SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room

AGENDA
April 23, 2024

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

I. Approval of Agendas
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

As provided in the Ralph M. Brown Act, Government Code Sections 54950 et seq., the Board of Directors may meet in closed session with members of the staff, district employees and its attorneys. These sessions are not open to the public and may not be attended by members of the public. The matters the Board will meet on in closed session are identified on the agenda or are those matters appropriately identified in open session as requiring immediate attention and arising after the posting of the agenda. Any public reports of action taken in the closed session will be made in accordance with Gov. Code Section 54957.1

III. Closed Session Business

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to General Strategic Planning for Outpatient Ophthalmology & Podiatry Surgical Services. Estimated date of Disclosure 4/23/24.

D. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation: Conference with Legal Counsel. BETA Claim No. 24-000528

E. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation: Conference with Legal Counsel. BETA Claim No. 23-001587

F. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter – One (1) Item. Estimated Date of Disclosure January 1, 2025 for materials that are not part of an individual's private personnel file.

G. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

H. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item).

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda.

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

Pursuant to Gov. Code Section 54957.1; Action(s) to be taken Pursuant to Closed Session Discussion

A. Chief of Staff Report
Recommended Action: Information only; no action taken

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
Recommended Action: Approve/Disapprove Report as Given

2. Quality Division Update –Quality Report
Recommended Action: Approve/Disapprove Report as Given

C. Discussion Regarding Trade Secrets Pertaining to General Strategic Planning for Outpatient Ophthalmology & Podiatry Surgical Services
Recommended Action: Information Only; No Action Taken

D. Discussion Regarding BETA Claim No. 24-000528
Recommended Action: Approve/Deny BETA Claim No. 24-000528

E. Discussion Regarding BETA Claim No. 23-001587
Recommended Action: Approve/Deny BETA Claim No. 23-001587

F. Discussion Regarding Confidential Personnel Matter
Recommended Action: Information Only: No Action Taken

G. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only: No Action Taken

H. Conference with Legal Counsel
Recommended Action: Information Only; No Action Taken

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments

submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. **March 26, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove March 26, 2024 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. **Porterville Academy of Health Science (PAHS) Health Career Scholarship**
Recommended Action: Approve/Disapprove

B. **Resolution 04-23-2024/01 Ophthalmology Dissolution Of Outpatient Ophthalmology Surgical Service Line**
Recommended Action: Approve/Disapprove Resolution 04-23-24/01

C. **Resolution 04-23-2024/02 Dissolution Of Outpatient Podiatry Surgical Service Line**
Recommended Action: Approve/Disapprove Resolution 04-23-24/02

D. **Resolution 04-23-2024/03 Ordering Even-Year Board of Directors Election; Consolidation of Elections; and Specification of the Election Order**
Recommended Action: Approve/Disapprove Resolution 04-23-24/03

E. **March 2024 Financials**
Recommended Action: Approve/Disapprove March 2024 Financials

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – May 28, 2024 at 5:00 p.m.

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

MEDICAL EXECUTIVE COMMITTEE	04/03/2024
BOARD OF DIRECTORS APPROVAL	
	04/23/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
April 23, 2024 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

		Pages	Action
I.	**Policies**:		**APPROVE**
	• Hypoglycemic Reaction: Immediate Treatment of Patients Experiencing	1-6	↓
	• Medical Device Alarm Safety	7-11	
	• Restraint Use – Medical/Surgical and Behavioral Restraint	12-20	
	• Scope of Services, Plan for the Provision of Patient Care Service	21-26	
II.	**Forms**:		
	• Code Blue Form	27-30	
	• Confidentiality Agreement	31-33	
	• Moderate Sedation Orders – Endoscopy	34	

SUBJECT: **HYPOGLYCEMIC REACTION: IMMEDIATE TREATMENT OF PATIENTS EXPERIENCING**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 6**

PURPOSE:

Patients experiencing hypoglycemic reactions will be treated immediately and consistently following this procedure unless otherwise ordered by the attending physician.

POLICY:

Immediate, consistent treatment of hypoglycemia by the nursing staff will help decrease the possibility for further complications such as unconsciousness and further injury.

AFFECTED AREAS/PERSONNEL: *REGISTERED NURSES (RNs), LICENSED VOCATIONAL NURSES (LVNs), ALL PATIENT CARE AREAS*

EQUIPMENT:

- Bedside capillary glucose meter
- Fast acting carbohydrates (available in nourishment rooms on units).
- 50% Dextrose
- Glucagon

SPECIAL PRECAUTIONS:

1. When accepting admission orders for a known diabetic patient, regardless of admission, ask the physician for any specific orders that he/she may prefer for hypoglycemic reactions. If none are indicated, this procedure should be utilized.

2. When admitting a diagnosed diabetic patient, discuss with him/her and DOCUMENT the normal symptoms he/she displays when developing hypoglycemia. Elicit what type of treatment regime is normally effective for him/her.

PROCEDURE:

HYPOGLYCEMIC REACTION IN THE RESPONSIVE PATIENT THAT IS ABLE TO EAT.

1. Check the patient's blood sugar using the bedside capillary glucose meter.

2. While performing the test, evaluate the patient's neurological level to include responsiveness and orientation, as well as other overt symptoms such as diaphoresis, shakiness, hunger, headache, tingling of lips/fingers, slurred speech or behavioral changes. Document the findings.

3. Capillary blood sugar (CBS) <70, give orally 1 source of fast acting carbohydrate (See table).

Fast Acting Carbohydrates (Rule of 15)

Carbohydrate source	Amount to be given	G of Carbohydrates
Fruit Juice	4 oz	15g
Regular Soda	6 oz	15-20g
Non-fat milk	8 oz	12g
Chewable Glucose Tab w/water	4 tabs	15g
Packet of regular sugar	3 packets	12g

4. Notify the physician of the patient's CBS, assessment and treatment initiated.

5. Repeat CBS in 15 minutes (based on the patient's condition).

6. If the CBS is still <70, treat again.

7. Test and treatment to be repeated until CBS >70.

*NOTE: For hypoglycemic reactions occurring between the hours of 12:00 midnight and 4:00am, give a 15-30gm carb snack **with** protein such as the following:*

- *8 oz non-fat milk (12g) with 4 oz juice (15g)*
- *4 oz regular pudding (21g)*
- *1 package of graham crackers (18g) with 1 packet of peanut butter*

HYPOGLYCEMIC REACTION IN A RESPONSIVE, BUT NPO PATIENT, WITH IV ACCESS

1. Check the patient's blood sugar using the bedside capillary glucose meter.

2. While performing the test, evaluate the patient's neurological level to include responsiveness and orientation, as well as other overt symptoms such as diaphoresis, shakiness, hunger, headache, tingling of lips/fingers, slurred speech or behavioral changes. Document the findings in the Nursing Event Notes.

3. If CBS level 50-70, administer 12.5G (25mL) bolus of 50% Dextrose IVP x1 dose.
If CBS level <50, administer 25G (50mL) bolus of 50% Dextrose IVP x1 dose.

4. Notify the physician of the patient's CBS, assessment and treatment initiated.

5. Recheck CBS level after 15 minutes.

6. Repeat treatments based outline in #3 & #4 until CBS >70.

HYPOGLYCEMIC REACTION IN A RESPONSIVE, BUT NPO PATIENT, WITHOUT IV ACCESS

1. Check the patient's blood sugar using the bedside capillary glucose meter.
2. While performing the test, evaluate the patient's neurological level to include responsiveness and orientation, as well as other overt symptoms such as diaphoresis, shakiness, hunger, headache, tingling of lips/fingers, slurred speech or behavioral changes. Document the findings in the Nursing Event Notes.
3. If CBS level <70, administer 1mg Glucagon IM. Attempt to obtain IV Access
4. Notify the physician of the patient's CBS, assessment and treatment initiated.
5. Recheck CBS level after 15 minutes.
6. If IV access is obtained, follow steps for "Responsive, NPO, with IV Access" (See above).

   If IV access is unsuccessful & the repeat CBS <70, administer 1mg Glucagon IM x1 and notify prescriber. *****Do not administer more than 2 doses of Glucagon in total*****

HYPOGLYCEMIC REACTION IN THE UNRESPONSIVE PATIENT WITH, IV ACCESS

1. Check the patient's blood sugar using the bedside capillary glucose meter.
2. While performing the test, evaluate the patient's neurological level to include responsiveness and orientation, assess the patient's vital status (adequate airway and pulse), and other overt symptoms. Document the finding in the nursing intervention/assessment.
3. REMEMBER: Call Rapid Response and notify the physician STAT of the patient's condition, CBS level and treatment indicated. If no response to therapy and/or unable to reach the physician, notify the Emergency Department physician for evaluation.
4. If CBS level<70, administer a 25G (50mL) bolus of 50% Dextrose IVP.
5. Recheck CBS level after 15 minutes.
6. If CBS remains <70 and/or the patient remains unconscious, administer a second 50mL bolus of 50% Dextrose IVP.
7. Recheck CBS level after 15 minutes.
8. Continue this treatment & CBS level rechecks until CBS ≥100 or as instructed by the physician.

HYPOGLYCEMIC REACTION IN THE UNRESPONSIVE, WITHOUT IV ACCESS

1. Check the patient's blood sugar using the bedside capillary glucose meter.

2. While performing the test, evaluate the patient's neurological level to include responsiveness and orientation, assess the patient's vital status (adequate airway and pulse), and other overt symptoms. Document the finding in the nursing intervention/assessment.

3. REMEMBER: Call Rapid Response and notify the physician STAT of the patient's condition, CBS level and treatment indicated. If no response to therapy and/or unable to reach the physician, notify the Emergency Department physician for evaluation.

4. If CBS level <70, administer 1mg Glucagon IM. Attempt to obtain IV Access.

5. Recheck CBS level after 15 minutes.

6. If IV access is obtained, follow steps for "Unresponsive, with IV Access" (See above).

   If IV access is unsuccessful & repeat CBS <70, administer 1mg Glucagon IM x1 and notify prescriber. *****Do not administer more than 2 doses of Glucagon in total*****

ONCE PATIENT HYPOGLYCEMIA RESOLVES

1. If the patient is not NPO and is not scheduled for a meal within 30 minutes, give him/her appropriate nutritional snack.

2. If the patient is NPO, ask the physician for IV orders.

PATIENT EDUCATION

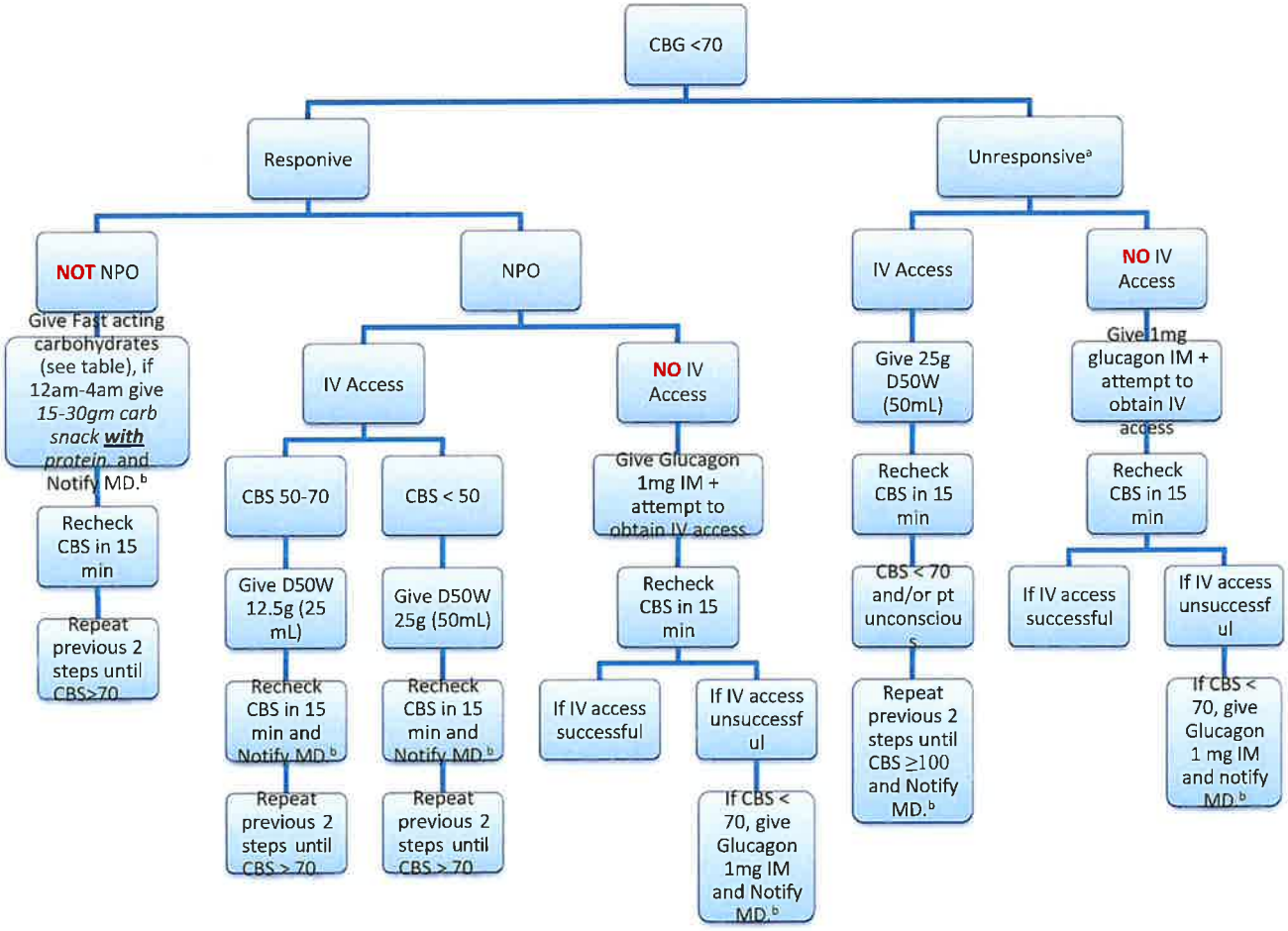
Explain the signs/symptoms of hypoglycemia to the patient. Instruct the patient in treatment protocol.

DOCUMENTATION

Documentation should include:

- Patient assessment. Including Blood sugar findings.
- Amount and type of juice and/or snacks given.
- Medications administered.

- Physician notification.
- Other pertinent observations



****Ensure Physician is notified after any intervention****

Fast Acting Carbohydrates (Rule of 15)

Carbohydrate source	Amount to be given	G of Carbohydrates
Fruit Juice	4 oz	15g
Regular Soda	6 oz	15-20g
Non-fat milk	8 oz	12g
Chewable Glucose Tab w/water	4 tabs	15g
Packet of regular sugar	3 packets	12g

15-30g carb snack **with** protein such as the following:

• 8 oz non-fat milk (12g) with 4 oz juice (15g)
• 4 oz regular pudding (21g)
• 1 package of graham crackers (18g) with 1 packet of peanut butter

REFERENCES:

- American Diabetes Association Professional Practice Committee; 6. Glycemic Goals and Hypoglycemia: *Standards of Care in Diabetes—2024*. *Diabetes Care* 1 January 2024; 47 (Supplement_1): S111–S125. https://doi.org/10.2337/dc24-S006
- Lexicomp (2024, February 23). Glucagon. Retrieved February 23, 2024.
- Lowe RN, Williams B, Claus L. Diabetes: how to manage patients experiencing hypoglycaemia. *Drugs in Context*. 2022;11:1-12. doi:https://doi.org/10.7573/dic.2021-9-11

SUBJECT: **MEDICAL DEVICE ALARM SAFETY**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 5**

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

PURPOSE:

To improve the safety to clinical alarm systems. The scope of this policy primarily encompasses alarms on medical devices designed to alert staff and practitioners to an actual or potential life-threatening patient condition.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

DEFINITIONS:

1. MEDICAL DEVICE: A piece of equipment designated by the Food & Drug Administration as a medical device.

2. CRITICAL ALARMS: Alarms on medical equipment designed to alert staff to the presence of a life-threatening or potentially life threatening condition.

3. NON-CRITICAL ALARMS: Alarms on medical equipment designed to alert staff to the presence of a non-life threatening condition.

POLICY: IDENTIFICATION OF ALARM SIGNALS

The organization shall identify alarms on medical equipment based on the following:

- Input from the medical staff and clinical departments
- Risk to patients if the alarm signal is not attended to or if it malfunctions
- Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
- Potential for patient harm based on internal incident history
- Published best practices and guidelines

Based on the above analysis, a list of medical devices and attendant critical alarm signals is appended to this policy as ATTACHMENT A, and is incorporated by reference herein.

AFFECTED PERSONNEL/AREAS: This policy applies to all care settings and services for which medical devices utilized in the provision of patient care contain alarms.

EQUIPMENT:

- Cardiac Monitors
- Ventilators

- IV Pumps
- Hemodialysis Machines
- Pulse Oximeters
- Bed/Chair Alarms
- Fetal Monitors
- Radio Room (Emergency Room)

PROCEDURE:

Critical Alarms

AUTHORITY TO SET ALARM PARAMETERS

Unless otherwise specified in ATTACHMENT A of this policy, initial parameters for critical alarms will be consistent with default settings established by the device manufacturer. Changes to the manufacturer default settings may only be made upon order of the patient's physician, or qualified designee, who is familiar with the patient's clinical condition.

AUTHORITY TO CHANGE ALARM PARAMETERS

Unless otherwise specified in ATTACHMENT A of this policy, critical alarm parameters may only be changed upon order of the patient's physician, or qualified designee, who is familiar with the patient's clinical condition.

AUTHORITY TO SET ALARM PARAMETERS TO OFF

Critical alarms may not be disabled or placed permanently in the off position unless directly ordered by the patient's physician.

TEMPORARY SUSPENSION OF ALARM SIGNALS

Critical alarms may be suspended while the patient is off the equipment, or staff is working directly with the patient, but must be returned to the on position when the equipment is placed back on the patient or when care is completed. Staff is expected to verify that critical (life threatening) alarms are in the on position

AUDIBILITY OF ALARM SIGNALS

Critical alarm volumes shall be set at a level so that staff can hear them. If there is competing noise in the area, or the patient is housed at some distance from staff, then the volume of alarms will be set high enough or augmented in a manner that allows staff to hear them.

MONITORING & RESPONDING TO ALARM SIGNALS

Staff shall monitor and respond to the activation of a critical alarm in a timely manner. Monitoring may be either direct or indirect depending on the patient's clinical condition, care setting, medical devices in use, and other pertinent factors.

VERIFYING ALARM FUNCTIONALITY & SETTINGS

Operational functionality of critical alarms will be checked in accordance with manufacturer instructions as part of the equipment(s) biomedical preventive maintenance and repair program. In addition, users of medical devices shall verify – as appropriate – that critical alarms are in the "on" position and sufficiently audible:

- Prior to using the device on a patient
- When assuming care of a patient (i.e. at the start of shift)
- Following removal and subsequent reapplication of the device on a patient due to patient care needs
- Prior to transferring a patient with the device to another care area.

Non-Critical Alarms

NON-CRITICAL ALARM SIGNALS

Non-critical alarm parameters shall be set either to the default settings established by the manufacturer or as clinically warranted based on the patient's condition. Parameters may be set and/or adjusted by the patient's physician or by staff trained and qualified to operate the equipment and understand the clinical implications of such action. In general, non-critical alarms should not be turned off, but the volume may be set so that it is not disruptive to the therapeutic milieu or contributes to alarm fatigue.

- It is recognized that medical devices contain alarm signals designed to alert staff to a wide variety of clinical presentations. In some instances, these presentations are reflective of a patient's "normal and expected" condition. Under these circumstances, it is permissible to suspend or turn off the alarm component(s) or parameter(s) designed to alert staff of a normal and expected clinical presentation.

Staff Training

STAFF TRAINING

Staff will be educated about the purpose and proper operation of alarm systems for which they are responsible. Evidence that staff have been trained to the medical device itself shall be considered inclusive of training on attendant alarm systems. Training shall be provided as part of staff's initial assessment of competency upon hire, when new medical devices are introduced into the organization, and as necessary.

PHYSICIAN TRAINING

Physicians and other practitioners shall also be educated about the purpose and proper operation of alarm systems for which they are responsible. Evidence that these individuals have been granted clinical privileges which require using a medical device shall be considered inclusive of training on attendant alarm systems.

IMPROVING ON MEDICAL DEVICE ALARM SAFETY

A cross-disciplinary team that includes representation from clinicians, clinical engineering, information technology, and risk management shall meet on as needed basis to:

- Improve and optimize critical alarm system configurations and practices
- Review trends and patterns in alarm-related events – including the potential issue of alarm fatigue – to identify opportunities for improving alarm use.

REFERENCES:

- National Patient Safety Goals® Effective January 2024 for the Hospital Program *Goal 6 Reduce patient harm associated with clinical alarm systems.* https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2024/npsg_chapter_hap_jan2024.pdf

ATTACHMENT A
List of Devices & Critical Alarms

Device	Alarm Signal	Default / Initial Parameters	Authority to Set Change Parameters
Cardiac Monitors	Ventricular Tachycardia	x	Physician
	Ventricular Fibrillation	x	Physician
	Asystole	x	Physician
Ventilators	Occlusion	x	Physician
	Disconnection	x	Physician
	Power Failure	x	Physician
IV Pumps*	Occlusion	x	Pharmacist
	Disconnection	x	Pharmacist
	Power Failure	x	Pharmacist
Hemodialysis Machines	Occlusion	x	Physician
	Disconnection	x	Physician
	Power Failure	x	Physician
Pulse Oximeters	Low Saturation	x	Physician
	Disconnection	x	Physician
Bed/Chair Alarms	Alarming	x	Nursing
	Power Failure	x	Nursing
	Disconnection	x	Nursing
Fetal Monitoring	Tachycardia	x	Physician
	Bradycardia	x	Physician
	Low Saturation	x	Physician
Radio Room (ER)	Volume	x	MICN or ER Physician

* Limited to continuous infusions of hazardous, anti-arrhythmic, sedative, and vasoactive medications necessary for hemodynamic and/or neurological stability in a critically ill patient.

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SUBJECT:	SECTION:
RESTRAINT USE –MEDICAL/SURGICAL AND BEHAVIORAL RESTRAINT	***Provision of Care, Treatment and Services (PC)*** 9 **Page 1 of ~~10~~**

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

PURPOSE:

To guide the application of ***Medical/Surgical and Behavior*** restraint in all settings with the goal of minimizing the frequency/duration of restraint use to that which is absolutely necessary for patient care and patient and provider safety.

SCOPE:

The following are not considered restraint under this policy:

- Standard healthcare practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes;
- Adaptive support in response to assessed patient need;
- Forensic or correctional restrictions used for security purposes.
- Four side rails for seizure precautions
- All beds in the Intensive Care Unit are designated as therapeutic care and the use of these side rails are not subject to the requirements of the standard.

POLICY:

1. Seclusion will not be employed on inpatient units.
2. Restraints will not be used as a means of corporal punishment, coercion, discipline, convenience, or staff retaliation
3. Physical restraint may be used according to his policy when warranted by the patient's condition and therapy and when less-restrictive means of protecting the patient are not indicated.
4. All staff assigned to apply or monitor restraint will demonstrate corresponding competence.
5. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint.

AFFECTED PERSONNEL/AREAS: *ALL ACUTE INPATIENT UNITS; EXCLUDES DPSNF*

PROCEDURE:

MEDICAL/SURGICAL RESTRAINT

1. ***Definition***

Medical/Surgical restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g., magnetic resonance imaging, surgery, etc.) is not considered restraint. *(See Appendix for examples of **medical/surgical restraint**).*

2. ***Indications***

Prior to the initiation and continuation of a medical/surgical restraint, the patient must be assessed to determine whether he/she requires restraint to prevent interference with his/her treatment plan.

3. ***Consideration of less-restrictive means***

Prior to the initiation and continuation of restraint, alternative means of protecting the patient will be considered. *(See Appendix for examples of Alternatives to Use of Restraint. These alternative methods should be documented in the EMR.)*

4. ***Conversation with Patient and Family***

To the extent practical, the issue of restraint will be discussed with the patient and family around the time of its use. Patient/family education will be documented.

5. ***Orders***

Restraint will be initiated or continued at the order of a treating physician with current privileges at SVMC. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted.

6. ***Initiation Without Orders***

If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.

7. ***Initial In-Person Physician Assessment within 24 hours of Initiation***

The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate. The physician will re-order or discontinue restraint at the time of that evaluation.

8. ***Ongoing In-person Physician Assessments and Continuation of Restraint Orders***

The treating physician will perform in-person assessments of a restrained patient at least once every 24 hours at which time restraint will be either reordered or discontinued as necessary.

9. ***Early Discontinuation of Restraint***

Restraint will be discontinued as soon as it is no longer warranted by the patient's actions or the nature of the patient's treatment plan. Documentation of restraint discontinuation is mandatory.

10. ***Patient Monitoring***

Monitor restrained patients as often as necessary to ensure safety and dignity and to attend to comfort needs. Patients will be observed at least every two ***(2)*** hours to ensure that restraint remains necessary, that restraining devices remain safely applied, and that the patient remains as comfortable as possible. Such monitoring will be documented every 2 hours.

11. ***Documentation***

The following will be documented in the medical record whenever medical restraint is applied:

a. The patient's actions or condition that indicated the initial and continued use of restraint;

b. The less-restrictive alternative(s) to restraint considered;

c. Restraint orders;

d. Patient monitoring;

e. Significant changes in the patient's condition;

f. Discussions and education with the patient and family (as appropriate) regarding restraint;

g. The patient's plan of care will be updated any time a restraint is used;

h. Removal of all restraints.

BEHAVIOR RESTRAINT

1. ***Definition***

Behavior Restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger.

Physical Holding is holding the patient in a manner that restricts the patient's movement against their will. Physical holding of a patient can be just as restrictive and just as dangerous as a restraining method that involve devices.
(For the purpose of regulation, a staff member picking up, redirecting, or holding an infant, toddler, or preschool aged child to comfort the patient is not considered a restraint)
Note: physical holding of a patient for the purpose of conducting routine physical examinations or tests. However, patients do have the right to refuse treatment. See §482.13(b) (2). This includes the right to refuse physical examinations or tests.

2. ***Consideration of Less-Restrictive Means***

Prior to the initiation and continuation of ***behavioral*** restraint, alternate means of protecting the patient and others will be considered. *(See Appendix)*

3. ***Conversation with Patient and Family***

To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate.

4. ***Discontinuation of Restraint***

Behavioral restraint will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.

5. ***Orders***

Behavioral restraint will be initiated or continued upon the order of a treating physician with current privileges at this institution. The order for restraint will include the type of restraint to be applied and will be based on specific violent/self-destructive behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. ***Behavioral*** restraint may not be ordered for longer than four (4) hours for adult patients, two (2) hours for children between nine and 17 years old, and one (1) hour for children eight years old or younger.

6. ***Initiation Without Orders***

An RN may initiate ***behavioral*** restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one ***(1)*** hour of its application.

7. ***Renewal of Restraint Orders***

Before the expiration of the original order, a ***behavioral*** restraint may be reordered by the treating physician based on the assessment of the RN. However, the physician must perform an in-person assessment at least every eight (8) hours for adults and at least every four (4) hours for patients 17 years old or younger.

8. ***Notification of the Nurse Manager/House Supervisor***

The nurse manager or house supervisor on duty will be notified:

a. of any ***behavioral*** restraint that continues to be applied for more than eight hours; and

b. Any reapplication of behavioral restraint within 12 hours after discontinuation.

9. ***Patient Monitoring***

Patient will be placed in ICU where staff will continuously observe patients in ***behavioral*** restraint. Such monitoring will be documented at least every 15 minutes.

10. ***Documentation***

Document the following in the medical record whenever ***behavioral*** restraint is applied:

a. The patient's actions or condition that indicated the initial and continued use of restraint;

b. The less-restrictive alternative(s) to restraint considered;

c. Restraint orders;

d. Patient monitoring;

e. Significant changes in the patient's condition;

f. Discussions and education with the patient and family (as appropriate) regarding restraint.

g. The patient's plan of care will be updated any time a restraint is used

CHEMICAL RESTRAINT

1. ***Definition***

A chemical restraint is any medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement that is not a standard treatment or dosage for the patient's condition. Therefore, administration of an antianxiety or antipsychotic drug to alleviate symptoms of mental illness need not be considered a chemical restraint. Routine scheduled use of medications or PRN use, either oral or IM, of these same medications for approved indications does not need to be considered a chemical restraint.

On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of ***behavioral*** restraint. The protections afforded the patient for this physical restraint *(See behavioral restraint above)* also ensures the patient's rights for chemical restraint.

REPORTING DEATHS RELATED TO RESTRAINT

As per 42 Code of Federal Regulations (CFR) 482.13 (e)-(g)

Staff will promptly notify management of the death of any patient during or within 24 hours of the end of an episode of restraint.

Management, in consultation with the department of Quality and Regulatory Affairs, will notify the California Department of Public Health (CDPH) (on behalf of the Centers for Medicare & Medicaid Services [CMS]) of any patient who dies during or within 24 hours of the end of restraint no later than by close of the next business day the discovery of:

- Each death that occurs while a patient is in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of the restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

Hospital staff do not need to report the death to CMS but must record the death in an internal log or other system only for deaths that occur when:

- No seclusion has been used, and
- The only restraints used on the patient were applied to the patient's wrist(s) and composed solely of soft, non-rigid, cloth-like materials.

STAFF EDUCATION:

1. During the initial orientation period, all levels of staff who have direct patient care responsibilities are oriented to this policy and procedure and trained in the proper and safe application and use of restraints.
2. Competency validation related to the proper and safe application and use of restraints is documented prior to the independent performance of the application or monitoring of a patient requiring restraint and then annually.

3. Only Registered Nurses (RN), who have demonstrated competence or physicians may apply restraints in an emergency situation.

4. Contract/agency staff with direct patient care responsibilities have documented competency in the hospital's restraint policies and procedures prior to caring for patients in restraints.

PERFORMANCE IMPROVEMENT:

It is the policy of Sierra View Medical Center to make every effort to reduce the use of restraints. Performance improvement activities will focus on reduction in the use of restraints with data collected on each episode until a baseline of aggregate data has been established and assessed. Once a baseline is established, targeted monitoring will be employed.

REFERENCE:

- The Joint Commission. (2021). Hospital Accreditation Standards. PC.01.03.05, PC.03.05.01, PC.03.05.03, PC.03.05.05, PC.03.05.07, PC.03.05.09, PC.03.05.11, PC.03.05.13, PC.03.05.15, PC.03.05.17, PC.03.05.19. Joint Commission Resources. Oak Brook, IL.

- Centers for Medicare and Medicaid Services. (2022). State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals 482.13(e)(1)(i)(C) retrieved on 7/22/2022 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

CROSS REFERENCE:

- Appendix A: Restraint Alternatives

Appendix A

Alternatives to the Use of Restraints

PHYSICAL MEASURES	**SPIRITUAL NEEDS**
Exercise & activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books & magazines)	Contact patient's pastor, minister, priest, rabbi
Anticipate & provide for basic needs of hunger (snacks), thirst & toilet	Offer sacraments of Communion, Reconciliation and Anointing of the sick as appropriate
Promote normal sleep patterns	Use sitter or volunteer to read to patient
Relaxation techniques	Use audio tapes
Use of lap/seatbelt in chair as a reminder	
Provide glasses, hearing aid, dentures	
Tape foley to abdomen of male patient	
Use busy vest or busy activity such as folding towels	
PSYCHOLOGICAL MEASURES	**ENVIRONMENTAL MEASURES**
Explain all procedures, be aware of fear of the unknown	1:1 communication to inform patient of safety precautions & orient to environment
Orient patient to reality often	Use of cushions/pads to maintain safety
Provide for companionship: family, friends, church members, volunteers, sitters	Locate patient next/close to nurse's station
Holding/cuddling infants & young children	Use appropriate lighting-nigh light, increase or decrease light in room depending on patient's eyesight or medical condition
Use TV, radio or music as diversion	Use of Geri chair
Allow patient to wear street clothes, underwear or shoes	Use bed alarms, door alarms as available
PHYSIOLOGICAL MEASURES	Decrease or control noise level
Review medications for side effects & interactions	Call light within reach
Review lab results for abnormal values	Floor or room uncluttered
Collaborate with other healthcare team members & evaluate treatment plan	Urinal or bedpan within reach
Initiate frequent bathroom rounds	Position tubes/drains out of site

Provide adequate pain medication	Control activity level (visitors, coordinate activities/treatments)
Eliminate itch (if scratching)	Schedule family/friends to stay with patient

Patient actions to be considered in the application of restraints

ACTION	EXAMPLE OF DEVICE	TYPE OF RESTRAINT
Patient severely combative or violent due to mental state	4 point soft restraints	Behavioral
Restricting movement of confused patient from removing medical device (IV, endotracheal tube, catheter, drains, etc.)	Soft wrist ties Mittens	Medical/Surgical
Confused patient attempting to climb out bed	Bed Alarm, use of Three side rails	NOT Restraint
Post-op patient needs to lay on her side without rolling out of bed	Bed rails	NOT Restraint
Patient with poor posture while sitting in chair	Seat belt/lap belt	NOT Restraint
Patient sliding out of chair	Over bed portable table (not placed under chair legs) Lap belt	NOT Restraint
Patient immobilized during MRI, circumcision, operative procedure	Soft wrist restraints Safety belt	NOT Restraint
Protection of patient from falling out of bed, using side rails	Bed rails (X2)	NOT Restraint
Patient transported via gurney or wheelchair	Safety belt	NOT Restraint
Patient under arrest, being guarded by Deputy Sheriff	Handcuffs	NOT Restraint

SUBJECT:	SECTION:
SCOPE OF SERVICES, PLAN FOR THE PROVISION OF PATIENT CARE SERVICE	***Medication Management (MM)*** **Page 1 of 6**

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

PURPOSE:

To define the scope of services provided by the Department of Pharmaceutical Services that address (types of patients, patient care, scope of functions, optimal use of medications, quality of life and outcomes, responsibilities and collaboration), departmental goals, staffing plans and qualification of staff, patient care, scope of functions, optimal use of medications, quality of life and outcomes, responsibilities and collaboration, department accountability to the medical staff and hospital administration.

POLICY:

SCOPE OF SERVICE

1. Responsibility and Accountability

   The Department of Pharmaceutical Services is responsible and accountable to the medical staff of Sierra View Medical Center through reporting and oversight of the Pharmacy and Therapeutics Committee. In addition, the department is responsible and accountable to the Governing Board of Sierra View Medical Center through the reporting and oversight of Hospital Administration.

2. Types of Patients Served

   The Department of Pharmaceutical Services at Sierra View Medical Center serves the following types of acute care patients:

   a. General Acute Care – Medical/Surgical, including Pediatrics

   b. Obstetrics/Gynecology, including Newborns

   c. Critical Care – Intensive Care and Telemetry

   d. Surgical Services

   e. Special Procedure – (i.e., Endoscopy, Urology Department,, Radiological Intervention)

   f. Emergency Medicine

The department of Pharmaceutical Services at Sierra View Medical Center serves the following types of ambulatory patients:

   a. Ambulatory Outpatient – (i.e., Physical Therapy, Nuclear Medicine)

   b. Outpatient Chemotherapy

   c. Cardiac Cath Lab

d. Wound Care Department

e. Urology Care

f. Ambulatory Surgery Center

g. Academic Health Center

h. Rural Health Clinic – Terra Bella

i. Surgery Clinic

3. Age of Patients Served

Prenatal:	Conception to Birth
Infancy:	0 -12 Months
Toddler:	12 -36 Months
Early Childhood:	3 – 6 Years
Middle Childhood:	6 -12 Years
Adolescence:	13 – 18 Years
Middle Adulthood:	19 - 65 Years
Late Adulthood:	65+ Years

4. Services/Procedures

Pharmaceutical care comprises both cognitive and product-related functions. Cognitive function includes the collection, evaluation, and assessment of pertinent information; the application of knowledge, professional judgment, and thought processes; experience; and communication of information. Pharmacists should use their knowledge of the patient, disease, and medications and integrate these elements to identify and resolve medication-related problems specific to the patient.

Product-related functions include the physical handling, preparations, and dispensing of medications. Thus pharmaceutical care encompasses the full spectrum of pharmaceutical services, including medication procurement, pharmaceutical services, storage, preparation, distribution, administration, provision of medication-related information to patients and other health professionals, and therapeutic, preventive, and diagnostic use of pharmaceuticals and related devices. Both cognitive and product-related activities are essential to the effective

provision of pharmaceutical care, and both should be viewed as supportive of the overall goal of optimal use of medications.

5. Hours of Operation:

Pharmaceutical Services are available to the patient at Sierra View Medical Center 24 hours a day, 7 days a week. Availability is defined as:

Normal Pharmacy Hours of Operation

Monday – Friday	0600 Hours to 2100 Hours
Saturday, Sunday & Observed Holidays	0600 to 1900 Hours

Pharmacist On-Call

Monday – Friday	2101 Hours to 0559 Hours
Saturday, Sunday & Observed Holidays	1901 Hours to 0559 Hours

Pharmacist Night Telepharmacy Services

Monday – Friday	2101 Hours to 0659 Hours
Saturday, Sunday & Observed Holidays	1901 Hours to 0659 Hours

6. Operation of Pharmacy during temporary absence of the Pharmacist

Operation will continue consistent with California Code of Regulations 1714.1 "Pharmacy Operations During the Temporary Absence of a Pharmacist" as follows:

(a) In any pharmacy that is staffed by a single pharmacist, the pharmacist may leave the pharmacy temporarily for breaks and meal periods pursuant to Section 512 of the Labor Code and the orders of the Industrial Welfare Commission without closing the pharmacy and removing ancillary staff from the pharmacy if the pharmacist reasonably believes that the security of the dangerous drugs and devices will be maintained in his or her absence.

If in the professional judgment of the pharmacist, the pharmacist determines that the pharmacy should close during his or her absence, then the pharmacist shall close the pharmacy and remove all ancillary staff from the pharmacy during his or her absence.

(b) During the pharmacist's temporary absence, no prescription medication may be provided to a patient or to a patient's agent unless the prescription medication is a medication that the pharmacist has checked, released for furnishing to the patient's agent.

(c) During such times that the pharmacist is temporarily absent from the pharmacy, the ancillary staff may continue to perform the non-discretionary duties authorized to them by pharmacy law. However, any duty performed by any member of the ancillary staff shall be reviewed by a pharmacist upon his or her return to the pharmacy.

(d) During the temporary absence of a pharmacist as authorized by this section, an intern pharmacist may not perform any discretionary duties nor otherwise act as a pharmacist

(e) The pharmacist on duty will be responsible for maintaining the security of the pharmacy in their absence.

DEPARTMENT GOALS

Pharmaceutical care is defined as the functions performed by a pharmacist in ensuring the optimal use of medications to achieve specific outcomes that improve a patient's quality of life: Further, the pharmacist accepts responsibility for outcomes that ensure from his or her actions, which occur in collaboration with patients and other health-care colleagues. The goals of the Department of Pharmaceutical Services at Sierra View Medical Center is to ensure individual patient care, ensure the optimal use of medications, ensure quality of life and positive outcomes, ensure responsibility in the relationship between the pharmacist, patient and other healthcare providers, and collaboration with all parties involved in the care of the patient.

OPTIMAL USE OF MEDICATIONS

Pharmacists are driven to independently evaluate medication-related problems because of their unique perspective and knowledge of medication therapy. They use their evaluations to make judgments regarding medication use. Pharmacists should advocate optimal medication use for individual patients in cooperation with other professionals and in consideration of their own unique evaluation and knowledge based on their own disciplines. Pharmacists should work with patients and other health professionals in designing and implementing therapeutic plans as necessary to achieve desired outcomes and avoid undesired effects. Thus, pharmaceutical care, which comprises all of these activities, is consistent with pharmacy's overall mission: To help people make the best use of medications.

QUALITY OF LIFE AND OUTCOMES

It is a goal of pharmaceutical care to improve patient's quality of life through achievement of predefined, medication-related, patient-specific therapeutic outcomes. These may include cure of a patient's disease, elimination or reduction of a patient's symptoms, arresting or slowing a disease process, or preventing a disease or symptoms.

RESPONSIBILITIES

There is a relationship between the patient, who entrusts his or her safety and well-being to the pharmacist, and the pharmacist, who commits to honoring that trust through competent professional actions that are in the patient's best interest. Moreover, the pharmacist should personally accept responsibility for patient outcomes (the quality of care) that ensue from his or her actions.

Providers of pharmaceutical care should commit themselves and the systems in which they work to continuous care on behalf of individual patients. They bear responsibility for ensuring that the patient's care is ongoing despite potential interrupting events such as health-care system transitions (e.g., discharge

from a hospital to return to a general ambulatory, community status) or work-shift changes, weekends, and holidays.

COLLABORATION

Overall patient care is made up of overlapping components of care, including medical care, nursing care, and medication management. Pharmacists bear the principle responsibility for medication management. Medication management should include the active participation of the patient (and responsible family members) in matters pertinent to medication use. Medication management should be collaboratively approached with other health-care providers in the context of the patient's complete care. Thus, pharmacists share responsibility for patient outcomes with patients and other health-care providers. Evaluation of the effectiveness will be performed via reports provided & reviewed in collaboration with other health care providers such as nursing and physicians. The reports will be generated from data collection & analysis of the data to identify levels of performance, patterns, and trends. The collaborative teams will review and analyze the reports/data and identify areas of opportunities for improvement. When opportunities are identified the collaborative teams work to improve on those elements and evaluate if the recommended improvements result in wanted outcomes.

STAFFING PLAN

The Department of Pharmaceutical Services at Sierra View Medical Center staffs the required professional and technical support personnel to accommodate all of the needs of the population it serves. Specifically by position:

- Manager of Pharmacy
- Pharmacy Clinical Coordinator/Pharmacist in Charge
- Clinical Pharmacists
- Pharmacy Technicians

The Pharmacist-in-Charge (PIC) may make staffing decisions to ensure sufficient personnel are present in the pharmacy to prevent fatigue, distraction, or other conditions that may interfere with a pharmacist's ability to practice competently and safely. If the PIC is not available, a pharmacist on duty may adjust staffing accordingly to workload if needed.

QUALIFICATIONS OF STAFF

- **Pharmacists** – All Clinical Pharmacists, including the Director, will be a graduate of an accredited school of pharmacy and licensed as a pharmacist in the State of California.
- **Pharmacy Technicians** – All Pharmacy Technicians will be a High School Graduate, and either a graduate of a recognized technical school or training program approved by the California State Board of Pharmacy, have an associates of arts degree in one or more fields of study directly related to the

duties performed by a pharmacy technician, or experience deemed "equivalent" by the California State Board of Pharmacy. In addition, they MUST possess a valid Pharmacy Technician Registration Certificate issued by the California State Board of Pharmacy.

AFFECTED AREAS/PERSONNEL: *PHARMACY*

REFERENCES:

- Hospital Accreditation Standards. (2023). Oak Brook, IL: Joint Commission Resources, Inc.
  - MM.03.01.01, EP 19
  - MM.08.01.01
    - MM.08.01.01, EP1
    - MM.08.01.01, EP 5
    - MM.08.01.01, EP 6
    - MM.08.01.01 EP 8
- Pharmacy Law: California Edition. (2023) San Clemente, California: Law Tech Publishing Group.
- California Code of Regulations (2024). Title 22. §70263. Pharmaceutical Service General Requirements. Accessed January 10, 2024. https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=%28sc.Default%29

SIERRA VIEW MEDICAL CENTER

CODE BLUE FORM

DATE:

LOCATIONS: ☐ FIELD ☐ ED ☐ OR ☐ INPATIENT MEDICAL ☐ INPATIENT SURGICAL
☐ OTHER:_____ ☐ PEDS ☐ OB ☐ NEWBORN ☐ OUTPATIENT Room #_____

Time Initiated:

ARREST TYPE:
☐ RESPIRATORY ☐ CARDIAC

WITNESSED: ☐ YES NO
HOSPITAL WIDE RESPONSE: ☐ YES ☐ NO

FAMILY NOTIFIED
☐ YES ☐ NO
☐ N/A ☐ PRESENT
NAME:_____

PMD NOTIFIED:
Name: _____
Time:_____ NA

Weights
Adult: _____
Pediatric: _____
☐ Broselow ☐ Actual

NAMES:
Pharmacist:_____
Nurse/TL:_____
Nurse:_____
Med Nurse:_____
RT:_____
CPR Coach:_____
Other:_____

SIGNATURES:
Recorder:_____
Physician:_____

AIRWAY/ VENTILATION
Initial: ☐ Spontaneous ☐ Apnea ☐ Agonal ☐ Assisted
Intubation Time _____ Size _____
Placement: _____ cm @Teeth/Gum Lip
Confirmation: ☐ Auscultation ☐ End Tidal CO2 (Colormetry)
Placement By: _____

CIRCULATION
1st PULSELESS Rhythm: _____
Time Compressions Started: _____
CCF% :_____
Feedback Zoll: Rate:_____
Depth:_____

Blood Glucose

Value				
Time				

Time	VITALS/ RHYTHM						INTERVENTIONS			MEDICATIONS											Interventions		
										Bolus / IVP						Infusions			IVF		Type	Time	Site
	BP	Rhythm	Heart Rate/Pulse	Respiratory Rate/Method Bagged, Spontaneous, Ventilated	SpO2	$ETCO_2$ Value (Capnography)	Compressions	Defib/Cardiovert Joules	External Pacing Rate/Amplitude	Amiodarone mg	Atropine mg	Epinephrine mg	Lidocaine mg	Sodium Bicarb mEq	Calcium Chloride mg	Dopamine (mcg/kg/min)	Epinephrine (mcg/min)	Norepinephrine(mcg/kg/min)	☐ NS ☐ LR		IV		
																					IV		
																					CVC		
																					ALINE		
																					NG/OG		

COMMENTS
Additional Meds, Interventions, etc.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
CODE BLUE FORM
Form # 009194 REV 1/24
White - Chart Medical Record Canary - Pharmacy Copy

Time Ended: _____
ROSC >20min: _____
Patient Outcome
☐ Survived
☐ Deceased Efforts term by Provider
☐ Deceased Advanced Directive/Family

Disposition
☐ Remain in Room
☐ Transferred to:
_____

PATIENT LABEL

27

CODE BLUE/CODE WHITE EVALUATION REVIEW FORM

For Quality Purposes Only • * Confidential, protected by California evidence code section 1157

QUALITY OF RESPIRATORY AND CARDIOPULMONARY RESUSCITATION

CPR Quality:

• Was continuous end tidal C02 monitoring (Capnography) used to monitor quality of CPR?	☐Yes ☐No / Not Documented
If yes, was an end tidal C02 value of >10 mmHg achieved?	☐Yes ☐No / Not Documented
• ROSC (Return of Spontaneous Circulation) If achieved, time documented?	☐Yes ☐No / Not Documented
• Was a feedback *device or technology used to monitor quality of compressions? (* e.g, an electronic sensor which connects to a monitoring device to measure= Zoll R series One Step CPR. Complete for compression rate, depth and full chest recoil and hands off timer)	☐Yes ☐No / Not Documented
If Yes, Was a compression rate 100-120/minute provided during CPR (target 110.min)?	☐Yes ☐No / Not Documented
If Yes, Was a compression depth of 2-2.4 inches provided during CPR?	☐Yes ☐No / Not Documented
• Were compressions interrupted (hands off period) for > 10 seconds at any time during CPR?	☐Yes ☐No / Not Documented
• Was CCF % (chest compression fraction) monitored and 60-80% (GOAL >80%)?	☐Yes ☐No / Not Documented
• Was a CPR Coach assigned to monitor the Quality of CPR (Compressions and Ventilation)?	☐Yes ☐No / Not Documented

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

Chest Compression:
☐ Delay ☐ No board ☐ Other (specify in comments section)

Defibrillation(s):
☐ Given, not indicated ☐ Indicated, not given ☐ Equipment malfunction
☐ Energy level lower / higher than recommended ☐ Initial delay, personnel not available to operate defibrillator
☐ Initial delay, issue with defibrillator access to patient ☐ Initial delay, issue with pad or paddle placement
☐ Other (specify in comments section)

Universal Precautions:
☐ Not Followed By All Team Members (specify in comments section)

Documentation:
☐ Signature of code team leader not on code sheet
☐ Incomplete Record ☐ Other (specify in comments section)

Alerting Hospital - Wide Resuscitation Response:
☐ Delay ☐ Pager issue(s) ☐ Other (specify in comments section)

Airway:
☐ Aspiration related to provision of airway ☐ Delay
☐ Intubation attempted, not achieve ☐ Delayed recognition of airway misplacement/displacement
☐ Multiple intubation attempts (# attempts _____) ☐ Other (specify in comments section)

Vascular Access:
☐ Delay ☐ Inadvertent arterial cannulation
☐ Infiltration/Disconnection ☐ Other (specify in comments section)

Leadership/Team Dynamics:
☐ Delay in identifying leader
☐ Knowledge of roles/responsibilities
☐ Knowledge of medications / protocols
☐ Knowledge of equipment
☐ Effective communication
☐ Other (specify in comments section)

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

Protocol Deviation:
☐ BLS ☐ ACLS / PALS ☐ NRP ☐ Other (specify in comments section)

Equipment:
☐ Availability ☐ Function ☐ Other (specify in comments section)

Comments:

_____
_____
_____
_____
_____

☐ RRT trigger(s) present but team not immediately activated
RRT Response Delay
☐ RRT criteria / process not known or misunderstood by those calling RRT.
☐ RRT communication system not working (e.g. phone, operator, pager)
☐ Incomplete or accurate information communicated
☐ Other (specify in comments)
☐ Essential patient data not available
☐ Medication delay
Equipment Issue:
☐ Specify equipment _____
☐ Availability
☐ Function
☐ Issues between RRT team and other caregivers / departments

Comments:

_____
_____
_____
_____
_____

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

SIERRA VIEW
MEDICAL CENTER

Porterville, California 93257

CONFIDENTIALITY AGREEMENT

Sierra View Medical Center (SVMC) CONFIDENTIALITY AND INFORMATION SECURITY AGREEMENT AND ACCEPTABLE USE AGREEMENT (Consolidated)

Purpose: The Health Insurance Portability and Accountability Act (HIPAA) , the Health Information Technology for Economic and Clinical Health Act (HITECH) and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted by law or unless authorized by the patient. These privacy laws apply to all members of the workforce. All SVMC workforce members are required to agree to and sign this agreement.

CONFIDENTIALITY STATEMENT

As an SVMC workforce member, I understand I may be working with confidential patient health and other sensitive information. This information may include, but is not limited to, medical records, personnel information, and financial information, proprietary business information regardless of whether such information is communicated electronically, verbally, graphically or on paper.

I understand and acknowledge that under HIPAA I am required to receive education on privacy and security regulations and organizational policies, procedures and directives relating to the protection of health information. I agree to obtain all required education before I access, use, or disclose any patient information.

I acknowledge it is my responsibility to respect and protect the privacy and confidentiality of patient and other sensitive information. I will not access, use, or disclose patient or other confidential information unless I do so in the course and scope of fulfilling my duties as an SVMC workforce member. I understand that I am required to report immediately any information about the unauthorized access, use, or disclosure of patient information. Initial reports go to my supervisor and to the Privacy Officer at (559)791-3838. If electronic media is involved, I will report the incident to the SVMC Help Desk at (559)788-6090.

I understand and acknowledge that, should I breach any provision of this agreement, I may be subject to civil or criminal liability and/or corrective actions consistent with applicable SVMC policies and/or directives. For more information on HIPAA-related policies, procedures or directives, contact your supervisor.

Initial_____ **Date**_____

INFORMATION SECURITY ACCEPTABLE USE POLICY

Purpose: To establish requirements that all workforce members of SVMC and any other persons with access to SVMC information systems must follow to prevent the improper disclosure of confidential information and to prevent unauthorized persons from gaining access to confidential information. SVMC has a duty to safeguard confidential information available within its information systems and to ensure that any use of its computers, laptops and other electronic devices complies with federal and state laws and regulations, and organizational policies and directives,

Access: The information systems of SVMC are used to further the business and patient care objectives of SVMC and its members. This use is called "acceptable use."

1. Access to SVMC organizational and patient information is permitted only according to approved policies and procedures.
2. All patient information on SVMC information systems are an extension of the medical record and are subject to approved policies and procedures governing patient medical records.
3. Only employees or approved agents of SVMC have access to business applications.
4. Other persons needing access must have a Data Access Agreement in place before being granted access to clinical applications

5. Only the minimally necessary privileges or network services for the performance of assigned job tasks are allowed.
6. Security mechanisms that protect information systems may not be disabled or circumvented for any reason.
7. SVMC Information Security monitors access to SVMC information systems and systems use.

Initial_____ **Date**_____

Passwords: Your password must meet SVMC standards for length and content (IT Information Security Policy).

Initial_____ **Date**_____

Workstation Use: There are many ways in which network resources can be breached through an individual workstation (Workstation Use and Security Policy and E-mail Policy).

1. Do not leave your workstation logged-in or unlocked when you are not present.
2. Do not leave printed material on a printer when you are not physically present.
3. SVMC IT Department determines which hardware and software are installed on workstations and portable computers. Users must not install additional hardware or software without the permission of the IT department. This includes free software or shareware downloaded from the Internet.
4. Do not connect any device to the network without the approval of the SVMC IT department.
5. Report any suspected infection by malware to the SVMC Help Desk.
6. A deliberate introduction of malware onto an SVMC computer will result in corrective action up to and including termination for the user and may be reported to law enforcement.
7. The use of this internet connection for the following activities is strictly prohibited:
    a. Spamming and Invasion of Privacy
    Sending of unsolicited bulk and/or commercial messages over the Internet using this connection or using it for activities that invade another's privacy.
    b. Intellectual Property Right Violations
    Engaging in any activity that infringes or misappropriates the intellectual property rights of others, including patents, copyrights, trademarks, service marks, trade secrets, or any other proprietary right of any party.
    c. Hacking
    Accessing illegally, or without authorization, computers, accounts, equipment or networks belonging to another party, or attempting to penetrate security measures of another system.
    d. Distribution of Internet Viruses, Trojan Horses, or Other Destructive Activities
    Distributing actual or information regarding Internet viruses, worms, Trojan Horses or denial of service attacks. Certain high bandwidth or potentially destructive protocols may not be available on this connection (e.g., bit torrent or p2p).
    e. Export Control Violations
    The transfer of technology, software, or other materials in violation of applicable export laws and regulations, including, but not limited to, the U.S. Export Administration Regulations and Executive Orders.
    f. Other Illegal Activities
    Using this connection in violation of applicable law and regulations, including, but not limited to,advertising, transmitting, or otherwise making available ponzi schemes, pyramid schemes, fraudulently charging credit cards, pirating or inappropriately distributing copy written material, or making fraudulent offers to sell or buy products, items, or services.
8. You understand that SVMC monitors all internet activity and you further understand that you should have no expectation of privacy whatsoever while utilizing this connection.

Initial_____ **Date**_____

Miscellaneous:

1. Patient information or protected health information (PHI) is any information related to the diagnosis, treatment or payment for healthcare that identifies the patient.
2. Patients have specific rights under California Law and HIPAA regarding their rights to privacy and confidentiality. These rights are outlined in our Notice of Privacy Practices.
3. Do not remove or send patient information or other confidential information outside the workplace without authorization.
4. Use an approved fax cover sheet containing the SVMC confidentiality notice with any outgoing fax.
5. Confidential information sent outside of SVMC by email must employ the use of encryption (E-mail Policy).
6. You may not access the medical record or account information of family members, dependents or any other individual, even if the person has signed a valid authorization giving you access or, if you are a legal guardian or personal representative, unless such access is necessary for patient care or to complete your assigned job duties. SVMC will not give you access to the electronic medical record just to look at your own record.
7. Documents containing confidential information must be disposed of in secure shredding bins. Magnetic media (disks, CDs, hard disks, backup tapes, etc.) must be disposed of in accordance with SVMC policies and must be degaussed, shredded, or formatted to render them unusable for retrieving information (Electronic Data Safeguard Policy.
8. Users must observe all intellectual property rights protected by copyright, patent, or trademark.
9. Users may not engage in communications that are threatening, defamatory, obscene, offensive or harassing.
10. Use of systems and other resources for political activity; illegal activities; gambling, or for personal gain or the gain of others for a non-SVMC purpose is prohibited.
11. Violations of this agreement and/or organizational policies relating to the protection of SVMC confidential information and the integrity of its information systems may result in a loss of access to information systems or to civil and criminal liability and/or corrective action consistent with applicable organizational policies.
12. For users that will be accessing the automated dispensing cabinets (i.e Pyxis), you acknowledge that all of your transactions on the system will be permanently recorded with your user ID, date and time stamp. These records will be maintained and archivec per the policies of this hospital; and will be available for inspection by the Drug Enforcement Administration (DEA) and the State Board of Pharmacy, State Board of Health or other auditing agency. Unauthorized access, release or dissemination of information with the system (including passwords) will subject the user to disciplinary action. As the user I acknowledge it is my responsibility to keep my password and BioID access limited for personal access only.
13. Inform supervisors and/or directors of any known or suspected instances of unauthorized use immediately.

Initial_____**Date**_____

Non-retaliation: SVMC will not permit retaliation for reporting a perceived or potential violation of the Code of Conduct, policies, laws or regulations including HIPAA or for participation in an investigation of any alleged violation.

Signature	Printed Name	Date

RETURN A COPY TO YOUR HUMAN RESOURCES DEPARTMENT. HR: RETAIN FOR DURATION OF EMPLOYMENT + 6 YEARS.

SIERRA VIEW MEDICAL CENTER **PHYSICIAN ORDERS**

TREATMENT

ALL ORDERS MUST BE DATED, TIMED AND SIGNED BY THE PRESCRIBING PHYSICIAN
Physicians: Please indicate your orders by checking the boxes or filling in the blank spaces below

PRE-OPERATIVE

- ❑ No lab work required
- ☑ HCG Female 10-55 or onset menses and post menopause (12 consecutive months without a menses.) Unless sterilized.
- ☑ Fingerstick glucose for diabetics

IVs

- ❑ LR 1000ml @ /hr
- ❑ NS 500ml @ TKO

- ❑ Tap Water Enema until clear for colonoscopy patients **ONLY**
- ❑

INTRA-OPERATIVE

- ❑ Fentanyl IVP give _____ mcg every _____ minutes PRN to maximum _____ mcg
- ❑ Demerol IVP give _____ mg every _____ minutes PRN to maximum _____ mg
- ❑ Versed IVP give _____ mg every _____ minutes PRN to maximum _____ mg
- ❑ O2 3 liter N.C.
- ❑ Benzocaine (Hurricane 20% spray) Topical x 1 for EGD's
- ❑ Lidocaine Jelly 2% 5ml Top to anus
- ❑ Other

POST-OP

- ☑ Routine recovery care
- ☑ Fingerstick glucose for diabetics
- ☑ Discharge from Recovery Area when discharge criteria met.

ALL ENDOSCOPY PATIENTS:

- ☑ Vital signs every 10 minutes x 3
- ☑ Clear liquids first. If tolerated, soft diet later. Advance as tolerated
- ☑ Dulcolax 10 mg suppository PRN gas pain
- ☑ Discharge from recovery area when discharge criteria are met.
- ☑ Rest at home today
- ☑ No driving or working with dangerous machinery for 24 hours
- ☑ Follow-up as scheduled
- ☑ Instruct the patient to call MD or go to the Emergency Department if severe vomiting, abdominal pain, fever or bleeding occurs
- ☑ If a polyp has been removed or biopsy taken, do not ingest aspirin or anticoagulants for _____ days.

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **TIME:** _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

MODERATE SEDATION ORDERS - ENDOSCOPY

Form # 014044 REV. 2/24

PATIENT'S LABEL

Senior Leadership Team	4/23/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	4/23/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
April 23, 2024
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	Action
		Approve ↓
Policies:		
• Authorized Drivers Program	1-5	
• Medical Record Retention and Destruction	6-9	
• Patient Safety Plan	10-16	
• Pre-Employment Fitness for Duty Evaluations	17-24	
• Salary Grades and Ranges	25-27	
• Shared Governance and Management Authority and Responsibility Matrix	28-37	
• Strategic Plan	38	
• Subpoenas, Summons and Complaints, Handling of	39-40	
Letters:		
• Congress Letter Cybersecurity Attack on Change Healthcare	41-49	
Report:		
• HR Annual Report	50-56	

SUBJECT: **AUTHORIZED DRIVER'S PROGRAM**	SECTION:

PURPOSE:

To establish guidelines for employees who drive vehicles for District use and ensure drivers are authorized to drive for District business. The District participates in the California Department of Motor Vehicle (DMV) Employer Pull Notice Program (EPN). (The Risk Management Department monitors the Motor Vehicle Records (MVRs) and maintains an "Authorized Driver List.")

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to ensure that employees' who drive District owned and private vehicles for District use are Authorized Drivers.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES WHOM ARE REQUIRED AS PART OF THEIR JOB TO DRIVE A HOSPITAL VEHICLE OR THEIR OWN VEHICLE FOR DISTRICT BUSINESS.

PROCEDURE:

1. An applicant applying for a position which will require driving on behalf of the District on a regular basis (at least once per week) will be required to be an Authorized Driver. The applicant must complete an Authorization for Release of Driver Record Information (Attachment A). Human Resources will forward the release to the Risk Management Department. This policy applies to employees driving District vehicles and their private vehicles for District use.

2. An employee who has excessive motor vehicle infractions shall not be considered for such program. Excessive is defined as:

    a. More than three moving citations during a three year period, or
    b. More than two moving citations and an at-fault accident during a three year period, or
    c. Any serious infraction such as DUI, reckless driving, participation in a speed contest, etc., or loss of driver's license within the last three years.

3. The Authorized Driver is required to abide by all local, state and federal traffic laws and regulations.

4. The Authorized Driver is responsible for maintaining a current valid CA driver's license and shall notify his/her director and the Risk Department in the event his/her license is suspended or revoked or has excessive motor vehicle infractions.

5. The Risk Department will evaluate the Authorized Driver's MVR's on an on-going basis through notification of incidents and DMV reports for excessive infractions. Sierra View Medical Center reserves the right to deem employees ineligible if they do not qualify for the Authorized Driver's Program.

6. The Risk Management Department will remove the Authorized Driver from the DMV Employer Pull Notice Program upon a job change to a non-driving position or termination of employment.

7. The Authorized Driver's Program is optional for those employees who drive personal vehicles for District business, but not on a regular basis.

Unsafe Drivers:

1. The Risk Management Department will notify the Authorized Driver's director if the Authorized Driver's MVR reflects excessive infractions. An Authorized Driver deemed to be an unsafe driver due to excessive motor vehicle infractions, when possible, will be placed in a position, which does not require driving on behalf of the District. This may result in the employee's termination in the event that no non-driving positions are available for which the employee is qualified.

2. Excessive motor vehicle infractions include both the use of the Authorized Driver's own personal vehicle as well as the District's vehicles.

3. It shall be the responsibility of the Authorized Driver's director, upon notification that an Authorized Driver is considered to be an unsafe driver, to ensure that the Authorized Driver does not drive on behalf of the District under any circumstances.

4. It shall be the responsibility of the Risk Department to:

- Provide the Authorized Driver with written notice that he/she can no longer drive on behalf of the District; and

- Send a copy of the written notice to the Human Resource Department.

Personal Vehicles:

1. Authorized Driver's vehicles used on District business shall be maintained in good working order at all times.

2. An Authorized Driver's personal vehicle insurance shall be primary applicable coverage when using their own vehicle on business in the event that an accident occurs. If the Authorized Driver was not at fault, the District will reimburse its driver for his/her out-of-pocket deductible up to $500.00.

3. The District's automobile insurance shall provide excess coverage for third party liability purposes only. The District maintains no coverage for damage to the Authorized Driver's vehicle, therefore it is:

   a. Required that employees using their own personal vehicles maintain at least state mandatory limits of liability insurance.

4. Failure to comply with this policy and procedure shall revoke participation in the Authorized Driver Program.

Rental Vehicles:

1. Refer to Attachment B

Reporting Motor Vehicle Incidents:

1. Authorized Drivers must report all motor vehicle incidents immediately to their director and the Director of Quality & Patient Safety.

2. Authorized Drivers must provide a copy of a police report when applicable.

3. To submit a claim, an Authorized Driver must complete a claim form and submit to the Office of Risk Management.

4. Determination of eligibility of claims reimbursement will be made upon completion of the investigation conducted by Risk Management.

Transporting Patients:

1. Under no circumstances shall Authorized Drivers transport patients using either the District's, employee's or patient's vehicle.

REFERENCES:

- DMV Employer Pull Notice Program (2021). Retrieved from https://www.dmv.ca.gov/portal/vehicle-industry-services/motor-carrier-services-mcs/employer-pull-notice-epn-program/.

Attachment A

Driver's Agreement:

While an employee of Sierra View Medical Center and a participant in the Employer Pull Notice program, I hereby agree to the following:

- Maintain a current, valid California driver's license
- Maintain at least state required limits of liability insurance/evidence of financial responsibility on my vehicles (such limits may not be adequate and I should consider higher limits for my own protection), and
- Drive safely and abide by all local, state and federal traffic laws and regulations.
- Complete and sign the Authorization For Release of Driver Record Information.
- Report any motor vehicle incidents within 48 hours to my department director and the Director of Quality & Patient Safety, as outlined in the policy and procedure.
- Notify my director and the Director of Quality & Patient Safety in the event my license is suspended or revoked or has excessive motor vehicle infractions.

☐ My signature acknowledges I am in receipt of a copy of the Authorized Driver's Program policy and will abide by the terms and conditions.

_____ Print Name

_____ Department

_____ Signature

_____ Date

Attachment B

Important Information You Should Know When Renting a Car On a Business Trip

1. Always name Sierra View Medical Center in the rental agreement. Some rental agencies may want the name of the person in whose name the credit card is issued and whose personal auto policy may be brought into play. Just make sure Sierra View is named on the rental agreement so the Sierra View commercial policy can respond.

2. Obtain a Certificate of Insurance from the Risk Management Dept. to carry with you. This provides you with the evidence of Sierra View insurance coverages in effect. Should you have an accident, show this certificate and the car rental agreement to the law enforcement officer.

3. Purchase the LDW (loss damage waiver) protection.

4. The Sierra View insurance policy, your credit card, or LDW protection, will not protect you if you allow someone to drive the auto that is not listed on the rental contract. You are 100% responsible for the vehicle's damage and down time.

5. When traveling to foreign countries, local automobile insurance should be purchased.

6. You may be held responsible if the keys are left in the car, or in some cases, seat belts are not worn at the time of the accident. This could void any rental insurance coverage purchased.

7. Driving under the influence can void rental insurance coverage.

8. Do not assume you have automatic protection as long as you rent with a major credit card. Most companies have removed this coverage.

9. Even if your prime insurance protects you for rental cars, your insurance company can deny your claim if the rental agency makes repairs to the auto before your insurance company inspects the auto.

10. Most credit cards companies or private insurance policies will not extend to rented vans or pickups.

SUBJECT:	SECTION:
MEDICAL RECORD RETENTION AND DESTRUCTION: DISPOSAL OF PROTECTED HEALTH INFORMATION	**Page 1 of 4**

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

PURPOSE:

This policy serves to outline the retention period and storage modalities for medical records within the organization; to establish the conditions and time periods for which medical records will be stored, retained, and/or destroyed after they are no longer active for patient care or business purposes; and to ensure appropriate availability of medical records.

DEFINITIONS:

MEDICAL RECORD – All documents, regardless of physical format, that hold demographic and medical information about a patient. Only the documents that are part of the designated record set are subject to the retention schedule.

ELECTRONIC RECORD – Any combination of text, graphics, data, audio, pictorial or other information represented in digital form that is created, modified, maintained, archived, retrieved or distributed by a computer system. Electronic records must be capable of generation in both human-readable and electronic form suitable for inspection, review and copying. Electronic records may be considered legal records and are managed according to their content.

ACTIVE RECORDS – Those medical records that will likely be needed for a short timeframe for day-to-day patient care purposes.

ARCHIVED RECORDS – Those medical records that are less likely to be needed on a day-to-day basis, but which have not reached the end of their specified retention period. These records are usually referenced or assessed infrequently.

RETENTION PERIOD – The period of time during which medical records must be maintained by an organization because the records have administrative, fiscal, legal, medical or other value.

RECORD RETENTION SCHEDULE – A schedule of standard and/or legally required retention periods for each type of record, considering the administrative, fiscal, legal, medical and historical value of those records.

DESTRUCTION OF RECORDS – Any action that prevents the recovery of information from the storage medium on which it was recorded. Method of destruction must be appropriate to the medium on which it is stored.

ARCHIVING/STORAGE OF RECORDS – The act of physically moving inactive or other records to a storage location until the record retention requirements are met or until the records are needed again.

STORAGE OF RECORDS – Storage areas for inactive records can include either an area inside the facility that has been approved for records storage use, or an off-site, private, professional record storage facility with which Sierra View Medical Center has an active contract for storage and retrieval services. NOTE: Storage warehouse, mini-storage facilities, and off-campus personal or rental property, including garages, basements, homes, trailers, etc., are NOT acceptable for storage of inactive medical records.

AFFECTED PERSONNEL/AREAS: *ALL HEALTH INFORMATION MANAGEMENT STAFF*

PROCEDURE:

This policy shall apply to health information that is generated during provisions of health care to patients in any of the hospital's patient care units, patient care departments, or hospital practices or by any of the hospital's agents in all of Sierra View's units, departments, and hospital-owned facilities.

1. Record Retention

    a. Record retention may be in the form of electronic medical records, paper documents, microfilm, electronic data storage, etc., but must be maintained in such a way that the information is available for clinical reference upon request. Opportunities for loss and/or damage must be minimized, and records must be secured to prevent unauthorized access.

    b. All clinical and administrative Sierra View Medical Center medical record information prior to document imaging (in the form of paper) will be kept for ten years after discharge or service date for inpatient and outpatient encounters. Pediatric charts will be retained for 20 years. The following will be kept indefinitely:

        - Master patient index
        - Death Register.
        - Surgery Register; and
        - Transplant Register

    c. Sierra View Medical Center medical record documents that are scanned and stored in the Legal Electronic chart and Enterprise Medical Record system will be available in electronic image format according to the guidelines listed above. The paper copy will be maintained for ninety days and then destroyed according to policy.

    d. Other acquired documentation from outside resources used for clinical decision making and treatment planning will be scanned and stored in the Legal Electronic chart and Enterprise Medical Record system and will be available in electronic image format according to the guidelines listed above. The paper copy received from outside facilities can be destroyed once appropriately (readable) scanned into Meditech.

2. Record Destruction and Disposal

   The destruction and disposal of PHI will be carried out in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations

   a. No protected health information will be destroyed before the minimum retention period has been met as indicated above.

   b. Confidential information includes that which contains PHI of a patient, relative or household member of a patient. All documentation containing PHI must be destroyed in a manner that prevents reconstruction. Destruction will be in the following manner:

• Paper	incinerating, shredding, or pulverizing
• Computerized data	in accordance with SVMC policies
• Radiology films	shredding or pulverizing
• Laser disks (WORM)	pulverizing
• Microfilm/fiche	shredding or pulverizing
• Patient labels	shredding
• Patient label ink cartridges	shredding

   c. Any documentation containing PHI must be personally shredded or placed in a secure recycling container. PHI must not be discarded in trash bins, unsecured recycling containers and other publicly accessible locations.

   d. Information Technology must be contacted to coordinate the destruction of any computerized media.

   e. Destruction of the legal medical record must be documented and maintained permanently and include the following:

      - Date of destruction
      - Method of destruction
      - Description of the destroyed documents
      - Inclusive dates covered
      - Statement that the records were destroyed in the normal course of business
      - Signatures of the individuals supervising and witnessing the destruction

   If destruction services are contracted, the contract must meet the requirements of the HIPAA privacy and security rules and a Business Associate Agreement must be executed with the contractor.

   Contracts between the hospital and its business associates will provide that, upon termination of the contract, the business associate will return or destroy and dispose of all consumer health information. The destruction of PHI by the business associate will be

documented in writing and sent to the hospital and include the information provided in Section 2e.

If such a return is not feasible, the contract will limit the use and disclosure of the information to the purposes that prevent its return or destruction and disposal.

REFERENCES:

- California Health and Safety Code § 123149 (2023). Retrieved from: https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-123149/#:~:text=(a)%20Providers%20of%20health%20services,additional%20requirements%20of%20this%20section.

- Title 22. California Code of Regulations. § 70751 (2024). Retrieved from: https://govt.westlaw.com/calregs/Document/IB47D04195B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

- Centers for Medicare & Medicaid Services (2012). CMS MLN Matters Special Edition 1022. *Medical Record Retention and Media Formats for Medical Records*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1022.pdf.

- Centers for Medicare & Medicaid Services (November 1, 2019). CMS General Information Eligibility, and Entitlement Manual Chapter Seven, 30.30.1.4. *Disposition for Medicare Records that are Imaged/Scanned*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c07.pdf.

CROSS REFERENCES:

- Records Management
- Legal Medical Record Standards

SUBJECT: **PATIENT SAFETY PLAN**	SECTION: *Leadership (LD)* **Page 1 of 7**

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

PURPOSE:

To establish an organizational-wide patient safety plan that promotes a culture of quality and patient safety.

POLICY:

To provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety throughout the organization. This will be accomplished through the establishment of a Patient Safety Committee whose responsibilities will be to:

- Support effective responses to Patient Safety Events;
- Integrate patient safety as a priority into new processes and the redesign of existing processes, functions, and services;
- Minimize individual blame or retribution for involvement in a patient safety event and reporting;
- Champion organization-wide education related to safety, risk reduction, and reporting of potential unsafe events or adverse outcomes;
- Promote an ongoing proactive approach to reducing risk.

AFFECTED AREAS/PERSONNEL:

ALL EMPLOYEES, MEDICAL STAFF, CONTRACTORS, STUDENTS, VOLUNTEERS.

DEFINITION:

Patient Safety Event: An adverse sentinel or potential adverse sentinel event, as described in HSC § 1279.1(b), that is determined to be preventable, e.g. to include misconnection of intravenous, enteral and epidural lines as well as preventable healthcare-associated infections (HAIs) as defined by the National Healthcare Safety Network or the Healthcare Associated Infection Advisory Committee. Refer to House-wide Policy & Procedures: *Patient Safety Event, and Serious Clinical Adverse Event.*

CORE PRINCIPLES AND RESPONSIBILITIES:

A. Performance Improvement and Patient Safety Committee (PIPS)

1. The Board of Directors has the ultimate authority and responsibility to require and support a patient safety program. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California Evidence Code, Section §1157.

2. The Performance Improvement/Patient Safety (PIPS) Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from other committees, departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization.

3. The PIPS Committee shall recognize and reinforce that members of the medical staff are responsible for making medical treatment decisions for their patients.

Membership:

The Patient Safety Committee will report to the PIPS Committee quarterly. The Patient Safety Committee consists of the following members and others as the committee may call on, to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

- Vice President of Quality and Regulatory Affairs (Executive Sponsor)
- Patient Safety Officer
- Patient Safety Nurse
- Wound Care Nurse
- Director of Pharmacy
- Performance Improvement Specialist
- Maternal Child Healthcare Leadership
- Medical Surgical Nursing Unit LeadershipCritical Care Services Leadership
- Surgical Services Leadership
- Emergency Department Leadership

Responsibilities:

The Patient Safety Committee will meet at least quarterly, shall maintain a record of its proceedings and activities, and shall report findings, conclusions, recommendations and follow-up to Performance Improvement/Patient Safety Committee, Medical Executive Committee and the Board of Directors.

The Committee will do all of the following:

Receive and review reports of patient safety events to include, but not limited to:

a. All serious clinical adverse events (Patient Safety Events). (Refer to House-wide policy: *Serious Clinical Adverse Event).*

b. Hospital acquired infections (HAI) that are determined to be preventable. (Refer to House-wide policy, Infection Prevention Plan).

Monitor implementation of corrective actions for patient safety events.

Make recommendations to eliminate future patient safety events. The Patient Safety Committee has adopted the failure mode and effects analysis model for proactive process redesign.

Review and revise the Patient Safety Plan at least annually and more often if necessary to evaluate and update the patient safety plan and to incorporate advancements in patient safety practices.

B. Reporting System for Patient Safety Events

The facility has established a reporting system for patient safety events that allows anyone involved, including, but not limited to, healthcare practitioners, employees, patients and visitors, to make a report of a patient safety event to the hospital. Refer to House-wide policy, *Serious Clinical Adverse Event.*

C. Analysis of Adverse Events

The facility has defined and established a policy that outlines the actions to be taken in response to an adverse event. (Refer to House-wide policies *Patient Safety Event and Serious Clinical Adverse Event).*

D. Culture of Safety

Sierra View Medical Center has adopted a just culture model that supports and encourages occurrence reporting, whereby enabling the hospital to carry out its responsibility for providing quality care in a safe environment.

E. Education and Training

Staff and healthcare practitioners receive education and training on hire and during initial and annual orientation on issues regarding job-related aspects of patient safety, including Just Culture and Systems Theory. Records of such education are maintained.

F. Disclosure

Patients, and when appropriate, their families, are to be informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. (Refer to House-wide policy and procedures, *Serious Clinical Adverse Event).*

G. National Patient Safety Goals

Implement the Joint Commission recommended goals through education and monitoring activities to ensure compliance with the standards.

H. Leadership (LD 03.01.01)
Consider information from patient, family, staff and other individuals related to their opinions, needs and perceptions of risks to patients and suggestions for improving patient safety.

SCOPE OF ACTIVITIES

Performance/Quality Improvement

1. Establish measurable objectives for improving patient safety and quality. Measurable objectives shall be based on the elements of patient safety and error reduction, which are described in this plan.

2. Review and disseminate available information about the Joint Commission Sentinel Event Alerts. Review current process and analyze recommendations listed in the Sentinel Event Alert. Implement appropriate action to improve processes related to patient safety.

3. Assure that prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.

4. Assure that when organizational processes are designed or redesigned, information from other organizations related to potential risk to patient safety, including occurrence of sentinel events, is reviewed and risk reduction strategies are incorporated.

5. Perform a Healthcare Failure Mode Effect Analysis (HFMEA) as required and selected based on information published by the Joint Commission related to patient safety and medical errors and/or through identification of a high-risk problem prone process.

Patient Safety

1. Perform an annual risk assessment and prioritize goals in collaboration with hospital leaders to reduce the risk of patient safety events. (Refer to House wide Policy & Procedure, *Risk Management Plan*).

2. Develop an organization-wide approach to the reporting and evaluation of unusual occurrences.

3. Review all occurrence reports, and when appropriate, develop a thorough and credible root cause analysis, appropriate plan of correction and follow up plan. (Refer to House Wide Policy & Procedure, *Serious Clinical Adverse Event*). All sentinel events will be reported to, evaluated and monitored for completion by the Patient Safety Committee and will be reported to the Performance Improvement/Patient Safety Committee.

4. Develop procedures for immediate response to unusual occurrences, including care of the affected patient, care of involved clinicians, containment of risk to others and preservation of factual information for subsequent analysis.

5. Develop systems for internal and external reporting of information relating to unusual occurrences.

Aggregate and trend all risk management information/data to identify patterns in processes or outcomes, which may lead to untoward patient events. Evaluate patient grievances and complaint trends and patterns.

Human Resources

1. Assure patient safety information is presented to all new employees as part of the New Hire Orientation Program.

2. Define a mechanism for the support of staff that are involved in medical errors and sentinel events. Provide individuals emotional and psychological support through Care for the Caregiver Program and/or Employee Assistance Program (EAP). Members of the Medical Staff can be referred to the Care for the Caregiver program and/or Medical Staff Office for assistance.

Education

1. Ensure all staff members participate in ongoing in-services, education, and training to increase his or her knowledge of job-related aspects of patient safety. Patient safety information is included in staff annual orientation and training.

2. Assure that ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.

Infection Prevention

1. Perform an annual risk assessment and prioritize goals in collaboration with hospital leaders to reduce the risk of transmission of infections and prevent Hospital Acquired Infections (HAI). (Refer to House wide Policy & Procedure, *Infection Prevention Plan*)

2. Conduct infection prevention activities and surveillance to monitor HAI as outlined in the Infection Prevention Plan.

3. Assist with methods to reduce surgical site infections as designed in the Surgical Care Improvement Project.

4. Monitor infections related to indwelling lines, to include but not be limited to, intravenous, enteral, and epidural lines and indwelling catheters.

Pharmacy

1. Ensure safe and optimal use of medications to improve patient's clinical outcomes.

2. Assist with procurement, distribution, storage, dispensing and safe use of pharmaceuticals for patients.

3. Assure that process and product-purchasing decisions support the safe use of intravenous lines to include safeguards such as unique connection ports that prohibit the use of any intravenous, epidural, or enteral feeding line to be used for anything other than its intended purpose except in emergent situations.

4. Facilitate improvement initiatives through the Medication Safety Committee that reduce medication-related patient safety events.

Environment of Care (Safety Officer)

1. Assure that measurements related to patient safety and error reduction are incorporated in the seven (7) plans of the Environment of Care.

2. Aggregate, assess and report organizational data related to patient safety events, intervention and follow-up.

National Patient Safety Goals for Hospitals:

Sierra View Medical Center will follow and educate yearly on patient safety goals, released by the Joint Commission.

National Quality Forum's Four Safe Practices:

Develop structures, programs, policies, and practice that support the National Quality Forum's (NQF) four safe practices involved in creating and sustaining a patient safety culture which includes:

1. Improve the accuracy of patient identification

2. Improve the effectiveness of communication among caregivers,

3. Improve the safety of using medications,

4. Reduce the harm associated with clinical alarm systems.

Compliance with this goal will be guided by the principles as outlined within the Consensus Report: NQF Safe Practices for Better Healthcare – 2010 Update, and monitored by the Patient Safety Committee with results reported to and measured annually by the Leapfrog Group via the Leapfrog Group's Hospital Safety Score.

REFERENCES:

- California Evidence Code 1157, § Title 22 (2017).

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Health and Safety Code § 1279.1(b), 1279.6 and 1279.7.
- Meyer, G., Denham, C. R., Battles, J., Carayon, P., Cohen, M. R., Daley, J., McAuliffe, M. (2010). Safe Practices for Better Healthcare-2010 Update. National Quality Forum Safe Practices, 1-406.

CROSS REFERENCES:

- SERIOUS CLINICAL ADVERSE EVENT
- ANNUAL INFECTION PREVENTION PLAN
- JUST CULTURE
- PATIENT SAFETY EVENT
- RISK MANAGEMENT PLAN

PURPOSE:

To define the pre-placement,annual and periodic requirements for protecting the health and safety of employees and patients.

POLICY:

Pre-placement, annual/periodic and fitness for duty health screenings are performed on current and prospective employees to ensure they are free of communicable disease and to determine their physical and mental ability to perform within a job classification without endangering their own health and safety, the health and safety of patients, or their fellow employees.

AFFECTED AREAS/PERSONNEL: *ALL SIERRA VIEW MEDICAL CENTER (SVMC) EMPLOYEES*

PRE-PLACEMENT REQUIREMENTS

A. An offer of employment is contingent upon successful completion of the pre-placement process. All required screenings are provided by SVMC free of charge and does not reimburse these fees if the applicant elects to complete these services offsite.

1. Clearance is based on findings related to screening test results, the history and physical findings, and the applicant's ability to perform within the essential requirements of the job description and essential physical demands of the position.

B. All prospective employees must complete a history, physical, and required screening tests prior to the date of hire.

C. The history, physical and screening includes, but is not limited to, the following:

Performed by a designated Medical Practitioner

1. Completion of a health history.

2. Examination based on significant findings in the health history and vital signs.

3. Visual acuity and color vision testing.

Performed at SVMC's Employee Health Department

1. Tuberculosis screening.

2. Evaluation of immunization status for vaccine preventable diseases related to the potential for occupational exposure.

3. Drug screening for safety sensitive positions.

4. Mask Fit Test

5. Examinations and/or tests identified to be necessary for the determination of the ability of the applicant to perform the essential duties of the position offered.

   a. Additional records such as disability ratings and permanent restrictions may be required prior to determination of the prospective employee's ability to perform in a specific position.

D. Accommodation of prospective employees unable to perform within the requirements of the job description will be evaluated in compliance within Americans with Disabilities Act (ADA) regulations.

1. The Human Resources Representative and Department Director will be included in the determination of accommodations or the inability of the facility to accommodate a prospective employee.

E. Failure to provide information regarding prior or current injuries and/or illness, whether work related or not, may be sufficient grounds for withholding clearance for employment or immediate release from employment.

ANNUAL AND PERIODIC EVALUATION/SCREENINGS– RETURN TO WORK-FITNESS FOR DUTY-JOB TRANSFER

A. Annual and/or periodic evaluations and screenings are provided in the following conditions, but not limited to:

1. Required by Regulation from local, state and federal recommendations or mandates For those job categories or departments that require screening as outlined in the regulatory requirements and SVMC's policies, procedures and practices.

2. Fitness for Duty: At the request of Human Resources/Employee Health Services (EHS) who have a valid concern that an employee is working in an unsafe manner that could cause harm to self or others, has a physical or mental impairment, or following a significant change in health due to a serious health condition.

3. Request for Accommodation: At the request of an employee who seeks a job restriction or job accommodation.

4. Job Transfer: When a job transfer is made to a position that is significantly different in scope and skills, the employee must be cleared through Employee Health prior to placement.

a. Assessment is made to determine the ability of the employee to perform the essential functions of the job, job accommodations, need for education, and communicable disease surveillance.

5. New baseline screening for infectious diseases may be added to annual evaluations to meet infection prevention criteria.

6. Screenings for infectious diseases may be required periodically due to emergency disasters and pandemics.

B. Evaluations for the above conditions may include:

1. **Personal health review.**

a. A review of illnesses during the past year, especially absences due to illness, to verify, to the extent reasonably possible, that an individual is able to continue performing assigned duties and continues to be free of infectious disease.

2. **Screening Test** as indicated by response to the health review, as required by regulations or job duties. May include:

a. Breath, blood and/or urine drug screen.

b. Blood alcohol level

c. Tuberculin screening.

d. Other diagnostic/screening tests.

e. Respirator fit testing.

f. Other medical surveillance

C. Human Resources and Employee Health Services (EHS) will evaluate with the employee, any noted restrictions and the ability of SVMC to accommodate them. If it is determined that the employee is unable to perform assigned duties, or no reasonable accommodation can be made, the Department Director will be advised.

TUBERCULOSIS SCREENING - INITIAL-PERIODIC-ANNUAL

A. TB Surveillance is performed during the pre-placement exam and at least annually **(in the month of May)** to screen all SVMC Employees for Latent Tuberculosis Infection (LTBI). All

employees must complete required skin testing or screening questionnaire for positive convertors each May.

1. Tuberculin Skin Test (TST) done at another facility will be accepted if completed between January and May of the current year.

2. On those occasions where the employee chooses to have TST read by a trained individual other than EHS, it is the responsibility of the employee to provide EHS with documentation.

3. After May 31, non-compliant employees will be placed on administrative leave.

B. Tuberculin Skin Testing/TST (Mantoux technique), questionnaire and/or chest x-ray (if there is a history of a positive skin test), are current methods for screening for tuberculosis.

1. A TST Mantoux will be placed for pre-employment, annualand post exposure for employees that have had negative TST in the past. A baseline TST completed elsewhere will be accepted as part of the 2 step onboarding requirement if completed within 2 weeks of start date.

2. Pregnancy is NOT cause for deferring TSTs.

C. For employees with a history of a positive TST, the TB questionnaire will be reviewed by the employee health nurse and employees with questionable signs and symptoms for tuberculosis will be sent for a chest x-ray.

D. At time of hire, if it has been more than 12 months since a TST was placed, or documentation of TST within the last 12 months cannot be provided, the prospective employee will have another TST (2-Step TST) placed at least one week but no longer than 3 weeks after the first negative test. If the employee fails to have completed this by the end of the third week, they will be removed from the schedule.

E. Employees who convert from negative to positive results from TST or have an initial positive test will be evaluated and treated according to guidelines from the California Department of Public Health.

1. If a skin test is positive, a chest x-ray will be performed to determine evidence of active TB. Current positive reactors are required to have a chest x-ray when symptoms are present during their annual questionnaire screening.

a. Prospective employees in the new hire process will be directed to follow-up with their health care provider or county of residence for possible treatment of latent TB. New hires with a previous positive will complete a baseline questionnaire and X-ray within two weeks of start date. SVMC will accept a prior X-ray as

long as it is less than three (3) months old from hire date per TCPH department's recommendation.

b. If the potential employee has symptoms of active TB or a chest X-ray suggestive of active TB, they will not be cleared to work and will be sent directly to their healthcare provider or the County Health Department.

- Documentation of findings and any necessary treatment for active disease will be completed before the prospective employee will be considered for placement, and they will be referred to their primary care physician.

VACCINE PREVENTABLE DISEASES – IMMUNIZATIONS

A. All employees are tested for and offered immunizations to vaccinate against preventable diseases without cost, if determined to be susceptible to these diseases.

Employees will be required to sign consent for each vaccine administered or sign the declination if they are determined to be susceptible but decline immunization.

If an employee declines a vaccine for a disease they have been determined to be susceptible to, they may later request to be vaccinated.

B. Education regarding the benefits of vaccination and the potential health consequences of disease or illness for themselves, their family members, and patients is provided. The current Vaccine Information Statement (VIS) on the vaccine is provided and the employee is given an opportunity to ask any questions related to the vaccine.

C. Failure to complete mandatory testing, immunizations, or declination documentation within 90 days of hire will result in removal from the schedule or suspension until completed.

D. Immunization is provided for employees as follows:

1. **Tdap** (Tetanus, Diphtheria and Acellular Pertussis)

   a. One (1) time if no prior Tdap.

2. **MMR** (Rubella, Rubeola and Mumps)

   a. Two (2) doses of MMR given at least 28 days apart if Rubeola titer is not sufficient.

   b. One (1) dose of MMR if Rubella titer or mumps is not sufficient.

3. **Varicella** (Chickenpox)

a. Two (2) doses given at least 4 weeks apart, if titer is not sufficient.

4. **Hepatitis B** Vaccine is available to all employees.

a. Three (3) doses of vaccine administered over a six-month period.

b. A hepatitis B antibody screen will be done one (1) month after the third dose.

c. Those not responding to the vaccine will be given the option of a booster or repeating the series.

d. Employees may decline the vaccine and may receive the vaccine at any time following declination.

5. **Influenza Vaccine**

a. Annually, every employee must either be vaccinated, provide documentation of vaccination, or sign a written declination.

b. Employees who decline will be required to wear a surgical mask while within three (3) feet of patients, visitors, or other Healthcare Professionals (HCP) for the duration of the flu season as designated by Infection Prevention, but no sooner than March 31st.

6. Other vaccines or medications available will be administered during outbreaks or as advised by the Infection Prevention Committee/Advisor.

DRUG SCREENING

A. All drug and alcohol tests, pre-placement and reasonable suspicion are administered according to National Institute on Drug Abuse standards.

1. Federal standards are recognized when determining results of a drug or alcohol test.

2. Positive results are reviewed by the contracted Medical Review Officer (MRO).

3. If the MRO confirms a positive result, Employee Health Services will notify Human Resources:

a. The applicant is not eligible for hire and Human Resources will communicate withdrawal of the job offer.

b. The employee for reasonable suspicion testing is positive and Human Resources will take the appropriate action.
(*For more information please refer to the policy on "Drug and Alcohol in the Workplace")*

COMPLIANCE

SVMC employees, at time of hire, agree to participate, as directed, in emergencies and community disasters during scheduled and unscheduled hours. As a designated disaster service worker, SVMC employees are required to assist in times of need pursuant to the California Emergency Services Act. (Gov.t Code 3100, 3102.) Given the level of risk to infectious diseases during pandemics, SVMC employees are expected to comply with local, state, and federal regulatory recommendations and mandates as outlined by the regulatory agency. Failure to do so can constitute a safety risk which will be evaluated by Risk Management and Human Resources.

Employees who fail to comply with the required health evaluations, screenings, and fitness for duty evaluations as outlined in this policy on a routine basis, and in periodic times of health disasters, present a safety risk to themselves or others. Employees failing to comply may be subject to disciplinary action up to and including separation.

REFERENCES:

- California Code of Regulations, Title 22, §70723., 2017.
- California Emergency Services Act, (Gov.t Code §3100. 3102).
- Centers for Disease Control and Prevention (CDC) (2016): Tuberculosis. Retrieved on 02/02/18 from https://www.cdc.gov/tb/topic/testing.
- Centers for Disease Control and Prevention (CDC) (2019) : Guideline for infection Control in Health Care Personnel.
- Evans, G. (2012). A house divided: A muddled mandate on health care worker flu shots goes to HHS. Hospital Infection Control and Prevention: 39: 3.
- The Joint Commission, (2021). 2021 hospital accreditation standards. Oak Brook, Illinois.
- California Department of Public Health

CROSS REFERENCES:

- DRUGS AND ALCOHOL IN THE WORKPLACE Link

- EQUAL EMPLOYMENT OPPORTUNITY Link
- REASONABLE ACCOMODATIONS Link

SUBJECT: **SALARY GRADES AND RANGES**	SECTION: ***Human Resources*** **Page 1 of 3**

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

PURPOSE:

To define the manner in which Sierra View Medical Center (SVMC) administers salary. This includes the assignment of wage pay grades and salary ranges which are established and administered for all positions at SVMC.

POLICY:

To ensure the fair and consistent practice of administering rates of pay, all non-exempt and exempt positions are classified into one of a series of pay grades and salary ranges.

Pay Grades –Jobs of approximate equal value, as determined by job content and evaluation methods, are grouped together. Pay grades are established as a tool for organization and management of the wage administration system.

Salary Ranges – Structures containing a reference to wage minimums and maximums for the pay grade. An employee's actual base hourly rate of pay falls within the salary range for their job classification. Employees shall not be paid less than the pay range minimum or more than the pay range maximum.

Wage Tiers – A one-dimensional expression of an actual base hourly rate of pay with no minimum or maximum wage range. Salaried tiers are not expressed as a salary range, and therefore their job titles are not listed with a grade and range reference. Tier wage structures are listed independently for grouping like positions.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES/CONTRACTORS*

PROCEDURE:

Comparison with wage surveys throughout the year ensures competitiveness and external equity for pay ranges and tiers. At times, market conditions may indicate a need to increase pay grades and tiers for certain positions.

SVMC shall participate in the California Hospital Association's (CHA) annual compensation survey and use published results to determine external wage competitiveness when appropriate. Comparative wage surveys from professional organizations may be used for job classifications that are not surveyed by the CHA. The Human Resources department shall direct the participation of the survey process. Specific external market conditions may require more frequent analysis for specific job classifications when responding to unusual market or staffing situations.

WAGE STRUCTURE:

1. The District maintains wage pay grades and salary range structures, defined as salary range minimums, midpoints and maximums. Individual positions are benchmarked to equivalent

salary grades reported by CHA's annual management and non-management compensation surveys.

2. Wage tier structures for designated non-exempt positions contain tiered sequences expressed as one-dimensional minimums.

3. The District's wage structures are publicly accessible and non-exempt wage structures are available to staff electronically on the hospital's intranet.

4. Wage actions affecting exempt and non-exempt positions and/or their respective wage structures may be based on the following considerations:

   - The District maintains wage grades and ranges for exempt and non-exempt positions.
   - Wage pay grades are represented by a number and separated by a spread of 5%. The spread between the salary range minimum and maximum is 40%.
   - Specific job classifications and their incumbents may be adjusted to maintain their relationship between existing salary range with CHA. .
   - When individual positions are adjusted to a higher grade and range, incumbents falling below the minimum are moved to the new grade minimum or adjusted within the new pay grade during salary administration.
   - Exempt and non-exempt positions lacking a survey comparison are benchmarked to similarly surveyed and ranked positions within the SVMC wage structure.
   - Labor market, competitive forces and the need to complete searches expeditiously determine exempt (management) pay grades and salary range designations.
   - When responding to unusual market or staffing situations, the President/Chief Executive Officer (CEO) may authorize establishment of pay ranges and tier structures outside of these guidelines.

MAKING SALARY OFFERS:

1. Department Directors are responsible for auditing their position control reports to ensure accuracy of position titles, position control numbers and wage pay grade and tier assignments.

2. Prior to making any wage offers to either external or internal candidates, Human Resources will review the department's internal wage equity.

3. All contingent offers of employment must be made by the Human Resources Department. Human Resources will determine the rate of pay and use a 2% increment increase for each year of experience as it relates to the position and internal equity.

4. Wage offers which exceed 50% of the incumbent's pay grade range require VP of HR approval. In the absence of the VP of HR, AOC may approve.

REFERENCES:

- California Hospital Association – Annual Compensation Survey (Rep.). (n.d.). Retrieved from https://www.calhospital.org.

SUBJECT:	SECTION:
SHARED GOVERNANCE AND MANAGEMENT AUTHORITY AND RESPONSIBILITY MATRIX	*[Enter manual section here]*

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

PURPOSE:

To ensure the correct individual(s) are identified in managing the decision-making process for timely action to be carried out according to scope of a person/groups authority and responsibility.

DEFINITIONS:

1. The Matrix is a decision table that sets out who can approve a change or action, subject to cost limits, and/or areas of responsibility.

POLICY:

A. The Authority and Responsibility Matrix will be used as a guideline in carrying out roles and responsibilities of the Vice President and the President/Chief Executive Officer (CEO) job duties.

B. The Board of Directors will approve or disapprove items placed on the governing board agenda according to the Governing Board Bylaws, Policy and Procedures, and the strategic initiatives of the District.

AFFECTED PERSONNEL/AREAS: *President/CEO and Vice Presidents*

PROCEDURE:

A. The President/CEO and Vice Presidents will use the Matrix to guide actions and responsibilities that are within the authority limits of their roles.

B. The action(s) of the responsible individual(s) will develop, participate, recommend, and/or approve as outlined in the matrix.

C. The Governing Board will provide scope and authority over the governance of the District.

CROSS REFERENCES:

Purchase Authorization
Check Signing and Cash Disbursements for Department Limit

Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
MISSION AND VALUES			
Adopt or change mission/vision, philosophy, or values of the hospital	Approve	Recommend to Board	Develop in consultation with others
Set system policies related to hospital	Approve	Develop in consultation w/ others	Develop in consultation with others
Community Needs Assessment	Receive annual community report and assure assets are deployed to meet community needs through capital, annual budgeting.	Recommend annual community report to BOD.	Set system standards and expectations for community needs assessment.
BOARD APPOINTMENT			
Appoint/remove Board of Directors (note: Board Chair is selected by the Board)	Appoint/Remove		
Appointment of Board Committee members	Board Chair appoints		
Nomination / Appointment of Foundation Board members of controlled foundation.	Appoint/Remove		

CORRESPONDENCE TO THE BOARD

INVOLVED/REPORTING PARTY	DELEGATE RESPONSIBILITY/RESOLUTION TO
Board of Directors	Board or Fair Political Practices Commission
CEO	Board
Community members (non-patient/family)	Board
Contracted Entity and/or Vendors	CEO and Chief of Staff (if involving Medical Staff members)
Employee	Human Resources

Foundation	CEO
Medical Staff Independent Contractor	Chief of Staff and CEO (if involving hospital operations)
Medical Staff employed by Contracted Entity	Contracted Entity and/or Chief of Staff and/or CEO
Patient/Patient Family	Patient Grievance Committee
Senior Leadership Team	CEO
Volunteers/Chaplain Assistants	Human Resources

Note: All concerns addressed to Board of Directors will be forwarded to Secretary of the Board and reported out at the next scheduled meeting. Any concerns that are not resolved to the satisfaction of the reporting party will be brought back to the Board of Directors for notification and conclusion.

ARTICLES AND BYLAWS			
Amend articles, bylaws, or other governing documents	Approve	Recommend to Board	
Amend bylaws of Volunteer League	Approve	Recommend to Board	Develop in consultation with others
Amend bylaws of Foundation Boards	Approve	Recommend to Board	Develop in consultation with others
STRATEGIC DEVELOPMENT AFFILIATIONS/ACQUISITIONS			
Acquisition arrangements	Approve	Recommend to Board	Participate in consultation with others.
Management contract (entire health care facility)		Approve	
ıual aggregate capital commitment is budgeted	Approve	Recommend to Board	Recommend Contract
ıual aggregate capital commitment is unbudgeted	Approve if >$500,000	Approve if under $500,000 Recommend if over $500,000	Recommend Contract
Lease of health care facility with annual aggregate financial commitment over specified amount where SVMC is either landlord or tenant.	Approve if > $500,000	Approve if under $500,000 Recommend if over $500,000	Develop lease and/or contract

Partnership/ LLC/ Joint Venture	Approve	Recommend to Board	Participation in consult with others
Formation of new legal entities that involve major work	Approve	Recommend to Board	Participation in consult with others
STRATEGIC PLANNING			
Strategic Plan	Approve	Recommend to Board	Develop in consultation with others
Annual goals and objectives	Approve	Recommend to Board	Develop goals and objectives
Comprehensive master plan and annual program development plans	Approve	Recommend to Board	Develop in consultation with others
PROGRAMS AND SERVICES			
Establish/change names of system and corporations	Approve	Recommend to Board	Develop recommendation
Initiation or closure of major work	Approve	Recommend to Board	Develop recommendation
Construction Budget of Master Plan approval	Approve Annual & all projects >$500,000 unbudgeted	Recommend to Board	Develop recommendation
CORPORATE RESTRUCTURING			
Dissolution, liquidation, consolidation or mergers of corporations or other legal entities	Approve	Recommend to Board	Develop plan.
FINANCE			
Debt authorization (including loan guarantees)	Approve	Recommend to Board	Develop
Long range financial plan (LRFP)	Approve	Recommend to Board	Develop

Unbudgeted expenditures	Approve >$500,000	Approve <$500,000	Recommend Project Initiation Document
Cumulative substitutions of capital	Approve if over $1M	Recommend to Board	Develop
Sale of property	Approve	Recommend to Board	Develop
Purchase of Property(Limited to geographic area: West Oak from Jaye Street to North Sinarle Place; Sinarle Place between West Oak and West Garden; West Garden from Sinarle Place to Jaye Street; West side of Jaye Street from West Oak Street to half way between Garden Street and Olive Avenue.	Ratify and approve all purchases up to $500,000 or approve over the $500,000	Approve up to $500,000 (Ref. Resolution 02-25-2020/01)	Participate
Appointment of External System Auditor	Approve/Appoint	Recommend to Board	Participate
External Audit Report	Approve	Recommend to Board	Participate
Divesture of Services/Department	Approve	Recommend to Board	Participate
QUALITY/MEDICAL STAFF			
SVMC Quality Principles, Performance Metrics and Plan	Approve	Recommend to Board	Develop
Annual Summary Report on Delegated Governance Responsibilities	Approve format and review annual Quality Performance Improvement Plan. Facility Annual Plan Review and Proposed Plans.	Recommend to Board	Present to the Board
Annual Plan Review & Proposed Plan: Provision for Patient Care, Infection Prevention, Utilization Management, Risk, Performance Improvement, Med Error, Emergency Operations Plan & Life Safety Management Plan Annual Plan Review & Proposed Plan	Approve	Recommend to Board	Present to the Board

Quarterly Compliance, Marketing, Patient Experience Reports	Approve	Recommend to Board	Present to the Board
Annual Human Resources, Nursing Summary Reports	Approve	Recommend to Board	Present to the Board
Medical Staff bylaws/amendments	Approve		
Medical Staff Appointments	Approve		
Medical Staff Credentialing and Privileges	Approve		
Medical Staff disciplinary matters	Approve/Summarily suspend in accordance of Governing Bylaws	Summarily to suspend in accordance to Governing Bylaws.	
Grievances Review	Delegated to Grievance Committee	Participate	Participate/Approve Actions
Joint Conference Committee	Approve	Recommend to Board	Participate
MANAGEMENT STRUCTURE			
Appoint/ Remove President/CEO (and receive copy of annual evaluation	Appoint/Remove		
Appoint/Remove all Vice Presidents		Approve	
Appoint/Remove Directors			Approve
HUMAN RESOURCES			
Performance Merit Program	Approve	Recommend to Board	Develop
Administer Performance Merit Program		Approve	Manage

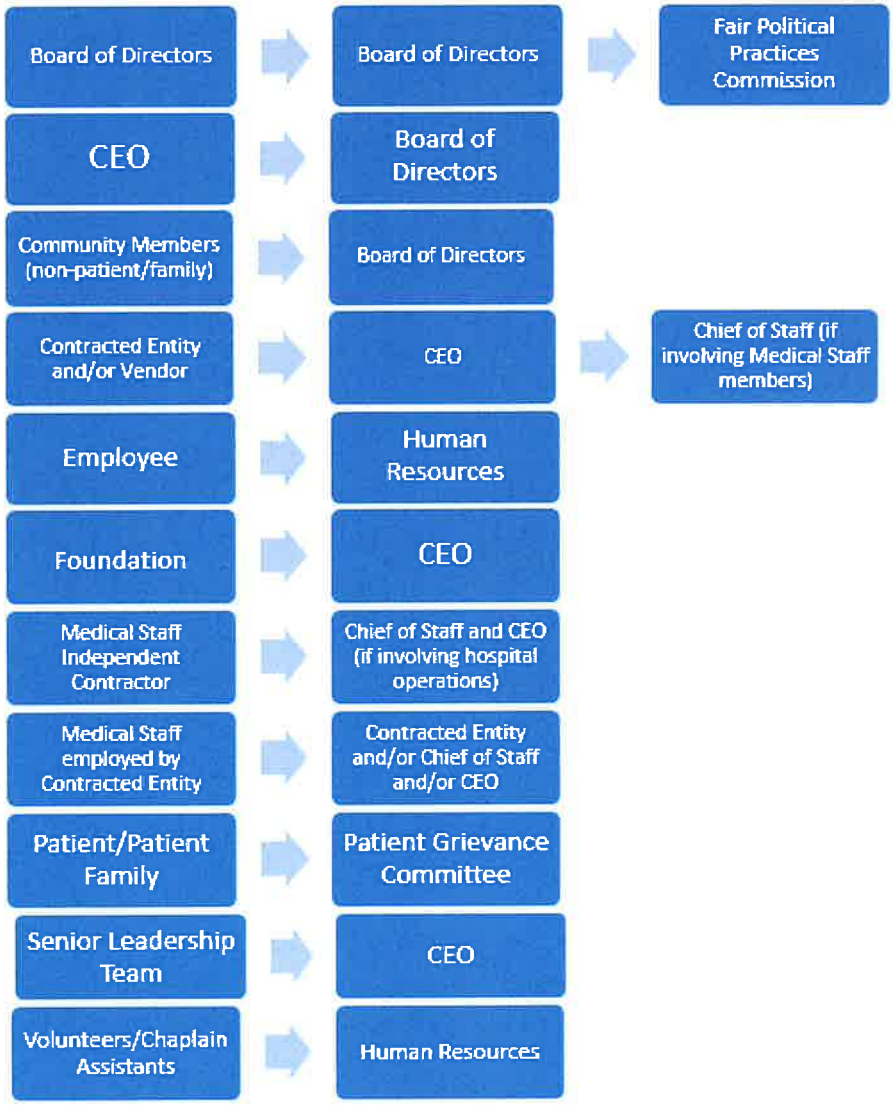
Employee Benefits:			
A. Retirement	Approve	Recommend to Board	Manage
B. Employee Benefits		Approve	Develop
C. Executive Benefits	Approve	Recommend to Board	Develop
Changes in overall compensation philosophy	Approve	Recommend to Board	Develop
Compensation policies and procedures Establish wage and salary structure and:			
A. Executive Management	Approve	Recommend to Board	Develop
B. Leadership Development and Succession planning and processes		Approve	Develop
C. Employee's		Approve	Develop
Major system-wide human resources policies and procedures	Approve	Recommend to Board	Develop
Union/Agency shop, other precedent setting language – Employer Resolution	Approve	Recommend to Board	Develop
INSURANCE/RISK MANAGEMENT			
Level of risk assumption in insurance program		Approve	Participate & Recommend
Policies and guidelines for insurance coverage		Approve	Participate & Recommend
Claims/Litigation			

General/Professional Insurance (Malpractice)/Workers Comp:			
A. Accepts or Rejects Claims or Suits	Approve	Recommend to Board	Participate & Recommend
B. Settlements over $200,000	Approve	Recommend to Board	Participate & Recommend
C. Settlements under $200,000		Approve	Participate & Recommend
Commercial litigation/uninsurable settlements			
A. Over $200,000	Approve	Recommend to Board	Participate & Recommend
B. Under $200,000		Approve	Participate & Recommend
Initiation of Claims or Suits		Approve as prosecuting authority.	Participate
Contracts/Leases			
A. Managed Care/Third Party payer agreements		Approve or delegate to CFO	CFO Approve
B. Lease or purchase of medical or other equipment and supplies with a total value in excess of $500,000 per contract/purchase order		Approve or delegate to CFO	CFO Approve
C. Real Estate purchases/sales/leases	Approve	Recommend to Board	Recommend & Develop transaction
D. Hospital or Health System/ Physician agreements		Approve	Recommend
E. Information service / technology agreements in excess of $250,000	If unbudgeted	Approve if budgeted	Develop
F. Management agreements	If unbudgeted	Approve if budgeted	Develop
G. Service agreements	If unbudgeted	Approve if budgeted	Develop

H. Consulting agreements	If unbudgeted	Approve if budgeted	Develop
COMPLIANCE			
Compliance policies and procedures & program	Approve	Recommend to Board	Develop

SIERRA VIEW MEDICAL CENTER

Internal Flow Chart
Correspondence to the Board of Directors



Note: All concerns addressed to Board of Directors will be forwarded to Secretary of the Board and reported out at the next scheduled meeting. Any concerns that are not resolved to the satisfaction of the reporting party will be brought back to the Board of Directors for notification and conclusion.

SUBJECT:	SECTION:
STRATEGIC PLAN	*Leadership (LD)*
	Page 1 of 1

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

PURPOSE:

To delineate responsibility for the Strategic Plan at Sierra View Medical Center (SVMC).

POLICY:

1. In conjunction with the Board of Directors, the President and Chief Executive Officer (CEO) will accept the leadership role in the preparation, development, and implementation of the Strategic Plan for Sierra View Medical Center.

2. Strategic planning will include definition of mission, vision, and values for the hospital and creating strategic, operational, programmatic and other plans and policies to achieve the mission and vision.

3. A copy of the strategic plan will be kept in the Administration offices.

4. Any and all data required for planning will be made available, as appropriate, to those involved in the strategic planning process.

5. The strategic plan is reviewed by the President/CEO and Senior Leadership, in conjunction with the Board of Directors, at least annually.

6. The Structure of the Strategic Planning Group may include the Board of Directors, Senior Leadership, Physicians, members of the community, and selected employees.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
SUBPOENAS, SUMMONS & COMPLAINTS, HANDLING OF	***Management of Information (IM)***

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

PURPOSE:

To outline steps to be taken when in receipt of a subpoena, summons or complaint.

DEFINITIONS:

Complaint: A formal statement initiating a lawsuit by specifying the facts and legal grounds for the relief sought.

Subpoena: A writ or court order directed to a person requiring their attendance at a particular time and place to testify.

Subpoena duces tecum: An order issued by a court at the request of one of the parties to a suit that compels a person to appear in court or to a deposition and to bring any relevant or specifically requested documents that are under their control.

POLICY:

Sierra View Medical Center (SVMC) will comply with the California Code of Civil Procedure, whereby ensuring the appropriate receipt and response to all appropriately served court orders and requests.

1. Orders naming Sierra View (Medical Center), (District Hospital), (Local Health Care District):

   Only designated employees may accept, from a process server, a subpoena, summons or complaint. The following are considered to be designated to receive subpoenas, summons or complaints between the hours of 0800 and 1630, Monday through Friday:

   a. Human Resources may receive court orders for production of documents related to the personnel file of a former or current employee. Refer to Human Resource Policy & Procedure Manual, *Employee's Right to Privacy.*

   b. The Payroll Department may receive court orders for payroll deductions (support payments, garnishments, etc.).

   c. Health Information Management (HIM) may receive court orders for production of medical records or Subpoena duces tecum. Refer to House-wide Policy & Procedures Manual, *Confidentiality*.

   d. Risk Management will be called to review and possibly receive all other subpoenas, summons or complaints. When applicable, Risk Management will subsequently contact the department or individual involved.

2. Orders naming individual employees:

   a. Process servers attempting to serve an employee of the District, shall be directed to Human Resources. Human Resources will determine if the employee is working and request the employee present to Human Resources to receive the document.

   b. If the employee is not available, the process server may choose to leave the document (California Code of Civil Proceedings 415.20). At this time the process server should be informed that there is no guarantee of the employee being on schedule and as such they may choose to serve the employee at their place of residence.

   c. If the court order is left with Human Resources, documented attempts will be made to inform the employee.

   d. If the employee does not respond within five (5) days of receipt, Risk Management should be contacted.

3. Orders naming non-employees (contractors/physicians):

   a. Sierra View Medical Center will not take receipt of any orders naming non-employees/contractors. If such are left by a process server, Risk Management should be contacted.

4. When a designated representative is not available, Risk Management should be contacted.

REFERENCE:

- California Code of Civil Procedure (1985.3(B) (2)).

CROSS REFERENCES:

- Human Resource Policy & Procedure Manual, *Employee's Right to Privacy*
- House-wide Policy & Procedures Manual, *Protection of Patient Privacy*
- House-wide Policy & Procedures Manual, *Release of Patient Information*

Congress of the United States

Washington, DC 20515

March 19, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

We write regarding the cybersecurity attack on Change Healthcare and the resulting disruptions that have affected patients, physicians, other health care providers, and the smooth operations of the nation's healthcare system.

We appreciate the Department of Health and Human Services' (HHS) announcement about assistance to hospitals dated March 5, 2024, and physicians dated March 9, 2024. We urge HHS to follow up on these announcements by using all its authorities to ensure timely payment across the board in Parts A, B, and C of Medicare.[1][2] Additionally, we ask for HHS to work with states to ensure Medicaid and the Children's Health Insurance Program (CHIP) are able to receive timely payments so that all aspects of the health care system can continue to remain open, fully functional, and accessible to patients. We appreciate the acknowledgement dated March 6, 2024, of the impact this attack has had on physicians and other providers and urge you to keep us informed.[3] We also ask that HHS take steps to address the inability of many patients to receive timely access to medications, given disruptions in verifying patients' identities and eligibility for coverage due to the Change Healthcare cyberattack.

We underscore that we are not requesting new taxpayer money into the health care system. Rather, we request that HHS use its existing authorities to ensure that money that should be flowing for services rendered under traditional Medicare and Medicare Advantage, and under Medicaid, continues to do so. Just as with hospitals anticipating Part A payments, multiple physician practices anticipating payment for Part B services rendered have seen their cash flow radically impaired given disruptions in clearinghouse operations and the impact on payers, including health plans participating in Part C.

Smaller physician practices already operate under slim financial margins, especially with the recent cuts in Medicare reimbursement. These challenges are also more acutely felt by practices in rural and underserved areas. While smaller practices potentially face possible closure, larger practices still face an inability to meet payroll. Additionally, while problems stemming from the Change Healthcare attack are not universal throughout the U.S. healthcare system, they are extremely dire for the practices and organizations that have been affected. Examples include billing and cash flow disruptions, prior authorization transmission delays, and remittal issues for

[1] https://www.hhs.gov/about/news/2024/03/05/hhs-statement-regarding-the-cyberattack-on-change-healthcare.html
[2] https://www.cms.gov/newsroom/fact-sheets/change-healthcare/optum-payment-disruption-chopd-accelerated-payments-part-providers-and-advance
[3] https://www.cms.gov/newsroom/press-releases/cms-statement-change-healthcare-cyberattack

electronic prescriptions. If the department needs flexibilities granted in law, please let us know so we can work together to ensure patient access and care are not negatively impacted.

For non-Medicare-related payments, we also ask that HHS continue its discussions with United Health Group, Optum, and Change Healthcare to provide financial and other assistance to affected healthcare organizations. We understand from providers that the assistance provided to date by UHG/Optum/Change does not fully mitigate the financial harm caused by the suspended and delayed payments from commercial insurers.

Additionally, we are concerned about the impact of this cyberattack on patients. Recent articles have detailed patients who must cover the entire cost of their medications, or even go without, when pharmacies are not able to find workarounds for the lack of access to insurance coverage information.[4] Furthermore, our offices have received concerns from constituents who have paid out-of-pocket for their medical supplies with no known solution for how to make them whole. We are worried about our constituents' ability to afford these expenses. In this current incident, individuals who have been forced to cover the costs of their medications and care out-of-pocket, particularly those on fixed incomes or reliant on high-cost medications, may encounter challenges in paying other bills in the coming weeks. Moreover, the exposure of personal and protected health information to other cybercriminals poses a lasting threat, increasing the risk of identity theft and targeted scams. This is particularly concerning for older Americans who are at an elevated risk of being targeted and becoming victims of financial scams and fraud.
As the Administration is called upon to aid the various impacted parties affected by the attack, we request timely responses from the Administration to the following questions:

1. Does CMS have the statutory or regulatory authority to provide Part B physicians and other health care providers that receive Advance Payments more flexible repayment terms?
2. Has the administration received concerns regarding patients having to pay out of pocket for medical services or medications?
3. Due to the high probability that sensitive information was compromised during this incident, can the Administration provide guidance on how Change Healthcare should proceed to ensure that patients are safeguarded against malicious actors?

Thank you for your timely attention to this request, at a moment of real crisis for a portion of our nation's healthcare system.

Sincerely,

[4] https://www.cybersecuritydive.com/news/change-healthcare-providers-impact/709236/; https://www.nbcnews.com/health/health-care/cyberattack-change-healthcare-patients-struggle-get-medication-rcna141841

Mariannette Miller-Meeks, M.D.
Member of Congress

Robin L. Kelly
Member of Congress

Kat Cammack
Member of Congress

Adam Smith
Member of Congress

Brett Guthrie
Member of Congress

Yvette D. Clarke
Member of Congress

C. A. Dutch Ruppersberger
Member of Congress

Mike Quigley
Member of Congress

Becca Balint
Member of Congress

Josh Gottheimer
Member of Congress

Elissa Slotkin
Member of Congress

Gregory F. Murphy, M.D.
Member of Congress

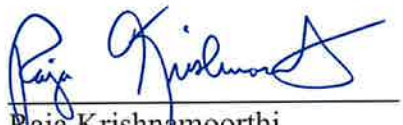
Katie Porter
Member of Congress

Mike Flood
Member of Congress

Eric A. "Rick" Crawford
Member of Congress

Angie Craig
Member of Congress

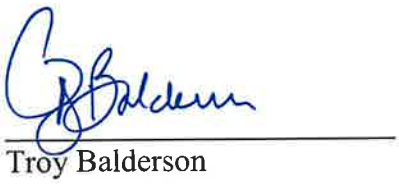
Austin Scott
Member of Congress



Raja Krishnamoorthi
Member of Congress

Marcus J. Molinaro
Member of Congress

Andy Harris, M.D.
Member of Congress



Troy Balderson
Member of Congress

Mario Diaz-Balart
Member of Congress

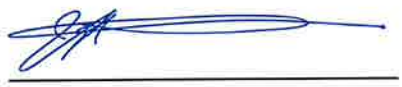
Daniel Meuser
Member of Congress

Andrew R. Garbarino
Member of Congress

Michael Guest
Member of Congress

Bill Pascrell, Jr.
Member of Congress

Dan Crenshaw
Member of Congress



Jefferson Van Drew
Member of Congress

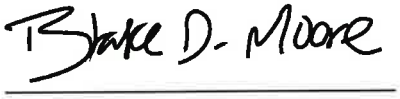
Michael Waltz
Member of Congress

Mikie Sherrill
Member of Congress

Jill Tokuda
Member of Congress

John Joyce, M.D.
Member of Congress

A. Drew Ferguson IV
Member of Congress



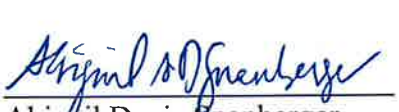
Blake D. Moore
Member of Congress

Randy K. Weber, Sr.
Member of Congress

David G. Valadao
Member of Congress

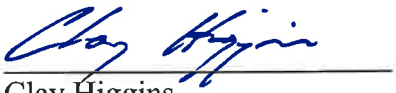
Kim Schrier, M.D.
Member of Congress

Mike Ezell
Member of Congress



Abigail Davis Spanberger
Member of Congress

Don Bacon
Member of Congress



Clay Higgins
Member of Congress

Anthony D'Esposito
Member of Congress

James P. McGovern
Member of Congress

Jenniffer González-Colón
Member of Congress

Juan Ciscomani
Member of Congress

Colin Z. Allred
Member of Congress

C. Scott Franklin
Member of Congress

Jay Obernolte
Member of Congress

Jan Schakowsky
Member of Congress

David J. Trone
Member of Congress

Aaron Bean
Member of Congress

Thomas H. Kean, Jr.
Member of Congress

Donald G. Davis
Member of Congress

Lori Trahan
Member of Congress

Burgess Owens
Member of Congress

Jonathan L. Jackson
Member of Congress

Brian Fitzpatrick
Member of Congress

Frank J. Mrvan
Member of Congress

Rick W. Allen
Member of Congress

Trent Kelly
Member of Congress

Norma J. Torres
Member of Congress

Rick Larsen
Member of Congress

Brandon Williams
Member of Congress

Kathy Castor
Member of Congress

Joseph D. Morelle
Member of Congress

Rich McCormick, MD, MBA
Member of Congress

Betty McCollum
Member of Congress

Glenn "GT" Thompson
Member of Congress

Brian J. Mast
Member of Congress

Michael C. Burgess, M.D.
Member of Congress

Nanette Diaz Barragán
Member of Congress

Daniel Webster
Member of Congress

Sanford D. Bishop, Jr.
Member of Congress

Blaine Luetkemeyer
Member of Congress

Greg Pence
Member of Congress

Zach Nunn
Member of Congress

David Rouzer
Member of Congress

Yadira Caraveo, M.D.
Member of Congress

Ashley Hinson
Member of Congress

Vicente Gonzalez
Member of Congress

Jasmine Crockett
Member of Congress

Nicholas A. Langworthy
Member of Congress

Robert E. Latta
Member of Congress

Zoe Lofgren
Member of Congress

Julia Brownley
Member of Congress

Gus M. Bilirakis
Member of Congress

Lisa Blunt Rochester
Member of Congress

Stephanie Bice
Member of Congress

Debbie Wasserman Schultz
Member of Congress

Danny K. Davis
Member of Congress

Daniel T. Kildee
Member of Congress

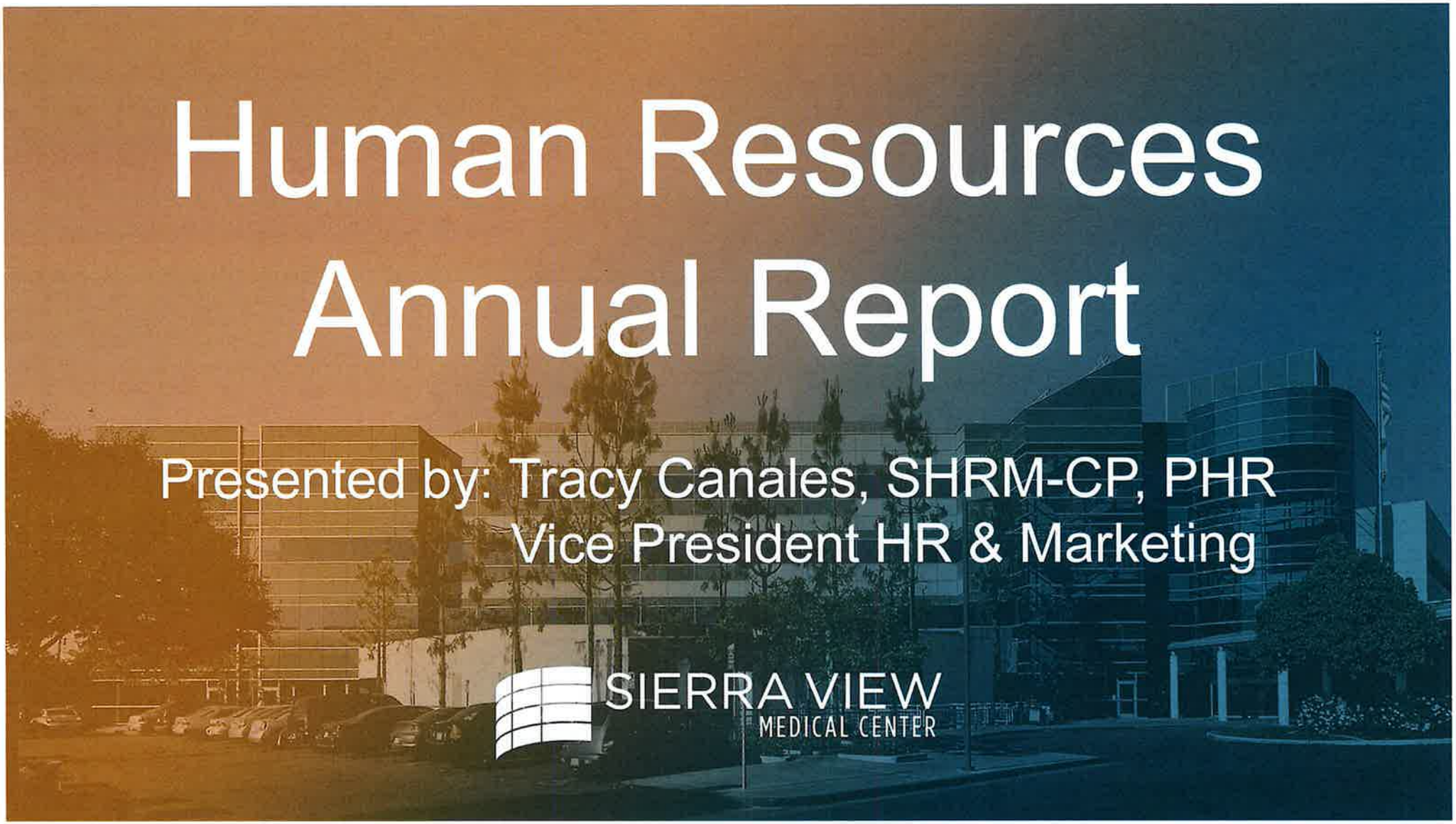
Steve Cohen
Member of Congress

Sheila Cherfilus-McCormick
Member of Congress

John R. Moolenaar
Member of Congress

Andy Barr
Member of Congress

Marc A. Veasey
Member of Congress


Human Resources
Annual Report
Presented by: Tracy Canales, SHRM-CP, PHR
Vice President HR & Marketing
SIERRA VIEW
MEDICAL CENTER

Recruitment

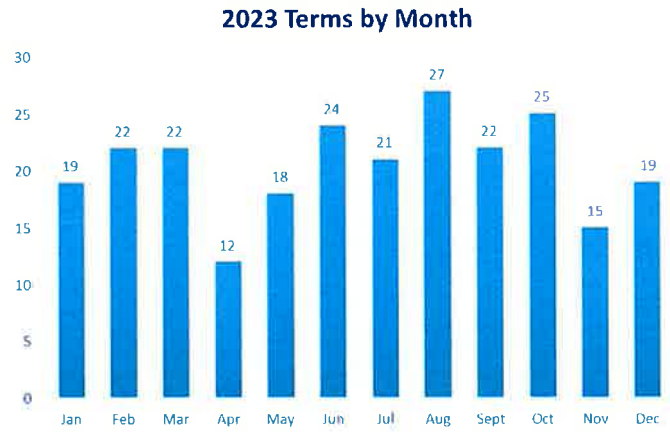
Recruitment	2022	2023	% Change
New Hires	256	228	-11%
Transfers	172	176	2%
Promotions	41	44	7%
Referred by an Employee	67	59	-12%
No. of Requisitions	445	410	-8%
No. of Applications	2,404	3,565	48%
Vacancy Rate	9.2%	8.9%	-0.3%

Recruitment via Geo-fencing	2022	2023	% Change
New Hires	59	21	-64%
Annual Cost	$ 4,575	$ 2,424	-47%
Cost per Hire	$ 78	$ 115	49%

Engagement & Retention - Turnover

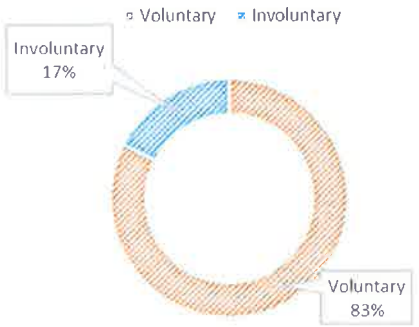
Turnover	2022	2023	% Change
Full Time & Part Time	149	140	-6%
Per Diems	85	106	25%
Turnover Rate (FT&PT)	19.1%	18.7%	-0.4%
CHA Turnover Rate (FT&PT)	14.9%	11.9%	-3.0%
SVMC Variance	-4.2%	-6.8%	-2.6%

RN Turnover	2022	2023	% Change
RN Full Time & Part Time	44	23	-48%
RN Per Diems & Seasonals	19	46	142%
RN Turnover Rate (FT&PT)	27.1%	15.1%	-12.0%
RN CHA Turnover Rate (FT&PT)	16.9%	13.4%	-3.5%
RN SVMC Variance	-10.2%	-1.7%	8.5%



Turnover	2022	2023	% Change
Total Terms	234	246	5%
Voluntary	201	203	1%
InVoluntary	33	43	30%

Terms Hired in Same Year	2022	2023	% Change
Terms hired in same year	50	60	20%
Turnover Rate	20%	26%	7%

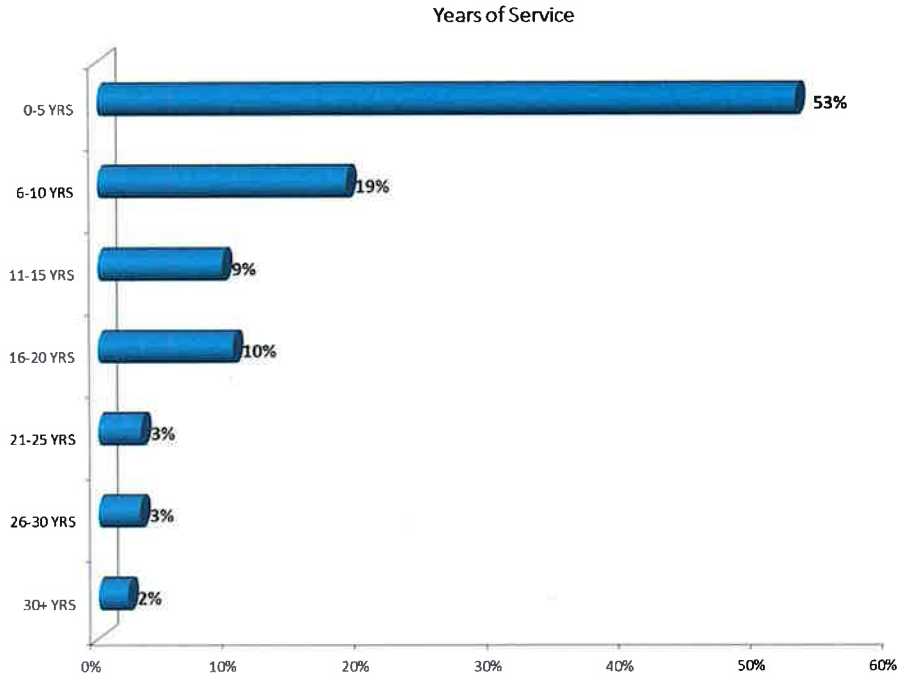


Engagement & Retention

Timely Evaluations	2022	2023	% Change
Timely Rate	76.9%	78.6%	1.7%

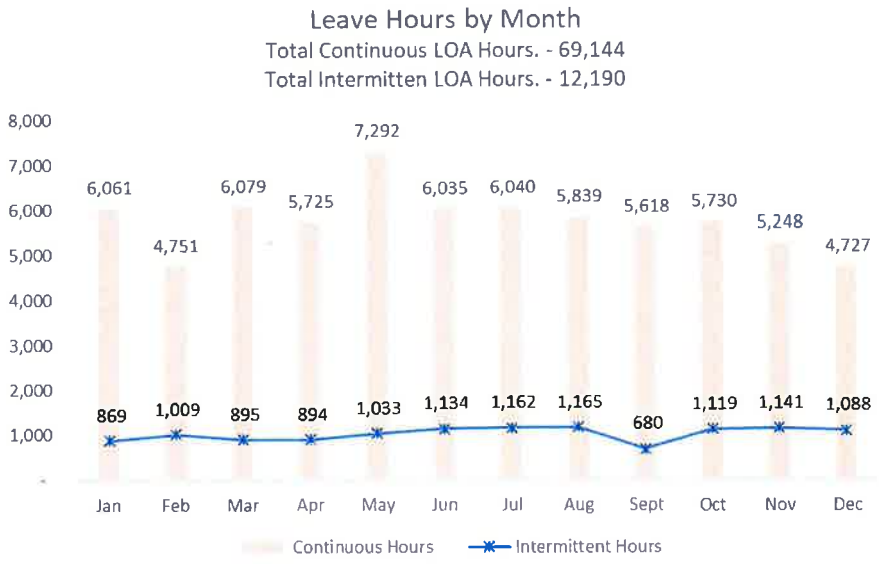
Retirement	2022	2023	Change
# of Participants	517	510	-1.4%

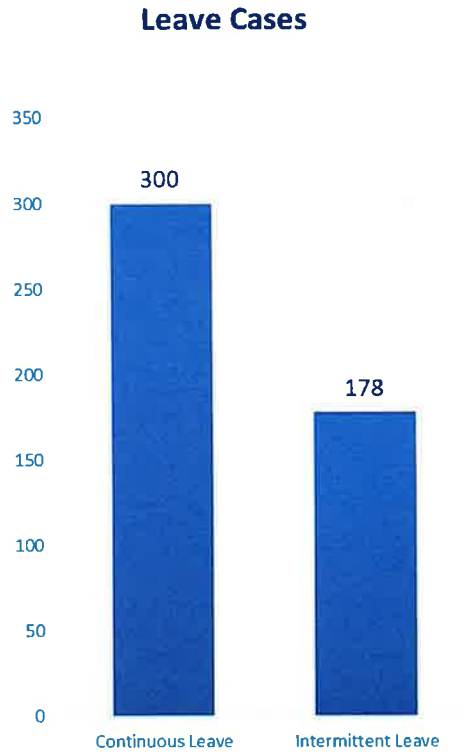
Milestone Achievements	2022	2023	% Change
Total Milestone Achievements	16	8	-50%
PhD Degree	0	0	0%
MA Degree	4	0	-100%
BA Degree	3	5	67%
Certification	9	3	-67%



Compliance - Leaves

Leaves	2022	2023	% change
Leave cases opened	1033	478	-54%
Total Employees	632	291	-54%
Total Leave Hours	122,687	81,334	-34%

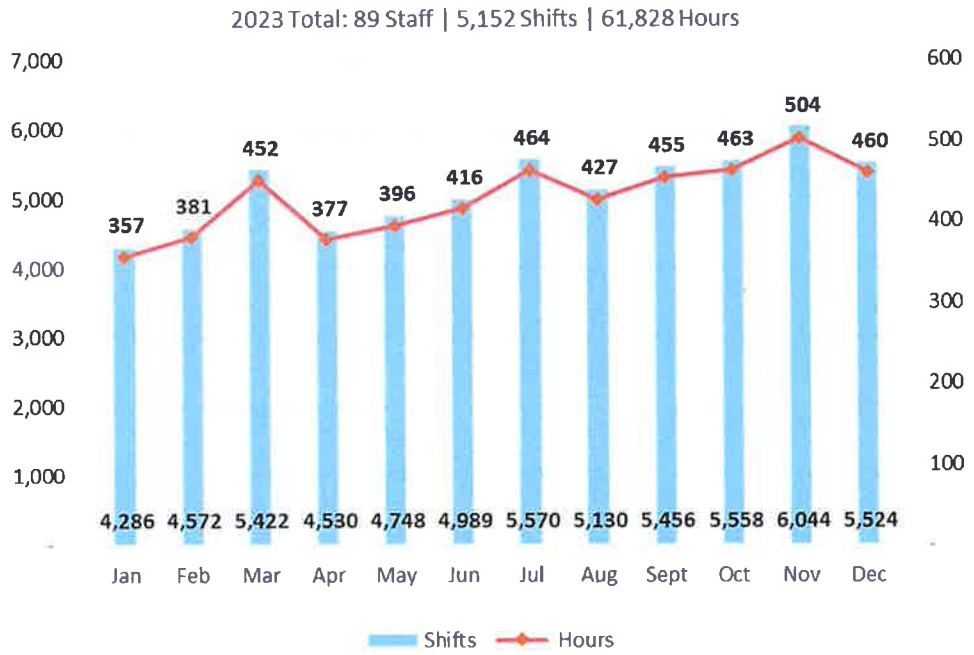




48 Hour Club Savings

Seasonal Program Savings

Inception Date: May 2022



SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS' RESOLUTION NO: 04-23-2024/01
DISSOLUTION OF OUTPATIENT OPTHALMOLOGY SURGICAL SERVICE LINE
AT SIERRA VIEW MEDICAL CENTER

WHEREAS, Sierra View Local Health Care District currently operates an ophthalmology surgical service line; AND

WHEREAS, it has been determined that discontinuation of said service line is in the best interest of the District;

THEREFORE, IT IS RESOLVED THAT: The current outpatient ophthalmology surgical service line shall be, and is hereby, dissolved.

CONSIDERED, PASSED AND ADOPTED, by the Board of Directors of Sierra View Local Health Care District, Tulare County, State of California at the regular meeting of the Board on April 23, 2024.

The vote of the Board is as follows:

Yes: ___

No: ___

Absent: ___

By: _____
Bindusagar Reddy, M.D., Chairman

Attest: _____
Areli Martinez, Secretary

(Official Seal)

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS' RESOLUTION NO: 04-23-2024/02
DISSOLUTION OF OUTPATIENT PODIATRY SURGICAL SERVICE LINE
AT SIERRA VIEW MEDICAL CENTER

WHEREAS, Sierra View Local Health Care District currently operates a podiatry surgical service line; AND

WHEREAS, it has been determined that discontinuation of said service line is in the best interest of the District;

THEREFORE, IT IS RESOLVED THAT: The current outpatient podiatry surgical service line shall be, and is hereby, dissolved.

CONSIDERED, PASSED AND ADOPTED, by the Board of Directors of Sierra View Local Health Care District, Tulare County, State of California at the regular meeting of the Board on April 23, 2024.

The vote of the Board is as follows:

Yes: ___

No: ___

Absent: ___

By: _____
Bindusagar Reddy, M.D., Chairman

Attest: _____
Areli Martinez, Secretary

(Official Seal)

SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS' RESOLUTION NO: 04-23-2024/03
ORDERING EVEN-YEAR BOARD OF DIRECTORS
ELECTION; CONSOLIDATION OF ELECTIONS; AND SPECIFICATIONS
OF THE ELECTION ORDER

WHEREAS, California Elections Code requires a general district election be held in each district to choose a successor for each elective officer whose term will expire on the first Friday in December following the election to be held on the first Tuesday after the first Monday in November in each even-numbered year; and

WHEREAS, other elections may be held in whole or in part of the territory of the district, and it is to the advantage of the district to consolidate pursuant to Elections Code Section 10400; and

WHEREAS, Elections Code Section 10520 requires each district involved in a general election to reimburse the county for the actual costs incurred by the county elections official in conducting the election for that district; and

WHEREAS, Elections Code Section 13307(3c) requires that before the nominating period opens, the governing body must determine whether a charge shall be levied against each candidate submitting a candidate's statement to be sent to the voters; and

WHEREAS, Elections Code Section 12112 requires the elections official of the principal county to publish a notice of the election once in a newspaper of general circulation in the district;

NOW, THEREFORE, IT IS ORDERED that an election be held within the territory included in this district on the 5th day of November 2024, for the purpose of electing members to the board of directors of said district in accordance with the following specifications:

sierra-view.com • (559) 784-1110 • 465 W Putnam Ave • Porterville, CA 93257

SIERRA VIEW MEDICAL CENTER

SPECIFICATIONS OF THE ELECTION ORDER

1. The Election shall be held on Tuesday, the 5th day of November 2024. The purpose of the election is to choose members of the board of directors for the following seats (list offices and terms):

   Director, Sierra View Local Health Care District Zone 1, 4 Year Term
   Director, Sierra View Local Health Care District Zone 2, 4 Year Term
   Director, Sierra View Local Health Care District Zone 3, 2 Year Short Term
   Director, Sierra View Local Health Care District Zone 4, 4 Year Term

2. This governing board hereby requests and consents to the consolidation of this election with other elections which may be held in whole or in part of the territory of the district, as provided in Elections Code 10400.

3. The district will reimburse the county for the actual cost incurred by the county elections official in conducting the general district election upon receipt of a bill stating the amount due as determined by the elections official.

4. The district has determined that the **__Candidate__** will pay for the Candidate's Statement.
   (District or Candidate)
   The Candidate's Statement will be limited to 200 words.

5 The district directs that the County Registrar of Voters of the principal county publish the notice of election in the following newspaper, which is a newspaper of general circulation that is regularly circulated in the territory: **The Porterville Recorder.**

THE FOREGOING RESOLUTION WAS ADOPTED upon motion of Director _____, Seconded by Director _____, at a regular meeting on this _____day of 2024, by the following vote:

AYES :_____
NAYS :_____
ABSENT: _____

_____
Director Areli Martinez
Secretary of Sierra View Local Health Care District

MINUTES OF A REGULAR MEETING OF THE
BOARD OF DIRECTORS OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The Annual meeting of the Board of Directors of Sierra View Local Health Care District was held **March 26, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:01 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, KASHYAP, PANDYA**

Others Present: Hefner, Donna, President/Chief Executive Officer, Hudson, Jeffery, VPPCS/CNO/DIO, Canales, Tracy, VP of Human Resources, Dickson, Doug, Chief Financial Officer, Mitchell, Melissa, VP Quality and Regulatory Affairs, Gomez, Cindy, Parsons, Malynda, Public Relations, Reed-Krase, Alex, Legal Counsel Sandhu, Harpreet, Chief of Staff

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director PANDYA, seconded by, Director KASHYAP and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:02 p.m. to discuss the following items:

A. Pursuant to Evidence Code Section 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

Vice Chairman Liberty Lomeli arrived at 5:07pm

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation- Quality of Care/Peer Review/Credentials

2. Quality Division Update – Quality Report

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to General Strategic Planning for Services, Facilities and Programs. Estimated date of Disclosure March 1, 2026.

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining Financial Planning. Estimated Date of Disclosure April 1, 2024.

Closed Session Items D,E and G were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:41 p.m., reconvening in Open Session at 5:41 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYAP, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report – Quality Repot

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

F. Discussion Regarding Trade Secrets Pertaining to General Strategic Planning for Services, Facilities and Programs
Information only; no action taken

C. Discussion Regarding Trade Secrets Pertaining to Financial Planning
Information only; no action taken

IV. Public Comments
No public Comments

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Director PANDYA, seconded by, Director MARTINEZ and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chair LOMELI and seconded by Director MARTINEZ to approve the February 27, 2024 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. Business Items

A. Single Audit Board FY23

Following review and discussion, it was moved by Vice Chair LOMELI, seconded by Director MARTINEZ and carried to approve the Investment Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes

MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

B. February 2024 Financials

Doug Dickson, CFO presented the Financials for February 2024. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $13,439,448. Supplemental Funds were $1,875,638. Total Operating Expenses were $14,146,531. Loss from operations of $707,083.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYUP and carried to approve the February 2024 Financials as presented. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Closed Session: Board adjourned Open Session at 6:12 p.m. and went into Closed Session at 6:17 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Seismic Compliance.

E. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter – Two (2) Items. Estimated Date of Disclosure January 1, 2025 for materials that are not part of an individual's private personnel file.

G. Pursuant to Gov. Code Section 54956.9(d)(3): Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item)

X. Open Session: Board adjourned Closed Session at 7:50 p.m. and went into open Session at 7:51 p.m. to discuss the following items:

D. Discussion Regarding Trade Secrets Pertaining to Seismic Compliance
Information only; no action taken

E. Discussion Regarding Personnel Matter
Information only; no action taken

F. Conference with Legal Counsel
Information Only; No Action Taken

XI. Announcements:

A. Regular Board of Directors Meeting – March 26, 2024 at 5:00 p.m.
B. Form 700 due April 1, 2024. Disclosure forms must be on file with the Board Administrator by that date.

The meeting was adjourned 7:55 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv