission. Infection control: standard precautions.
	Pneumonic Plague Apparent severe community-acquired pneumonia but with hemoptysis, cyanosis, gastrointestinal symptoms, shock.	Community-acquired pneumonia, Hantavirus pulmonary syndrome, meningococcemia, rickettsiosis, influenza		Gram-negative bacilli or coccobacilli in sputum, blood or lymph node; safety pin appearance with Wright or Giemsa stain;	Call hospital infection control and ICPHD. Ask family members/close contacts of patient to stay at the hospital (if already present) for public health interview/chemoprophylaxis; get detailed address and phone number information. Alert laboratory of possibility of plague. Infection control: droplet precautions in addition to standard precautions.
	Ricin (aerosolized) Acute onset of fever, chest pain and cough, progressing to respiratory distress and hypoxemia; not improved with antibiotics; death in 36-72 hours.	Plague, Q fever, staphylococcal enterotoxin B, phosgene, tularemia, influenza		Chest x-ray with pulmonary edema.	Call ICPHD Infection control: standard precautions.
	Staphylococcal Enterotoxin B Acute onset of fever, chills, headache, nonproductive cough and myalgia (influenza-like illness) with a NORMAL chest x- ray	Influenza, adenovirus, mycoplasma		Primarily clinical diagnosis.	Call ICPHD Infection control: standard precautions.
Acute Rash with Fever	**Smallpox** Papular rash with fever that begins on the face and extremities and uniformly progresses to vesicles and pustules; headache, vomiting, back pain, and delirium common.	Varicella, disseminated herpes zoster, vaccinia, monkeypox, cowpox		Clinical with laboratory confirmation; vaccinated, gowned and gloved person obtains specimens (scabs or swabs of vesicular or pustular fluid).	Call hospital infection control and ICPHD. Ask family members/close contacts of patient to stay at the hospital (if already present) for public health interview and vaccination; get detailed address and phone number information. Infection control: airborne and contact precautions in addition to standard precautions.
	Viral Hemorrhagic Fever (e. g., Ebola) Fever with mucous membrane bleeding, petechiae, thrombocytopenia and hypotension in a patient without underlying malignancy.	Meningococcemia, malaria, typhus, leptospirosis, borreliosis, thrombotic thrombocytopenic purpura (TTP), hemolytic uremic syndrome (HUS)		Definitive testing available through public health laboratory network	Call hospital infection control and ICPHD. Ask family members/close contacts of patient to stay at the hospital (if already present) for public health interview and follow-up; get detailed address and phone number information. Infection control: contact precautions in addition to standard precautions.
Neurologic Syndromes	**Botulism** Acute bilateral descending flaccid paralysis beginning with cranial nerve palsies.	Guillain-Barré syndrome, myasthenia gravis, midbrain stroke, tick paralysis, Mg++ intoxication, organophosphate, carbon monoxide, paralytic shellfish, or belladonna-like alkaloid poisoning, polio, Eaton-Lambert myasthenic syndrome		CSF protein normal; EMG with repetitive nerve stimulation shows augmentation of muscle action potential; toxin assays of serum, feces, or gastric aspirate available through the public health laboratory network.	Call ICPHD Request botulinum antitoxin Infection control: standard precautions.
	Encephalitis (Venezuelan, Eastern, Western, West Nile) Encephalopathy with fever and seizures and/or focal neurologic deficits.	Herpes simplex, post-infectious, other viral encephalitides		Definitive testing available through public health laboratory network	Call ICPHD Infection control: standard precautions.
Influenza-Like Illness	**Brucellosis** Irregular fever, chills, malaise, headache, weight loss, profound weakness and fatigue. Arthralgias, sacroiliitis, paravertebral abscesses. Anorexia, nausea, vomiting, diarrhea, hepatosplenomegal y. May have cough and pleuritic chest pain.	Numerous diseases, including Q Fever, brucellosis		Tiny slow-growing, faintly-staining, gram-negative coccobacilli in blood or bone marrow culture. Leukocyte count normal or low Anemia, thrombocytopenia possible. CXR nonspecific: normal bronchopneumonia, abscesses, single or miliary nodules, enlarged hilar nodes, effusions. Serologic testing and culture available through the public health laboratory network	Notify your laboratory if brucellosis suspected --microbiological testing should be done in a biological safety cabinet to prevent lab-acquired infection. Call ICPHD Infection control: standard precautions.
	Tularemia (Typhoidal, Pneumonic) Fever, chills, rigors, headache, myalgias, coryza, sore throat initially; followed by weakness, anorexia, weight loss. Substernal discomfort, dry cough if pneumonic disease.			Small, faintly-staining, slow-growing, gram-negative coccobacilli in smears or cultures of sputum, blood. CXR mayshow infiltrate, hilar adenopathy, effusion. Definitive testing available through the public health laboratory network	Notify your laboratory if tularemia suspected --microbiological testing should be done in a biological safety cabinet to prevent lab-acquired infection. Call ICPHD Infection control: standard precautions.

Adapted from California State and Local Health Department Bioterrorism Surveillance and Epidemiology Working Group, 2001.

IMPERIAL VALLEY HEALTHCARE DISTRICT

Title: **Child Care Disaster Plan**	Policy No. EOC-00148
	Page 1 of 3
Current Author: Jorge Mendoza	Effective: 2/26/1993
Latest Review/Revision Date:01/2025	Manual: EOC / Emergency Management

Collaborating Departments: Child Care Center	Keywords: Child Care Disaster Plan; Daycare; Child Care Center; Emergency Operations Plan; EOP; Hospital Command Center; HCC		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 Establish guidelines for providing safe childcare services during an activation of the PMH Emergency Operations Plan.

2.0 Scope: District wide

3.0 Policy:

3.1 During activation of the EOP, childcare for employees will be coordinated by the Director of the PMH Child Care Center.

3.1.1 The hours of operation will be 24/7 or as determined.

3.2 The Child Care Center staff will be supplemented by the Manpower Pool as necessary and available

3.3 All child care activities will be conducted at the Child Care Center. In the event this area is unsuitable due to safety reasons, the director shall make arrangements with the Hospital Command Center to set up another site in a safe location utilizing the Pediatric Safe Area Checklist (*Refer to Attachment A*)

3.4 The Child Care Center will maintain constant communications with the HCC

3.5 Child Care Center will accept all employees children reporting to work as part of an emergency or disaster response

3.6 The Child Care Center will accept all non-employee children who present to the hospital without a parent or guardian present, only after receiving a medical screening evaluation and having been determined to be uninjured or without illness.

3.7 The Child Care Center staff will follow normal procedures for release of children in regular attendance

3.8 Employees are required to wear regular hospital-issued name badges or bring a driver's license for identification

4.0 Definitions:

4.1 HCC – Hospital Command Center – emergency operations center for the hospital during activation of the PMH EOP

4.2 EOP – [PMH] Emergency Operation Plan <*Refer to policy Emergency Operations Plan; EOC-00213>*

5.0 Procedure:

5.1 Immediately after notification of a disaster, the Child Care Center Director, or their designee, will account for all children and staff present.
5.2 A list of all children and staff present will be sent to the HCC
5.3 If the EOP is activated outside normal Child Care Center operating hours, a call back system for Child Care Center staff will be initiated by the HCC as necessary
5.4 Identification of children and their parent or guardian is critical during an emergency or disaster situation.
- 5.4.1 When an employee arrives at the Child Care Center, they will complete the Identification and Emergency Information Form (*Refer to Attachment B*);
- 5.4.2 Employee's children will only be released to their parent, guardian, or an individual listed on the child's Identification and Emergency Information Form (*Refer to Attachment B*)
- 5.4.3 Each employee's child will be given a white wrist band that includes the name of the parent or guardian in permanent ink

5.5 All children who present to the hospital without an injury or illness that do not have a parent or guardian present during an emergency or disaster will be admitted to the Child Care Center and the following information will be gathered and maintained by the HCC. This information will be sent to the Imperial County Medical Health Operational Area Coordinator via the REDDINET System:
- 5.5.1 Location where child was found (if brought in by ambulance/bystander)
- 5.5.2 Gender
- 5.5.3 Ethnicity/Race
- 5.5.4 Hair/Eye Color
- 5.5.5 Other distinguishing characteristics (i.e.; birthmarks; scars; etc.)
- 5.5.6 Name (if possible)
- 5.5.7 Name of parent/guardian (if possible)
- 5.5.8 Photo (if camera available)
- 5.5.9 Other pertinent information that can be obtained (address, phone number, etc.)
- 5.5.10 Each non-employee child will be given a blue arm band containing the child's name (if known) along with the parent or guardian's name (if known) written on it in permanent ink
- 5.5.11 The HCC will coordinate with local authorities (law enforcement; Child Protective Services; etc.) to identify and locate the parents or guardians of unattended children
- 5.5.12 The Child Care Center will coordinate with the HCC for meals and snacks needed from the Dietary Department.
- 5.5.13 A supply of games, toys, videos, and craft supplies will be made available for children. Age appropriate activities will be coordinated by the Child Care Center staff.

6.0 References:

6.1 The Issues At Hand – Pediatric Reunification, Children's Hospital Los Angeles
6.2 Pediatric Disaster Resource and Training Center Children's Hospital Los Angeles
6.3 PMH policy EOC-00213; Emergency Operations Plan

7.0 Attachment List:

7.1 Attachment A – Pediatric Safe Area Checklist
7.2 Attachment B – Identification and Emergency Information Form (LIC-700)

8.0 Summary of Revisions:

8.1 Revised footer pediatric safe area checklist attachment A
8.2 Updated PMHD to PMH

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

PEDIATRIC SAFE AREA CHECKLIST*

ITEM	NO	YES
Are needle boxes at least 48 inches off the floor?		
Do the windows open?		
Are the windows locked?		
Are there window guards?		
Do the windows have blinds or drapes that might pose a drowning hazard?		
Are there any water basins, buckets, or sinks that might pose a drowning hazard?		
Can children be safely contained in this area (consider stairwells, elevators, doors)?		
Do you have any distractions for the children (age- and gender-appropriate videos, games, toys)?		
Is the area poison proof? (Check for cleaning supplies, Hemoccult developer, choking hazards or cords that should be removed or locked away.)		
Are the electrical outlets child safe and covered?		
Does the area have smoke and fire alarms?		
Are med carts and supply carts locked?		
Should separate areas for various age groups be created?		
Have drills for managing this area been conducted with all relevant departments?		
Is there a security plan for the unit?		
Is there a plan to identify the children?		
Is there a plan for assessing the mental health needs of children?		
Are there any fans or heaters in use? Are they safe?		
Is there an onsite or nearby daycare center? Could they be of help?		
Is there enough staff to supervise the number of children? (Younger children will require more staff.)		
Are there a sign-in and sign-out sheet for all children and adults who enter the area?		
Will children need to be escorted away from the safe area to bathrooms?		
Are age-appropriate snacks available for children?		
Are there sleeping accommodations available (i.e., foam mats on the floor)? Are there enough to avoid co-sleeping (to reduce the risk of Sudden Infant Death Syndrome)?		

**Adapted from the Chicago Department of Health*

Hospital Guidelines for Pediatric Preparedness

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE ZIP		BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

LIC 700 (8/08)(CONFIDENTIAL)

Imperial Valley Healthcare District

Title: **CODE SILVER – Active Shooter Situation Response**	Policy No. EOC-00184 Page 1 of 4
Current Author: Jorge Mendoza	Effective: 5/24/2014
Latest Review/Revision Date: 1/2025	Manual: EOC / Emergency Management

Collaborating Departments: Brawley Police Dept; Calexico Police Dept	Keywords: gun; weapon; gunshot; armed		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC	MEC	BOD 4/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The objective of this plan is to provide guidance in the event an individual is actively shooting persons in the hospital or on the campus by:

1.1.1 Providing guidance for proper notification of staff, patients, and visitors

1.2 Providing guidance for initial and long-term response to an active shooter event

2.0 Scope: District wide

3.0 Policy:

3.1 Pioneers Memorial Hospital (PMH) has policies in place to recognize and prevent violence in the workplace

3.1.1 HRD-0020; Zero Tolerance for Violence in the Workplace

3.1.2 EOC-00175; Hospital Emergency Codes – refer to CODE GRAY section

3.2 It is the policy of PMH to provide a plan to alert hospital staff, patients, and visitors that a shooter appears to be actively engaged in killing or attempting to kill people in the hospital or on the hospital campus.

3.3 As soon as the situation becomes safe, it is the policy of PMH to respond quickly and efficiently to minimize the loss of life and injury during, and immediately after, an active shooter event.

4.0 Definitions:

4.1 Active Shooter – A person or persons who appear to be actively engaged in killing or attempting to kill people in the hospital or on the hospital campus. In most cases active shooters use firearm(s) and display no pattern or method for selection of their victims. In some cases, active shooters use other weapons and/or improvised explosive devices to cause additional victims and act as an impediment to police and emergency responders. These improvised explosive devices may detonate immediately, have delayed detonation fuses, or detonate on contact.

4.2 Cover – Refers to anything that is capable of physically protecting an individual from gunfire. Examples: concrete wall, large tree, vehicle engine compartment, etc.

4.3 Concealment – Is an object or area which only affords being hidden from view. It will not stop or slow bullets. *Examples*: bushes, plaster or sheet-rock walls, closed curtains or blinds, etc.

5.0 Procedure:

5.1 During an Active Shooter Incident, the safety of PMH Staff, patients, and visitors will be

the highest priority for all involved. You cannot help others if you become part of the situation

5.2 The first employee to identify an active shooter situation:
- 5.2.1 Should call the hospital emergency number **(4-4-4-4)** and ask the operator to announce a CODE SILVER (with the location of the incident) and a description of the person(s) with the weapon, and type of weapon if known.
- 5.2.2 Employees working in **off-site locations should dial 9-1-1** and provide as much information listed in section 5.3.1 as possible to the 9-1-1 dispatcher.
- 5.2.3 Evacuate patients, visitors and staff if safe to do so

5.3 The hospital operator upon notification will:
- 5.3.1 Immediately notify Brawley Police Department and provide as much of the following information as possible:
  - 5.3.1.1 Exact location of the shooter(s) in the area
  - 5.3.1.2 Number of shooters
  - 5.3.1.3 Physical description of the shooters
  - 5.3.1.4 Number and types of weapons held by the shooters
  - 5.3.1.5 Number of potential victims at the location
- 5.3.2 Overhead page CODE SILVER (and the location) three times
- 5.3.3 Notify hospital Administration, or the House Supervisor after hours

5.4 If an active shooter comes into the area where you are and enters your unit, office or meeting room, you should (in preference and priority):
- 5.4.1 Run (First preference and priority)
  - 5.4.1.1 Have an escape route and plan in mind
  - 5.4.1.2 Leave your belongings behind
  - 5.4.1.3 Keep your hands visible
- 5.4.2 Hide (Second preference and priority)
  - 5.4.2.1 Hide in an area out of the shooter's view
  - 5.4.2.2 Turn off lights
  - 5.4.2.3 Close blinds
  - 5.4.2.4 Block entry to your hiding place and lock the doors
  - 5.4.2.5 Hide behind furniture if possible
  - 5.4.2.6 Silence your cell phone
- 5.4.3 Fight (Third preference and priority) **Note: If confronted directly and as a last resort only when your life is in imminent danger**
  - 5.4.3.1 Attempt to incapacitate the shooter
  - 5.4.3.2 Act with physical aggression, improvise weapons and throw items at the shooter
  - 5.4.3.3 Yell loudly and **commit to the effort**
  - 5.4.3.4 Moving people are harder to shoot

5.5 If you are in an outside area and encounter an active shooter, you should:
- 5.5.1 Try to remain calm
- 5.5.2 Move away from the active shooter or sound of gunshot(s) and/or explosion(s)
- 5.5.3 Look for appropriate locations for cover/concealment (i.e. brick walls, retaining walls, parked vehicles, etc.)

5.5.4 Call 911 and provide information listed above (5.3.1)

5.6 What to expect from responding officers – Police officers responding to an active shooter are trained to proceed immediately to the area in which shots were last heard in order to stop the shooting as quickly as possible. The first responding officers may be in teams; they may be dressed in normal patrol uniforms, or they may be wearing external ballistic vests and Kevlar helmets or other tactical gear. The officers may be armed with rifles, shotguns and handguns.

5.6.1 **Do exactly as the team of officers instruct.** The initial responding officers will be focused on stopping the active shooter and creating a safe environment for medical assistance to be brought in to aid the injured

5.6.1.1 Put down any items in your hands (i.e. bags, jackets)

5.6.1.2 Immediately raise hands and spread fingers

5.6.1.3 Keep hands visible at all times

5.6.1.4 Avoid making quick movements toward officers such as attempting to hold on to them for safety

5.6.1.5 Avoid pointing, screaming and/or yelling

5.6.1.6 Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which the officers are entering the area

5.6.2 When the police arrive the following should be available:

5.6.2.1 Number of shooters

5.6.2.2 Number of individual victims and hostages

5.6.2.3 Type and number of weapons possibly in possession of the shooter

5.6.2.4 All necessary individuals still in the area

5.6.2.5 Identity and description of participants, if known

5.6.2.6 Keys to all involved areas as well as floor plans

5.6.2.7 Location and phone numbers in the affected areas

5.7 As soon as it is safe to do so, the Administrator, designee or House Supervisor, if after hours will activate the PMH Emergency Operations Plan and open the Hospital Command Center in a safe location and active the HICS

5.8 As soon as it is safe to do so, after coordinating with law enforcement, the Administrator, designee or House Supervisor will evaluate the need to activate the PMH Hospital Evacuation/Shelter in Place Plan

5.9 Available staff from each department will supply the HCC with a list of patients and/or staff known to be in the area of the incident

5.10 The Incident Commander (IC) will designate a Public Information Office (PIO) who will provide, approved, information to the media as it is available.

5.11 The IC will establish a Family Information Center, away from the public and media, for family members of those involved in the incident

5.12 A “Lock Down” of the PMH Facility will be activated in accordance with policy *EOC-00074; Hospital Emergency Lock Down*

5.12.1 Coordination with law enforcement will be necessary to enhance PMH Lock Down Procedures

5.13 The Emergency Department will activate Emergency Department Bypass of all incoming patients in accordance with Imperial County EMSA Policies

5.13.1 Notification of the ED Bypass will be sent to local hospitals and emergency medical transport services via the Rapid Emergency Digital Data Network (REDDINET) as soon as possible

5.14 Medical care for victims:

5.14.1 When safe to do so, medical care to victims will be provided in accordance with current trauma triage and care standards

5.14.2 It will be the goal of PMH to coordinate PMH staff with local emergency responders (Police, Fire Department, Ground and Air Ambulance Personnel) to appropriately triage all victims involved in an active shooter event

5.14.3 The crime scene and evidence will be maintained, to the extent possible while providing medical care

5.15 Debriefing

5.15.1 Hot Washes should take place as soon as possible after the “all clear” has been given in order to complete an After Action Report/Improvement Plan (AAR/IP).

5.16 An AAR/IP should be completed in accordance with PMH policy EOC-00213.

6.0 References:

6.1 US Department of Homeland Security Active Shooter – How to Respond, October 2008

6.2 Journal of Healthcare Risk Management – Using prospective hazard analysis to assess an active shooter emergency operations plan

6.3 California Hospital Association – Active Shooter Checklist

6.4 FEMA-IS907 Active Shooter: What You Can Do

6.5 Hospital Association of Southern California – Health Care Emergency Codes, A Guide for Standardization (September 2011)

6.6 Imperial County Emergency Medical Services Agency policy #4220 “Hospital Diversion”

6.7 PMH policy CLN-01922; Emergency Department Bypass

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Updated PMHD to PMH

Imperial Valley Healthcare District

Title: **Earthquake Response Plan**	Policy No. EOC-00174
	Page 1 of 6
Current Author: Jorge Mendoza	Effective: 02/26/1996
Latest Review/Revision Date: 1/2025	Manual: EOC – Emergency Management

Collaborating Departments: Facilities, Nursing	Keywords:		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish guidelines for staff to follow during and immediately after an earthquake that causes damages to the facility and/or injuries to personnel or patients.

2.0 Scope: District wide

3.0 Policy:

3.1 It is the policy of Pioneers Memorial Hospital (PMH) to maintain a safe environment for staff, patients, and visitors during an earthquake.

3.2 In accordance with PMH Emergency Operations Plans (EOP) CLN-00213, the Hospital Incident Command System (HICS) will be utilized during all evacuation activities.

3.3 If it is determined by the Incident Commander that evacuation is warranted the Hospital Operator will overhead page "CODE TRIAGE" three times to communicate that the hospital is activating the EOP.

3.4 The Emergency Department will be placed on Ambulance Diversion in accordance with Imperial County EMS Policy #4220, until it is determine that it is safe to accept additional ambulance patients by the Incident Commander.

3.5 Staff will be trained and become familiar with the plan. The plan will be included as part of the PMH Disaster Exercise and Evaluation Plan to test for readiness and deficiencies.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 GENERAL

5.1.1 The actual movement of the ground in an earthquake is seldom the direct cause of death or injury. Most casualties result from falling objects and debris because the shocks can shake, damage, or demolish buildings and generate huge ocean waves (seismic sea waves), each of which can cause great damage. Earthquakes usually strike without warning. In most cases the shock occurs and is ended in seconds, which precludes any personal protective action during the tremor. If the seismic action is a prolonged shaking and rolling, it is sometimes necessary to take protective measures. The best action is to drop under a table, cover your head and hold this position until the shaking stops and it is safe to come out. The scope of this procedure covers response to all types of

earthquakes.

5.2 INJURIES ARE COMMONLY CAUSED BY:

- 5.2.1 Partial building collapse, collapsing walls, falling ceiling plaster, light fixtures, and pictures
- 5.2.2 Flying glass from broken windows and mirrors
- 5.2.3 Overturned bookcases, fixtures, and other furniture and appliances
- 5.2.4 Fires, broken gas lines, and similar causes. The danger may be aggravated by the lack of water due to broken mains.
- 5.2.5 Fallen power lines
- 5.2.6 Drastic human actions resulting from panic

5.3 IMMEDIATE RESPONSE MEASURES – ALL PERSONNEL

- 5.3.1 Upon detection of shock – remain in place.
- 5.3.2 Remain calm. Think through the consequences of any action you take. Try to calm and reassure others.
- 5.3.3 If indoors, drop-cover-hold until shaking stops. Watch out for high storage areas, shelves, and tall equipment that might slide or topple. Stay away from windows and mirrors. Encourage others to follow your example. Usually it is best not to run outdoors.
- 5.3.4 After the initial shock has ended, and a reasonable interval has passed with no further shock, survey immediate surroundings to determine injuries and damage.
- 5.3.5 Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.
- 5.3.6 If telephones are operating, the Department Manager or designee will call the switchboard for the Chief Executive Officer or House Supervisor and report condition of patients, damage in the unit and function of utilities
- 5.3.7 If you are in a patient care area and are not seriously injured, your first responsibility is to the patients in your vicinity. If possible reassure them and attempt to calm those who may be hysterical or panic stricken. If there are obvious injuries from falling objects, shattered glass, or if patients or personnel are trapped under debris, you must request assistance and perform first aid within your capability where possible until additional medical personnel arrive to assist in treatment or rescue.
- 5.3.8 Check for fire or fire hazards from broken electrical lines or short circuits and follow the Hospital Fire Response Procedure in the Hospital Fire Plan (EOC-00330) if a fire is discovered or reasonably expected.
- 5.3.9 Do not attempt to lead or assist any patients to leave the hospital until you are directed to do so by the Chief Executive Officer/Incident Commander or Designee. If the hospital has not been rendered unsafe by the earthquake, it is advisable to keep the patients inside and, if possible, in their rooms.
- 5.3.10 Make sure all ambulatory patients wear shoes in areas near debris and glass.
- 5.3.11 Immediately clean up spilled medications, drugs, and other potentially harmful materials using appropriate personal protective equipment.
- 5.3.12 Check closets and storage shelve areas. Open closet and cupboard doors

carefully and watch for objects falling from shelves.

5.3.13 Be prepared for addition "after shocks." Although most of these are smaller than the main shock, some may be large enough to cause additional damage.

5.4 HOSPITAL STAFF ACTIONS IMMEDIATELY AFTER THE EARTHQUAKE

5.4.1 The Hospital Administrator, designee, or House Supervisor (if after hours) will activate the Hospital Emergency Operations Plan and have the operator call a "Code Triage"

5.4.2 Proceed carefully.

- In many hospital settings, floors will be covered with broken glass and/or spilled chemicals, making passage difficult. It is very common for people to cut their feet on broken glass in earthquakes.
- Find out if anyone is injured. Administer treatment or summon medical assistance.
- Check for people who might be trapped in patient's rooms, nursing stations, and other spaces. Leave doors open.
- Check for fires and extinguish them or summon for help.
- Check for potential chemical hazards, gas leaks, or broken water lines.
- Turn off if damage to line is suspected.
- Turn off and unplug unnecessary equipment.
- Improvise as necessary
- Clear hallways and evacuation routes
- Do not smoke or allow open flames e.g. lighter, burners.
- If you notice the smell of gas, open window and doors and leave the area
- Do not touch fallen or damaged electrical wires.
    - If electrical wiring is damaged, do not touch.
    - Observe basic safety. Do no touch wet electrical items
    - Notify Hospital Command Center (HCC)
- Check to see if power is on.
    - Patients on Life Support Systems might need emergency medical attention.
- Nurses and other medical staff should calm patients and tell them to remain in their rooms (if these are intact).
    - Alternative is to assemble patients in corridors and to wait there until a detailed assessment of building damage is made.
- Move patients to interior walls, away from windows and glass; pull curtains to protect from glass.
- Expect potential disagreements over discharging patients.
    - Some physicians may want to discharge their patients: others may not.
    - It is paramount that medical staff, especially physicians, participates in hospital disaster drills and become familiar with hospital policy regarding authority on patient discharge in an

emergency.

- Do not use food or water until told it is safe to do so.
- The Department Manager or Charge RN will prepare a summary of damage to your area and communicate it to the HCC.
- If your building has not sustained heavy structural damage, you do not need to evacuate immediately. However, Damage to the hospital utilities may require later movement of patients or evacuation.
- Post signs in dangerous areas.
- If your building has sustained major damage, you may need to evacuate remember these two points:
  - Evacuation should not be spontaneous. The decision to evacuate should be made by hospital administration.
  - The decision to evacuate should follow a detailed assessment of structural damage. Evacuation is a very serious matter; people could be injured. In past earthquakes, hospitals have been unnecessarily evacuated because superficial damage was mistaken for structural damage.
- Continue to complete patient charting and charges.
- Notify Hospital Command Center (HCC) and Security Officer of any unsafe situations.

5.5 DURING THE AFTERMATH

5.5.1 Expect aftershocks. They can inflict additional damage to weakened structures.

5.5.2 Rescue essential supplies, equipment, and records if you can do so safely.

5.5.3 Document proper damage as soon as possible. Take photographs of damage and label with date and time. Structural damage may require an engineering analysis. Take pictures of damage if able.

5.5.4 Resume essential hospital functions. Although clerical and other support staff might initially be pressed into service to assist in evacuation or patient care functions – especially in a severely damaged hospital building – other hospital functions must continue.

5.6 IF YOUR ARE NOT AT THE HOSPITAL

5.6.1 Check the safety of your family.

5.6.2 Listen to the Emergency Broadcast Station.

5.6.3 Report to the hospital to assist, if possible, unless radio broadcasts direct you to do otherwise. Report to the Manpower Pool in the Auditorium for assignment. Do not report to your regular department.

5.7 RECOVERY

5.7.1 The recovery process will begin as soon as it is determined that it is safe to do so.

5.7.2 Assessment of damage and final determination of when and how a department or the facility will be made safe for occupancy will be done jointly by the Engineering, Nursing, Administration, Radiation Safety Officer and Public Safety Officials in conjunction with the Imperial County Office of Emergency Service

(OES).

5.7.3 Efforts will not be made to reopen a department or facility until the safety of the environment and the ability to deliver medical care has been assured by Facilities Management and the Safety Officer.

5.7.4 Photographic and video documentation will be taken of all damage and reported to the Hospital Insurance Carrier. All needed Repairs will be made after approval from insurance adjuster.

5.7.5 Prior to reopening, each affected area will be thoroughly cleaned/decontaminated, needed equipment and supplies replaced, utility and medical gas function verified by engineering and respiratory therapy and linens cleaned/replaced.

5.7.6 After needed repairs have been completed notifications will be made to the Brawley Fire Department, California Statewide Health Planning and Development (OSHPD) and the California Department of Public Health Licensing and Certification Division.

5.7.6.1 Each of the above agencies will conduct building safety inspections as well as the ability of PMH to provide patient care.

5.7.7 After passing all inspections the HCC will notify the Hospital Operator to overhead page the “All Clear” order three times.

5.7.8 The HCC will notify the Imperial County OES and Medical Health Operational Area Coordinator (MHOAC) that the facility is no longer operating under EOPs and able to accept patients.

5.7.9 PMH will provide Critical Stress Incident Debriefing for all employees that request assistance in accordance with the PMH Employee Assistance Program.

5.7.10 Immediately following the event, the Hospital Emergency Preparedness Manager will conduct Hot-washes and debriefings with all staff and coordinating agencies involved to identify the effectiveness and deficiencies of the response.

5.7.11 Within forty-five (45) days of returning to normal operations, the Hospital Emergency Preparedness Manager will submit a Draft After Action Report and Improvement Plan to the PMH Safety Committee for approval.

6.0 References:

6.1 Imperial County Medical Health Branch Response Plan
6.2 Imperial County EMS Policy #4220 Ambulance Diversion
6.3 California Code of Regulations Title 22, 70741 Disaster and Mass Casualty Program
6.4 California Code of Regulations Title 22, 70743 Fire and Internal Disasters
6.5 California Code of Regulations Title 22, 70746 Disruption of Services
6.6 California EMSA, HICS Implementation Guide
6.7 California Emergency Management Agency, California Emergency Plan
6.8 California Emergency Management Agency Department of Health, California Emergency Medical Mutual Aid Plan
6.9 FEMA Earthquake Response Procedures
6.10 Hospital Earthquake Preparedness: Issues for Action, California Hospital Association

7.0 Attachment List: Not applicable

8.0 Summary of Revision:

8.1 Updated PMHD to PMH

IMPERIAL VALLEY HEALTHCARE DISTRICT

Title: **Emergency Preparedness – House Supervisor's Role**	Policy No. EOC-00186
	Page 1 of 2
Current Author: Jorge Mendoza	Effective: 9/1/1995
Latest Review/Revision Date: 032/2025	Manual: EOC / Emergency Management

Collaborating Departments: Nursing Admin	Keywords: Code TRIAGE; hospital emergency; disaster; Emergency Operations Plan (EOC); Hospital Incident Command Center (HICC)		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish the role of the House Supervisor during both internal and external hospital emergencies

2.0 Scope: House Supervisors

3.0 Policy:

3.1 After normal business hours, the House Supervisor will assume the role of the Incident Commander and be responsible for activation of the Emergency Operations Plan during an emergency event.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 Notification is received via the Emergency Department of disaster (external); if internal from House Supervisor or reporting party

5.1.1 The House Supervisor will notify the Administrator On-Call and/or Chief Nursing Officer (CNO) to receive approval to activate the Emergency Operations Plan and call a **Code TRIAGE**.

5.2 If internal, the House Supervisor will report to the site of emergency and will:

5.2.1 Determine what help is indicated and notify the Switchboard Operator (i.e. Fire Department, Engineering, etc.)

5.3 If external, the House Supervisor will notify the Emergency Department and begin to determine patient care capacity.

5.3.1 Patient care capacity will be determined using the following guidelines:

5.3.1.1 Immediate Category Casualty – Will require at least one hour of care; and a General Surgeon, Registered Nurse (critical care); one Respiratory Technician; one clerk. If surgery is required staff required will increase and broaden.

5.3.1.2 Delayed Category Casualty – Will require at least 15 minutes of care by a physician, Registered Nurse, and a Clerk for evaluation, reassessment and basic care

5.3.1.3 Capacity updates will be required as personnel arrive or victims increase due to walk-ins

5.3.1.4 Capacity updates will be maintained and entered into the Rapid Emergency Digital Data Network (REDDINET).

5.3.1.5 Blood capacities – Unless phone system is not functioning, this will be handled directly between the San Diego Blood Bank, El Centro Regional Medical Center Laboratory and the PMH Laboratory

5.4 The House Supervisor will open the Hospital Command Center and assume the role of the Hospital Incident Commander until they can be relieved.

5.4.1 Once relieved, the House Supervisor will assume the role of Situation Unit Leader or other role as assigned by the Incident Commander.

6.0 References:

6.1 Hospital Incident Command System Implementation Guide, California EMSA

6.2 PMH Policy EOC-00213; Emergency Operations Plan

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Updated PMHD to PMH

Imperial Valley Healthcare District

Title: **CODE WHITE – Hospital Evacuation Plan**	Policy No. EOC-00185
	Page 1 of 18
Current Author: Jorge Mendoza	Effective: 8/11/1995
Latest Review/Revision Date: 1/2025	Manual: Environment of Care

Collaborating Departments: Nursing		Keywords: Shelter in place, emergency management plan	
Approval Route: List all required approval			
PSQC	Other: Safety 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The PMH Evacuation Plan has been developed to provide PMH personnel with a plan of action should an emergency arise that may lead to an evacuation of patient care facilities. It outlines responsibilities of individuals and departments, prioritizes evacuation requirements and conceptually establishes how the evacuation should take place. The Evacuation Plan has been developed as a portion of a more comprehensive Emergency Management Plan for PMH. It has been designed to integrate with existing fire safety plans, the Hospital Incident Command System and other PMH Emergency Operating Procedures.

1.2 The orderly evacuation of a hospital is an entirely different process than is recommended for most other buildings and involves special considerations. Due to the fact that so many patients may be medically unstable and dependent on mechanical support equipment, complete evacuation of the facility is to be initiated as a last resort, and must proceed in a planned and orderly manner.

1.3 A "Code White" will be announced to alert employees of the decision to initiate a partial or total evacuation.

2.0 Scope: Hospital wide

3.0 Policy:

3.1 The PMH Evacuation Plan (the plan) will be reviewed and updated regularly or as major changes/events at PMH occur. A scheduled review of the plan will be conducted by the PMH Emergency Management Committee to coordinate with other PMH, Local, and State Emergency Operations Plans (EOPs)

3.2 The evacuation of any floor or building shall be initiated on order of the Incident Commander (according to the HICS and PMH EOPs) or by a Public Safety Officer (Police or Fire Department).

3.3 In accordance with IVHD EOPs, the Hospital Incident Command System (HICS) will be utilized during all evacuation activities.

3.4 Upon notification, the Hospital Operator will overhead page "CODE TRIAGE" three times.

3.5 The Emergency Department will be placed on Ambulance Diversion in accordance with Imperial County EMS Policy #4220, until it is determined that it is safe to accept

additional ambulance patients by the Incident Commander after coordinating with cooperating agencies.

3.6 A "Code White" will be called to notify hospital staff of that there is a need for a partial or total evacuation of the facility. The PBX operator will announce overhead "Code White – Please report to your supervisor" and repeat three times.

3.7 Staff will be trained and become familiar with the plan. The plan will be included as part of the PMH Disaster Exercise and Evaluation Plan to test for readiness and deficiencies.

4.0 Definitions:

4.1 Partial Evacuation – Patients, visitors and staff are transferred to other areas within the hospital.

4.1.1 Horizontal Evacuation – Movement of patients horizontal from one side of a fire/smoke barrier door(s) to the other side, e.g. from East Wing of Med/Surg to the West Wing of Med/Surg.

4.1.2 Vertical Evacuation – Movement of patients to a safe area on another floor, building, or outside. Movement should be downward to a safe level.

4.2 Total Evacuation – Patients are transferred from PMH to an outside area, alternate care sites or another hospital facility.

4.3 Immediate – Less than one (1) hour

4.4 Urgent – Less than four (4) hours

4.5 Assembly Area – A pre-designated, remote location away from the building and out of the way of responding emergency personnel where visitors, staff and patients meet after an evacuation so they can be accounted for that allows for easy access for patients to be transported to their next location.

4.6 Staging Areas – Locations at which resources are kept while temporarily awaiting incident assignments.

5.0 Procedure:

5.1 The decision to evacuate from unsafe areas shall be based on the following information:

5.1.1 Public Safety Officer (Police or Fire) has determined the building is not safe for occupancy.

5.1.2 Extended loss of utilities that create unsafe conditions for patients or staff

5.1.3 The Hospital Administrator, Chief Nursing Officer or House Supervisor has determined that adequate patient care cannot be provided.

5.1.4 Evacuation should only be attempted when you are certain the area chosen to evacuate to is safer than the area you are leaving.

5.2 Activation of the plan:

5.2.1 The decision to evacuate is a difficult one. Patients should only be evacuated when absolutely necessary. Situations worthy of evacuation include danger posed by fire, smoke, flooding or a potential exposure to hazardous materials.

Evacuation may also be required as a result of structural damage to the hospital or the potential damage imposed by severe climatic changes, or other potential events, where personnel and patients are in more danger within the facility than any risks posed by evacuation. Not all emergencies will require an emergency evacuation response. The procedures that follow apply only to those situations when an actual evacuation is necessary.

5.2.2 During any evacuation, unique challenges will be faced due to the physical layout of the facility and the unstable nature of the patients within the facility. All staff members perform important roles in the implementation of an evacuation.

5.2.3 The decision to implement the plan should be determined by the Incident Commander. Once consideration is being given to implement an evacuation, the EOP/HICS should be activated and the Hospital Command Center (HCC) should be opened.

5.2.4 The PBX operator will be notified to page a “Code White” overhead by the Incident Commander or designee.

5.2.4.1 Upon hearing a “Code White” PMH employees will return to their home department and report to their supervisor if safe to do so.

5.2.4.2 Supervisors will utilize the staff schedules as an accountability list.

5.2.4.3 Each department director, manager, or designee will report to the HCC to receive a status update from the Incident Commander. The areas to be evacuated as well as other critical information will be communicated in this status update.

5.2.4.4 Each department director, manager, or designee will report back to their department and communicate necessary actions.

5.2.5 Hospital employees in the vicinity of an incident requiring immediate life-saving action may order the partial (either horizontal or vertical) evacuation of a particular area when conditions are life threatening. When life threatening conditions are present, DO NOT wait to hear a “Code White” prior to taking action. The objective is to get patients and personnel to safe assembly areas.

5.2.6 Hospital employees should immediately assume the responsibilities of their assigned roles upon activation of the plan. Inter-hospital and regional coordination of activities should be coordinated under the California Emergency Plan, the California Emergency Mutual Aid Plan and the Imperial County Medical Health Branch Response Plan.

5.3 Communication during an evacuation is critical to the success of the operation. The Hospital Command Center will be activated and the following notifications and

methods of communication will be implemented in accordance with the PMH Emergency Communications Plan:

- 5.3.1 Notification to 911 communications center (Phone or 800mhz Radio System)
- 5.3.2 Notification to Imperial County Emergency Operations Center or Medical Health Operational Area Coordinator (MHOAC) (Phone or 800mhz Radio System)
- 5.3.3 Implement REDDINET Communications with cooperating agencies.
  - 5.3.3.1 REDDINET carries critical data and communications for disaster management including:
    - 5.3.3.1.1 Emergency Medical Communications connecting hospitals and service providers within regional healthcare systems
    - 5.3.3.1.2 Real-time hospital diversion status
    - 5.3.3.1.3 Special screens allow for data to be input on patient capacity, victim identification and dispatch information so that there is even and accurate distribution of patients to hospitals in the region.
    - 5.3.3.1.4 Serves as a virtual command and control center for managing emergency transport, treatment locations and resource allocation
- 5.3.4 Family Notifications will be coordinated through the HCC, as soon as reasonable, and will include the patient's destination

5.4 Hospital Priorities during evacuation:

- 5.4.1 Safety of patients, visitors and staff in immediate danger
- 5.4.2 Activation of the EOP/HICS and HCC
- 5.4.3 Partial or total evacuation of the Facility
- 5.4.4 Controlled access to facility
- 5.4.5 Census and accountability:
  - 5.4.5.1 Staff/volunteers
  - 5.4.5.2 Patients/Visitors
- 5.4.6 Patient discharge
  - 5.4.6.1 Physicians should discharge as many patients as possible without compromising care in order to lower patient census
- 5.4.7 Evaluation of non-essential services

5.5 Evacuation Responsibilities:

- 5.5.1 The Incident Commander assigned for an incident should retain full authority and remain responsible for the decision-making process. Evacuation responsibilities for specific departments are summarized below.
- 5.5.2 All Hospital Employees:
  - 5.5.2.1 If a disaster occurs in a patient care area, or threatens a patient care area, employees should remove patients who are in immediate danger. DO NOT WAIT FOR INSTRUCTIONS. Patients should be taken to the nearest safe area on the same floor if possible

(horizontal evacuation). If the patients are not in immediate danger and the alarm has been activated, WAIT for evacuation orders.

5.5.2.2 Do not leave patients unattended. It should be ensured that hospital staff members assume responsibility for patients under someone else's care before they leave to report to pre-assigned disaster response assignments. For example, appropriate hand-off must be conducted before leaving any patient.

5.5.3 Security Department**:**

5.5.3.1 All members of the hospital's Security Department should immediately communicate with their department for a head count and to receive emergency orders. Communication should be done by radio or telephone. They should be prepared to perform a variety of duties including but not limited to:

5.5.3.1.1 Ensure an officer is dispatched to the front entrance of the hospital to meet emergency responders and direct them to the scene of the problem.

5.5.3.1.2 Ensure that officers are dispatched as needed to direct entrances/exits and activate lock-down procedures for the facility.

5.5.3.1.3 Security officers should follow their Emergency Preparedness Security Plan.

5.5.3.1.4 Security staff, using radios or alternate communications systems, should be located at exits of patient care units to ensure that all patients, visitors and staff are accounted for.

5.5.4 Labor Pool:

5.5.4.1 It is anticipated that a significant number of people will volunteer their help during an emergency, including family members, visitors and nearby residents. The PMH Human Resources Department should help manage this influx and assign personnel to register these volunteers and assign them to a specific staging area. They should be prepared to perform a variety of duties including but not limited to:

5.5.4.1.1 Report to the Planning Officer or other representative assigned at the HCC for a head count and to receive emergency assignments.

5.5.4.1.2 Manage and establish the control centers and staging areas for volunteers and patient families/visitors.

5.5.4.1.3 Record volunteers level of fitness, as they may be needed to transport patients up & down stairs.

5.5.4.1.4 Ensure that responsible personnel are assigned to stay with relatives in the hospital waiting area and provide the HCC

with the names of family members and volunteers that are at the facility.

5.5.4.1.5 All volunteers should sign-in at the facility and should provide their full name, contact information, credentials, and list any special talents – especially knowledge of another language.

5.5.5 Food Services:

5.5.5.1 Food service employees at PMH should be prepared to perform a variety of duties including but not limited to:

5.5.5.1.1 Assist in directing visitors in the food service areas to exit the hospital**.**

5.5.5.1.2 Immediately clear hallways of all tray carts, steam carts and food serving carts (if safe to do so)

5.5.5.1.3 Prepare and serve nourishment to patients, family members, volunteers, staff and other personnel if good health practices can be maintained.

5.5.5.1.4 Set up menus or backup services in a disaster situation and maintain adequate supplies.

5.5.5.1.5 Evaluate the impact of the disaster situation to determine if utilities and appliances in the kitchen and cafeteria areas should be shut off and are safe.

5.5.6 Engineering Department:

5.5.6.1 Engineering and Facilities Staff should report to the leadership of their assigned work unit. They should be prepared to perform a variety of duties including but not limited to:

5.5.6.1.1 Help move patients and assist as directed by the unit leadership.

5.5.6.1.2 Ensure that hallways or traffic areas are clear of carts and equipment and be responsible for setting up extra beds if needed.

5.5.6.1.3 Transport supplies and bring resources in from other areas of the facilities as requested.

5.5.6.1.4 Stand by to ensure shutdown of gas valves, HVAC system, and other equipment as appropriate.

5.5.6.1.5 Maintain and control functioning of all available elevators, ventilation equipment and emergency generators.

5.5.6.1.6 Assume additional duties as needs.

5.6 Evacuation of non-patient areas

5.6.1 Should an incident occur of such magnitude requiring total evacuation from the building or evacuation of a specific floor, the staff personnel on that floor should immediately evacuate to a pre-designated Assembly Area, to await specific emergency response assignments. For purposes of identification, staff members of these non-patient care areas should be classified as non-clinical.

Under emergency conditions, this group of personnel should report to the manpower pool to receive emergency response assignments if they do not have pre-designated duties.

5.6.2 Persons in immediate danger should vacate first via the nearest exit. Prior to opening an interior door, first using the back of your hand, feel the door for heat. NEVER open a door that feels hot to the touch. Try to find an alternative exit.

5.6.3 In threatened areas, first close all windows and doors if you can do so without placing yourself in danger.

5.6.4 In an area where there are visitors, calmly gather them in one area and direct them to form in a single file line and escort them to the nearest exit. Assign one volunteer or employee to lead them, and one volunteer or employee to be last in line. These visitors should be sent or escorted to the pre-designated assembly area for the department they were in. Visitors should remain in the assembly area until an "all clear" communication or other directions are given.

5.6.5 Always close doors you pass through.

5.6.6 Once you have reached the designated assembly area, ensure that all patients, visitors and staff are accounted for. Notify the HCC of the number of people in your assembly area and if all persons have been accounted for.

5.7 Evacuating Patient Care Areas:

5.7.1 During an evacuation of patient care areas, patients should be prioritized for evacuation in the following order:

5.7.1.1 Patients, staff and visitors in immediate danger

5.7.1.2 Ambulatory patients

5.7.1.3 Semi-ambulatory patients

5.7.1.4 Non-ambulatory patients

5.7.1.5 Critical/Surgical Patients

5.7.1.6 Equipment and medications

5.7.2 Response to a disaster situation should typically be addressed by one or more of the following activities:

5.7.2.1 Shelter in Place – based upon the type of building construction and fire protection systems in place; staff, patients and visitors may be instructed to remain where they are until further instructions are provided to them. Closing doors and windows in patient rooms should provide initial protection from fire. In most incidents, the safest place for a patient is his/her room. NEVER HESITATE TO RELOCATE BECAUSE OF IMMINENT DANGER.

5.7.2.2 Certain instructions may be given to maintain order and keep everyone informed of the latest status of the incident. Initiation of the Shelter in Place Plan requires that all routine activities stop, and the preparations are made to enable immediate movement of patients

should the incident necessitate such actions as outlined in the following types of patient evacuation.

5.8 General Evacuation Procedures:

5.8.1 During an emergency, initial evacuation of persons in immediate danger must take precedence over all other actions. Initial evacuation routes are posted in prominent locations in all departments. Initiation of a vertical or complete evacuation of the hospital, with the exception of the need to move people that are in immediate danger, should be coordinated under direction of the HCC. Incident specific evacuation routes and the process by which departments should be evacuated must be coordinated through the HCC.

5.8.2 Horizontal Partial

5.8.2.1 Evacuation routes are posted in each department

5.8.2.2 If assigned route is impassible, use an alternate safe route for evacuation. Staff needs to be aware of where the route ends to ensure evacuees are not being led to an area with no access or possible entrapment.

5.8.2.3 The Dept. Manager/Charge Nurse for the area being evacuated will assign one or more employees to control foot traffic and maintain order during the evacuation

5.8.2.4 Maintain clear pathways and exits to allow access for staff and responding authorities

5.8.2.5 Move patients into the hallway and through smoke barrier doors into another compartment

5.8.2.6 Assemble all patients, visitors and staff in an **internal** assembly area and conduct an accountability check

5.8.3 Horizontal Complete

5.8.3.1 Evacuation routes are posted in each department

5.8.3.2 If assigned route is impassible, use an alternate safe route for evacuation. Staff needs to be aware of where route ends to ensure

evacuees are not being led to an area with no access or possible entrapment.

5.8.3.3 The Dept. Manager/Charge Nurse for the area being evacuated will assign one or more employees to control foot traffic and maintain order during the evacuation

5.8.3.4 Maintain clear pathways and exits to allow easy access for staff and responding authorities

5.8.3.5 Move patients into the hallway and through smoke barrier doors into another compartment

5.8.3.6 Assemble all patients, visitors and staff in an **external** assembly area and conduct an accountability check

5.8.4 Vertical Partial:

5.8.4.1 Evacuation routes are posted in each department

5.8.4.2 If assigned route is impassible, use an alternate safe route for evacuation. Staff needs to be aware of where route ends to ensure evacuees are not being led to an area with no access or possible entrapment.

5.8.4.3 The Dept. Manager/Charge Nurse for the area being evacuated will assign one or more employees to control foot traffic and maintain order during the evacuation

5.8.4.4 Maintain clear pathways and exits to allow easy access for staff and responding authorities

5.8.4.5 Elevators will only be used with approval of Fire Department Personnel

5.8.4.6 If elevators are capable of being operated, Engineering will coordinate employees to cover all elevators with keys. Keys to operate the elevators are available in the Engineering Office.

5.8.4.7 If possible designate separate stairwells for ascent and decent

5.8.4.8 Move to an **internal** assembly area and conduct an accountability check

5.8.5 Vertical Complete:

5.8.5.1 Evacuation routes are posted in each department

5.8.5.2 If assigned route is impassible, use an alternate safe route for evacuation. Staff needs to be aware of where route ends to ensure

evacuees are not being led to an area with no access or possible entrapment.

5.8.5.3 The Dept. Manager/Charge Nurse for the area being evacuated will assign one or more employees to control traffic and maintain order during the evacuation

5.8.5.4 Maintain clear pathways and exits to allow easy access for staff and responding authorities

5.8.5.5 Elevators will only be used with approval of Fire Department Personnel

5.8.5.6 If elevators are capable of being operated, Engineering will coordinate employees to cover all elevators with keys. Keys to operate the elevators are available in the Engineering Office.

5.8.5.7 If possible designate separate stairwells for ascent and decent

5.8.5.8 Move to an **external** assembly area and conduct an accountability check

5.8.6 If total evacuation is necessary, buildings will be evacuated starting with upper floors down to ground floors.

5.8.7 If time permits, shut off oxygen, water, lights and gas.

5.8.7.1 Any type of medical gas intervention must be coordinated with clinical departments to protect patient safety.

5.9 Clinical Considerations:

5.9.1 Nursing staff should report to their own department for a head count and emergency assignment.

5.9.2 Maintain continuity of patient care whenever possible

5.9.3 Emphasis will always be placed on evacuating patients prior to attempting evacuation of equipment and supplies.

5.9.4 Evaluate the needs of each patient including necessary medical equipment, special personnel requirements, medications, etc.

5.9.5 Although the removal of substantial amounts of medical supplies and equipment from the facility may often be impossible, consideration must be

given to carrying essential pieces of equipment and supplies from the hospital to assembly areas and alternate care sites.

5.9.6 The Charge Nurse for each unit will be responsible for ensuring the following items are brought to the assembly area/alternate care site:
- 5.9.6.1 Unit staffing sheet
- 5.9.6.2 Care Coordination Sheets (M/S Only)
- 5.9.6.3 Tackle box with all patient medications

5.9.7 The HUC for each unit will be responsible for ensuring the following items are brought to the assembly area/alternate care site:
- 5.9.7.1 Admission clipboard
- 5.9.7.2 Copy of the unit census
- 5.9.7.3 Patient's physical charts
- 5.9.7.4 Medication profiles
- 5.9.7.5 Copy of the physician on-call list
- 5.9.7.6 Copies of the Patient Clinical Status Information for Evacuation Form (Attachment D)
  - 5.9.7.6.1 This form should be utilized when transferring patients to alternate care sites or other healthcare facilities during an evacuation in the event that IVHD has no capabilities of printing or copying medical records.

5.9.8 Ambulatory patients should be asked to join hands and proceed in a line with staff at the head and rear of the line to the predetermined assembly area. If an ambulatory patient requires an escort for assistance, the Charge Nurse will assign someone to assist

5.9.9 The immediate safety of the patient at this time must be given preference over aseptic techniques.

5.9.10 Be alert for further instructions and changing environmental hazards. Make periodic checks to assess patient's safety and emotional health.

5.9.11 In collaboration with physicians evaluate the condition of each patient to determine the best available method for transportation.

5.9.12 Remember, if horizontal evacuation is implemented, it could be just the initial step in a series of movements to safety. BE ALERT FOR FURTHER INSTRUCTIONS.

5.9.13 Non-Ambulatory patients, modes of transportation:
- 5.9.13.1 Beds – special care needs to be considered when evacuating patients from their room on their beds. Because of room design or

bed size, some beds may become lodged in the doorways when exiting

5.9.13.2 Rolling stretchers

5.9.13.3 Wheelchairs

5.9.13.4 Commercial products – stair chairs, evacuation sleds, etc. These items are located in the stairwells.

5.9.13.5 Hand Carry – special care is required before performing any of these techniques as they can be potentially harmful to patients and staff

5.9.13.5.1 Blanket carry

5.9.13.5.2 Four-Hand carry

5.9.13.5.3 Seated Carry

5.9.13.5.4 Blanket Drag

5.9.13.5.5 Infants and small children

5.10 Confirm evacuation area

5.10.1 The Charge Nurse will be responsible to ensure that their department has been evacuated.

5.10.2 Every room, including bathrooms, showers, staff areas, etc. will be visually inspected

5.10.3 After visually inspecting the rooms the door will be closed and an "EVACUATED" door tag will be placed on the outside of the door

5.11 Medical/Surgical Department

5.11.1 The Department Manager or designated leadership responsible for nursing staff should direct activities of the department.

5.11.2 Orthopedic patients who are fastened into traction devices may not fit through doorways. Ropes and straps may have to be removed or cut to move the patient.

5.12 Labor and Delivery Department/Pediatrics Department:

5.12.1 Assign support staff to wheel incubators, instruments and supplies with the patient if needed to complete Labor and Delivery procedures.

5.12.2 Ensure that as many children/babies as possible should be evacuated with their mothers.

5.12.3 Children/Babies can be in the mother's arms or be carried by staff.

5.12.4 Incubator babies should be moved in their incubators to other locations (if possible). If necessary, multiple babies may be placed into a single incubator.

5.13 Critical Patients (ICU or post-operative recovery patients)

5.13.1 The Department Manager/Charge Nurse will evaluate patients in the Intensive Care Unit/Recovery Room in collaboration with the patients attending physician for possible discharge. Use established discharge criteria as a guide to transfer as many patients as possible out of the Intensive Care Unit/Recovery Room. Staff should coordinate with medical/surgical staff and

respiratory therapists to evaluate whether it is appropriate to shut-off medical gases and ventilation equipment and provide interim support

5.13.2 For patients with Arterial Lines and Swan Ganz, disconnect the transducer from patient cable and take the pressure bag with the patient

5.14 Evacuation of Operating Room Patients:

5.14.1 Upon activation of the Emergency Operations Plan, the remaining elective surgical schedule will be cancelled

5.14.2 If anesthesia has begun, but the surgical procedure has not started:

5.14.2.1 The anesthesiologist shall terminate the anesthetic as soon as it is safe to do so

5.14.2.2 The anesthesiologist and circulating nurse shall accompany the patient to a safe location

5.14.3 If a surgical procedure is in progress:

5.14.3.1 The surgeon and anesthesiologist shall determine when it is safe to terminate the procedure and move the patient

5.14.3.2 The anesthesiologist and circulating nurse shall accompany the patient to a safe location

5.15 Special Needs populations:

5.15.1 Prisoners will be moved by their law enforcement guards. If the event is emergent and guards are not readily available, staff will move the prisoner. Special precautions should be taken with regards to handcuffs and restraints. Prisoners will be kept in a separate assembly area awaiting transport

5.15.2 Patients under respiratory isolation shall be given a mask to wear. Gloves, gowns, and masks will be worn by staff evacuating the patient in respiratory isolation.

5.15.2.1 The Hospital Infection Control Department or House Supervisor will coordinate with personnel at assembly areas and alternate care

sites to establish isolation areas for all patients with isolation precautions ordered.

5.16 Evacuation of patients on ventilators:
- 5.16.1 A respiratory therapist, or other trained individual, shall be available for each patient that requires ventilations and will accompany the patient being evacuated
- 5.16.2 When wall oxygen is turned off, switch ventilator to room air and/or obtain portable oxygen tank
- 5.16.3 If there is no power, patients must be ventilated manually using a bag-valve device
- 5.16.4 A limited number of portable oxygen powered ventilators are available that can be used during emergency situations

5.17 Dialysis Patients:
- 5.17.1 Discontinue dialysis immediately and move the patient to a safe area
- 5.17.2 If time and conditions permit, give blood back to patient before moving
- 5.17.3 Evacuate patient to a location that allows for monitoring. If such an area is not available, contact the HCC and request portable monitors as needed**.**

5.18 Tracking Resources:
- 5.18.1 The HCC will assign a Patient Tracking officer to implement a tracking system using Patient Tracking Forms:
  - 5.18.1.1 Disaster/Victim Tracking Form (HICS 254)
  - 5.18.1.2 Master Patient Evacuation Tracking Sheet (HICS 255)
  - 5.18.1.3 Patient Evacuation Tracking Form (HICS 260)
  - 5.18.1.4 The HCC will ensure pertinent patient tracking information is input into the REDDINET system
- 5.18.2 Equipment relocated with patients should be noted on the Patient Evacuation Tracking Form (HICS 260)
- 5.18.3 A Transportation Officer will be assigned by the HCC. The Transportation Officer will be responsible for:
  - 5.18.3.1 Assembling evacuation teams from the Labor Pool
  - 5.18.3.2 Ensuring coordination with outside agencies responsible for patient transportation
  - 5.18.3.3 Establish and implement a Transportation Action Plan
  - 5.18.3.4 Assign staff to each floor for evacuation manpower
  - 5.18.3.5 Report to department being evacuated and supervise evacuation. If a complete hospital evacuation duties may be performed from HCC.
  - 5.18.3.6 Coordinate with Department Managers/Charge Nurse for order of patients being evacuated

5.19 Accounting for all patients, staff and visitors is critical during any evacuation, whether partial or total. The following system will be utilized to ensure that everyone has been

accounted for during activation of the Evacuation Plan. (See Accountability Work Sheet, Attached)

5.19.1 During an emergency situation, all staff should report to their assigned work area for a head count prior to assuming pre-designated disaster response duties, if it is safe to do so. If it is unsafe to report to your normal work area, report to the pre-designated assembly area for your department.

5.19.2 Once at the assembly area, the Charge Nurse or Department Manager will be responsible for conducting a roll call using the department staffing sheet and patient census.

5.19.3 Patient family and visitor information must be collected, if they are going to remain on the hospital campus, and added to the total count for your assembly area. Instruct family and visitors that they MUST check-out with staff if they are going to leave the hospital.

5.19.4 If there are any discrepancies noted, coordinate with the HCC to conduct a search of the facility (this should begin by checking all assembly areas). If life threatening conditions exist, search activities must be coordinated with local emergency response personnel. Be prepared to give the following information to emergency responders:

5.19.4.1 Name and approximate age of missing person(s)

5.19.4.2 Last known location

5.19.4.3 Any disabilities or communication barriers

5.19.4.4 Any special medical concerns

5.20 Confirmation of Evacuation:

5.20.1 Confirmation of facility evacuation will be the responsibility of the Incident Safety Officer or their designee.

5.20.2 Each affected area will be visually inspected to confirm that all patients, staff and visitors have been evacuated to a safe area. If it is determined that it is unsafe to visually inspect each area this must be coordinated with responding fire department personnel.

5.20.3 The HCC will notify responding public safety officers of areas that have been determined to be clear and those that remain to be checked.

5.21 Assembly Areas: (See Assembly Area Guide, Attached)

5.21.1 Assembly areas are temporary meeting places that have been carefully selected to provide the most appropriate and safe environment for initial evacuation of the hospital. They are not designated as Alternate Care Sites;

however basic and emergency care can and should be provided in these areas.

5.21.2 Designated departments will share the same assembly areas based on patient needs and possible resource requirements.

5.21.3 The HCC will designate a leader for each assembly area. The Assembly Area Leader will be responsible for coordinating activities and resource requests with the HCC as well as maintaining accountability for their designate area.

5.21.4 Color-coded signs with department names will be placed at assembly areas.

5.21.5 Upon departure from their home department every patient and visitor will be given a color-coded wrist band to ease identification and tracking.

5.21.6 Patients in ancillary departments will be transported to the assembly area assigned to their home department and given the appropriate color-coded wrist band.

5.21.7 Once in the appropriate assembly area, patients will be triaged for transport to alternate care sites or other facilities using standard triage criteria (most critical first). An appropriate color triage tag will be filled out and attached to the patient.

5.21.7.1 Red – Critical, move first

5.21.7.2 Yellow – Delayed

5.21.7.3 Green – Stable

5.21.7.4 Black – Deceased, not likely to survive, move last

5.21.8 All patients, visitors and an appropriate number of staff will remain in their assigned assembly areas until an “All Clear” has been issued, appropriate alternate care sites have been established or all patients have been transferred to another facility.

5.21.9 Patients and staff may be moved to other assembly areas as needed based on specific patient needs as determined by the HCC. It will be the responsibility of the Assembly Area Leaders to track and document movement of patients and staff between assembly areas and report this information to the HCC.

5.21.10 If it is determined that an assembly area is unsafe during an incident, the HCC will designate a safe alternative to be established.

5.21.11 Staff in non-clinical areas will evacuate the facility utilizing the nearest exit as posted on the evacuation maps. Staff will remain together or re-group with their home department and check-in with supervisor for accountability.

5.22 Recovery:

5.22.1 The recovery process will begin as soon as it is determined that it is safe to do so.

5.22.2 Assessment of damage and final determination of when and how a department or the facility will be made safe for occupancy will be done jointly by the

Engineering, Nursing, Administration, Radiation Safety Officer and Public Safety Officials in conjunction with the Imperial County OES.

5.22.3 Efforts will not be made to reopen a department or facility until the safety of the environment and the ability to deliver medical care has been assured by Facilities Management and the Safety Officer.

5.22.4 Photographic and video documentation will be taken of all damage and reported to the Hospital Insurance Carrier. All needed Repairs will be made after approval from insurance adjuster.

5.22.5 Prior to reopening, each affected area will be thoroughly cleaned/decontaminated, needed equipment and supplies replaced, utility and medical gas function verified by engineering and respiratory therapy and linens cleaned/replaced.

5.22.6 After needed repairs have been completed notifications will be made to the Brawley Fire Department, California Statewide Health Planning and Development (OSHPD) and the California Department of Public Health Licensing and Certification Division.

5.22.6.1 Each of the above agencies will conduct building safety inspections as well as the ability of PMH to provide patient care.

5.22.7 After passing all inspections the HCC will notify the Hospital Operator to overhead page the “All Clear” order three times.

5.22.8 The HCC will notify the Imperial County OES and MHOAC that the facility is no longer operating under EOPs and able to accept patients.

5.22.9 In the event of a total evacuation took place, the Public Information Officer will contact local media agencies to make a public announcement that operations have returned to normal.

5.22.10 The HCC will begin to contact all other healthcare facilities that received patients during the evacuation to coordinate transferring patients back to PMH in order to relieve the surge of patients at their facility.

5.22.11 PMH will provide Critical Stress Incident Debriefing for all employees that request assistance in accordance with the IVHD Employee Assistance Program.

5.22.12 Immediately following the event, the Hospital Disaster Preparedness Coordinator will conduct Hot-washes and debriefings with all staff and

coordinating agencies involved to identify the effectiveness and deficiencies of the response.

5.22.13 Within forty-five (45) days of returning to normal operations, the Hospital Disaster Preparedness Coordinator will submit a Draft After Action Report and Improvement Plan to the PMH Safety Committee for approval.

5.22.14 Within ninety (90) days the IVHD Board of Directors will approve the After Action Report and Improvement Plan and it will be submitted to the Imperial County MHOAC and Imperial County Disaster Council.

6.0 References:

6.1 Imperial County Operational Area Medical Health Branch Disaster Plan
6.2 Imperial County EMS Policy #4220 Ambulance Diversion
6.3 California Hospital Association, Hospital Evacuation Plan Checklist
6.4 California Code of Regulations Title 22, 70741 Disaster and Mass Casualty Program
6.5 California Code of Regulations Title 22, 70743 Fire and Internal Disasters
6.6 California Code of Regulations Title 22, 70746 Disruption of Services
6.7 California EMSA, HICS Implementation Guide
6.8 California Emergency Management Agency, California Emergency Plan
6.9 California Emergency Management Agency Department of Health, California Emergency Medical Mutual Aid Plan

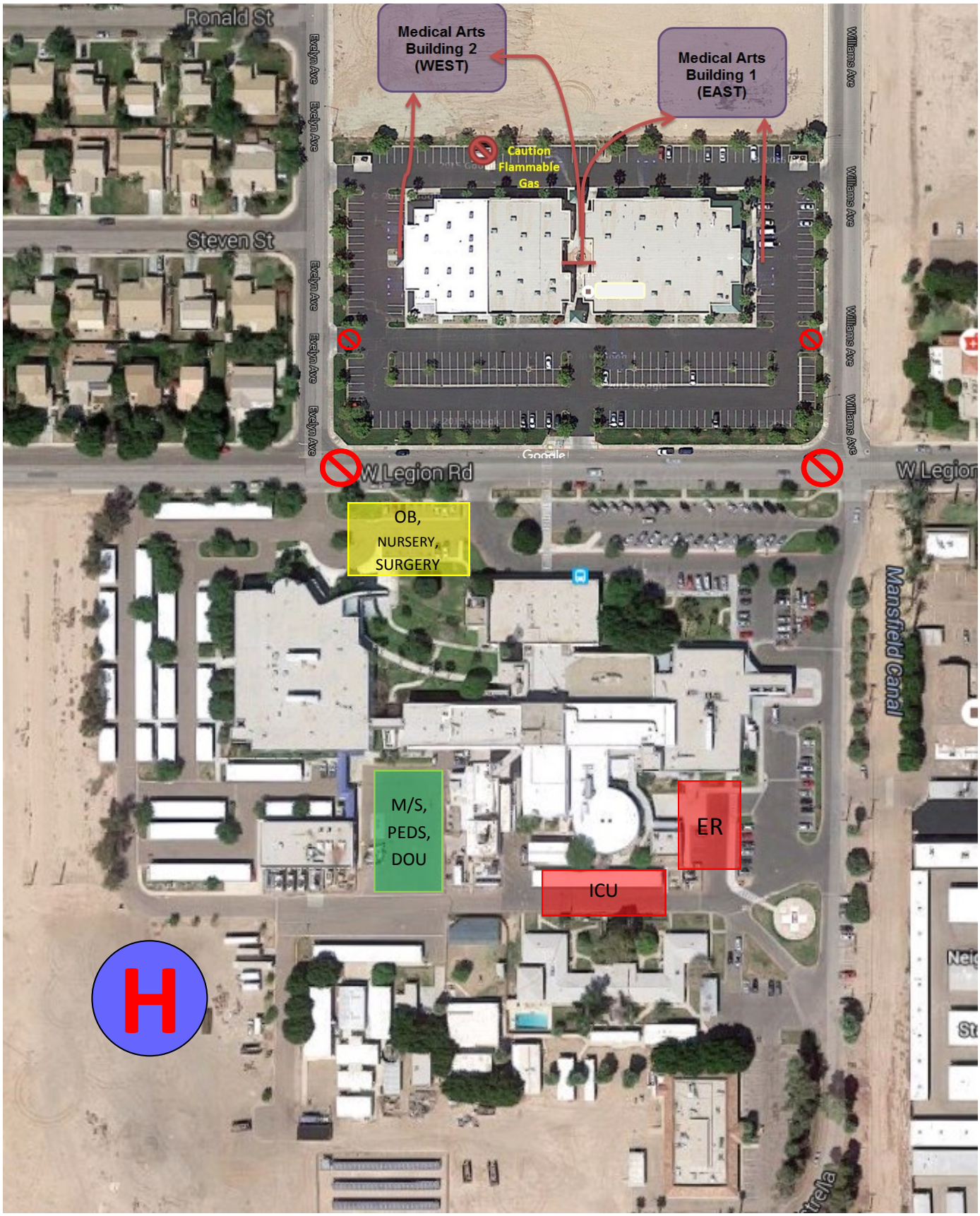
7.0 Attachment List:

7.1 Attachment A – Assembly Area Map
7.2 Attachment B – Accountability Worksheet
7.3 Attachment C – Evacuation and Shelter in Place Decision Tree
7.4 Attachment D – Patient Clinical Status Information for Evacuation

8.0 Summary of Revisions:

8.1 Updated PMHD to PMH or IVHD when applicable

Assembly Area Map



***Designated assembly areas may change at the discretion of the Hospital Incident Commander based on the location, size or nature of the incident.**

Pioneers Memorial Hospital
Evacuation Assembly Area Accountability Worksheet
Date:_____Assembly Area:_____ Completed By:_____

Patient/Visitor Name	MR# Visitor	Dept.	Triage Level (R,Y,G,B)	Time Departed	Destination

Hospital Evacuation and Shelter In Place Decision Tree

Event

- Event requiring facility to consider whether evacuation or Shelter in Place (SIP) plans should be activated
- External and internal intelligence regarding event

Must Shelter-In-Place

- The external environment would pose a greater danger to patients, staff and visitors than evacuation (e.g., chemical/ biological agent release, nuclear incident plume)
- Adequate and timely facility and/or mutual aid resources are not available or accessible (e.g., earthquake)

Must Evacuate

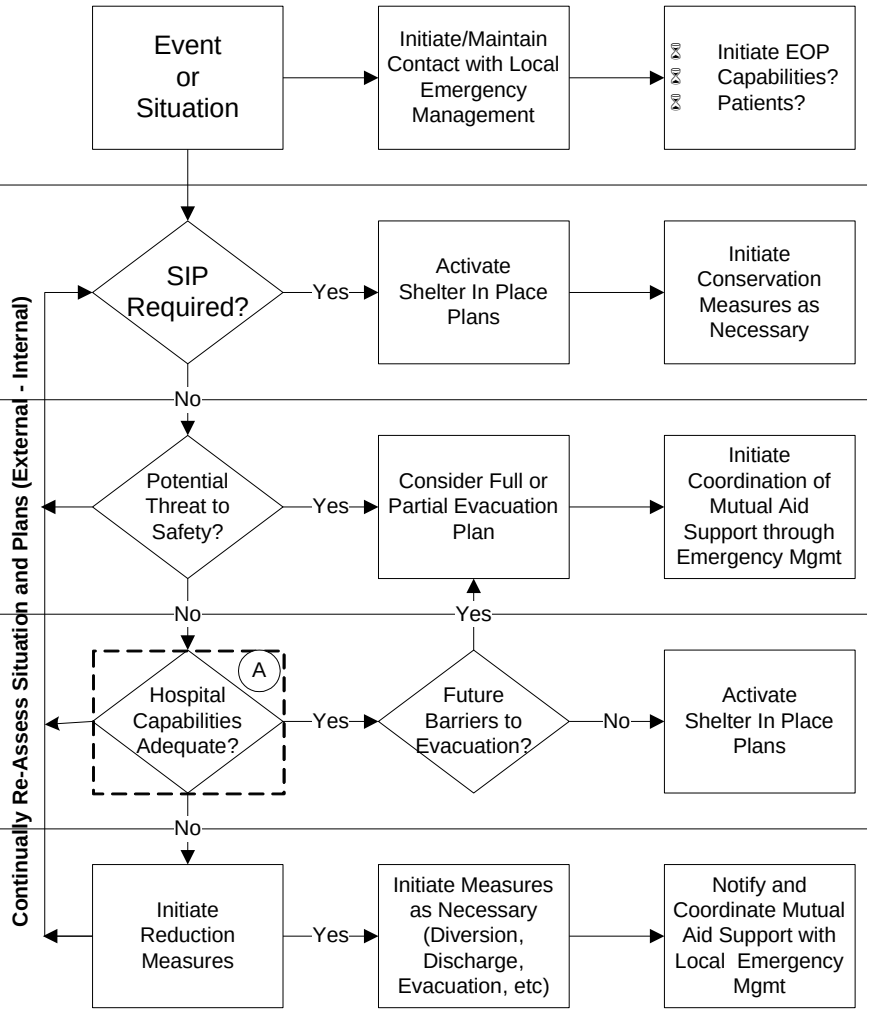
- The proximity, scope and/or expected duration of event poses an immediate threat to patient and staff safety
- Adequate and timely facility and/or mutual aid resources are available and accessible to support Full or Partial evacuation

Shelter In Place or Evacuation Decision

- Duration and scope of threat to hospital clear but may evolve
- Hospital capabilities adequate to care for patients and staff with available support for estimated event duration
- May or may not be barriers mutual aid resources should evacuation become necessary

Need to Implement Reduction Measures

- Hospital capabilities not adequate to maintain full operations for estimated duration of event
- Determination made that reduction measures necessary (for example, conservation of resources, curtailment of services and/or partial hospital evacuation)
- No identified barriers to mutual aid resources



(A) Hospital Capabilities may include communication, resources (medical/non-medical supplies and equipment), utilities, staff, food, water, safety and security (including safety of facilities).

PATIENT CLINICAL STATUS INFORMATION FOR EVACUATION

Purpose: To provide pertinent clinical information when sending an acute care patient for direct emergency admission to another acute care hospital due to disastrous event at Pioneers Memorial Hospital, Brawley, California

Date of status change:_____ Time: _____

Instructions: To be completed by nurse and sent along with the Face Sheet, Medication Administration Record and any other pertinent information that can be copied provided there is electricity available.

Patient name: _____
Date of birth: _____
Social Security #: _____

Facility name: _____
Address: _____
Phone number: _____
Facility name: _____
Contact name:_____
Name of physician notified: Phone #: Date: Time:
Name of family notified: Date: Time:
Allergies/Reactions (include medications, food, latex environmental etc.):
□ No known allergies

_____
_____
_____
_____

Isolation Precautions: □ MRSA □ VRE □ C-Diff □ Tuberculosis □ Other:
Risk: □ aspiration □ falls □ skin breakdown **Devices** (i.e. pacer):

_____

Reason for transfer (Pioneers Memorial Hospital Emergency Evacuation)

_____
_____
_____

Diet:

_____
_____

VITAL SIGNS Date:_____ Time:_____
Temperature: _____ Pulse: _____ □ Urinalysis Attached
Respiration: _____ Blood pressure:_____ □ Pulse Oximetry
□ Initial Glasgow
PAIN LEVEL: □ mild □ moderate □ severe Coma Scale (if completed)
Pain location: _____ □ Blood Sugar
Time of last medication: _____ If insulin given: Type:_____
Time: _____ Dose: _____
Date of last bowel movement: _____ Date of last urine void:
_____
Any recent medication changes: □ No □ Yes, specify:
_____
Patient is usually:
□ alert & oriented x 3 □ alert but disoriented/confused □ poor alertness/somnolent □ agitated □ combative □ Other
_____
TYPE OF CHANGE: (mark all that apply)
Respiratory/Cardiac:
□ **Shortness of breath:** □ room air □ O2 at: _____ *liters per minute:*
□ Nasal Cannula □ Mask
□ **Cough:** □ productive □ non-productive □ wheeze □ blood tinged sputum
□ frank hemoptysis
□ **Chest pain:** relieved with sublingual Nitroglycerin: □ Yes □ No
□ palpitations
Change in Mental Status/Condition:
□ disoriented/confused □ seizure activity □ decreased responsiveness
□ agitated □ combative □ unresponsive □ Other_____

TYPE OF CHANGE CONTINUED: (mark all that apply)
Fall: □ No □ Yes If yes, □ witnessed □ unwitnessed
History of falls: □ No □ Yes, date of last fall: _____
Fell from: □ bed □ chair □ standing Height of fall: _____ onto: □ carpet
□ linoleum □ cement □ grass □ tile □ other:_____
Cause of fall, if known (slip, trip, dizziness, etc.): _____
Can resident recall fall? □ No □ Yes, resident's statement:
_____
_____
_____
Head injury: □ Yes □ No □ Unknown Loss of consciousness: □ Yes □ No □ Unknown

Resident on Anticoagulation/blood thinner therapy (Coumadin, Heparin, Aspirin, NSAIDS, Plavix, Lovanox): □ No □ Yes
If on Coumadin, date of last INR: _____
Results: _____
Other changes in condition:
_____

Skin integrity status_____
Recent Surgery (date & description)_____
_____
Recent Hospitalization (date & diagnosis)_____
_____

Resident has a history of:
□ Alcohol abuse □ Deep vein thrombosis/Pulmonary Embolism
□ Hypertension □ Recent infection
□ Asthma/Chronic Obstructive Pulmonary Disease
□ Delirium □ Liver disease □ Seizure disorder
□ Bleeding disorder/coagulopathy
□ Dementia □ Myocardial Infarction/Heart Attack □ Stroke
□ Cancer □ Depression □ Osteoporosis □ Syncope
□ Chest pain/angina □ Diabetes □ Parkinson's disease
□ Urinary Tract Infection
□ Chronic renal disease □ Fever □ Pneumonia □ Other: _____
□ Congestive Heart Failure □ Gait/balance disorder
□ Postural hypotension _____
□ Constipation □ Gastrointestinal bleeding □ Psychiatric disorder (specify):_____

Code Status/Hospital Status (mark as applicable):
□ Full code □ Do not intubate □ Do not resuscitate □ Do not hospitalize (ED visit for acute care is permissible.)
□ **Copy of Advance Directive / Living Will / Treatment Limitations/ DNR / DNH order form sent with resident if applicable.**

Sent with resident: □ Medication Administration Record □ History & Physical
□ Face Sheet
□ Electrocardiogram (EKG) □ Recent Labs □ Chest X-Ray
□ Physician Progress Notes (last 3 dates) □ Nursing Progress Notes (last 3 dates)

Other pertinent information:

_____

_____

Signature/Title:_____

Print Name: _____

Unit Name: _____Phone #: _____

Date: _____

Imperial Valley Healthcare District

Title: **Shelter In Place Plan**	Policy No. EOC-00188
	Page 1 of 5
Current Author: Jorge Mendoza	Effective: 8/11/1995
Latest Review/Revision Date: 1/2025	Manual: EOC – Emergency Management

Collaborating Departments: Purchasing, Dietary, Nursing, Engineering, Patient Registration		Keywords: HICS, Hospital Incident Command System, EOP, Emergency Operation Plan	
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To provide Pioneers Memorial Hospital (PMH) staff with guidance in the performance of their duties in the event of a Shelter in Place incident (i.e. toxic environment outside the facility, earthquake, hazardous material spill inside the facility, etc.)

2.0 Scope: District wide

3.0 Policy:

3.1 The PMH Shelter in Place Plan (the plan) will be reviewed and updated regularly or as major changes/events at PMH occur.

3.2 The decision to Shelter in Place shall be initiated by the Incident Commander (according to the Hospital Incident Command System and PMH Emergency Operations Plan (EOP)) or by a Public Safety Officer (Police or Fire Department).

3.3 In accordance with PMH EOPs, the Hospital Incident Command System (HICS) will be utilized during all Shelter in Place incidents.

3.4 Upon notification by the Incident Commander, the Hospital Operator will overhead page "Code Triage" three times.

3.5 The Emergency Department will be placed on Ambulance Diversion in accordance with Imperial County EMS Policy #4220, until it is determined that it is safe to accept additional ambulance patients by the Incident Commander.

3.6 PMH Staff will be trained and become familiar with the plan. The plan will be included as part of the PMH Disaster Exercise and Evaluation Program to test for readiness and deficiencies.

4.0 Definitions:

4.1 Emergency Operations Plan (EOP) – EOP's outline the strategy for responding to and recovering from a threat, hazard, or other incident.

4.2 Hospital Incident Command System (HICS) – An incident management system designed for use in a hospital that is compliant with SEMS and NIMS.

4.3 Hospital Command Center (HCC) – A designated location in the hospital prepared to convene coordinate response activities, resources and information during an emergency or disaster.

4.4 Medical Health Operational Area Coordinator (MHOAC) – Designated by the Imperial County EMSA, the MHOAC is responsible for coordinating disaster medical and health

resources within Imperial County and be the point of contact for coordination with the Regional Disaster Medical and Health Coordinator/Specialist.

5.0 Procedure:

5.1 Activation of the Shelter in Place Plan:

5.1.1 Not all emergency situations require sheltering in place. When it becomes apparent that an external danger may result in injury, possible exposure, or loss of life to patients, visitors and staff, the Incident Commander is responsible for ordering the facility or departments to shelter in place. Rapid decision making is vital during a possible shelter in place emergency.

5.1.2 The “Evacuation and Shelter In Place Decision Tree” will be utilized to determine whether evacuation or sheltering in place is appropriate.

5.1.3 Sheltering in place should be ordered based on the circumstances of the threat. Hospital Command Staff should evaluate the nature of the threat as it occurs. In most situations it may be safer and more medically responsible to shelter in place verses evacuating departments and/or buildings.

5.1.4 The Incident Commander will assess the availability of resources and reassess regularly to determine the proper course of action.

5.1.5 If it is determined that patients, visitors and staff are safer inside the facility than outside, sheltering in place will be ordered.

5.1.6 The Incident Commander will activate the Hospital Command Center (HCC) and assign necessary positions and HICS Job Action Sheets.

5.2 Shelter In Place Communications:

5.2.1 Communications during a shelter in place incident is critical to the success of the operation. The HCC will make the following notifications and activate the PMH Emergency Communications Plan:

5.2.1.1 Notification to 911 communications center (Phone or 800 MHz Radio System).

5.2.1.2 Notification to Imperial County Medical Health Operational Area Coordinator (MHOAC) (Phone or 800 MHz Radio System)

5.2.1.3 Establish ReddiNet communications with cooperating agencies.

5.2.1.4 Appropriate notifications to patient’s families will be coordinated by the HCC, as soon as reasonable.

5.2.2 The Hospital Operator will be utilized for announcements and sheltering orders, approved by the Incident Commander, via the Hospital Intercom.

5.3 Shelter In Place Procedures:

5.3.1 Every situation is different, local emergency response officials (Police or Fire Department) may issue special instructions to follow.

5.3.2 Upon notification, all staff should report to their department for a head count and emergency assignment.

5.3.3 The Department Manager/Charge Nurse will be responsible for accounting for all patients and staff using a current unit census and staffing sheet.

5.3.4 PMH Staff will remain inside the building and advise patients and visitors to do

the same.

5.3.5 Identification of available resources should be made immediately upon activation of the plan.

5.3.5.1 Department Managers/Charge Nurses should immediately assess the amount and types of resources on hand in their department and report this information to HCC. (i.e. medical supplies, food, water, staff etc.)

5.3.5.2 The HCC in coordination with the Materials Management Department will determine how long PMH can sustain shelter in place procedures without assistance from outside agencies. The HCC will utilize HICS Form 258 for resource tracking.

5.3.5.3 If deficiencies are found, the HCC will coordinate with the Imperial County MHOAC to obtain additional supplies to sustain operations.

5.3.5.4 During all shelter in place operations, the HCC should inform all departments that all resources are to be conserved as appropriate.

5.3.6 The HCC will establish a workforce plan to address the needs of staff for the expected duration of the incident (i.e. food/water needs, etc.)

5.3.7 The HCC will coordinate with all Departments and Physicians to establish a patient management plan, including cancellation of elective admissions and procedures.

5.3.8 PMH Security and Engineering Staff will initiate a lock-down of the facility in accordance with PMH Policy EOC-0074, Emergency Lock-Down.

5.3.9 Each nurse is responsible for his/her own patients. The following guidelines should be observed:

5.3.9.1 If patients are in immediate danger, move them to a designated area in accordance with the PMH Evacuation Plan.

5.3.9.2 Patients who should not be moved may be left in their room with extra pillows and blankets over them for protection.

5.3.9.3 Beds should be moved as far away from windows as possible.

5.3.9.4 Patients in ancillary departments should be moved to their normal department, if it is safe to do so, for accountability and continuity of care purposes.

5.3.9.5 If it is safe to do so and the resources are available, regular patient care should be continued.

5.3.10 Department Managers/Charge Nurses should make all resource requests (i.e. supplies, pharmaceuticals, staffing, etc.) through the HCC.

5.3.11 If an external toxic atmosphere is present refer to PMH Policy EOC-00449 for response guidance.

5.3.12 All staff must remain alert for changing conditions and further instructions, as sheltering in place may progress to activation of the PMH Evacuation Plan if conditions deteriorate.

5.3.12.1 While sheltering in place, department charge nurses should coordinate with their staff to determine evacuation priorities for the department.

5.4 Recovery Operations:

5.4.1 The recovery process will begin as soon as it is determined that it is safe to do so.

5.4.2 Assessment of damage and final determination of when and how a department or the facility will be made safe for occupancy will be done jointly by the Engineering, Nursing, Administration, Radiation Safety Officer and Public Safety Officials in conjunction with the Imperial County OES.

5.4.3 Efforts will not be made to reopen a department or facility until the safety of the environment and the ability to deliver medical care has been assured by Facilities Management and the Safety Officer.

5.4.4 Photographic and video documentation will be taken of all damage and reported to the Hospital Insurance Carrier. All needed Repairs will be made after approval from insurance adjuster.

5.4.5 Prior to reopening, each affected area will be thoroughly cleaned/decontaminated, needed equipment and supplies replaced, utility and medical gas function verified by engineering and respiratory therapy and linens cleaned/replaced.

5.4.6 After needed repairs have been completed notifications will be made to the Brawley Fire Department, California Statewide Health Planning and Development (OSHPD) and the California Department of Public Health Licensing and Certification Division.

5.4.6.1 Each of the above agencies will conduct building safety inspections as well as the ability of PMH to provide patient care.

5.4.7 After passing all inspections the HCC will notify the Hospital Operator to overhead page the “All Clear” order three times.

5.4.8 The HCC will notify the Imperial County OES and MHOAC that the facility is no longer operating under EOPs and able to accept patients.

5.4.9 The Public Information Officer will contact local media agencies to make a public announcement that operations have returned to normal.

5.4.10 PMH will provide Critical Stress Incident Debriefing for all employees that request assistance in accordance with the PMH Employee Assistance Program.

5.4.11 Immediately following the event, the Hospital Emergency Preparedness Coordinator will conduct Hot-washes and debriefings with all staff and coordinating agencies involved to identify the effectiveness and deficiencies of the response.

5.4.12 Within forty-five (45) days of returning to normal operations, the Hospital Emergency Preparedness Manager will submit a Draft After-Action Report and Improvement Plan to the PMH Safety Committee for approval.

5.4.13 The Final After-Action Report and Improvement Plan and will be available to the Imperial County MHOAC and Imperial County Office of Emergency Services upon request.

6.0 References:

6.1 Imperial County Medical Health Branch Response Plan 2077

6.2 Imperial County EMS Policy #4220 Ambulance Diversion 2003
6.3 California Hospital Association, Hospital Shelter In Place Planning Checklist
6.4 California Code of Regulations Title 22, 70743 Fire and Internal Disasters
6.5 California Code of Regulations Title 22, 70746 Disruption of Services
6.6 California EMSA, HICS Implementation Guidebook 2006
6.7 California Emergency Management Agency, California Emergency Plan 2009
6.8 California Emergency Management Agency Department of Health, California Emergency Medical Mutual Aid Plan 2007

7.0 Attachment List:

7.1 Attachment A – Evacuation and Shelter In Place Decision Tree
7.2 Attachment B – HICS Form 258 – Hospital Resource Directory

8.0 Summary of Revisions:

8.1 Updated PMHD to PMH

Imperial Valley Healthcare District **ANNUAL REVIEW**

Title: **Workplace Violence Prevention Plan**	Policy No. EOC-00071
	Page 1 of 6
Current Author: Jorge Mendoza	Effective: 5/30/2018
Latest Review/Revision Date: 1/2025	Manual: EOC – Security Management

Collaborating Departments: HR, Compliance, Nursing, Security, Quality	Keywords:		
Approval Route: List all required approval			
PSQC	Other: Safety Committee 3/2025		
Clinical Service _____	MSQC 4/2025	MEC 4/2025	BOD 5/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 Pioneers Memorial Hospital (PMH) is committed to providing a work environment that is free from violence, threatening or intimidating conduct. No individual may engage in any verbal or physical conduct which intimidates or threatens harm to any employee, physician, contracted staff or volunteer. This policy outlines the steps that PMH will take in order to ensure the safety of all employees, physicians, contracted staff, and volunteers while on the premises.

2.0 Scope: District wide

3.0 Policy:

3.1 PMH has a zero-tolerance policy for workplace violence (HRD-00020). All acts of violence or threats against any employee, physician, volunteers or others are to be reported immediately. PMH commits to investigating violence, respond to incidents and support victims of violent acts. PMH expects that employees and staff that experience violence, or witness a violent act, will make a report to their supervisor or human resources.

3.2 Staff will not be retaliated against for reporting any type of violence or participating in an investigation of a violent act. This includes seeking assistance from local emergency services or law enforcement when a violent incident occurs. Discrimination against victims or reports of violence will not be tolerated.

4.0 Definitions:

4.1 Dangerous Weapon – An instrument capable of inflicting death or serious bodily injury

4.2 Threat of Violence – A statement or conduct that causes a person to fear for his or her safety because there is reasonable possibility the person might be physically injured and that serves no legitimate purpose.

4.3 Workplace Violence – Any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

4.3.1 The threat or use of physical force against and employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

4.3.2 An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the

employee sustains an injury;

4.3.3 Four workplace violence types as designated by Cal/OSHA:

4.3.3.1 Type 1 violence – workplace violence committed by a person who has no legitimate business at the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime

4.3.3.2 Type 2 violence – workplace violence directed at an employee by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient

4.3.3.3 Type 3 violence – workplace violence against an employee by a present or former employee, supervisor, or manager

4.3.3.4 Type 4 violence – workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee

4.4 Assault – an unlawful attempt, coupled with present ability, to commit a violent injury on the person of another (Penal Code Section 240)

4.5 Battery – any willful and unlawful use of force or violence upon the person of another (Penal Code Section 242)

5.0 Procedure:

5.1 Identifying Violence Risk Factors

5.1.1 Environmental risk factors

5.1.1.1 The identification, monitoring, and correction of potential workplace hazards or health and safety concerns are outlined within the PMH Injury and Illness Prevention Plan (IIPP) (HRD-00126).

5.1.1.2 If an employee identifies a safety hazard that requires immediate attention a “Facilities Safety Hazard” work order should be placed via the PMH intranet.

5.1.2 Patient specific risk factors – patient care providers should be cognizant of a patient’s mental status and any condition or treatment that may cause the patient to behave unpredictably, disruptively, uncooperatively, or aggressively. History of violence and/or current disruptive or threatening behavior is considered risk factors for violence. If any violence risk factor is identified this must be communicated with the entire patient care team.

5.1.2.1 If a patient exhibits violence risk factors (disruption, uncooperativeness, aggression, unpredictable behavior, verbal threats) staff will place designated sign (*Attachment C) to alert patient care team. Signage will be placed at doorway for single occupancy rooms, and HOB for patients in double occupied room. Staff member will document in patients EMR placement of sign due to signs of violence. If patient is transferred, violence risk factors will be communicated to other members of the healthcare team.

5.1.3 Risk factors for visitors or other persons who are not employees – All PMH employees should be aware of their surroundings. If any employee identifies a visitor or other person who has a known history of violence or is displaying

disruptive or threatening behavior, PMH Security should be alerted.

5.2 Communication with employees regarding workplace violence issues will follow the process outlined for safety issues in the PMH IIPP. It is imperative that all patient care employees understand:

5.2.1 The need to communicate during patient hand off if the patient (or family) has had any history of violence during the current visit and/or if known previous visits at PMH

5.2.2 The reporting process outlined in section 5.6

5.2.3 Employee concerns will be investigated by the appropriate department depending on the type of violence reported. The investigating department/ individual will communicate how follow up will occur.

5.3 Violent Incident Log

5.3.1 Every violent incident that occurs against an employee, physician, volunteer or other person working on PMH premises will require an entry into the PMH Violent Incident Log.

5.3.2 PMH contracted security staff will solicit information from the employee who experienced the workplace violence and complete the PMH Workplace Violence Security Report form (Attachment A) immediately following the incident. All fields of the form must be completed as each is a required element in the Cal/OSHA Healthcare Workplace Violence Prevention Regulation.

5.3.2.1 Once completed, this form will be provided to the PMH Safety Officer with copies to the Emergency Preparedness Manager and the Employee Health Nurse. The Security Officers will provide a report to the Risk Manager. The Safety Officer is responsible for inputting this information into the PMH Violent Incident Log.

5.3.3 Workplace violence incidents that are identified through PMH's quality review report (QRR) process will be entered into the Violent Incident Log by the Employee Health Nurse.

5.4 Training

5.4.1 Initial training – All current PMH employees will receive initial training regarding the WVP Plan when the WVP Plan is first established. All new employees will receive training regarding the WVP Plan during New Employee Orientation.

5.4.2 Refresher training – All employees that perform patient contact activities and those employees' supervisors will be provided refresher training during annual orientation. The refresher training will include a review of the topics listed in the initial training as well as the results of the annual review of the WVP Plan.

5.4.3 Any employee that received training not completed in person will be provided with a method to interact and have questions answered by someone knowledgeable of the PMH WVP Plan within one business day.

5.4.4 Additional hands-on training is required to those employees that are assigned to respond to notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior. PMH will provide the Crisis Prevention Institute: Nonviolent Crisis Intervention Foundation Course to these employees.

5.4.4.1 This training will be provided initially upon assignment with a refresher training at least annually in addition to the training in 5.4.1 and 5.4.2

5.4.5 Contract staff – the PMH employee responsible for the onboarding/orientation of the contract staff member will ensure that the contracted employees have received the appropriate level of training according to the job duties/area/ department where the contracted individual will be working.

5.4.6 Ensuring compliance – work place violence prevention is a component of the PMH Safety Program. The enforcement of the safety program is outlined in the PMH IIPP section 5.4.

5.5 Responding to a violent incident

5.5.1 Any employee that is feeling threatened by or has been a victim of violence within PMH facilities should immediately obtain additional staff assistance and activate a “Code Grey” to the location.

5.5.1.1 PMH security personnel, House Supervisor as well as other PMH employees will respond to the location.

5.5.1.2 Only those employees that have received the training listed in 5.4.4 shall intervene in the violent incident if necessary.

5.5.1.3 If a violent incident is ongoing or there is a continued threat to the safety of any employee or others do not hesitate to request assistance from local law enforcement.

5.5.1.4 PMH Security personnel will contact Brawley Police Department if assistance is needed to control the situation or to take a report if necessary.

5.5.1.5 PMH Security will complete a PMH Workplace Violence Security Report (Attachment A) and submit to the Safety/Security Manager within one business day.

5.5.2 Immediate medical care or first aid will be provided to any employee(s) that have been injured. The employee(s) will be assisted to the emergency department for further evaluation if desired.

5.5.3 The Employee Assistance Program will be offered to all employees involved.

5.5.3.1 A follow-up phone call or face-to-face discussion will be conducted by the Employee Health Nurse approximately 14 days after the initial incident.

5.5.4 A post-incident debrief should occur as soon as possible following an incident with all involved in the incident. Consider what risk-reducing measures need to be implemented to decrease the chance of additional incidents with the person.

5.5.5 If any physical attack or threat with a dangerous weapon was made against the employee the PMH House Supervisor will investigate and complete a PMH Workplace Violent Incident Reporting Tool (Attachment B) as well as a Quality Review Report. Ensuring all employees involved in the incident are listed. The completed form will be placed in the Employee Health Nurse’s mailbox by the end of the House Supervisor’s shift.

5.6 Reporting a violent incident

5.6.1 PMH will report any act of assault or battery against an employee to the local law

enforcement agency within 72 hours if the incident:

5.6.1.1 Results in an injury

5.6.1.2 Involved the use of a firearm or other dangerous weapon, even if there is no injury

5.6.2 PMH will report to the Division of Occupational Safety and Health of the Department of Industrial Relations (the Division) in accordance with Title 8, Section 3342.

5.6.2.1 In addition to the incidents listed about in 5.6.1, PMH must also report any use of physical force against an employee by a patient or visitor that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

5.6.3 The PMH Employee Health Nurse will be the primary person responsible for completing the reports to the Division. In the event the Employee Health Nurse in unavailable within the required timeframe there are multiple other authorized reporters, including the Emergency Preparedness Manager and the Safety Officer.

5.6.3.1 Reports will be provided to the Division through a specific online service established by the Division for this purpose

5.6.3.1.1 The Chief Human Resource Officer is the facility representative for the reporting system and has authority to approve or deny additional users.

5.7 Recordkeeping

5.7.1 Records of workplace violence hazard identification inspections (including name of person conducting the inspections), evaluations, and corrective actions shall be created and maintained for one year.

5.7.2 Training records shall be created and maintained for a minimum of one year and include training dates, contents, names and qualifications of person conducting the training, and names and job titles of all persons attending the training session.

5.7.3 Records of violent incidents, including violent incident logs, reports to regulatory bodies, and workplace violence injury investigations will be maintained for a minimum of five years.

5.7.4 The preceding records mentioned with no medical information will be made available to employees and their representatives upon request within fifteen days after the request is received in accordance with California Code of Regulations – Title 8, Section 3204.

5.8 Annual Review of the Workplace Violence Prevention Plan (WVP Plan)

5.8.1 The WVP Plan will be reviewed annually to reflect new or modified procedures, include newly recognized hazards, to determine if the WVP Plan is deficient in any area.

5.8.2 Employees will be given the opportunity to be involved in the development and review of the WVP Plan and procedures within the plan.

5.8.3 The Violent Incident Log will be reviewed to determine trends and if applicable

determine countermeasures to decrease future incidents.

6.0 References:

6.1 PMH Policy HRD-00020; Zero Tolerance for Violence in the Workplace
6.2 "Healthcare Workplace Violence Prevention: How to Comply with the Cal/OSHA Regulation" – California Hospital Association, January 2017
6.3 Cal/OSHA Healthcare Workplace Violence Prevention Regulation - California Code of Regulations – Title 8, Section 3342
6.4 Cal/OSHA Injury and Illness Prevention Program Regulation - California Code of Regulations – Title 8, Section 3203
6.5 Cal/OSHA Access to Employee Exposure and Medical Records - California Code of Regulations – Title 8, Section 3204
6.6 Title 22 California Code of Regulations Division 5
6.7 Health and Safety Code 1257.7(d)

7.0 Attachment List

7.1 Attachment A – Bold "A" Be ALERT Sign
7.2 Attachment B – PMH Workplace Violent Incident Reporting Tool
7.3 Attachment C – PMH Workplace Violence Security Report

8.0 Summary of Revisions:

8.1 Updated Attachment B Workplace Incident Reporting tool footer.
8.2 Updated PMHD to PMH

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

PMHD WORKPLACE VIOLENT INCIDENT REPORTING TOOL

Hospital facility: IMPERIAL VALLEY HEALTHCARE DISTRICT	**Date of incident:**
House Supervisor completing tool:	**Time of incident:**

IDENTITIES OF PARTIES INVOLVED WILL NOT BE REPORTED TO CAL/OSHA BUT MUST BE INCLUDED IN OUR RECORDS. IF THE AGGRESSOR IS A PATIENT PLEASE LIST THE MEDICAL RECORD NUMBER ONLY.

Victim(s) (first and last names):	**Aggressor(s) (MR # if patient, if other first and last name):**

THE FOLLOWING INFORMATION IN THIS REPORT IS MANDATORY AND WILL BE USED TO REPORT INCIDENTS TO CAL/OSHA (REQUIRED BY LAW)

1. Who was the aggressor? *(check one)*

- ☐ Patient(s)
- ☐ Spouse /partner of patient (current or former)
- ☐ Family of patient
- ☐ Friend of patient
- ☐ Stranger
- ☐ Supervisor/manager
- ☐ Spouse /partner of employee (current or former)
- ☐ Family of employee
- ☐ Friend of employee
- ☐ Co-worker
- ☐ Licensed independent medical provider
- ☐ Former employee
- ☐ Outside vendor
- ☐ Aggressor not listed above

2. Where did the incident occur? *(check one)*

- ☐Emergency room
- ☐Surgery
- ☐Labor & delivery
- ☐Radiology & imaging
- ☐Onsite ambulatory outpatient clinic
- ☐Offsite ambulatory outpatient clinic
- ☐Admissions/registration
- ☐Pharmacy
- ☐Inpatient room
- ☐Administrative offices
- ☐Cafeteria
- ☐Kitchen
- ☐Storage room/area
- ☐Hallway
- ☐Stairway
- ☐Waiting room
- ☐Restroom/bathroom
- ☐Break room
- ☐Lobby/reception area
- ☐Parking lot
- ☐Outside premises
- ☐Location not listed above

3. What type of incident occurred? *(check all that apply)*

- ☐Biting by aggressor
- ☐Choking
- ☐Grabbing
- ☐Hair pulling
- ☐Kicking
- ☐Punching/slapping
- ☐Pushing/pulling
- ☐Scratching
- ☐Shooting
- ☐Spitting at/on
- ☐Stabbing
- ☐Striking
- ☐Rape/attempted rape
- ☐Unwanted physical sexual contact
- ☐Type of physical force not listed above
- ☐Use of (i.e., assault with) firearm or other dangerous weapon:
  - ☐Gun
  - ☐Knife
  - ☐Furniture/furnishings (e.g., lamp)
  - ☐Medical equipment
  - ☐Other weapon

4. How many employees were injured?

5. What types of injuries were known to be sustained? *(check all that apply)*

- ☐Death
- ☐Amputation
- ☐Asphyxiation/suffocation
- ☐Burns
- ☐Bruising/abrasion
- ☐Cut/puncture
- ☐Dislocation/fracture
- ☐Head injury
- ☐Internal injury
- ☐Open wound
- ☐Sprain/strain
- ☐Stress/psychological impairment
- ☐Injury type not listed above
- ☐Injury type unknown by the hospital at this time
- ☐ N/A –No known injured employees at this time

6. At the time of the incident were any of the injured employees: *(check all that apply)*

- ☐On break/lunch
- ☐Arriving/leaving the facility
- ☐Working past scheduled shift
- ☐No special circumstances apply
- ☐Don't know specific circumstances
- ☐N/A –No known injured employees

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

9. If another employer's employees are affected, describe that employer(s): *(check all that apply)*

☐ N/A –No employees of other employers affected

☐Contractor providing services to the hospital
If known: Company name_____

☐Emergency services or medical transport personnel
If known: Company name_____

☐ Licensed independent provider
If known Company name_____

☐Vendor
If known: Company name_____

☐Other
If known: Company name_____

☐Don't know the type of employer

10. Did the use of physical force or a dangerous weapon begin while an employee was alone with the aggressor?
☐ Yes ☐ No

11. Did the use of physical force or a dangerous weapon begin while an employee(s) was in an isolated area?
☐ Yes ☐ No

12. Did the use of physical force or a dangerous weapon begin in a *location* that was unfamiliar or new to the employee(s)?
☐ Yes ☐ No ☐ Don't know if location was unfamiliar or new to employee(s)

13. At the time of the use of physical force or a dangerous weapon was any employee *doing a task* that was unfamiliar or new to them? ☐ Yes ☐ No ☐ Don't know if task was unfamiliar or new to employee(s)

14. During the use of physical force or a dangerous weapon, was the employee(s) assisted by: *(check all that apply)*

☐Internal security
☐Local law enforcement in response to 911 call
☐Nearby employees
☐Assistance provided that is not listed above
☐Employee received no assistance

15. If local law enforcement was contacted via 911, what assistance did they provide? *(check all that apply)*

☐N/A local law enforcement not called
☐Local law enforcement did not respond
☐Officers provided assistance via phone
☐Officers deployed to the scene
☐De-escalated the situation without physically subduing the aggressor
☐Physically intervened and subdued the aggressor(s)
☐Arrested the aggressor(s)
☐Assistance provided that is not listed above

16. Is there a continuing threat to employees due to unresolved engineering, work practice, and/or administrative controls that need to be addressed? ☐ Yes ☐ No

17. Which of the following are planned or under consideration for addressing the continuing threat? *(check all that apply)*

☐ **Engineering control modifications**

If known, please provide type of engineering control:
☐Physical layout (incl. accessible escape routes, unimpeded line of sight)
☐Physical access control
☐Physical barriers
☐Alarm system
☐Lighting
☐Monitoring systems (e.g., metal detectors, closed circuit video, mirrors)
☐Removing/securing objects with weapon potential
☐Reducing overcrowding in waiting room
☐Other engineering control modification

☐ **Other type of modification**

☐**Further investigation to identify appropriate exposure control measures is in progress** (investigation includes speaking with involved employees)**.**

☐ **Work practice control modifications:**

If known, please provide the type of control:
☐Increased staffing levels
☐Added/increased security personnel
☐Additional employee training
☐Implementation or change in buddy system
☐Improved communication among staff about aggressive/violent patients
☐Reduced waiting times
☐Other work practice modification

☐ **N/A –No continuing threat to employees**

18. If the victim is an employee, provide an Employee Assistance Program brochure even if the employee does not feel the need to speak to someone at this time. If the victim is NOT an employee refer to the Human Resources department to determine eligibility for services.

☐ Employee Assistance Program brochure provided
☐ Non-Employee referred to HR

Imperial Valley Healthcare District

Title: **Medical Equipment Management Plan**	Policy No. EOC-00404
	Page 1 of 3
Current Author: Mario Garcia	Effective: 1/1/1996
Latest Review/Revision Date: 4/2025	Manual: EOC – Medical Equipment Mgmt

Collaborating Departments: Risk, Material Management		Keywords: DNV NIAHO PE.7, SR.1, SR.3, SR.5 and SR.6		
Approval Route:				
MARCC	PSQC	Other: Safety Committee		
Clinical Service _____		MSQC	MEC	BOD 6/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To describe the processes associated with ensuring safe medical equipment use for patients, staff and visitors.

2.0 Scope: District wide

3.0 Policy:

3.1 The plan is implemented by creating, maintaining, evaluating and improving policies and procedures for managing equipment used for but not limited to patient care, treatment and/or diagnostics.

3.2 The selection and acquisition of medical equipment is performed collectively with Bio-Medical, Materials Management, Risk Management, Administration, Medical Staff, and clinical departments as applicable.

3.3 Criteria for identifying, evaluating and inventorying medical equipment is based on equipment function, associated physical risks with use, maintenance requirements and equipment incident history.

3.4 Owned, leased, rented and borrowed/loaned medical equipment that requires preventative maintenance within the organization is included in this plan.

3.5 The clinical and physical risks associated with medical equipment use is assessed and minimized by inspection, examination and maintenance efforts of the Bio-Medical department, designated users and approved contractors.

3.6 The processes for monitoring and managing equipment hazard notices, recalls and alerts are outlined in policy ADM-00668, recall plan for product and equipment.

3.7 The process for investigating and reporting deaths or serious injury or illness associated with a medical device will be managed as per the Safe Medical Device Act of 1990 (see policy EOC-00409 Safe Medical Devices).

3.8 The process for reporting and investigating equipment management problems, failures and user errors will be managed as per policy EOC-00398, Equipment safety and report plan.

3.9 The emergency procedures that address specific problems in the event of medical equipment failures are delineated in policy and procedures associated with the specific failure.

4.0 Definitions:

4.1 CMMS – Computerized Maintenance Management System

5.0 Procedure:

5.1 Medical Equipment Selection process

5.1.1 Medical Equipment shall be FDA approved and meet the needs of the requisitioning department.

5.2 Medical Equipment Acquisition process

5.2.1 Medical Equipment will be purchased per policy ADM-00657, Requisition and Purchase of Special Items Including Services (Capital Requests).

5.2.2 Upon receipt of medical equipment, verification of correct equipment will be the responsibility of the Materials Management department and requisitioning department.

5.2.3 The Bio-Medical department will inspect, inventory and apply equipment control/ identification tag and service sticker denoting equipment last date of inspection/ service and next inspection/maintenance due date (see policy EOC-00401 Incoming Equipment Inspections)

5.3 Medical Equipment Safe Use process

5.3.1 Training on the proper use of equipment, including rentals and demos will be provided to staff per policies HRD-00165 Medical Equipment User Orientation.

5.4 Medical Equipment Inventory

5.4.1 Medical Equipment Inventory is located in the office of the Bio-Medical department

5.4.1.1 Inventory will be updated at least monthly to reflect changes, additions or deletions.

5.4.2 Preventive Maintenance is scheduled via Computerized Maintenance Management System (CMMS) per equipment manufacturer recommendations

5.5 Medical Equipment Reporting and Investigating Problems, Failures and User Errors

5.5.1 All actual or potential equipment problems, failures or user errors will be reported to the Bio-Medical department through the CMMS to generate a work order per Policy EOC-00398, Equipment safety report plan.

5.5.1.1 The CMMS will document the reported problem/failure which will alert the Bio-Medical department.

5.5.1.2 The Bio-Medical department will investigate and if possible determine the cause and if required repair or contract to repair equipment by vendor.

5.5.1.3 The Bio-Medical department will document findings and corrections.

5.5.1.4 The Bio-Medical department will recommend additional operator training to the Safety Committee as required.

5.5.2 All medical equipment problems, failures or user errors that actually or potentially affect the quality of care or risk of harm to patients and/or staff will be reported via Quality Review Report (QRR) policy ADM-00481, Quality Review Report.

5.5.3 An Equipment Safety Report will be submitted at least quarterly (was monthly) to the Safety Committee and will include the following information:

5.5.3.1 Number of instances of “no trouble found”
5.5.3.2 Number of instances of “operator error”
5.5.3.3 Number of instances of “equipment abuse”
5.5.3.4 Number of recalls of medical equipment
5.5.3.5 Recommendations for follow-up, training and/or corrective action
5.5.3.6 Number of instances of “Could Not Locate”

5.5.4 Report all test equipment and calibration failures to the safety committee, monthly.

5.5.5 Biomedical Engineering will consult with Risk Management on failed equipment impact and medical equipment testing.
5.5.5.1 As directed, Biomedical Engineering will retest all impacted equipment.

5.5.6 An annual evaluation regarding the effectiveness of the plan will be reported to the Safety Committee.

6.0 References:

6.1 DNV NIAHO Standards PE.7, SR.1, SR.3, SR.5 and SR.6
6.2 Policy-00049, Manufacturers Recalls and Hazardous Device Notices.
6.3 Policy EOC-00409 Safe Medical Devices
6.4 Policy EOC-00398, Equipment safety and report plan
6.5 Policy ADM-00657, Requisition and Purchase of Special Items Including Services (Capital Requests)
6.6 Policy EOC-00401 Incoming Equipment Inspections
6.7 Policy HRD-00165 Medical Equipment User Orientation and Training Program
6.8 Policy ADM-00481, Quality Review Report

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed with no additions or deletions
8.2 Changed the author

BOD Retired Policy Request List

1. ED Charting Requirements CLN-00991 Osman Valencia

Pioneers Memorial Healthcare District

Title: **Emergency Department (ED) Documentation Requirements**	Policy No. CLN-00991
	Page 1 of 2
Current Author: Osman Valencia	Effective:
Latest Review/Revision Date 1/18/2025	Manual: Clinical

Collaborating Departments: Nursing, HIM, IS, Dr. James Nelson, ED Policy Review Group	Keywords: Documentation, Charting, Emergency EMR		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service _____	MSQC 2/2025	MEC 2/2025	BOD

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

REQUEST TO RETIRE

1.0 Purpose:

1.1 To establish guidelines for accurate and complaint records.

2.0 Scope: ED

3.0 Policy:

3.1 Patient records shall reflect chronological and accurate documentation of care and outcomes.

3.2 Falsifying records is illegal and may result in legal action.

3.3 Records are hospital property and may be required in legal proceedings.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 Charting Requirements:

5.1.1 Document all assessments, medications, treatments, and nursing procedures.

5.1.2 Sign entries with name and title (e.g., RN, LVN, EDA/CNA).

5.2 Only approved abbreviations are to be used. (Refer to Use of Abbreviations and Symbols CLN-00053 & Prohibited Abbreviations CLN-02865).

5.3 All medications are to be documented with dose, time, route, site, and Follow-up response.

5.3.1 Late Entries:

5.3.1.1 State with "Late Entry" and include date and time.

5.4 Special Documentation:

5.4.1 Document height, weight, allergies, current medications, pharmacy, medical history, primary care provider, and specialist. Tetanus history when relevant.

5.4.2 Last menstrual period (LMP) for female patients, if applicable.

5.5 Additional Requirements:

5.5.1 Intake/Output: summarize at discharge or transfer.

5.5.2 Family-Reported Information: Document anything relevant

5.5.3 Unusual conditions: note any unexpected patient findings.

5.5.4 Physician Communication: Note provider notifications and response times.

5.6 Electronic Medical Record (EMR)

5.6.1 Follow EMR training per competency checklist.

5.6.2 Scan paper forms into EMR and forward originals to medical records.

5.6.3 Use downtime paper documentation during outages; scan into EMR once restored.

5.6.4 Protect passwords and log out when leaving the workstation.

5.7

6.0 References:

6.1 California Code of Regulations Title 22, Section 70215

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 None

Imperial Valley Healthcare District

Title: **Advance Directives**	Policy No. CLN-00610
	Page 1 of 4
Current Author: Carol Bojorquez	Effective:
Latest Review/Revision Date: 11/04/2024	Manual: Clinical / Case Management

Collaborating Departments: Case Management, Health Information Management, Information Systems, Nursing, Registration, Quality, Compliance, Outpatient Clinics	Keywords: Advance Directives, End of Life, POLST, Power of Attorney

Approval Route				
	PSQC April 2025	Other:		
Clinical Service _____		MSQC April 2025	MEC May 2025	BOD

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To define Imperial Valley Healthcare District's Pioneers Memorial Hospital policy surrounding the formulation, assessment, and honoring of a patient's Healthcare Advanced Directive(s) (AD).

2.0 Scope:

2.1 Inpatient Setting, Outpatient and Ambulatory Care Setting

3.0 Policy:

3.1 Patients with decision-making capacity have the right to formulate and execute advance healthcare directives regarding their health care needs. This right includes the ability to:

- 3.1.1 Designate an agent to make health care decisions on their behalf through execution of a Durable Power of Attorney for Healthcare (DPAHC)
- 3.1.2 Designate a surrogate to make medical decisions on their behalf during the course of receiving care and services, when they are no longer able to make such decisions.
- 3.1.3 Formulate directives in writing, verbally, or both.
- 3.1.4 Review, change or modify their directive(s) at any time either in writing, verbally, or both.
- 3.1.5 Be informed of the extent to which the organization is either unable or unwilling to honor a directive.

3.2 The organization will honor a patient's directive to the extent permitted by law and organization policy. Provision of care will not be contingent upon or denied on the bases of the presence of absence of an Advance Directive. Advance Directives will be honored within the limits of the law and the capabilities of the hospital and its affiliated clinics.

- 3.2.1 Examples of Advance Directive documents include but are not limited to the State of California Advance Directives and 5 Wishes booklet, The Physician Order Life Sustaining Treatment (POLST) is recognized as an Advance Directive and must be authenticated by a physician.

4.0 Definitions:

4.1 Patient – For the purposes of this policy, the term "patient" means the individual

receiving care and/or the individual(s) authorized to make health care decisions on his / her behalf.

4.2 Advance Directive – A statement (either oral or written) expressing a patient's wishes relative to health care decisions commonly seen in such documents as "living wills" and Durable Power of Attorney for Health Care.

4.2.1 Agent – A person designated to make healthcare decisions for a patient through the use of a Power of Attorney for Healthcare. The agent has the same authority to decide about most health care that the patient would have, subject to any limits or restrictions placed by the patient.

4.2.2 Capacity – The ability to understand the nature and consequences of proposed health care and to make and communicate health care decisions. Unless otherwise demonstrated, a patient is presumed to have capacity.

4.2.3 Power of Attorney for Healthcare – A legal document designating an agent to make health care decisions for the patient. The document must be dated, signed, and either witnessed or notarized. It is presumed to be permanently valid (durable) until / unless it is modified or terminated.

4.2.4 Surrogate Decision Maker – Any designated individual, who may or may not be related to the patient (who lacks decision making capacity), but who has had an ongoing relationship with the patient such that he/she is able to convey the patients' previously expressed wishes or has some understanding of the patient's values and probable choices. This individual may be formally appointed (e.g. by the patient in a PAHC, by the court in a conservator or guardian proceeding, etc), or in the absence of an appointment, may be informally authorized.

5.0 Procedure:

5.1 Inpatient Setting

5.1.1 <u>Patient Registration</u>

5.1.1.1 The patient presents Patient Registration point of entry: Emergency Department, Outpatient Surgery/Admitting Offices.

5.1.1.2 The patient is informed of their right to formulate and execute an Advance Directive. Patient Registration interviews the patient and/or families about Advance Directive. If one is present, it is noted and scanned into the patient's medical record, if one is not present the patient will be asked to provide a copy – This process may be completed via phone during pre-registration for a direct admit or Outpatient Surgery.

5.1.1.3 A notice of the organization's Advance Directive policy is provided at the time an individual is admitted as an Inpatient. The notice is presented at the time of registration.

5.1.1.4 Upon request, the patient will be provided with information / assistance on how to formulate and execute an Advance Directive. If necessary, a Social Service Consult may be initiated.

5.1.1.5 The presence of an Advance Directive will be assessed upon

admission to the inpatient setting.

5.1.1.6 If the patient has a written directive in his/her possession, it shall be noted, and a copy of the directive shall be placed in the patient's electronic medical record and a copy is placed in the patient's physical chart sent to the unit by Patient Registration.

5.1.1.7 For Advanced Directives located in the electronic medical record, Patient Registration staff will reproduce a paper copy for inclusion in the patient's chart.

5.1.1.8 If the patient has a written directive not in his/her possession, it shall be so noted, and the patient / family will be asked to provide a copy to the patient's primary nurse or registration staff to be placed in the patient's medical record.

5.1.2 Nursing

5.1.2.1 If the patient is admitted, Patient Registration comes to the floor with the Advance Directive.

5.1.2.2 The physician must write the appropriate order reflective of the patient's Advance Directive.

5.1.2.3 The Unit Clerk places the Advance Directive in the hard chart located in the nursing department (paper documentation).

5.1.2.4 If the patient requests a change or wants information on an Advance Directive, nursing will consult Social Services through the electronic medical record system.

5.1.2.5 The patient's attending physician will be called by the nurse regarding any Advance Directive(s) formulated by the patient. Where necessary and indicated, the physician shall discuss the directive(s) with the patient and provide appropriate treatment orders. Discussion and orders shall be documented in the medical record.

5.1.3 Case Management

5.1.3.1 The Social Worker/Discharge (DC) Planner upon patient / family request for an AD will be available for further assistance with education on how to complete the process.

5.1.3.2 If the patient is unwilling or unable to obtain a copy, the Social Worker or Case Manager will offer an Advanced Directive booklet and will provide education related to completion of such document.

5.1.3.3 If changes are made to the patient's Advance Directive status facilitated by Social Services /Discharge Planner, the modified document will be scanned into the patient's electronic medical record.

5.1.3.4 The Social Worker / DC Planner staff will notify nursing and the physician of the change in Advance Directive status.

5.1.4 Health Information Management

5.1.4.1 For the discharge patients that had a written Advance Directive in his/her possession at the time of admission, Health Information Management will make sure the Advance Directive was scanned in the

medical record.

5.1.4.2 Patient/family brings Advance Directive to Health Information Management. The Advance Directive is scanned into the patient's medical record.

5.2 Outpatient and Ambulatory Care Setting

5.2.1 The following applies to patients presenting for care in outpatient and ambulatory care settings:

5.2.1.1 The organization provides the notice of its Advance Directive policy to outpatients (or their representatives) that are in the emergency department, outpatient clinics, who are in an observation status, or who are undergoing Outpatient surgery.

5.2.1.2 Information is available to patients regarding their right to formulate and execute an Advance Directive.

5.2.1.3 Upon request, the patient will be provided with information on how to formulate and execute an Advance Directive. Assistance will be provided to patients to complete an Advance Directive if requested.

5.2.1.4 The existence of an Advanced Directive will not be routinely assessed. However, if a patient proactively makes such a directive known, it shall be documented in the patient's medical record. If it is a written directive, a copy shall be placed in the patient's medical record.

6.0 References:

6.1 CMS Medicare Conditions of Participation: §482.13(a/b)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Minor grammar revisions

8.2 Revised Patient registration section 5.1.1.4

8.3 Revised Case Management Section to include Discharge Planner

8.3.1 Include request for Social Worker/Discharge Planner

8.3.2 Social Worker/Discharge planner will provide assistance and education.

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: May 29, 2025

SUBJECT:

Authorize the renewal of Workers' Compensation Coverage with BETA Risk Management Authority ("BETARMA") for coverage in the State of California.

BACKGROUND:

Pioneers Memorial Healthcare District, *now doing business as Imperial Valley Healthcare District (IVHD)*, has purchased its Workers' Compensation coverage through BETARMA since the inception of the Program. For most coverage years, a Workers' Compensation dividend was awarded but for the 2025/2026 contract year, IVHD did not qualify for an annual dividend due to a high loss ratio. Please note that the Workers' Compensation proposal for the 2025/2026 coverage year includes the skilled nursing facility, Pioneers Memorial Skilled Nursing Center.

KEY ISSUES:

Employers Liability:

Bodily Injury by Accident	$2,000,000	Each Accident
Bodily Injury by Disease	$2,000,000	Policy Limit
Bodily Injury by Disease	$2,000,000	Each Employee

CONTRACT VALUE: $1,907,038 annual contribution (to be paid in monthly installments)

CONTRACT TERM: One Year Term (July 1, 2025 – June 30, 2026)

BUDGETED: Yes

BUDGET CLASSIFICATION: Workers' Compensation Insurance

RESPONSIBLE ADMINISTRATOR: Carly Loper, CFO

DATE SUBMITTED TO LEGAL: 5-22-2025 **REVIEWED BY LEGAL:** [X] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [X] 1st [ ] 2nd

RECOMMENDED ACTION:

That the Board authorizes the renewal of Workers' Compensation Coverage with BETA Risk Management Authority ("BETARMA") for coverage in the State of California, as outlined.

BETA HEALTHCARE GROUP

RENEWAL QUOTE FOR

Pioneers Memorial Hospital / Imperial Valley Healthcare District

Date May 20, 2025

BETA HEALTHCARE GROUP

BETA Healthcare Group

Our Expertise, Your Peace of Mind

BETA Healthcare Group has a long established and growing commitment to healthcare — it's all we do. As the largest professional liability insurer of hospitals on the West Coast providing liability and workers' compensation coverages, we offer solutions that combine distinctive product features, sophisticated underwriting, competitive pricing, and responsive claims and risk management services to meet an organization's needs as they grow and change.

Why BETA?

- **Comprehensive suite of coverages designed for healthcare**
- **Innovative, sustainable patient and employee safety programs**
- **Expert, empathic, and responsive claims management**
- **Member designed and governed organization**

Workers' Compensation And Employer's Liability Renewal Quote

May 20, 2025
Named Member: Pioneers Memorial Hospital / Imperial Valley Healthcare District

COVERAGE INFORMATION AND RENEWAL QUOTE TERMS

Issuing Company	BETA Risk Management Authority (BETARMA); A.M. Best Company rating: A (Excellent); FSC VIII
Coverage Type	Workers' Compensation
Transaction Type	Renewal
Estimated Annual Payroll	$71,264,860
Estimated Annual Contribution	$1,907,038
Contract Period	July 01, 2025 at 12:01 a.m. to July 01, 2026 at 12:01 a.m.
Payment Plan	Monthly Installments

COVERAGE INFORMATION

Workers' Compensation	California

EMPLOYERS LIABILITY

Bodily Injury by Accident	$2,000,000 Each Accident
Bodily Injury by Disease	$2,000,000 Policy Limit
Bodily Injury by Disease	$2,000,000 Each Employee

REQUIRED INFORMATION TO BIND COVERAGE

- Written order to bind received by BETARMA before July 1, 2025

DEPOSIT REQUIREMENT *(see Deposit Invoice)*

Deposit	$0
Monthly Installment	$158,919.84
Total	**$158,919.84**

Please mail payments to:
BETA Healthcare Group
P.O. Box 500030
San Diego, CA 92150-0030

Please send ACH payments to:
Bank: **Zions Bancorporation, DBA California Bank & Trust**
Account name: **BETA Healthcare Group** Routing Number:**122232109**
Account number: **5801246801** Account type: **Checking**

Thank you for the opportunity to provide you this quote. This quote is based on the rating and underwriting information provided to date and can be subject to additional underwriting, pricing or rating considerations. Please note that contributions, fees and class code eligibility are subject to change based on a complete underwriting process. If coverage is bound, the policy will be subject to audit.
This quote may also be subject to a safety survey and compliance with its recommendations.
Quote is valid only through effective date noted above.

Workers' Compensation And Employer's Liability Renewal Quote

ANNUALIZED RATE DEVELOPMENT

State	Class Code	Description	Annual Estimated Payroll	Base Rate	Estimated Standard Contribution	Net Rate	Estimated Annual Contribution
CA	8834	Physicians Practices and Outpatient Clinics-all employees-including Clerical Office Employees and Clerical Telecommuter Employees	$6,413,837	$1.44	$92,359	$1.58	$101,250
CA	9043	Hospitals-all employees-including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons	$64,851,023	$2.54	$1,647,216	$2.78	$1,805,788
		TOTAL	**$71,264,860**		**$1,739,575**		**$1,907,038**

CA CONTRIBUTION DEVELOPMENT Rating Period 07/01/2025 - 07/01/2026

Description			Contribution
Standard Contribution			**$1,739,575**
Experience Modification	2.36	$2,365,822	
Modified Contribution			**$4,105,397**
Contribution Adjustment *	0.46	($2,198,359)	
Timely Reporting 2% Discount - Earned	Yes		
Subject Contribution			**$1,907,038**
California Insurance Guarantee Association			Not Applicable
Workers' Compensation Administrative Revolving Fund	1.2370		$23,590
Uninsured Employers Benefits Trust Fund	0.0818		$1,560
Subsequent Injuries Trust Fund	3.0148		$57,493
Occupational Safety and Health Fund	0.1885		$3,595
Labor Enforcement and Compliance Fund	0.1058		$2,018
Workers' Compensation Fraud Account	0.4096		$7,812
Reverse Surcharges			($96,068)
ESTIMATED ANNUAL CONTRIBUTION TOTAL			**$1,907,038**

WC Dividends

Annual WC Dividend **$0**

Dividend and Installment Information located on next page

Net WC Program Cost **$1,907,038**

CARE Fund **$8,100**

Net Rate and Contribution Adjustment factors may be rounded

Workers' Compensation And Employer's Liability Renewal Quote

Annual WC Dividend: **N/A**

The July 1, 2025 renewal marks another year that BETARMA has returned dividends to its membership. The above referenced dividend amount is based on each Workers' Compensation (WC) member's contribution to the financial performance of BETARMA's WC line of coverage dating back to when the member first joined the program. Years of membership and claims results relative to paid contributions determine the percentage allocation that each member receives from the annual dividend pool. If a member does not receive a dividend as noted by $0 above, that means the member's loss ratio (incurred claims costs/contributions) is too high to qualify for this year's dividend or the member is new to BETARMA and is not eligible to receive a dividend this year.

Dividend Installments: The 2025 dividends listed above will be paid in two installments on October 1, 2025 and on April 1, 2026. For the Annual Dividend, each installment is contingent upon the named member renewing the Workers' Compensation (WC) coverage with BETARMA on July 1, 2025 and maintaining the coverage contract at the time a dividend payment is made.

CARE Program 2025/2026 estimate: **$8,100**

BETA Risk Management Authority (BETARMA) will continue its CARE Program; Commitment - Accountability - Responsibility - Engagement during the 2025 Contract Year. The CARE program is designed to help our members improve their overall employee safety exposures, controls and performance through a reimbursement process aimed specifically at the most frequent causes of employee injuries within their organization. On an annual basis, your Risk Management and Employee Safety Consultant will partner with you to create a customized Service Plan that will help to maximize the benefit of your CARE Fund use.

Timely Reporting: To be eligible to receive the Timely Reporting credit, the median lag time for reporting claims to BETA during the previous calendar year is three (3) days or fewer.

BETA's Employee Safety and Wellness Initiative focuses on eight key loss prevention areas, or domains: Ergonomics, Fleet Safety and Mobile Ergonomics, Manual Material Handling, Opioid and Polypharmacy Prescribing, Stay at Work/Return to Work, Safe Patient Handling and Mobility, Slip, Trip and Fall Prevention and Workplace Violence Prevention. Best practice strategies, outlined in the Employee Safety and Wellness Initiative Guideline, serve as the basis of BETA's incentive program designed to keep the workforce safe. In addition to promoting safe and responsible behavior, the initiative offers a significant return on investment which may favorably impact your experience modification (Ex-Mod) factor.

Workers' Compensation And Employer's Liability Renewal Quote

CONTRIBUTION AND BILLING

Policy Minimum Contribution 40% of bound Estimated Annual Contribution

Due at Binding

Deposit: $0 *(see deposit invoice)*

First Installment: $158,919.84

Total amount due: $158,919.84

Proposed Billing Schedule

Due Date:	*Amount:*
07/01/2025	$158,919.84
08/01/2025	$158,919.84
09/01/2025	$158,919.84
10/01/2025	$158,919.84
11/01/2025	$158,919.84
12/01/2025	$158,919.84
01/01/2026	$158,919.84
02/01/2026	$158,919.84
03/01/2026	$158,919.84
04/01/2026	$158,919.84
05/01/2026	$158,919.84
06/01/2026	$158,919.76

Note *Monthly Contribution are due on the 1st of the month*

General Conditions

Acceptance of coverage is demonstrated through a written order to bind coverage and BETARMA's receipt of first installment by July 15, 2025. If the 1st installment and any applicable deposit are not received by the due date, it will be assumed that our offer of coverage was not accepted and any coverage in place may be cancelled by us.

Coverage does not include volunteers. If you would like a quote through our Volunteer Insurance Program please contact us directly.

Coverage does not include employees who reside outside of the State of California. If you have employees permanently residing outside of the State of California and would like a quote for coverage please contact us directly.

Blanket Waivers of Subrogation are included at no additional cost. If you require a Specific Waiver of Subrogation please contact us directly. Specific Waivers of Subrogation will be provided at no additional cost.

By accepting the terms of this quote you also agree to the following:

- Comply with BETARMA Employee Safety in order to develop a Service Plan and execute as agreed.
- Provide all relevant data related to the underwriting and claims administration on an as needed basis.
- Provide quarterly IRS 941 Forms and quarterly Productive Hours Form within 45 days post quarter close.

BETARMA reserves the right to rerate based on a material change in projected exposure.

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: May 29, 2025

SUBJECT:

Authorize the renewal of Healthcare Entity Comprehensive Liability (HCL) Coverage, Directors & Officers Liability Coverage and Automobile Coverage with BETA Risk Management Authority ("BETARMA").

BACKGROUND:

Pioneers Memorial Healthcare District, *now doing business as Imperial Valley Healthcare District (IVHD)*, has purchased its general liability, malpractice, excess liability, directors & officer's liability, and auto liability coverage through BETARMA since the inception of the Program. For the 2025/2026 contract year IVHD qualified for an annual dividend of $60,359 based on Pioneers Memorial Hospital's contribution to the financial performance of BETARMA's liability lines of coverage dating back to when Pioneers Memorial Hospital joined the Program. In addition, the quote also provides IVHD with a **2%** credit under the BETA Heart Risk credit AND a **6%** credit under the ED Risk Management Initiative. (BETA Heart Risk credit for 2024/2025 was not awarded; ED Risk Management Initiative credit for 2024/2025 was 2%.)

KEY ISSUES:

	2025/2026 rate	**2024/2025 rate (post dissolution)**
Auto	$24,026	$24,026
D&O	$429,834	$373,769
HCL	$1,486,886	$1,412,481

*HCL (combined for hospital, ER group and hospitalists group)

HCL Contribution: $1,547,245
Annual Dividend: $60,359
HCL Annual Contribution less Annual Dividend: **$1,486,886**

CONTRACT VALUE: $1,880,387 net annual contribution

CONTRACT TERM: One Year Term (July 1, 2025 – June 30, 2026)

BUDGETED: Yes

BUDGET CLASSIFICATION: Liability Insurance

RESPONSIBLE ADMINISTRATOR: Carly Loper, CFO

DATE SUBMITTED TO LEGAL: 5-22-2025 **REVIEWED BY LEGAL:** [X] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [X] 1st [ ] 2nd

RECOMMENDED ACTION:

That the Board authorizes the renewal of Healthcare Entity Comprehensive Liability (HCL) Coverage, Directors & Officers Liability Coverage and Automobile Coverage with BETA Risk Management Authority ("BETARMA"), as outlined.

BETA HEALTHCARE GROUP

RENEWAL QUOTE FOR

Imperial Valley Healthcare District

Date May 22, 2025

BETA HEALTHCARE GROUP

BETA Healthcare Group

Our Expertise, Your Peace of Mind

BETA Healthcare Group has a long established and growing commitment to healthcare — it's all we do. As the largest professional liability insurer of hospitals on the West Coast providing liability and workers' compensation coverages, we offer solutions that combine distinctive product features, sophisticated underwriting, competitive pricing, and responsive claims and risk management services to meet an organization's needs as they grow and change.

Why BETA?

- **Comprehensive suite of coverages designed for healthcare**
- **Innovative, sustainable patient and employee safety programs**
- **Expert, empathic, and responsive claims management**
- **Member designed and governed organization**

Healthcare Entity Comprehensive Liability Renewal Quote

May 22, 2025
Named Member: Imperial Valley Healthcare District

COVERAGE INFORMATION AND RENEWAL QUOTE TERMS

Issuing Company	BETA Risk Management Authority (BETA$_{RMA}$); A.M. Best Company rating: A (Excellent); FSC VIII

Coverage	Healthcare Entity Comprehensive Liability, *coverage includes:*
	• Professional Liability (claims made and reported)
	• General Liability (occurrence)
	  • Bodily Injury and Property Damage
	  • Personal Injury and Advertising Injury Liability
	  • Employee Benefit Administration Liability
	  • Fire and Water Damage Legal Liability sub-limit
	  • Asbestos Liability sub-limit (claims made and reported)
	  • Pollution Liability sub-limit (claims made and reported)

Form	HCL (07/2024)
Effective Date	July 01, 2025
Retroactive Date	March 15, 2024 (applicable to professional liability coverage only)
Contract Period	July 01, 2025 at 12:01 a.m. to July 01, 2026 at 12:01 a.m.

Risk Management Resource Fund (RMRF) 2025/2026 estimate: **$14,340**

Each contract period, BETA Healthcare Group (BETA) provides our hospitals, healthcare facilities and participating medical groups 1% of the named member's annual contribution for the primary limits of liability (up to $5 million) for qualified risk management education expenses. The RMRF is subject to various minimums and maximums depending on the facility or organization and is a "use it or lose it" reimbursement program offered to members to supplement the costs associated with their risk management programs. The RMRF is provided to BETA$_{RMA}$ members in addition to our many complimentary risk management services and other reimbursement programs. The above estimate will be impacted by a renewal deductible change or a reduction in limits below the primary $5 million.

Peer Review Network (PRN)

BETA's PRN is a voluntary program designed to assist member hospitals with medical staff peer review.
If a member has a need to conduct external reviews, BETA will pay up to $2,500 for all reviews during the contract period to compensate outside reviewers for their time.

BETA HEART Risk Management Credit: **2%**

BETA's most recent risk management offering is a holistic approach to reducing harm in healthcare. BETA HEART ® (healing, empathy, accountability, resolution and trust) is a coordinated effort designed to guide member healthcare organizations in implementing a reliable and sustainable culture of safety grounded in a philosophy of transparency. BETA HEART is a multi-year program that is an interactive and collaborative process that supports the organization, its' staff and patients. It is comprised of the following domains:

- Culture measurement and debrief
- Rapid Event Response and Analysis domain*
- Communication domain applying empathic communication skills and deployment of the Communication Resource team
- Care for the Caregiver program
- Early resolution process

Each of the five domains that are successfully implemented qualifies for a 2% primary contribution credit up to 10% annually. If your organization participated in BETA HEART and successfully completed the requirements for a given domain, the credits received will be indicated above. Credit amounts will be impacted by a renewal deductible change. Organizations that did not participate or did not fully meet requirements will have "N/A" stated above.

*Validating in the Rapid Event Response and Analysis (RERA) domain prompts an amendment to the coverage contract which offers the member organization a HEART SIR structure.

Healthcare Entity Comprehensive Liability Renewal Quote

OB Risk Management Initiative Credit: **3%**

BETA is continuing its risk management efforts to reduce the frequency and severity of obstetrical claims by offering evidence-based performance improvement strategies to participating BETARMA member OB departments. If a member demonstrated 100% compliance with all elements of the OB initiative criteria during the current contract year (Tier I), a 2% rate credit on the primary contributions will be awarded at the next renewal. In addition, a member can earn up to a 4% credit for successful completion of two of the options set forth in Tier II of the initiative. Members must achieve all elements of Tier I in order to qualify for Tier II credits. Credit amounts will be impacted by a renewal deductible change. If your hospital participated in the OB initiative (Quest for Zero: OB) and successfully completed all requirements, confirmed through a validation survey, the credit received will be indicated above. Hospitals that did not participate or did not implement all requirements will have "N/A" stated above.

ED Risk Management Initiative Credit: **6%**

BETA continues to focus its efforts on improving reliability and reducing risk in our member's emergency departments. If 100% of all ED physicians, PAs, NPs and nurses covered by BETARMA completed the required on-line courses for Tier I, a 2% rate credit on the primary ED contributions will be awarded. In addition, a member can earn up to a 4% credit for successful completion of two of the options set forth in Tier II of the initiative. The minimum ED contribution credit is $5,000 for Tier I or Tier I and Tier II combined. Members must achieve all elements of Tier I in order to qualify for Tier II credits. If your organization participated in the ED initiative (Quest for Zero: ED and successfully completed all requirements, confirmed through a validation survey, the credit will be awarded at the next renewal. Credit amounts will be impacted by a renewal deductible change. If your organization participated in the ED initiative and successfully completed all requirements, the credit received will be indicated above. Organizations that did not participate or did not implement all requirements will have "N/A" stated above.

Emergency Medicine Education Fund

This fund provides up to $500 per physician, advanced practice provider or for nurse leadership in annual tuition reimbursement for a number of emergency medicine seminars or courses aimed at improving patient safety in the emergency department. Please inquire about the courses that meet the education and reimbursement criteria of this program.

Annual Liability Dividend: **$60,359**

The July 1, 2025 HCL renewal marks the 33rd consecutive year that BETARMA has returned dividends to its membership. The above referenced dividend amount is based on each liability member's contribution to the financial performance of BETARMA's liability lines of coverage dating back to when the member first joined the program. If a member does not receive a dividend as noted by "N/A" above, that means the member's loss ratio (incurred claims costs/contributions) is too high to qualify for this year's dividend or the member is new to BETARMA and is not eligible to receive a dividend this year.

Dividend Installments: The 2025 dividends listed above will be paid in two installments on October 1, 2025 and on April 1, 2026. For the Annual Dividend, each installment is contingent upon the named member renewing all expiring lines of liability coverage with BETARMA on July 1, 2025 and maintaining each coverage contract at the time a dividend payment is made.

2025 Annual Renewal Contribution

Primary Contribution (up to $5M Limits)	$1,434,049
Contribution for Limits in Excess of Primary	$113,196
Total Annual Contribution:	**$1,547,245**
Annual Dividend	$60,359
Annual Contribution Less Annual Dividend	**$1,486,886**

Contribution Remittance

Annual Contribution Due	**$1,547,245**
Monthly Installment Contribution Due	$128,937.08

Monthly Contributions are due on 7/1/2025 and are late if received after 7/15/2025

Healthcare Entity Comprehensive Liability Renewal Quote

Imperial Valley Healthcare District

Liability Limits	$15 million per occurrence and $25 million aggregate • $1 million per occurrence and $3 million aggregate sub-limit per covered physician subject to the entity's $15 million per occurrence and $25 million aggregate limits *All defense expenses are paid outside of the per occurrence limits* *All sub-limits are subject to the per occurrence and aggregate limits*
Deductible	$5,000 Indemnity Only

Imperial Valley Healthcare District	
2025 Annual Contribution Due	$5,150.00
Monthly Installment Contribution Due	$429.17

BETA RMA reserves the right to rerate based on a material change in projected exposures

Healthcare Entity Comprehensive Liability Renewal Quote

Pioneers Memorial Hospital

Pioneers Memorial Hospital	
2025 Annual Contribution Due	$1,275,617.00
Monthly Installment Contribution Due	$106,301.42

	Exposures	**Estimated Census for 7/1/2025 to 7/1/2026**
1	Acute Care Beds	16,075.00
2	Cribs and Bassinets	2,575.00
3	C-Sections Deliveries	753.00
4	Day Care	126,986.00
5	Emergency Visits	30,551.00
6	Non-Urgent ER Visits	22,125.00
7	Nurse Midwives	2.00
8	Nurse Practitioner (Non-ER)	9.59
9	Outpatient Visits	130,610.00
10	Perinatal Beds	4,189.00
11	Physicians Group 3	0.25
12	Physicians Group 7	0.30
13	Surgeries: Inpatient	1,721.00
14	Surgeries: Outpatient	2,749.00
15	Vaginal Deliveries	1,340.00

BETA RMA reserves the right to rerate based on a material change in projected exposures

Healthcare Entity Comprehensive Liability Renewal Quote

Pioneers Memorial Skilled Nurse Center

Pioneers Memorial Skilled Nurse Center	
2025 Annual Contribution Due	$29,048.00
Monthly Installment Contribution Due	$2,420.67

Exposures		**Estimated Census for 7/1/2025 to 7/1/2026**
1	Skilled Nursing Facility	29,703.00

BETA$_{RMA}$ reserves the right to rerate based on a material change in projected exposures

Healthcare Entity Comprehensive Liability Renewal Quote

Pioneers Vituity

Pioneers Vituity	
2025 Annual Contribution Due	$237,430.00
Monthly Installment Contribution Due	$19,785.83

	Exposures	Estimated Census for 7/1/2025 to 7/1/2026
1	ER Providers - MDs, DOs, NPs, PAs	52,676.00

BETA$_{RMA}$ reserves the right to rerate based on a material change in projected exposures

Directors, Officers And Trustees Liability Renewal Quote

May 22, 2025
Named Member: Imperial Valley Healthcare District

COVERAGE INFORMATION AND RENEWAL QUOTE TERMS

Issuing Company	BETA Risk Management Authority (BETA$_{RMA}$); A.M. Best Company rating: A (Excellent); FSC VIII
Coverage	Directors, Officers and Trustees Liability, coverage includes: • Entity coverage • Duty to defend • Employment practices liability • Anti-trust coverage sub-limit - $1 million per claim
Form	D&O (07/2024)
Type	Claims Made and Reported
Effective Date	July 01, 2025
Retroactive Date	January 01, 2024
Contract Period	July 01, 2025 at 12:01 a.m. to July 01, 2026 at 12:01 a.m.
Liability Limits	$10 million per occurrence and $10 million aggregate *Defense expenses are paid within the limits of liability*
Indemnity and Defense Deductible	Deductibles applicable to Section 2 Coverages Coverage (A): $0 each Claim Coverage (B): $10,000 each Claim including Defense Expenses Coverage (C): $10,000 each Claim including Defense Expenses Coverage (D): $150,000 each Claim including Defense Expenses Coverage (E): $0 each Claim
Annual Contribution	**$429,834**

BETA$_{RMA}$ reserves the right to rerate based on a material change in projected exposures

Auto Liability and Physical Damage Renewal Quote

May 22, 2025
Named Member: Imperial Valley Healthcare District

COVERAGE INFORMATION AND RENEWAL QUOTE TERMS

Issuing Company: BETA Risk Management Authority (BETA$_{RMA}$); A.M. Best Company rating: A (Excellent); FSC VIII

Coverage: Automobile Liability & Physical Damage, coverage includes:

- Bodily Injury and Property Damage Liability
- Uninsured/Underinsured Motorist Coverage sub-limit - $1 million per accident
- Hired/Non-Owned Auto Liability
- Medical payment - $5,000 per accident
- Collision Coverage - fair market value
- Comprehensive Coverage - fair market value

Form: Auto (07/2021)

Type: Occurrence

Effective Date: July 01, 2025

Contract Period: July 01, 2025 at 12:01 a.m. to July 01, 2026 at 12:01 a.m.

Liability Limits: $10 million per Accident - Combined Single Limit

- Bodily Injury and Property Damage Liability
- Hired/Non-Owned Auto Liability
- $1 million Sub-limit Uninsured/Underinsured Motorist Coverage

Deductible: Physical Damage - $250 Comprehensive and $500 Collision

Liability - $0 Auto Liability

Vehicles by Type

Total Vehicles:	9
Patient Transport (excluding ambulances)	1
Private Passenger Vehicles (including non-patient-transport vans)	7
Tractor Trailer	1

Vehicle Types: Ambulance/Large Bus; Heavy Vehicle/Small Bus; Medical Vehicle/Motor Home; Non-Operational Vehicle; Patient Transport (excluding ambulances); Private Passenger Vehicle (including non-patient-transport vans); Tractor Trailer; Trailer Towed by Vehicle; *Utility Vehicle / Golf Cart*

BETA$_{RMA}$ reserves the right to rerate based on a material change in projected exposures

Annual Contribution: **$24,026**

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: May 29, 2025

SUBJECT:

Review and authorize property insurance coverage provided through broker, Alliant Insurance Services, Inc. ("Alliant"). Property insurance includes coverage for Property, Boiler & Machinery, Commercial Cyber Liability and Pollution. Other coverages include Cyber Breach Response endorsement, Crime and the Deadly Weapon Response Program.

BACKGROUND:

Pioneers Memorial Healthcare District, *now doing business as Imperial Valley Healthcare District (IVHD)*, has purchased coverage for Property, Boiler & Machinery, Commercial Cyber Liability, Pollution, Cyber Breach Response, Crime and Deadly Weapon Response through the services of Alliant for many years. Alliant does extensive research and review of the Market to provide the most competitive and strongest policies. This year Alliant provided renewal property proposals from Liberty Mutual Fire Insurance Company ("Liberty"), which is rated A (Excellent) with A.M. Best Ratings and A (Strong) with Standard & Poor's Ratings AND an option through the Hospital All Risk Property Program (HARPP). Pioneers maintained coverage through HARPP for many years in the past until Liberty provided more competitive options. Even when Pioneers did not hold HARPP coverage for property from 2022-2024, coverages for Cyber Breach Response endorsement, Crime and the Deadly Weapon Response Program were still held through HARPP. For the 2025/2026 coverage year, Alliant revisited the HARPP option for IVHD and also provided a special bundle pricing to include Earthquake coverage through the same policy. More detailed information can be found in the attached "IVHD 2025/2026 Property Coverage Analysis". Also attached is the Alliant Schedule of Coverages, which outlines the various coverage renewal premiums for 2025/2026. ("Not to Exceed" premiums have been provided for Cyber Breach Response endorsement, Crime and the Deadly Weapon Response Program.)

KEY ISSUES:

Total Insured Values (Property):	**$295,104,604**
Cyber Limit:	$2,000,000; $75,000,000 Program Policy Aggregate
Cyber Deductible:	$50,000
Pollution Limit:	$2,000,000 Per Incident; $25,000,000 Aggregate
Pollution Deductible:	$50,000
ADWRP Limit:	$500,000 Each Event; $500,000 Annual Aggregate
ADWRP Deductible:	$10,000 Each Event including Claims Expenses
Notified Individuals (BBR):	250,000 Notified Lives Limit
Notification Threshold:	100 Notified Lives
Legal, Forensics, PR/CM Limit:	$500,000

RENEWAL COVERAGES:

Property Coverage (Overview attached)

LIBERTY (with EQ):	**$913,985**
HARPP (with EQ):	**$707,278**

HARPP Pollution Coverage
Total Cost: $12,290 APIP premium (included in HARPP option)

HARPP Cyber Program
Total Cost: included in above APIP premium with Pollution (included in HARPP option)

Alliant Deadly Weapon Response Program (ADWRP)
Total Cost: Not to Exceed $8,255

Alliant Crime Insurance Program (ACIP)
Total Cost: Not to Exceed $9,570

Beazley Breach Response (BBR)
Total Cost: Not to Exceed $48,169

CONTRACT VALUE

*HARPP is the recommended option due to cost savings

TOTAL PREMIUM: $773,272 (HARPP + ADWRP, ACIP & BBR)

CONTRACT TERM: One Year Agreement (July 1, 2025 – June 30, 2026)

BUDGETED: Yes

BUDGET CLASSIFICATION: Insurance

RESPONSIBLE ADMINISTRATOR: Carly Loper, CFO

DATE SUBMITTED TO LEGAL: 5-22-2025 **REVIEWED BY LEGAL:** [X] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [X] 1st [ ] 2nd

RECOMMENDED ATION:

That the Board reviews and authorizes property insurance coverage and other coverages provided through broker, Alliant Insurance Services, Inc. (“Alliant”), as outlined.

IVHD 2025/2026 Property Coverage Analysis

Here are some of the benefits that will benefit Imperial Valley Healthcare District through HARPP:

- Per Occurrence limit $350,000,000 (subject to policy exclusions) which is above the Total Insured Values (TIV) vs Liberty Mutual Blanket Limits which are tied to your Statement of Values
    - HARPP does not tie your coverage to the statement of values whereas Liberty Mutual uses your statement of values as your limits
- No Water Damage Deductible vs $100,000 with Liberty
- No sublimit for business interruption
    - Including 365 days extended period of indemnity
    - Includes temporary and long-term housing for hospital resident patients
- Automatic acquisition of new locations up to $50,000,000 except:
    - $25,000,000 automatic acquisition for 90 days for vacant properties
    - $10,000,000 automatic acquisition for 120 days for Licensed vehicles
- Course of Construction Limit of $25,000,000 vs $2,500,000 with Liberty
- Extra Expense $25,000,000 vs $5,000,000 with Liberty
- Boiler & Machinery Limit of $100,000,000 vs Liberty Mutual included in Blanket Limits which are tied to your Statement of Values
- Risk Control Services
    - Free monthly webinar classes

This year on the renewal, **Liberty Mutual** has:

- Increased the water damage deductible from $75,000 top $100,000
- The rate has increased 5% due to the Fire Loss at the Skilled Nursing Center on 8/6/2023
- Premium has increased 28.5% due to the increase in TIV and Rate

Here is the Total Insured Valued (TIV) increase and the Liberty premium comparison from last year to this year.

Policy Term	Coverage	Carrier	Total Insured Values (TIV)	Premium	Net Premium
07/01/2024 - 07/01/2025	Property, Boiler & Machinery	Liberty	240,958,172	$ 244,934	$ 208,194
07/01/2025 - 07/01/2026	Property, Boiler & Machinery	Liberty	295,104,640	$ 314,752	$ 267,539

Total Insured Values (TIV) increased 22% due to:

- Addition of 2 buildings that were added (Heffernan Memorial Healthcare District)
    - Medical Office Building: 601 Heber Ave; Calexico, CA 92231
    - Medical Office Building: 400 Mary Ave; Calexico, CA 92231
- We increased the following 2 building values to 100% Marshall & Swift valuation since these 2 building were undervalued according to both HARPP and Liberty Mutual
    - Main Hospital: 207 West Legion Road; Brawley, CA 92227
    - Women's Center: 207 West Legion Road; Brawley, CA 92227
- All locations were trended the following factors:
    - 2.01% for real property
    - 1.51% for personal property

IVHD 2025/2026 Property Coverage Analysis

The Total Premium paid by Imperial Valley Healthcare District for the 7/1/2024 – 7/1/2025 Policy Term including the current Earthquake Premium (1/1/25 – 1/1/26) is the following:

Policy Term	Coverage	Carrier	Total Insured Values (TIV)	Premium	Net Premium
01/01/2025 – 01/01/2026	$10M Earth Movement	Beazley	227,271,732	$ 434,356	$ 386,056
01/01/2025 – 01/01/2026	$10M xs $10M Earth Movement	Golden Bear	227,271,732	$ 275,600	$ 248,100
07/01/2024 - 07/01/2025	Property, Boiler & Machinery	Liberty	240,958,172	$ 244,934	$ 208,194
07/01/2024 - 07/01/2025	HARPP Cyber & Pollution	APIP	240,958,172	$ 10,729	$ 10,035
TOTAL Premium:				**$ 965,619**	**$ 852,385**

With the **Liberty Mutual** option for the policy period 7/1/2025 – 7/1/2026 Policy Term including the current EQ Premium is the following:

Policy Term	Coverage	Carrier	Total Insured Values (TIV)	Premium	Net Premium
01/01/2025 – 01/01/2026	$10M Earth Movement	Beazley	227,271,732	$ 434,356	$ 386,056
01/01/2025 – 01/01/2026	$10M xs $10M Earth Movement	Golden Bear	227,271,732	$ 275,600	$ 248,100
07/01/2025 - 07/01/2026	Property, Boiler & Machinery	Liberty	295,104,640	$ 314,752	$ 267,539
07/01/2025 - 07/01/2026	HARPP Cyber & Pollution	APIP	295,104,640	$ 13,140	$ 12,290
TOTAL Premium:				**$ 1,037,848**	**$ 913,985**

IVHD 2025/2026 Property Coverage Analysis

The **HARPP** Premium we are proposing to Imperial Valley Healthcare District for the 7/1/2025 – 7/1/2026 policy term will also include the EQ policy effective the same term of 7/1/2025 – 7/1/2026 and all of the same coverage you currently have including, increased sublimit, broader policy language and Risk Control Services. All the policies will be included with HARPP. Here is the HARPP Premium. At this time, the net premium is just an estimate. The Gross Premium is correct.

Policy Term	Coverage	Carrier	Total Insured Values (TIV)	Premium	Estimated Net Premium
07/01/2025 - 07/01/2026	Property, Boiler & Machinery, Earthquake, Cyber, and Pollution	APIP	295,104,640	**$ 1,013,078**	**$ 876,313**

The HARPP premium is showing a discount of -$24,770 (gross premium) lower than the Liberty Mutual option including the Earthquake policy. We are expecting the following estimated return on the earthquake policy below. In addition, there will be an estimated short rate penalty of $21,000 on the primary EQ placement for cancelling this policy midterm. This penalty is a one time charge since we are canceling the policy midterm. The HARPP Premium is lower in premium to include this penalty.

Policy Term	Coverage	Carrier	Total Insured Values (TIV)	Premium	Net Premium	Estimated Return Premium
01/01/2025-01/01/2026	$10M Earth Movement	Beazley	227,271,732	$ 434,356	$ 386,056	$ -168,000
01/01/2025-01/01/2026	$10M xs $10M Earth Movement	Golden Bear	227,271,732	$ 275,600	$ 248,100	$ -137,800
TOTAL Premium:					**$ 634,156**	**$ -305.800**

IVHD 2025/2026 Property Coverage Analysis

With the HARPP Premium and we deduct the estimated earthquake return premium, the HARPP the total premium would be $707,278 for the HARPP Option.

Policy Term	Coverage	Carrier	Total Insured Values (TIV)	Premium/ Estimated Return Premium
07/01/2025 - 07/01/2026	Property, Boiler & Machinery, Earthquake, Cyber, and Pollution	APIP	295,104,640	**$ 1,013,078**
01/01/2025 – 01/01/2026	Earth Movement	Beazley/Golden Bear	227,271,732	**$ -305.800**
TOTAL Premium:				**$ 707,278**

ALLIANT SCHEDULE OF COVERAGES

Pioneers Memorial Healthcare District Year Over Year Premium

								RECOMMENDED RENEWAL PROGRAM			
Effective Date	Expiration Date	Coverage	Policy Number	Insurance Company	Limits	Deductible/SIR	24/25 Premium	25/26 Renewal	Premium Difference Compared to Expiring	% Prem Variance	Notes
7/1/2024	7/1/2025	Property Total Insurable Values: $240,958,172	YAC-L4L-445988-014	Liberty Mutual Insurance Company	$96,906,101 Blanket Real Property $35,946,478 Blanket Personal Property $108,105,593 Blanket Loss of Time Element $5,000,000 Blanket Extra Expense Not Covered Earth Movement Not Covered Flood Various Sublimits apply	$25,000 Policy Deductible Per Occurrence 24 Hours Waiting Period for Loss of Business Income or Extra Expense Various Deducitbles apply	$208,193.90 Net commission	$267,539 Net commission	**$ 59,345**	28.50%	**HARPP OPTION (Property, Boilery & Machinery, Earthquake, Cyber, Pollution $350,000,000 Per occurrence Limit (Varlious sublimits apply) $25,000 Deductible per occurrence (varous deductibles apply) Gross Premium: $1,013,078 Approx. Net: $876,313**
7/1/2024	7/1/2025	APIP – "All Risk" Property Program - Pollution	ISPILLSCAZ08004	Ironshore Specialty Insurance Company	$25,000,000 Policy Program Aggregate $2,000,000 Per Pollution Incident $2,000,000 Per Named Insured Aggregate Various Sublimits apply	$50,000 Each Pollution Incident After July 1, 2021 $500,000 Each Pollution Incident Prior to July 1, 2021 Various Deductibles Apply	$9,337.22 Including Taxes and Fees, net commission	$12,290 Including Taxes and Fees, net commission	$ 2,953	31.63%	Included in above APIP premium with HARPP Option
7/1/2024	7/1/2025	APIP – Cyber	FN2405500	Lloyd's of London - Beazley Liberty Surplus Insurance Corporation Associated Industries Insurance Company, Inc.	$2,000,000 Annual Aggregate/Member $75,000,000 Annual Policy and Program Aggregate Limit for all Named Insured's combined Various Sub-limits apply	$50,000 Per Claim 8 Hour Waiting Period for Dependent/Business Interruption Loss	Included in above APIP premium	Included in above APIP premium			Included in above APIP premium with HARPP Option
7/1/2024	7/1/2025	APIP Cyber - BBR + Boost	FN2405500-BBR	Lloyd's of London – Beazley Syndicates: 2623/623	$500,000 Breach Response Costs $250,000 Notified Individuals $500,000 Legal / Forensics /Public Relations & Crisis Management Combined $2,000,000 Additional Breach Response Limit per Member / Insured First Party Loss coverages: $2,000,000 Business Interruption Loss resulting from Security Breach $2,000,000 Business Interruption Loss resulting from System Failure $750,000 Dependent Business Loss resulting from Dependent Security Breach $100,000 Dependent Business Loss resulting from Dependent System Failure $2,000,000 Cyber Extortion Loss $2,000,000 Data Recovery Costs	100 Notified Individuals $10,000 Legal / Forensics /Public Relations & Crisis Management Combined, but $5,000 for Legal Services only	$43,790.00 Including Taxes and Fees, net commission	Not to Exceed: $48,169 Including Taxes and Fees, net commission			5% - 10% increase. 5%: $52,500 + $1,669.50 (taxes & fees) - $8,190 (commision credit) = $45,980 10%: $55,000 + $1,749 (taxes & fees) - $8,580 (commission credit) = $48,169
7/1/2024	7/1/2025	Crime	01-309-02-02	National Union Fire Insurance Company of Pittsburgh, PA (AIG)	$5,000,000 All Lines of Coverages • Employee Theft Including Faithful Performance of Duty • Forgery or Alteration • Inside Premises Theft of Money and Securities • Inside Premises Robbery and Safe Burglary Other Property • Outside the Premises • Computer Fraud • Funds Transfer Fraud • Money Orders and Counterfeit Paper Currency	$25,000	$8,700.00 Net commission	Not to Exceed: $9,570 Including Taxes and Fees, net commission			5% - 10% increase. 5%: $11,419 - $2,284 (commision credit) = $9,135 10%: 11,963 - $2,393 (commission credit) = $9,570

ALLIANT SCHEDULE OF COVERAGES

Pioneers Memorial Healthcare District Year Over Year Premium

								RECOMMENDED RENEWAL PROGRAM			
Effective Date	Expiration Date	Coverage	Policy Number	Insurance Company	Limits	Deductible/SIR	24/25 Premium	25/26 Renewal	Premium Difference Compared to Expiring	% Prem Variance	Notes
7/1/2024	7/1/2025	Deadly Weapon Response Program	PJ24000500112	Lloyd's of London	$500,000 Each and Every Deadly Weapon Event Including Claim Expense $500,000 In the Annual Aggregate $250,000 Each and Every Deadly Weapon Event For • Counselling Services • Funeral Expenses • Business Interruption • Demolition, Clearance, Memorialization • Extra Expense • Threat $25,000 Per Person and $500,000 Annual Aggregate for Medical Expenses $50,000 Per Person and $500,000 Annual Aggregate for Deadly Weapon Death and Dismemberment $500,000 Each and Every Deadly Weapon Event for 1st Party Property Damage $500,000 Transit Extension – Bus, Coach, Train owned by insured and reported on schedule Various Sublimits apply	$10,000 (for 100%) each and every Deadly Weapon event including Claim Expenses	$6,140.24 Including Taxes and Fees, net commission	Not to Exceed: $8,255 Including Taxes and Fees, net commission			$8,000 + 255 (taxes & fees) = $8,255
9/1/2024	9/1/2025	Pollution Liability – UST Number of tanks: 1	G46810272 008	ACE American Insurance Company	$1,000,000 Per Storage Tank Incident $1,000,000 Aggregate Limit for Claims & Remediation Costs for UST Incident $1,000,000 Aggregate Limit for Legal Defense Expenses for UST Incident $2,000,000 Total Policy Aggregate Limit of Liability	$5,000 Per Storage Tank Incident	$1,210.00 Net commission				
12/1/2024	12/1/2025	Fiduciary Liability	SFD31211420-05	Hudson Insurance Company	$3,000,000 Aggregate Pending or Prior Proceeding Date: 12-01-1998 Various Sublimits apply	$10,000 Except $200,000 Each Class Action / Derivative Claim	$7,006.42 Net commission				
1/1/2025	1/1/2026	Difference in Conditions - Primary $10M Total Insurable Values: $227,271,730	D21481250801	Beazley Excess and Surplus Insurance, Inc.	$10,000,000 Each Occurrence and in the Annual Aggregate in respect of Earth Movement Sub-Limits: $8,363,724 Ordinance or Law - Demolition and Increased Cost of Construction combined $500,000 Accounts Receivable $2,000,000 Utility Services $1,000,000 Data Various Sublimits apply	10.00%Values Per Unit of Insurance $25,000 Minimum Per Occurrence for Earth Movement	$386,056.00 Including Taxes and Fees, net commission				
1/1/2025	1/1/2026	Difference in Conditions - $10M x/s $10M	FDX03000014-03	Golden Bear Insurance Company	$10,000,000 excess of $10,000,000 per occurrence and in the aggregate as respects the peril of Earth Movement	Per Primary	$248,100.00 Including Policy Fees, net commission				
TOTAL							**$918,533.78**	**$ -**	**$ 2,952.78**		

DISCLAIMER: These budget estimates are based on current market conditions and projections based on available data and current loss experience. These budget projections are not bindable quotes. They are subject to change if further losses are incurred or if there are sudden changes in the insurance market. The budget projections can increase or decrease once underwriters are able to complete a full review based on losses, exposure and market conditions at the time of quoting.