SIERRA VIEW
MEDICAL CENTER

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

AGENDA
February 28, 2023

OPEN SESSION (4:30 PM – 4:35 PM)

The Board of Directors will call the meeting to order at 4:30 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 4:35 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:00 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

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 (Time Limit – 5 minutes)

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

3. Compliance Report – Quarter 2

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

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Strategic Planning (1 Item). Estimated Date of Disclosure – February 2026

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – December 2023

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – June 2024

G. 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

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

3. Compliance Report – Quarter 2
Recommended Action: Approve/Disapprove Report as Given

C. Discussion Regarding Trade Secret – Pertaining to Service
Recommended Action: Information only; no action taken

D. Discussion Regarding Trade Secret – Strategic Planning
Recommended Action: Information only; no action taken

E. Discussion Regarding Trade Secret – Pertaining to Service
Recommended Action: Information only; no action taken

F. Discussion Regarding Trade Secret – Pertaining to Service
Recommended Action: Information only; no action taken

G. Conference with Legal Counsel about recent work product
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.

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. **January 24, 2023 Minutes of the Annual Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove January 24, 2023 Minutes of the Annual Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **Approval of Amendment to Bylaws of the Board of Directors Section 5.2.1Regular Monthly Board Meeting Time Change**
Recommended Action: Approve/Disapprove Section 5.2.1

B. **January 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

C. **Investment Report**
Recommended Action: Approve/Disapprove Investment Report

D. **Capital Budget Report**
Recommended Action: Approve/Disapprove Capital Budget Report

E. **Annual Institutional Report for Graduate Medical Education**
Recommended Action: Information only; no action taken

F. **Board Self Evaluation and Goals**
Recommended Action: Information only; no action taken

XI. Announcements:

A. Regular Board of Directors Meeting – March 28, 2023 at T.B.D.

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. – 5:00 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	02/01/2023
BOARD OF DIRECTORS APPROVAL	
	02/28/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
February 28, 2023 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**
• Abduction of Newborn/Code Pink-Maternal Child Health Response	1-2	↓
• Adverse Drug Reactions	3-5	
• Borrowing/Purchasing or Lending/Selling Medications to other Hospitals and/or Community Pharmacies	6-9	
• Laboratory and Moderate Complexity POC Competency	10-17	
• Controlled Substances	18-27	
• Death Summaries for Inpatient, Skilled Nursing and Emergency Department Medical Record	28	
• Delegation of Duties Laboratory Medical Director	29-30	
• Dilution of Rocephin and Lidocaine for IM Injections in Pediatric Patients 2 Months to 12 Years	31	
• Donor Breast Milk	32-34	
• Drug Samples	35	
• Emergency Blood Release	36-37	
• Guidelines for Product Dating	38-41	
• Investigational Drugs	42-44	
• Medication – Errors	45-49	
• Neuromuscular Blocking Medication for Prolonged Muscle Relaxation of Intubated Patients in the ICU	50-55	
• Newborn Screening Tests	56-57	
• Non-Formulary Medication	58-60	
• Patient/Family/Caregiver Education	61-62	
• Patient Information Minimum for Pharmacist Review	63-64	
• Precedex Drip for Sedation of Patients in the Critical Care Setting	65-70	
• Prescriber Use of Own Medication	71	
• Restriction of Communication	72	
• Sliding Scale Electrolyte Replacement Protocol	73-79	
• Visitor Guidelines	80-85	
II. Forms:		
• Physician Orders Diabetic Ketoacidosis	86-87	

SUBJECT:	SECTION:
ABDUCTION OF NEWBORN/CODE PINK – MATERNAL CHILD HEALTH RESPONSE	**Page 1 of 2**

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

PURPOSE:

Establish nursing guidelines in the event of a missing infant or a suspected abduction.

POLICY:

- Nursing staff will respond immediately to the report of a missing infant.
- All actions will be coordinated with the Abduction Of An Infant/Child Policy.
- All staff will be in-serviced on his/her responsibilities when an infant is reported missing.

AFFECTED AREAS/ PERSONNEL: *ALL MCH PERSONNEL*

PROCEDURE:

1. Upon notification of a missing newborn, ~~all Maternal Child Health personnel will:~~the following will be done at Maternal Child Health Services (MCH).

2. ~~MCH personnel will immediately phone extension "55" (Emergency PBX operator) and state "Code Pink" and the location of the occurrence, alerting the entire hospital of the possible abduction.~~

   a. Charge Nurse or designated nurse will immediately Dial 55 Code Pink, and identify location of the occurrence.

   b. Immediately notify Security Officers on MCH unit.

   c. All available staff will immediately go to all exits.

   d. Observe for anyone leaving.

   e. The security will pPrevent any further entrances or exits from the department.

~~3.~~2. A room-to-room search will be conducted by registered nurses to account for all infants.

   a. The mother's room and nursery will be searched as appropriate. Care will be given to protect the crime scene where the abduction occurred to preserve any evidence.

   b. All personnel on duty when the abduction occurred will remain on the unit until the authorities complete proper questioning.

   c. All personnel are requested to refrain from discussing this incident with anyone other than the authorities.

   d. All babies will remain in the mother's room with parents to promote a sense of security.

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3. If all infants are accounted for, Code Pink may be cancelled./cleared.
4. Submit an incident report as appropriate.

DOCUMENTATION:

1. Document ~~education~~ the incident of CODE PINK called and the details of outcomes ~~infant security~~ in the electronic medical record.

REFERENCE:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist-. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- AWHONN Standards and Guidelines for Professional Nursing Practice in the Care of Women and Newborns (2019), (8th Ed). Washington, D.C.; AWHONN.

CROSS REFERENCE:

- ~~ABDUCTION OF AN INFANT/CHILD ABDUCTION PROCEDURES – CODE PINK & CODE PURPLE~~

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SUBJECT: **ADVERSE DRUG REACTIONS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To encourage the early detection and reporting of adverse drug reactions in an effort to facilitate the safe and effective use of medications and biologicals in the facility.

POLICY:

Adverse drug reactions (ADRs) will be identified, evaluated, monitored, and documented by all health care staff members.

A. ***Definition*:**

Adverse drug reaction is defined as any response to a medication, excluding therapeutic failure, that is undesired, unintended, or unexpected in standard doses, resulting in one or a combination of the following:

1. A discontinuing of a medication or modifying a dose in response to an unintended physiological response;
2. An initial or prolonged hospitalization as a result of a medication reaction;
3. A disability or a life-threatening condition;
4. The use of another prescription medication to mitigate or reverse an unintended consequence;
5. Congenital anomalies or death; or
6. An effect of complicating the diagnosed disease state, such as any untoward side effect, injury, toxicity, sensitivity reaction, or significant failure or expected pharmacological action.

NOTE: This is not intended to include common and expected effects and/or changes discovered by routine monitoring.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, CHIEF MEDICAL OFFICER, MEDICAL STAFF, RESPIRATORY THERAPISTS*

PROCEDURE:

A. The health care staff member identifying the adverse drug reaction or drug administration error shall do the following:

1. Report the reaction to the primary care physician or on-call physician as appropriate, and to the supervising nurse, as appropriate. Drug administration errors, adverse drug reactions or incompatibilities that have harmed or have the potential to harm the patient must be immediately reported. If the outcome is unknown, it should also be reported immediately.

2. A report will be put into the medical center's adverse event data base.

B. The physician notified will document all Adverse Drug Reactions in the patient's medical record and allergy section of the medical record, if appropriate.

C. The supervising nurse shall ensure that the nursing staff has notified a physician, documented the reaction, and notified the pharmacy.

D. The pharmacist will enter an ADR intervention in the computer system and in the allergy section under the patient profile if not already done.

E. The pharmacist shall:

1. Conduct an ongoing screening for possible Adverse Drug Reactions. Furthermore, upon medication order entry, the pharmacist shall investigate:

   a. The sudden discontinuation of a drug followed by a STAT dose of diphenhydramine (Benadryl) and/or a corticosteroid (e.g. prednisone), naloxone, dextrose 50%, flumazenil.

   b. Any STAT dose of subcutaneous epinephrine.

   c. Any abrupt decrease in dosage or discontinuation, followed by a STAT serum level.

   d. Any of the above instances that result in an actual ADR will then be documented in the hospital's adverse event database and the physician contacted to confirm the event.

F. The Pharmacy and Therapeutics (P&T) Committee shall:

1. Review the ADR reports and trends and make an analysis and policy recommendation, if necessary.

2. Present the ADR report to the Performance Improvement/Patient Safety (PIPS) Committee with recommendations for action necessary to reduce the incidence and severity of adverse drug reactions in the hospital.

3. Recommend, if appropriate, the preparing of a Med Watch (the FDA Medical Products Reporting Program) FDA Form 3500 to be forwarded to the Food and Drug Administration.

REFERENCES:

- Title 22 (n.d.).Retrieved on November 23, 2022, from http://carules.elaws.us/code/t.22_d.5_ch.1_art3_sec.70263

SUBJECT: **BORROWING/PURCHASING OR LENDING/SELLING MEDICATIONS TO OTHER HOSPITALS AND/OR COMMUNITY PHARMACIES**	SECTION: **Page 1 of 4**

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

PURPOSE:

To ensure the organization addresses and maintains a system to obtain prescribed medications not currently available or routinely stocked by the pharmacy.

POLICY:

The Pharmacy Department ensures that prescribed medications are available 24 hours per day by providing a process for borrowing medications from other facilities in the community, when waiting for normal supply delivery from the wholesaler would cause a delay in therapy to the patient. In order to maintain this service, the Pharmacy will reciprocate with other facilities within the community by loaning medications to other facilities when supply on hand permits. Records are maintained to ensure accountability of medications either borrowed, loaned, purchased, or sold, and to track the safe transport of those medications.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

A. "BORROWING/PURCHASING"

For any merchandise borrowed or purchased from another Hospital or Community Pharmacy, the procedure outlined below shall be followed:

1. The "Selling-Borrowing Form" bearing the following shall be prepared:

   a. Name, address, and phone number of hospital or pharmacy from which the medication was borrowed/purchased

   b. Name of contact person at the lending facility

   c. The name, strength, quantity, NDC#, lot#, and expiration date of medication being borrowed and track and trace information

   d. Date of transaction

   e. Signature of the individual (employee of Sierra View Medical Center or courier) picking up merchandise

   f. If any bill or "paperwork" is received from the pharmacy when the merchandise is picked up, it shall be affixed to the Selling-Borrowing Form.

g. The hospital copy of the Selling-Borrowing Form is given to the pharmacy buyer.

h. The Pharmacy Buyer will reconcile all Selling-Borrowing Forms at the end of the month. Selling-Borrowing Forms for purchased items will be forwarded to accounts payable for processing and payment. Borrowed items will be ordered and returned to the lending facility if not already completed and noted on the form

2. The "Selling-Borrowing" form for the specific loaning facility will be completed to include:

a. Date of the transaction

b. Item/strength of the item borrowed

c. Quantity borrowed

d. Indicated that the item was "Borrowed"

e. Signature of the person completing the transaction

f. Date the medication was returned

3. All packages either sent or received will have lot numbers and expiration dates affixed so as to expedite drug recall procedures as they arise.

B. LENDING/SELLING

For any medication loaned or sold to another hospital or pharmacy, the following procedure will be followed:

1. It should be determined that by loaning or selling the medication requested, there is a sufficient quantity of medication left to accommodate the needs of the patients of the hospital.

2. Complete a "Selling-Borrowing Form" to include:

a. The borrowing facilities' name and address

b. Contact name at the borrowing facility

c. Phone number of the borrowing facility

d. Date the transaction is taking place

e. Item loaned (Include strength, , dose form, NDC#, lot#, and expiration date, track and trace information)

f. Quantity loaned

g. Signature of Sierra View Medical Center representative completing the transaction

3. A copy of the original receipt is given to the representative of the borrowing facility. The original will be given to the pharmacy buyer.

4. The Pharmacy Buyer will reconcile all Selling-Borrowing Forms at the end of each month. Debit Memo Forms for sold items will be forwarded to accounts receivable for processing and billing. The pharmacy buyer will contact the borrowing facility for all loaned items not yet returned to determine the borrowing facility's disposition.

C. RECONCILING BORROWED/LOANED MEDICATIONS

The Record of Medication Loaned/Borrowed or Purchased/Sold shall be reviewed at the end of the month by the Pharmacy Buyer for reconciliation of items borrowed/loaned or purchased/sold.

D. UTILIZING THE COURIER SERVICE FOR TRANSPORTATION

Whenever possible, hospital staff should be utilized to pick up medications being borrowed or to deliver medications being returned. However, when hospital staff is not available, the contracted courier service will be utilized. The phone number of the courier service is maintained at the Pharmacy Buyer's desk, as well in the Main Pharmacy. The service uses computerized, archived records of dispatches for delivery, which include the pickup location and time, the delivery location and time, and the driver's name and permit number. The courier service is bonded and drivers are screened by the Department of Transportation and undergo pre-employment criminal background checks.

When using the courier service, verify that the quantity of the medication being sent matches the quantity being received and that the package(s) have not been tampered with **before** signing the

voucher and before the driver leaves. If a discrepancy occurs, call the lending institution and verify the quantity being sent. If the amount received is not correct, notify the courier dispatcher immediately and report the discrepancy. Notify the Pharmacist in Charge as soon as possible of the report. Staple the copy of the courier voucher to the Borrowed Medication Receipt.

SUBJECT:	SECTION:
LABORATORY AND MODERATE COMPLEXITY POC COMPETENCY	1078 **Page ~~4 of 9~~**

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

PURPOSE:

Provides a mechanism for executing and evaluating the competencies needed by employees to provide safer practices and desired quality outcomes to customers; to identify areas of growth and professional development; and provide opportunities for ongoing passive and active learning to achieve continuous quality improvement.

DEFINITION:

Competency: ability to meet the performance standards in the application of knowledge, skills and behaviors that are required to meet organizational and departmental requirements under the varied and unpredictable circumstances of the healthcare setting.

POLICY:

The staff member's competency assessment includes the following: Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen collection, handling, processing and testing; Monitoring, recording and reporting of test results; Review of intermediate test results or worksheets, QC, proficiency testing, and preventive maintenance performance; Direct observation of performance of instrument maintenance function checks and calibration; Test performance as defined by laboratory policy; Problem solving skills as appropriate to the job.

AFFECTED PERSONNEL/AREAS: *Laboratory, Cath Lab*

PROCEDURE:

The following assessment methods will be utilized for all testing personnel:

1. Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen collection, handling, processing and testing.
2. Monitoring, recording and reporting of test results.
3. Review of intermediate test results or worksheets, QC, proficiency testing, and preventive maintenance performance.
4. Direct observation of performance of instrument maintenance function checks and calibration.
5. Test performance as defined by laboratory policy.
6. Problem solving skills as appropriate to the job.

PROCEDURE:

Competency Accountability - The accountability for competency assessment will occur at three levels:

1. Organizational – collaborative oversight will be provided by the Human Resources, Education and Quality departments

2. Designated director for each department - The Director in each department is responsible for:

   a. Conducting a needs assessment to identify both unit specific and house-wide competencies based on low volume, high risk, new workflow/process/equipment, problem prone areas

   b. Receiving and distributing information from Human Resources, Education and Quality departments

   c. Establishing a mechanism to identify unit-specific competencies with staff involvement

   d. Creating an environment that promotes timely competency assessment and ongoing growth and development

   e. Providing education to employees on the competency process

   f. Monitoring employees progress

   g. Participating in evaluation of the competency process

3. The employee is responsible for:

   a. Completing competencies as indicated

   b. Participating in competency development

Validation of Individual Competencies

1. The employee will be deemed "competent" when the competency assessment method has been completed and documented.

2. If successful completion is not achieved, the employee will be remediated and an action plan to complete the required competencies will be created in collaboration with the department manager/director, Human Resources, and Education Departments as applicable.

3. At the end of the action plan, if the employee has not completed their competencies as indicated, they will be removed from the work schedule and placed on a two (2) week Administrative Leave without pay, to seek another position for which they may be qualified and competent. Paid Time Off may not be utilized during the Administrative Leave.

4. At the end of the two (2) week Administrative Leave, if no other position has been sought or accepted, the employee will be separated from employment with the District.

REFERENCES:

- The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- OMH CLAS Standards – Standards 2 and 6

- California Code of Regulations (2020). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Performance Review Process

APPENDIX A

JOB CODE	JOB TITLE
81018	CARDIAC CATH LAB RAD TECH
8103	CARDIAC CATH LAB/IR RAD TECH LEAD
1505	CARE TRANSITION COACH
2729	CARE TRANSITION COORDINATOR
1862	CASE MANAGER
1862T	CASE MANAGER - AGENCY
1862B	CASE MANAGER - PD
1070	CENTRAL SUPPLY SUPERVISOR
8503	CERTIFIED HEMODIALYSIS CHIEF TECHNICIAN
8502	CERTIFIED HEMODIALYSIS MACHINE/SUPPLY TECHNICIAN
8500	CERTIFIED HEMODIALYSIS TECHNICIAN
8500R	CERTIFIED HEMODIALYSIS TECHNICIAN - AGENCY
8500B	CERTIFIED HEMODIALYSIS TECHNICIAN - PD
2712	CHARGE NURSE
9600	CHIEF RADIATION THERAPIST
1182	CLINICAL DIETITIAN
1182T	CLINICAL DIETITIAN - AGENCY
1182B	CLINICAL DIETITIAN - PD
9501T	CLINICAL LAB SCIENTIST - AGENCY
9501	CLINICAL LAB SCIENTIST INFORMATICS
9500	CLINICAL LAB SCIENTIST LEAD
9500B	CLINICAL LAB SCIENTIST LEAD - PD
9502	CLINICAL LAB SCIENTIST SPECIALIST
9506B	CLINICAL LAB SCIENTIST SPECIALIST - PD
9503	CLINICAL LAB SCIENTIST TRAINEE
1173	CLINICAL NUTRITION MANAGER
1656	CLINICAL PHARMACIST
1815	CLINICAL TEAM LDR/OR TECH
9500T	CLS - AGENCY
9501B	CLS I - PD
95001	CLS I (0 - 24 months experience)
9502B	CLS II - PD
95002	CLS II (25+ months experience)
4579	CNA
4581T	CNA - AGENCY
4580	CNA - LTC
4580B	CNA - LTC - PD
4579B	CNA - PD
4581R	CNA - REGISTRY
9905	CONTRACT STAFF-PHARMACIST
1179	COOK

1179B	COOK - PD
1180	COOK LEAD
1073	CP TECH I - NON CERT
1073B	CP TECH I - NON CERT - PD
1079	CP TECH II - CERTIFIED
1079B	CP TECH II - CERTIFIED - PD
81021	CT TECH
8102T	CT TECH - AGENCY
8102B	CT TECH - PD
81033	CT/MRI TECH LEAD
6278	DIET AIDE
6278B	DIET AIDE - PD
8104	ECHO TECH LEAD
1864	ED CARE COORDINATOR
1292	EDUCATOR, CLINICAL
1292B	EDUCATOR, CLINICAL - PD
5820	EMERGENCY DEPARTMENT COORDINATOR
1824	EMERGENCY SERVICES COORDINATOR
1824B	EMERGENCY SERVICES TECH - PD
1816	ENDO TECH
1816B	ENDO TECH - PD
6239	EVS AIDE I
6239T	EVS AIDE I - AGENCY
6239B	EVS AIDE I - PD
6249	EVS AIDE II
6249B	EVS AIDE II - PD
6255	EVS AIDE III
6255B	EVS AIDE III - PD
6250	EVS AIDE IV LEAD
0500	EVS SUPERVISOR
6270	FOOD SERVICE LEAD
6279	FOOD SERVICE WORKER
6279B	FOOD SERVICE WORKER - PD
6279T	FSW/DIETARY AIDE - AGENCY
1425	HEALTH CARE INTERPRETER
2738	INFECTION PREVENTION MANAGER
2737	INFECTION PREVENTION RN
81015	INTERV/ANGIO TECH
0421	LAB CLERK LEAD
2119	LABORATORY MANAGER
2727	LACTATION SPECIALIST
2727B	LACTATION SPECIALIST-PD
1501	LIC CLINICAL SOCIAL WORKER
1501B	LIC CLINICAL SOCIAL WORKER - PD
3462	LVN
3464T	LVN - AGENCY

3482	LVN - LTC
3482B	LVN - LTC - PD
3492	LVN - MDS COOR - LTC
3492B	LVN - MDS COOR - LTC - PD
3472	LVN - ONOCOLOGY
3462B	LVN - PD
3453	LVN - PI
3484R	LVN - REGISTRY
3442	LVN - UR NURSE
81061	MAMMOGRAPHY TECH
8106B	MAMMOGRAPHY TECH - PD
8106	MAMMOGRAPHY TECH LEAD
1504	MASTERS OF SOCIAL WORK
1504T	MASTERS OF SOCIAL WORK - AGENCY
1822	MEDICAL ASSISTANT
1820	MONITOR TECH
1820B	MONITOR TECH - PD
81031	MRI TECH
8103T	MRI TECH - AGENCY
8103B	MRI TECH - PD
7010	NEW GRADUATE/NOVICE RN - TIER 0
81051	NUCLEAR MED TECH
8105T	NUCLEAR MED TECH - AGENCY
1819	OBSTETRICAL TECHNICIAN - CERTIFIED
1818	OBSTETRICAL TECHNICIAN - NON CERT
1696	OCCUPATIONAL THERAPIST
1696B	OCCUPATIONAL THERAPIST - PD
1261	PALLIATIVE CARE MANAGER
1651	PERFORMANCE IMPROVEMENT PHARMACIST
1651B	PERFORMANCE IMPROVEMENT PHARMACIST-PD
1293	PERIOPERATIVE CLINICAL EDUCATOR
2728	PERITONEAL DIALYSIS RN COORDINATOR
2728B	PERITONEAL DIALYSIS RN COORDINATOR - PD
1652T	PHARMACIST - AGENCY
1650	PHARMACY CLINICAL COORDINATOR
5663	PHARMACY TECH
5664	PHARMACY TECH - EMERGENCY DEPT
5663B	PHARMACY TECH - PD
0671	PHARMACY TECH SUP
0442	PHLEBOTOMIST CERTIFIED LEAD
1684T	PHLEBOTOMIST/LAB AIDE - AGENCY
1684	PHLEBOTOMIST/LAB AIDE CERTIFIED
1684B	PHLEBOTOMIST/LAB AIDE CERTIFIED - PD
1692T	PHYSICAL THERAPIST - AGENCY
1692	PHYSICAL THERAPIST - STAFF
1692B	PHYSICAL THERAPIST - STAFF - PD

1695	PHYSICAL THERAPIST LEAD
4589	PHYSICAL THERAPY AIDE
4589B	PHYSICAL THERAPY AIDE - PD
4593T	PHYSICAL THERAPY ASSISTANT - AGENCY
4593R	PHYSICAL THERAPY ASSISTANT - REGISTRY
4593	PHYSICAL THERAPY ASST
4593B	PHYSICAL THERAPY ASST - PD
4590	PHYSICAL THERAPY COOR
0811	PHYSICAL THERAPY MANAGER
5807	PHYSICAL THERPAY AUTHORIZATION COORDINATOR/SCHEDULER
96001	RADIATION THERAPIST
9601B	RADIATION THERAPIST - PD
1724	RADIATION THERAPY AIDE
1724B	RADIATION THERAPY AIDE - PD
81011	RADIOLOGIC TECH
8101T	RADIOLOGIC TECH - AGENCY
8101B	RADIOLOGIC TECH - PD
8105	RADIOLOGIC TECH LEAD
8102	RADIOLOGY AIDE
8100T	RADIOLOGY AIDE - AGENCY
8108B	RADIOLOGY AIDE - PD
9204T	RCP - AGENCY
9204R	RCP - REGISTRY
9201B	RCP I - PD
92001	RCP I (0 - 36 months experience)
9204B	RCP II - PD
92004	RCP II (37+ months experience)
0600	RCP LEAD
2700	REGISTERED NURSE
7005T	RN - AGENCY
7005R	RN - REGISTRY
2712T	RN CHARGE NURSE - AGENCY
0914	RN CLINIC MANAGER
0911	RN CLINICAL MANAGER
2732	RN FIRST ASSIST
2732T	RN FIRST ASSIST - AGENCY
2732B	RN FIRST ASSIST - PD
7010	RN NEW GRADUATE
2102	RN NURSING SUPERVISOR
2102B	RN NURSING SUPERVISOR - PD
7001C	RN Per Diem Tier II
7002C	RN Per Diem Tier III
7003C	RN Per Diem Tier IV
7004C	RN Per Diem Tier V
7005C	RN Per Diem Tier VI
7006C	RN Per Diem Tier VII

2722	RN PRECEPTOR (2nd Position Only)
2730	RN PRE-HOSPITAL LIAISON
4909	RNA - LTC
81046	RVT ULTRASONOGRAPHER TECHNOLOGIST
1503	SOCIAL SERVICES DESIGNEE
1502	SOCIAL WORK ASSISTANT
1502B	SOCIAL WORK ASSISTANT - PD
1694	SPEECH THERAPIST
1694B	SPEECH THERAPIST - PD
1652	STAFF PHARMACIST
1652B	STAFF PHARMACIST - PD
1810	SURGICAL ORDERLY
1810B	SURGICAL ORDERLY - PD
1814T	SURGICAL TECH - AGENCY
1814	SURGICAL TECH - CERTIFIED
1814B	SURGICAL TECH - CERTIFIED - PD
1813	SURGICAL TECH - NON CERT
1813B	SURGICAL TECH - NON CERT - PD
81041	ULTRASONOGRAPHER
8104T	ULTRASONOGRAPHER - AGENCY
8104B	ULTRASONOGRAPHER - PD
8104R	ULTRASONOGRAPHER - REGISTRY
81047	ULTRASONOGRAPHER LEAD
5885	UNIT CLERK
5885B	UNIT CLERK - PD
2735	WOUND CARE RN SPECIALIST
1294	CERTIFIED LACTATION EDUCATOR/SECRETARY
1294B	CERTIFIED LACTATION EDUCATOR/SECRETARY - PD

SUBJECT:	SECTION:
CONTROLLED SUBSTANCES	***Medication Management (MM)*** **Page 1 of 10**

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

PURPOSE:

To ensure that medications defined as controlled substances under Division 10 of the Uniform Controlled Substances Act are procured, distributed and accounted for in accordance with all Federal and State laws and regulations.

DEFINITIONS:

Cactus Sink – Designated pharmaceutical waste container for all controlled substances.

POLICY:

The Department of Pharmaceutical Services shall be responsible for the organizational compliance of all laws and regulations governing the procurement, distribution and accountability of controlled substances of Schedule II, III, IV and V at Sierra View Medical Center. The Pharmacy under definition of Drug Enforcement Agency registration will not procure, retain or dispense medications that fall under definition of schedule I under the Uniform Controlled Substances Act. Systems (procedures) will be developed and maintained by the Department of Pharmaceutical services to ensure accountability, with valid audit trails and record retention.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, ANESTHESIA*

PROCEDURE:

A. GENERAL INFORMATION

1. All controlled substances at SVMC are stored, managed, secured, and reviewed through the Pyxis C-II Safe and by the Pyxis Med Station dispensing cabinets.

B. ORDERING

Controlled substances are procured through the wholesaler by the initiation of:

1. Schedule II – Pharmacists who have been granted power of attorney shall order through the wholesaler's ordering system via CSOS (Controlled Substance Ordering System). When there are technical problems with CSOS software or internet access, then DEA 222 paper forms will be utilized.

2. Schedule III-V's are ordered through the wholesalers ordering system.

C. RECEIPT AND STORAGE

1. Controlled Substances received from vendors/other pharmacies:

   a. Vendor invoices are compared with order form, confirmed with physical count, and then signed and dated by a Pharmacist.

b. Any discrepancies are handled immediately.

2. Received inventory placed in C-II Safe by a licensed pharmacist

a. Quantity received, invoice number, date ordered, and User ID of who received them is recorded on the Vendor/Pharmacies Report. (DEA 222 number also required if Schedule II's are received).

b. These reports are filed and retained on-site for 3 years and in readily retrievable storage for no less than 7 years prior to destruction.

c. The DEA222 order form, delivery receipt from the wholesaler and CII safe report "medications received from vendors" that shows drug and quantity added to CII safe are all reviewed and signed by pharmacist checking in the medication and then reviewed and signed by the pharmacist in charge.

D. DISPENSING

1. Physician orders for medications including controlled substances are entered by the Physician via CPOE (Computer Physician Order Entry) or faxed to the Inpatient Pharmacy.

2. A Pharmacist evaluates the medication order for safety, efficacy, and appropriateness, and then verifies the approved order into the patient's profile as found in the hospital's information system.

3. Controlled substances are removed from the C-II Safe and placed into the various units Pyxis MedStations throughout the facility by the Narcotic Technician.

a. A Pharmacist checks all medications, including controlled substances, that are dispensed to Pyxis prior to the medications leaving the pharmacy.

b. The Narcotic Technician is required to run Pyxis vs. C-II Safe Compare reports prior to the end of their shift to verify that the exact quantity of each controlled substance dispensed was received by the Pyxis MedStation and that there are no discrepancies. These reports are to be given to the Technician Supervisor for review. Any open discrepancy is immediately reported to the pharmacist in charge.

4. Controlled substances removed from the units' Pyxis MedStations by Pharmacy personnel must be returned to the C-II Safe. If not, a discrepancy will show in the Compare Report until documentation is provided to clear the variance. Documentation must be provided within 24 hours to clear the variance. At the end of each shift, an "Open Discrepancy Report" is run to confirm inventory and identify any open discrepancies. All discrepancy reports are reviewed and signed and dated by the pharmacist in charge.

5. If a controlled substance is lost or is missing after an exhaustive search, a Lost Medication Report must be filed with the DEA immediately upon discovery and with the Board of Pharmacy within thirty days.

6. After the medication order is processed by the Pharmacist, the medication becomes available to the nurse for administration via the unit's Pyxis Med Station.

E. WASTING AND ADMINISTRATION

1. When a physician ordered dose is less than the unit dose stocked medication in Pyxis:

   a. The Pyxis will require a witness upon removal of all controlled medication prior to removal.

   b. The nurse and the witness will waste the excess medication in the proximally located Cactus Sink.

   c. The administering nurse will scan the patient's wrist band and the medication.

   d. Scanning of the medication will create documentation of the administered dose.

   e. The nurse will administer the medication.

2. Controlled substances removed from Pyxis without authorization or review by the pharmacist via override requires a witness.

3. Override medication removals are reported and evaluated on the Pyxis override report generated daily by the inpatient pharmacy.

Unapproved removals are reported into the hospital's occurrence reporting system and the pharmacy director is notified immediately.

4. Wasting of controlled medication in the Pharmacy must be done by two pharmacists:

   a. Upon discovery or creation of a controlled medication requiring it to be wasted, i.e., broken vial, damaged package, creation of a unit dose medication from a bulk package, the following will occur:

      - Pyxis CII Safe is accessed and the Expiration Function is selected
      - Uncheck option for placing into "destruction bin"

         1. A description for reason for wasting of medication is typed in the field provided.

2. Pharmacist will login to Pyxis and witness transaction

3. Remaining or residual drug is physically wasted in pharmacy designated Cactus Sink with witness.

4. A daily Undocumented Discrepancy Waste Report is run in the pharmacy to identify any absent documentation. Any open discrepancies are immediately reported to the pharmacist in charge.

F. MONITORING

1. The Narcotic Technician is required to perform regular patient chart audits, comparing controlled substance removal records with patient eMAR documentation.

2. Pharmacy runs a monthly Proactive Diversion Report that looks at controlled substance utilization using standard deviation determinations. Unusual usage by any nursing staff is reported to the Nursing Manager of that unit and a full comparison check of targeted controlled substance removals from Pyxis with patient eMAR documentation is required to be completed within 72 hours. Based on the results of that investigation, the following will happen:

   - Nothing – the investigation reveals no problems and all documentation is confirmed
   - Progressive Discipline – The Nursing Manager finds that poor documentation issues are revealed but no evidence of diversion exists. This will result in disciplinary action that may be as basic as verbal warning but could result in termination based on that employee's past history. Progressive Discipline is coordinated in conjunction with HR (Human Resources). All errors are documented in the hospital's incident reporting system.
   - Diversion Investigation – The Nursing Manager's investigation reveals substantial deficits in documentation. At that point, Pharmacy is contacted to assist with expansion of the employee's history via Pyxis reports. See Diversion below.

G. DIVERSION OF CONTROLLED SUBSTANCES

1. The Clinical Director of the unit where the suspected employee works will conduct a full investigation with the expanded Pyxis report from Pharmacy. Pharmacy and HR may be called to assist with this investigation.

2. Human Resources will be notified that a suspected diversion has occurred. If a diversion is validated by the investigator, HR in conjunction with Nursing Administration, will inform the CEO (Chief Executive Officer) of the hospital

and file the police report. If applicable, a report will also be filed with the licensing board of the suspected diverter (Board of Registered Nurses, or the Department of Consumer Affairs for Pharmacists, and Physicians).

3. Based on the results of the investigation, any suspected diversion of controlled substances is to be reported immediately upon discovery to the DEA (Drug Enforcement Agency).

H. PYXIS ANESTHESIA SYSTEMS

All controlled substances are pulled by the Narcotic Technician according to par levels set in the Anesthesia Carts. A MedStation auto restock report is run and the meds are pulled from C-II Safe to replenish and make sure that the Anesthesia Carts are at maximum level daily. A Pharmacist will verify that all medications and quantities are correct before they are taken to the stations.

I. REMOVING OUTDATES FROM INVENTORY

When Schedule II-V medications are outdated, they are removed from inventory and placed in the drawer segregated in the C-II Safe designated specifically for controlled substance outdates and held until processed through the recover service (See "Disposition" below).

J. DISPOSITION

1. Return for manufacturer credit/destruction.

2. At regular intervals (quarterly, or more frequently as required), a Pharmaceutical Reverse Distributor that is under contract to process expired medications. Controlled substances are processed in the following manner.

   a. Expired Schedule II medications contained in the outdate drawer in the C-II Safe are inventoried by the reverse distributor personnel. The inventory is then verified against the "dispensed" with the transaction date and the DEA Form 222 number.

   b. The recovery service issues a DEA Form 222 as a registered distributor to the Hospital (supplier) for each line item medication that is being returned by NDC number, up to 10 line items per form.

   c. The top copy "Supplier's Copy 1" is retained by the Pharmacy. A copy is made and placed in the "Expired C-II Safe Inventory" folder, until a "Manufacturer Return Report – Schedule Drugs" is received. Once received, it is reconciled against the DEA 222 and the original forwarded to the DEA in accordance with regulation.

d. Schedule III, IV and V

Expired Schedule III, IV and V medications contained in the outdate drawer in the C-II Safe are inventoried by the reverse distributor personnel. A "Controlled Substances Inventory and Transfer" document is generated by the recovery service and a copy retained in the "Expired C-II Safe Inventory" folder and reconciled when a "Manufacturer Return Report – Schedule Drugs" and/or a "Disposal Report – Schedule Drugs" is received and reconciled.

K. DOCUMENTATION AND RECORD RETENTION AND INVENTORY

1. All documentation regarding procurement, distribution and/or disposal of controlled substances shall be kept on-site for at least 3 years and in readily retrievable storage off-site for no less than 7 years prior to destruction.

2. A physical inventory will be conducted no less than twice a month for all Scheduled medications. All discrepancies will be reconciled and brought to the attention of the Pharmacist in Charge.

3. A biennial ~~bi-annual~~ inventory will be completed in accordance with DEA regulations and retained ON SITE for no less than 7 years.

4. Physical inventory audits are performed in all areas where controlled substances are maintained and are performed during required monthly unit/area inspections. Results of inventory audits will be monitored and reported as a performance improvement indicator to identify and trend any problems. Subsequent action and control will be implemented as deemed necessary and appropriate.

5. At least every three months, the pharmacist in charge will compile an inventory reconciliation report of all Federally Scheduled CII Drugs stored in the pharmacy. Additionally products containing the following substances in the following strengths per tablet, capsule, other unit, or specified volume, a reconciliation report at least quarterly:
A. Alprazolam, 1 milligram/unit.
B. Alprazolam, 2 milligrams/unit.
C. Tramadol, 50 milligrams/unit.
D. Promethazine/codeine, 6.25 milligrams of promethazine and 10 milligrams of codeine per 5 milliliters of product.

For any controlled substance not identified above, an inventory reconciliation report shall be prepared for identified controlled substances lost no later than three months after discovery of the loss of that controlled substance. This report shall be completed if the loss is discovered either by inventory activities or in any other manner. The report shall cover the period from the last physical count of that controlled substance before the loss was discovered through the date of

discovery. At a mimimum, any pattern(s) of loss(es) identified by the pharmacist in charge shall require an inventory reconciliation report for each pattern of loss identified, as defined by the pharmacy's policies and procedures. Any reportable loss, as specified in section of 1715.6 of CCR, shall also require an inventory reconciliation report.

An inventory reconciliation report shall require:

a. A physical count of all quantities of each federal controlled substance covered by the report that the pharmacy or clinic has in inventory. The biennial inventory required by federal law may count as one of the mandated inventories, so long as the biennial inventory was taken no more than three months from the last inventory required.

b. A review of the acquisitions and dispositions of each controlled substance covered by the report since the last inventory reconciliation report covering that controlled substance.

c. A comparison of the physical count with the acquisitions and dispositions to determine if there are any variances.

d. All records used to compile each inventory reconciliation will be maintained in the pharmacy for at least three years in a readily retrievable form.

e. Identification of each individual involved in preparing the report and possible causes of overages shall be identified in writing and incorporated into the inventory reconciliation report.

f. The inventory reconciliation report shall be dated and signed by the individual (s) performing the inventory, and countersigned by the pharmacist-in-charge and readily retrievable in the pharmacy for three years. A counter signature is not required if the inventory was personally completed by the pharmacist-in- charge.

6. The pharmacist-in-charge shall ensure that the Pyxis Med Stations located outside of the pharmacy:

g. All controlled substances added to the Pyxis stations are accounted for (not just CII);

h. Access to the Pyxis machines is limited to authorized personnel

i. Ongoing evaluations of discrepancies or unusual access associated with controlled substances is performed;

j. Confirmed losses of controlled substances are reported to the Board of Pharmacy.

L. REPORT OF THEFT, LOSS OR SHIPPING DISCREPANCY

1. Pursuant to Division 10, Chapter 3, Article 1, Section 11103 of the State Health and Safety Code "The theft or loss of any substance regulated Pursuant to Section 11100 discovered by any licensee or any person regulated by the provisions of this chapter, shall be reported to the Department of Justice within THREE (3) days after such discovery. "Any difference between the quantity of any substance regulated pursuant to Section 11100 received and the quantity shipped shall be reported to the Department of Justice within THREE (3) days of the receipt of actual knowledge of the discrepancy.

2. Pharmacy shall submit to the Board a report containing information according to California Code of Regulations Title 16, Division 17, Article 2, Section 1715.6 no later than thirty (30) days after the date of discovery of the following:

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Any loss of a controlled substance ein one of the following categories that causes an aggregate amount of unreported losses discovered in that category, on or after the same day of the previous year to equal or exceed:

a. For tablets, capsules, or other oral medication, 99 dosage units.
b. For single-dose injectable medications, lozenges, fild, such as oral, buccal and sublingual, suppositories, or patches, 10 dosage unites.
c. For injectable multi-dose medications, medications administered by continuous infusion, or any other multi-dose unit not described in subparagraph (A), two or more multi dose vials, infusion bags, or other containers.

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Any loss of a controlled substance regardless of the amount, attributed to employee theft, in addition to the reporting requirements and time frames mandated by Business and Professions Code section 4104.

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Any other significant loss as determined by the pharmacist-in-charge, including but not limited to losses deemed significant relative to the dispensing volume of the pharmacy.

All reports under section 1715.6 Reporting Drug Loss of California Code of Regulations shall specify the identity, amount and strength of each controlled substance lost, and date of discovery of the loss, for all losses that have made the report necessary.

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~~2. Pharmacy shall report identified losses and known causes to the Board within 30 days of discovery unless the cause is theft, diversion, or self-use, in which case the report shall be made in 14 days of discovery. If the cause is unable to be~~

~~identified, further investigation shall be undertaken to identify the cause and actions necessary to prevent additional losses of controlled substances.~~

M. SUSPICIOUS ORDER REPORTING SYSTEM

1. Orders for controlled substances may be considered suspicious if it is an unusual size, unusual pattern or frequency.

2. The pharmacist in charge will report any suspicious orders to the DEA's Suspicious Orders Report System (SORS) online

N. LICENSED EMPLOYEE, IMPAIRMENT, THEFT AND DIVERSION: PHARMACY PROCEDURES

1. The Department of Pharmacy shall report to the Board, within 14 days of the receipt or development thereof, the following information with regard to any licensed individual employed in or working with the pharmacy.

   a. Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice.

   b. Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.

   c. Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs.

   d. Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

   e. Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects their ability to practice.

   f. Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

   ~~f.~~g. If the cause is unable to be identified, further investigation shall be to taken to identify the cause and actions necessary to prevent additional losses of controlled substances.

2. The report required to be submitted to the Board of Pharmacy shall include sufficient detail to inform the Board of facts upon which the report is based,

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including the estimate of the type and quantity of all dangerous drugs involved, the time frame of the losses, and the date of the last controlled substance inventory. All reports to the Board are immune from civil or criminal liability.

FORMS:

Form Name	*Obtained From*	*Process*
DEA Form 222	Drug Enforcement Administration	Complete and send in request form to DEA (allow 2 weeks for processing). If request forms are needed, the DEA may be contacted and additional request forms will be mailed (allow 2 weeks for processing).
Expired C-II Safe Inventory Forms	Printed Locally	Form is printed from the C-II Safe
Pyxis vs. C-II Safe Compare Reports	Printed Locally	Form is printed from the C-II Safe
MedStation Auto Restock Forms	Printed Locally	Form is printed from the C-II Safe

REFERENCES:

- California Board of Pharmacy. Retrieved -June 21, 2022, from https://www.pharmacy.ca.gov/about/news_release/board_update_may_22.pdf
-
- Department of Justice. Drug Enforcement Administration Diversion Control Division. Retrieved October 26, 2021, from https://www.deadiversion.usdoj.gov/21cfr/cfr/index.html.
- Nursing Practice Act. (n.d.). Retrieved October 23, 2017, from http://www.rn.ca.gov/practice/npa.shtml.
- Marquardt, K.A., Tharratt, R.S., Musallam, N.A. Fentanyl remaining in a transdermal system following three days of continuous use. *Ann Pharmacother.* 1995; 29: 969-971.

CROSS REFERENCE:

- Wasting or Returning Controlled Substances Policy

SUBJECT:	SECTION:
DEATH SUMMARIES FOR INPATIENT, SKILLED NURSING AND EMERGENCY DEPARTMENT MEDICAL RECORD	**Page 1 of 1**

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

POLICY:

Sierra View Medical Center (SVMC) shall ensure that all patients that have expired at this facility have a dictated note, otherwise known as a final or death summary, dictated and in their medical record within 14 days of discharge. This note will indicate the reason for admission, the findings and course in the hospital and the events leading to death.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL/MEDICAL STAFF*

PROCEDURE:

- All patients who have expired in this facility, inpatient, skilled nursing or Emergency Department, shall have a final summary to include the above stated information.
- It will be the responsibility of the Health Information Management Department to monitor these medical records to make sure that the proper documentation is present.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Medical Record Guidelines for Physicians

SUBJECT:	SECTION:
DELEGATION OF DUTIES LABORATORY MEDICAL DIRECTOR	***ADMINISTRATION*** **Page 1 of 2**

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PURPOSE:

In accordance with standards established by the Clinical Laboratory Improvement Amendments (CLIA) and adopted by the College of American Pathologists (CAP) TLC.11425 (Delegation of Functions), the Medical Director for Sierra-View Medical Center's clinical laboratory has delegated responsibilities and authority to Section Directors / Technical Supervisors (Section Heads) and General Supervisors, meeting the CLIA qualifications for the specialties supervised.

DEFINITIONS:

N/A

POLICY:

All section heads for Sierra-View Medical Center's clinical laboratory services meet the CLIA requirements for supervising high-complexity testing (GEN.53400). The performance of section directors/technical supervisors and General Supervisors (GEN.55525) are assessed upon initial appointment, and annually thereafter. Technical Supervisors / Technical Directors have authority and responsibilities to include:

- Ensuring availability to the laboratory section as needed for on-site, telephonic or electronic consultation.
- All technical and regulatory compliance for the assigned discipline or service. Implements and maintains CAP standards, selection of equipment and methodologies, validation and implementation of new methods and instruments, communication of laboratory data, resolution of technical problems and ensuring remedial actions are taken when necessary, and an appropriate education, research and development for the sections' disciplines.
- Ensuring policies and standard operating procedures (SOPs) are relevant and appropriate, and SOPs are reviewed biennially. Oversees biennial accreditation self-inspections on opposite years of CAP onsite inspections.
- Establishes and maintains an effective Quality Management (QM) program for the clinical service that covers all areas of the laboratory and beneficiaries of services. This includes establishing quality indicators of pre- analytic, analytic, and post-analytic phases of testing, investigating and resolving quality variances, and performs rootcause-analyses when necessary.
- Ensuring enrollment in Proficiency Testing programs for all analytes, and ensuring compliance with Quality Assurance, Quality Control, and Performance Improvement programs. Ensures a safe work environment for staff.
- Personnel Management: ensuring staff qualifications, training, competency, and continuing education requirements are met.
- All Technical Directors/Supervisors identify training needs and have authority to train and competency assess technical staff that support patient care responsibilities in their clinical sections.

Each clinical service has one or more General Supervisor(s) under the supervision of the section technical director. General Supervisors have delegated authority to:

- Resolution of technical problems in accordance with policies and procedures established by the laboratory director or technical supervisor.
- Monitoring test performance and ensure remedial actions at taken when test systems deviate from established performance specifications.
- Performing training and competency assessment in their disciplines, but must meet the general supervisor qualifications for high complexity testing if assessing staff performing high-complexity testing.
- Ensures qualified, credentialed and trained personnel perform testing, and staff records are maintained.
- Facilitate staff participation in section and NIH-wide continuing education programs.

NOTE: The following functions may not be delegated, and are only facilitated/approved by the Medical Director:

Attestation statements for Immunohematology proficiency testing.

REFERENCES:

LD.04.05.01, The Joint Commision 2022

SUBJECT:	SECTION:
DILUTION OF ROCEPHIN AND LIDOCAINE FOR IM INJECTIONS IN PEDIATRIC PATIENTS 2 MONTHS TO 12 YEARS	**Page 1 of 1**

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PURPOSE:

To reconstitute ceftriaxone (Rocephin®) with 1% Lidocaine at an age appropriate dose and reduce injection site pain.

AFFECTED AREAS/PERSONNEL: *CDU/PEDIATRICS/ED RN, LVN*

POLICY:

1. 1% Lidocaine is to be used when reconstituting ceftriaxone (Rocephin®) for IM injections in pediatric patients age 2 months to 12 years.

2. Maximum dosage for 1% Lidocaine should not exceed 5 mg/ kg.

3. Use the following table for reconstituting ceftriaxone (Rocephin®):

Dose Size	Concentration	Amount of lidocaine to be added
250 mg vial	250mg/ml	0.9 ml
500 mg vial	250mg/ml	1.8 ml
1 gm	250mg/ml	3.6 ml
2 gm	250mg/ml	7.2 ml
500mg vial	350 mg/ml	1 ml
1 gm	350 mg/ml	2.1 ml
2 gm	350 mg/ml	4.2 ml

4. Avoid using a needle longer than 1" for infants and young children.

5. Do not inject more than 1 ml of medication for an infant and 2 ml for a toddler or older child in any one site.

6. For preferred injection sites see Pediatric Nursing Procedures.
Note: 250mg/ml has lower incidence of injection site reactions

REFERENCES:

- Hughes, H. and Kahl, L. (2021). The harriet lane hand book 22rd edition. Elsevier. Philadelphia, PA.
- SAGET pharmaceuticals (October 2021). Ceftriaxone for injection, USP. Schaumburg, IL.

SUBJECT:	SECTION:
DONOR BREAST MILK	*[Enter manual section here]*
	Page 1 of 3

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PURPOSE:

To provide clinical guidelines for the use of Donor Breast Milk (DBM) when mother's own milk is not available. Human milk is the preferred feeding for all infants, including premature and sick newborns with rare exceptions.

DEFINITION:

Donor Breast Milk (DBM)
Breastmilk received from "Mother's Milk Bank- that follows the mandatory guidelines from the Human Milk Banking Association of North America (HMBANA) to ensure the safest product possible is provided. All donors provide milk on voluntary basis. Only healthy women who are non-smokers and have a healthy lifestyle are accepted as donors.

POLICY:

A. A physician must order the use of Donor Breast Milk.
B. The parent or guardian will receive written information on Donor Breast Milk; physician and staff will give them opportunity to ask questions.
C. The staff will obtain a signed consent form prior to the use of Donor Breast Milk.
D. The hospital will obtain DBM from a milk bank licensed as a tissue bank by the California Department of health.
E. The hospital/department will maintain and track records of delivery and distribution of Donor Breast Milk.
F. Donor Breast Milk is indicated for the following:
    1. Infants less than 1500 grams at birth when mom cannot provide her own breast milk. The physician will order DBM until the baby is 1500 grams.
        Key Point: At 1500 grams, babies will begin transitioning to formula.
        Key Point: All attempts to transition the baby at least one week prior to discharge will be made.
        Key Point: This may include periods of time when mothers are pumping but their breast milk is not readily available to their baby.
    2. The physician will order DBM for babies under special circumstances and will be eligible to receive DBM until 1800 grams. (at which point they be transitioned to formula).
        2.1 Any baby with stage NEC –stage 11 or greater.
        2.2 Any baby with IUGR as defined as birth weight <10th percentile for gestational age.
        2.3 Any baby with a history of twin-to-twin transfusion (donor to recipient)
        2.4 Any baby at risk for compromised for gastrointestinal blood flow. (e.g. coarctation of the aorta, malrotation of the intestines, gastroschisis).

AFFECTED PERSONNEL/AREAS: *MATERNAL CHILD HEALTH SERVICES-PHYSICIANS, REGISTERED NURSES, AND LACTATION CONSULTANTS*

EQUIPMENT: N/A

PROCEDURE:

A. Physician provider will order Donor Breast Milk.
B. Parent/guardian consent must be obtained and documented in the patient's Electronic Medical Record (EMR).
C. Obtaining Donor Breast Milk
   1. DB will be obtained only from approved processing centers (Ni-Q).
   2. Milk should be immediately unpacked and stored appropriately (Ni-Q milk shelf stable). Verify that all containers are received in appropriate condition. Notify the milk centers if there are any problems.
   3. Document all milk on tracking log including: batch number, milk center name, date received, date expires, number of containers, and size of containers.
   4. Store in individual bins labeled with contents and separated by batch number.
D. Storage
   1. Store at room temperature until opened.
   2. Refrigerate after opening in either resealable pouch or sterile container.
   3. After initial opening, Human Donor Milk can remain in the refrigerator for 5 days.
   4. Do not freeze.
E. Dispensing milk:
   1. Each container will be signed out on the tracking log with the date dispensed and medical record number (s). One container of milk can be used for multiple recipients.
   2. DBM should be wiped with alcohol before opening container.
F. DBM Handling/Preparation & Use
   1. Breastmilk preparation and handling will be completed under aseptic technique.
   2. Inspect the pouch for any damage, leaking or bulging.
   3. Do not use damaged pouches.
   4. Shake pouch before opening.
   5. Twist off the resealable cap and place cap top down on clean surface.
   6. Pour the desired volume of the Human Donor Milk (HDM) plus needed.
   7. Reseal the unused portion in the pouch using the twist cap.
   8. Document on the donor milk log, amount used.
   9. Label pouch with current date and time; store either in the resealable pouch or sterile container in the refrigerator after opening.
G. Warming Recommendations:
   1. HDM temperature benefit allows for feeding "out of the pouch" as long the pouch is at room temperature.
   2. If HDM has been refrigerated, I-Q recommends standard warming protocol for infant feeding be followed to bring the temperature of HDM to room temperature prior to feeding.

REFERENCES:

Cite your current references here using APA format. References should not be older than 3-5 years unless you've checked and there is nothing more recent to add.

Use APA format to indicate book references like this:

Jones, F. (2019). Best practices for expressing, storing and handling human milk in hospitals, homes and child care settings (4th ed.). Texas: *Human Milk Banking Association of North America,* (HMBANA).

McGuire, W. & Anthony, M.Y., (2003). Donor human milk versus formula for preventing necrotizing enterocolitis in preterm infants: Systematic review. *Archives of Disease in Childhood, Fetal and Neonatal Edition*: 88:F11-F14. https://doi.org/10.1136/fn.88.1.f11

Meek, J. Y., Noble, L., & Section on Breastfeeding (2022). Policy statement: Breastfeeding and the use of human milk. *American Academy of Pediatrics*, 150 (1): e2022057988. https://doi.org/10.1542/peds.2022-057988

Tully, D.B., Jones, F., & Tully M. R. (2001) Donor milk: What's in it and what's not? *Journal of Human Lactation: Official Journal of International Lactation Consultant Association*, 17(2), 152-155. https://doi.org/10.1177/089033440101700212

Wight, N., Kim, J., Rhine, W., Mayer, O., Morris, M., Sey, R., & Nisbet, C. (2018). Nutritional support of the very low birth weight (VLBW) infant: A quality improvement toolkit. Stanford, CA: California Perinatal Quality Care Collaborative.

SUBJECT: **DRUG SAMPLES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the use of drug samples.

POLICY:

Definition of drug samples: Prescription and non-prescription medications which are provided to Sierra View Medical Center (SVMC) by pharmaceutical representatives for complimentary distribution to patients, as starter doses. Samples brought into Sierra View Medical Center by any other means may NOT be used.

Sample drugs are not permitted in Sierra View Medical Center. This includes hospital and outpatient clinics.

AFFECTED AREAS/PERSONNEL: *ALL DEPARTMENTS*

PROCEDURE:

1. Drug samples are not allowed in Sierra View Medical Center.

2. Pharmacy department will ensure no drug samples exist in the hospital and the clinics. Any drug samples found will be confiscated and destroyed properly.

SUBJECT: **EMERGENCY BLOOD RELEASE**	SECTION: **Page 1 of 2**

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

PURPOSE

To define the process for releasing blood components for transfusion in a time-sensitive emergency situation.

No blood components will be issued for transfusion before completion of processing or crossmatching. In the event of an emergency, the attending physician may request blood components from the blood bank department of the clinical laboratory and assume responsibility for the outcome of the use of those products by signing the emergency release form. This form must be returned to the blood bank department and attached to the original request for blood products. All physician requests for emergency blood products must be done so on patients who have been registered in the SVMC hospital information system, whether their identity is known or not. All requests for blood components must be accompanied with a *Request For Blood Component* form.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ABO/Rh Requirements:

   a. If time permits, a properly-labeled sample shall be obtained and the patient's ABO and Rh shall be determined. Type-specific blood shall then be issued when possible, or type-compatible blood issued if type-specific is not available.

   b. If there is insufficient time to obtain a specimen, or to perform tests to determine the ABO/Rh, Group O (PRBCs) is the only ABO group that can be administered to patients of unknown ABO. Do not rely on past records to determine the patient's ABO/Rh.

   c. Pull segments from units if the blood is issued before testing has begun.

   d. Issue blood.

   e. Units are issued in the laboratory information system (LIS) under the Emergency Issue Protocol. This will generate the Emergency Issue Card, which needs to be signed by the attending physician. If the patient has not yet been admitted into the hospital information system, the "computer down time" emergency issue card should be used.

2. Compatibility Testing:

   a. A properly collected and labeled patient sample must be collected and the routine compatibility testing procedure must begin. If the physician requires the blood for transfusion before the crossmatch is complete, it may be released if the "UNCROSSMATCHED BLOOD Emergency Unit Issue Card" has been signed, but the crossmatch must be completed in any event.

Massive Bleed Protocol:

- An elevated emergency level of response for patients that are in immediate jeopardy beyond the usual Emergency Release.

- Requires immediate communication to the Lab, "Emergency release of uncrossmatched

blood for a massive bleed in_____(location)."

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- Lab Blood Bank will tag and issue 2-4 units of PRBC and 1 unit of FFP if requested, per specific situation, and will work closely with Nursing Services to release continued blood products as needed. Crossmatched blood will be utilized upon availability.

- The other processes of Emergency Release, such as the use of the Emergency Release forms and follow up crossmatching, will still apply.

REFERENCES:

- American Association of Blood Banks, Standards for Blood Banks and Transfusion Services, 33rd Edition, 5.27, 2022.

- The Joint Commission (2022). Laboratory accreditation standards. QSA.05.11.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **GUIDELINES FOR PRODUCT DATING**	SECTION: **Page 1 of 4**

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

GENERAL:

All medications at Sierra View Medical Center (SVMC) will be stored in accordance with the most recent guidelines as established by the United States Pharmacopoeia (USP) and the National Formulary (NF) as well as manufacturer recommendations, and recommendations from the Centers for Disease Control and Prevention (CDC).

PURPOSE:

To define the appropriate use/duration for an agent in order to maintain compliance with the pharmaceutical industry standards.

POLICY:

All medications will be stored in accordance with the manufacturer, USP, or NF guidelines.

AFFECTED AREAS/ PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

1. Multi-dose vials

    a. All multi-dose medication containers shall display the concentration of the preparation made, dated (with the expiration date, not the date first opened), and initialed when opened.

    b. All multi-dose injectable medication containers will be refrigerated after opening, unless specifically labeled "DO NOT REFRIGERATE"

    c. Inspect prior to each use for suspected or visible contamination. Discard if contamination is suspected.

    d. If a multi-dose vial enters an immediate patient care area, it should be dedicated for single-patient use only.

    e. All multi-dose vials should be discarded after being used for a single patient whenever possible.

2. Warming of irrigation solutions

    a. Once the containers have been removed from the warmer, they should be identified as having been warmed and should not be returned to the warmer. If unopened, the plastic bottles may continue to be used until the manufacturer's expiration date, provided that they have not been warmed more than once.

b. Large volume intravenous (IV) solutions (VIAFLEX plastic containers):

i. IV solutions greater than 150ml may be warmed in their over pouches to temperatures and periods not exceeding:

1. 40°C (104°F) for 14 days

c. Arthromatic and Uromatic Containers:

i. May be warmed in their over pouches to temperatures and periods not exceeding:

1. 45°C (113°F) for 14 days
OR
2. 66°C (150°F) for 72 hours

d. Irrigation solutions in Plastic Pour Bottles:

i. May be warmed to temperatures and periods not exceeding:

1. 66°C (150°F) for 72 hours

2. 50°C (122°F) for 60 days

a. Discard container once removed from warmer

3. Refrigerated IV Solutions

a. Lactated Ringer's and Normal Saline 1000 ml Solutions;
i. 36°F (2°C)-46°F(8°C) for 30 days
ii. May not be returned to room temperature after being refrigerated

PRODUCT EXPIRATION DATING

Description	Requires Date & Initials (yes/no)	Expiration Date
Injectables		
Ampules	No	Discard immediately after use. Use filter needles as per policy.
Single Dose Vials (without preservatives)	No	Discard immediately after use
Multi-Dose Vials (with preservative)	Yes	28 days after opening
Insulin	Yes	28 days after opening
IV Solutions Mixed		
Mixed on unit/Patient care area	Yes	Discard 1 hour after mixing unless stability mandates an earlier expiration
Mixed in pharmacy	Yes	As indicated by the date on the IV label which is determined by the pharmacist
IV Solutions Unmixed		
IV solutions 100 ml or over	Yes	28 days after protective wrap removal
IV solutions less than 100 ml	Yes	15 days after protective wrap removal
Mini-Bag Plus VIAFLEX Containers		
5% Dextrose Injection, 50 & 100mL MINI-BAG Plus Container Single Pack	No	Use Immediately (Up to 24hrs)-if prepared in pharmacy date & initials required on label
0.9% Sodium Chloride, 50 & 100mL MINI-BAG Plus Container Single Pack	No	Use Immediately (Up to 24hrs)- if prepared in pharmacy date & initials required on label
Irrigation solutions		
Saline or Sterile Water	Yes	Discard 24 hours after opening
EENT solutions- nasal, otic, ophthalmic	Yes	Discard one year after opening or manufacturer's expiration date- whichever comes first
Oral Medications		
Liquids - elixirs, solutions, suspensions, syrups, solids	Yes	Discard 1 year after opening or manufacturer's expiration date- whichever comes first
Nitroglycerin tablets	Yes	Discard 6 months after opening
Topicals		
Solutions, ointments, creams, etc.	Yes	Discard 1 year after opening or manufacturer's expiration date- whichever comes first
Antiseptics – Alcohol, Betadine, Hibiclens, Phisohex	Yes	Discard 1 year after opening or manufacturer's expiration date- whichever comes first

REFERENCES:

- "Revised USP Standards for Product Dating, Packaging, and Temperature Monitoring," Am J Health-System Pharmacy Volume 57, Aug 1, 2000: 1441-1445.
- USP 797.(n.d.). Retrieved November 30, 2022 from http://www.usp.org/compounding/general-chapter-797.
- USP/NF<695>Packaging and Storage Requirements. Retrieved November 30, 2022 from https://www.uspnf.com/sites/default/files/usp_pdf/EN/USPNF/revisions/659_rb_notice.pdf.
- Medical Information Letter from Baxter Healthcare Corporation. Received December 17th, 2021.

SUBJECT: **INVESTIGATIONAL DRUGS**	SECTION: *Care of the Patient (TX)* **Page 1 of 3**

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

PURPOSE:

The purpose of this policy is to provide a mechanism for the proper storage, distribution and control of investigational medications.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide a safe practice environment for the use of investigational medications as well as ensuring the safety of our patients while participating in new potential advances in therapeutics.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, MEDICAL STAFF*

PROCEDURE:

1. Prior to an investigational drug being used at SVMC the study protocol must be reviewed and approved by:

   a. Compliance and Risk Departments
   b. The Pharmacy and Therapeutics Committee
   c. The Medical Executive Committee
   d. The SVMC Board of Directors

2. An Institutional Review Board (IRB) must approve each research protocol. A principal investigator or authorized sub-investigator, all of whom shall be members of Sierra View staff, shall supervise the use of each medication used in the study.

3. After approval from all of the aforementioned committees Advanced Clinical Systems and finance will be alerted so that the medical record and the billing for the investigational drug will be in compliance with the study protocol and State and Federal billing practices.

4. A valid Informed Consent approved by the Institutional Review Board must be signed and dated by:

   a. The Principal Investigator or an authorized Sub-Investigator, and
   b. The patient (subject) before he/she can be included in the research study. The study protocol which includes the Informed Consent must have prior written approval by an Institutional Review Board.

5. The Principal Investigator shall be responsible for the ongoing monitoring associated with the research study & applicable laws & regulations.

6. The following information about each research medication will be available in writing to Pharmacy Services and to the nursing staff caring for a subject prior to his/her receiving any doses of the medication:

   a. Name of drug or of the study if the drug is to be concealed
   b. Lot number
   c. Dosage forms and strength
   d. Usual dosage range, dosage schedule, and route of administration
   e. Possible reactions, side effects, adverse effects, or other signs and symptoms of toxicity
   f. Drug-drug and drug-food interactions
   g. Contraindications
   h. Storage requirements
   i. Instructions for dosage preparation and administration
   j. Instructions for disposition of unused doses
   k. Names of authorized prescribers

7. The Pharmacy Service will be responsible for receiving, properly labeling, storing, maintaining a balance and distributing each study medication under the general direction of the principal investigator. Investigational medications will be stored under appropriate conditions in a controlled-access location separated from regular pharmacy inventory. The research or study medications will be properly packaged and labeled in compliance with all applicable state and federal requirements.

8. A perpetual inventory will be maintained for each investigational medication stored in the pharmacy. The inventory will document every dose received, dispensed, returned, transferred or wasted as well as the current amount on hand. A re-order level should be determined in order to assure that adequate stock will always be on hand to prevent interruption of therapy. Inventory records will be maintained for at least two years after discontinuation of the study or longer if required by state or federal regulations.

9. When a study has been concluded, the pharmacist will return or otherwise dispose of all unused stock according to instructions of the sponsor and in accordance with applicable regulations.

10. Investigational medications from studies originating from outside the hospital will be required to include informed consent specifically for the hospital, provision of drug information, and a medication order specifically by the principal investigator, who has been granted Medical Staff privileges. These requirements will be met prior to initial administration of any investigational medication. Upon evaluation and if no contraindication exists, accommodations to the patient's continued participation in the protocol may be made.

References

1. ASHP Guidelines for the Management of Investigational Drug Products. https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/management-investigational-drug-products.ashx. Accessed November 28, 2022.

2. The Joint Commission – Hospital Standards Manual. MM.06.01.05. Accessed November 28, 2022.

SUBJECT: **MEDICATION – ERRORS**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define the process to be followed in handling and reporting medication occurrences.

POLICY:

All medication errors shall be defined, documented and addressed. This includes errors in prescribing, interpreting, ordering, dispensing, delivering, storing, administering and any recordation of drugs. Reporting of medication errors is the responsibility of the individual who discovers the error or anyone who has knowledge of an error.

AFFECTED AREAS/PERSONNEL: *ALL DEPARTMENTS*

MEDICATION ERRORS– DEFINITIONS:

A "medication ERROR" means any preventable or unintended medication occurrence that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:

Prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

TYPES OF MEDICATION ERRORS:

Medication errors are analyzed by the types of breakdowns within the medication system. The categories of errors may not be mutually exclusive because of the multidisciplinary and multifactorial nature of medication errors. Medication errors are categorized along each functional step of the medication cycle: ordering, transcription, preparation and dispensing, and administration.

1. Order Error – (typically exclusive to MDs)Types of ordering errors include: inappropriate medication selected by , failure to acknowledge allergy, inappropriate dose, illegible order, duplicate order, order not dated/timed, wrong patient/chart selected, contraindications, verbal order misunderstood, verbal order not written in the chart, wrong frequency, route, therapy duration, alert information bypassed or use of nonstandard nomenclature or abbreviations.

2. Transcription error –(typically non-physician related unless CPOE)Transcription involves both the orders that are manually transcribed onto manual record (e.g., electronic medication administration record (eMAR). Types of transcription errors include: orders not faxed to pharmacy, wrong medication, time, dose, frequency, duration, rate patient/chart, verbal order misunderstanding, wrong scheduling of doses in the eMAR.

3. Preparation/Dispensing Error – Types of preparation and dispensing errors include: Inaccurate labeling, wrong quantity, medication, dose, diluent, formulation, expired medication, overlooked drug/drug interactions, duplicate therapies and allergies. Also, Pyxis refill error, and delay in medication delivery.

4. Administration Error – Types of administration errors include: Wrong patient, dose, time, medication, route, rate, omission, extravasation (may be an ADR), pump problems, and unauthorized dose given.

5. Other - Any system breakdown that is not captured with one of the above predefined breakdown point should be classified as "other" and described.

Medication Error Exceptions:

1. Omission Error:

   An omission error is defined as the failure to administer an ordered dose to a patient before the next scheduled dose. Exclusions would be:

   a. a patient's refusal to take the medication or

   b. a decision not to administer the dose because of recognized contraindications. If an explanation for the omission is apparent (e.g. patient was away from nursing unit for tests or medication was not available), that reason should be documented in the appropriate records.

2. Wrong Time Error

   A wrong time error is defined as a failure to administer medication within 60 minutes from its scheduled administration time excluding doses that deviate due to logistical administration.

PROCEDURE:

1. If Medication Error reached the patient- IMMEDIATE ACTION:

   a. Notify the attending physician. If the attending physician is unavailable, the covering physician must be notified. When the covering physician is notified, the patient's attending physician must be notified as soon as available.

   b. Monitor the patient for adverse outcomes.

   c. Involved staff member is to complete the Risk Management Notification which is electronically submitted to the department directors, risk management and pharmacy.

2. If Medication Error did NOT reach the patient:

   a. Involved staff member is to complete the Risk Management Notification located in the hospital reporting database which is electronically submitted to the department directors, risk management and pharmacy.

Categorization:

1. Medication errors are stratified into 4 types of error categories and 9 categories of results (A-I)This is the standard accepted by National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP). The medication error index is listed below:

Error Type	Cat. Code	Category Result
No Error	A	Circumstances or events have the capacity to cause an error.
Error, No Harm	B	Error occurred, but the medication did not reach the patient.
	C	Error occurred that reached the patient, but did not cause patient harm.
	D	Error occurred that resulted in the need for increased patient monitoring, but did not cause harm.
Error, Harm	E	Error occurred that resulted in the need for treatment/intervention and caused temporary patient harm.
	F	Error occurred that resulted in initial prolonged hospitalization and caused temporary patient harm.
	G	Error occurred that resulted in permanent patient harm.
	H	Error occurred that resulted in a near-death (e.g., anaphylaxis, cardiac arrest).
Error, Death	I	Error occurred that resulted in patient death.

2. Medication errors are categorized initially by the staff member involved with the error and then reviewed by the pharmacy for appropriateness.

Medication Error Review for Categories I:

1. An ad hoc review council is formed to conduct a root cause analysis on all medication errors with an NCCMERP category of I. The focus of the peer review council is on identifying the root causes that led to the error.

2. The council consists of at minimum: A representative from Risk Management, Pharmacy, the Director of the unit and the staff involved in the error.

3. To recreate the sequential activities that resulted in the error, the staff involved in the error is asked to describe in detail the process they followed.

4. The ad hoc review council takes the findings and using a just culture model, will determine the category of culpability. Essential to maintaining a robust reporting of medication errors is that employees feel safe to report. Therefore, using a just culture model insures that employees are not disciplined for system failures; however, compliance with written policy and procedures is

essential. Attention to details is critical to preventing medication errors and non-compliance with policies and procedures is unacceptable.

5. Once the category of culpability is determined, the review council, absent of the Professional Practice member and in consultation with leadership from Human Resources will define what action will or will not be taken.

6. The RCAs along with the findings are forwarded to the Medication Patient Safety Committee for review and incorporation into the P&T quarterly report.

Medication Error Analysis: Concurrent and Retrospective:

1. The Multidisciplinary Medication Safety committee comprised of representatives from administration, pharmacy, nursing and medical staff will regularly analyze all actual and potential medication errors.

2. Risk Management Department in collaboration with the Pharmacist in Charge & Manager of Pharmacy Services will also prepare a quarterly summary of all medication errors. The summary will include, at minimum errors by type, and severity.

3. The quarterly summary, as well as the RCAs and associated recommendations will be presented at the Medication Patient Safety Committee for review of trends and to determine further actions. The data, findings, actions and recommendations are then forwarded to the P&T Committee. A copy of this report will also be provided to the Performance Improvement Department.

4. A concurrent review of the medication process will be conducted at least annually the process of which will be determined by the Medication Safety committee, MERP annual meeting.

Safe Medication Practices:

1. The organization will seek to identify and distribute appropriate external medication error alerts to physicians and clinical staff for the purpose of educating and improving current safe medication practices.

REFERENCES:

- California Health & Safety Code Sections 1339.63, Chapter 2.05. Minimization of Medication-Related Errors.
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Tariq, R. Vashisht, R. Sinha, A. Scherbak, Y. Medication Dispensing Errors And Prevention. https://www.ncbi.nlm.nih.gov/books/NBK519065/. Accessed November 28, 2022.

- National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) (2019). Retrieved from www.nccmerp.org.

CROSS REFERENCES:

- Pharmaceutical Services Manual *Adverse Drug Reactions*
- House-Wide Policy Manual, *Serious Clinical Adverse Event*

SUBJECT: **NEUROMUSCULAR BLOCKING MEDICATION FOR PROLONGED MUSCLE RELAXATION OF INTUBATED PATIENTS IN THE ICU**	SECTION: **Page 1 of 6**

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

PURPOSE:

To provide guidelines for the safe administration and monitoring of neuromuscular blocking agents to intubated patients in the Intensive Care Unit; to ensure the administration of the lowest and most effective dose needed to achieve therapeutic neuromuscular blockade; and to reduce the risk of prolonged paralysis and monitor for potential complications.

DEFINITIONS:

1. Neuromuscular Blocking Agent (NMBA): Medications which induce therapeutic paralysis.

2. Peripheral Nerve Stimulation (PNS): A device used in critical care to assess neuromuscular transmission when NMBAs are administered.

3. Train of Four (TOF): A method of PNS. The delivery of four electrical currents at intervals of 0.5 seconds which stimulate the nerve and provide indication of the amount of nerve blockage, allowing the user to assess the degree of paralysis.

POLICY:

A. It is the policy of Sierra View Medical Center that NMBA drips will be ordered, initiated, and monitored according to the standards developed, approved and outlined in this policy. This policy applies to adult patients in the Intensive Care Unit.

B. Neuromuscular blocking drips are never to be initiated until the patient is successfully sedated to the physician ordered target RASS level.

C. Paralytics are always to be weaned before sedatives.

D. The neuromuscular drip must be discontinued before the patient can be pronounced dead.

AFFECTED PERSONNEL/AREAS: *ICU, PHARMACY*

EQUIPMENT:

- Emergency Equipment
    1. Code Cart

- Bedside Equipment
    1. Continuous Cardiac Monitoring
    2. Non-Invasive Blood Pressure Device
    3. Pulse Oximeter
    4. Mechanical Ventilator and Oxygen Source

- Train of Four Monitoring (Sustained Neuromuscular Blockade)

1. Peripheral nerve stimulator (PNS)
2. Two pre-gelled electrode pads
3. Tow lead wires packaged with the PNS (red always placed closer to the heart)
4. Alcohol pads for skin degreasing and cleansing
5. Scissors or clippers if hair removal is necessary

PROCEDURE:

A. **Sustained Neuromuscular Blockade**

1. **Purpose**

   a. Facilitate mechanical ventilation and control airway pressure when analgesics and sedatives are not effective.

   b. Minimize oxygen consumption and CO_2 production in patients with severe hemodynamic instability and/or impaired oxygen delivery.

   c. Diminish muscle rigidity in tetanus.

   d. Decrease intracranial pressure in the brain-injured patient.

   e. Treatment of hyperthermia to facilitate cooling and control shivering.

   f. Treatment of shivering during cooling measures in therapeutic hypothermia in post cardiac arrest patients.

2. **Physician Responsibility**

   a. Consider all other modalities and treatments to improve the clinical situation and use NMBAs as a last resort.

   b. Educate the patient and/or patient representative on neuromuscular blocking agents.

   c. Establish and communicate the daily plan of care specific to mechanical ventilation to the care team while the patient is on neuromuscular blocking drip.

   d. Re-evaluate and document the need for continued NMBA use daily.

   e. Enter orders into CPOE:

      i. Continuous sedation and analgesia
      ii. Mechanical ventilation
      iii. Neuromuscular blocking drip with daily vacation as indicated.

iv. Train of Four monitoring every hour until stable for 4 consecutive hours, then train of four monitoring every 4 hours

v. DVT Prophylaxis as indicated

f. Immediately supervise administration of neuromuscular agent.

g. To re-evaluate patient prior to transport and be present during transport of patient. To ensure patient is adequately sedated prior to transport.

h. Re-evaluate need for continued mechanical ventilation

i. Provide orders for termination of mechanical ventilation once patient resumes spontaneous respirations and protective reflexes are present.

j. If the patient is also receiving corticosteroids, it is the responsibility of the physician to examine the patient closely for prolonged paralysis and/or acute polyneuropathy.

3. **Pharmacist Responsibility**

a. Ensure patient safety by identifying complications due to drug interactions or other medication-related issues.

b. Assess and evaluate NMB dosage daily and length of therapy as concurrent administration of NMB and aminoglycosides or corticosteroids are frequently considered to be causes of acute and prolonged muscle weakness in critically ill patients.

4. **Nursing Responsibility**

a. Baseline Physical Assessment – Complete systems assessment will be completed and documented prior to administration of NMBAs.

i. Ensure patient is receiving adequate sedation (Minimum Sedation of RASS -2) and analgesia before administering the neuromuscular blocking drip.

b. Reassessment – Systems will be reassessed with documentation every one hour or more frequently as indicated by the patient's condition, diagnosis, or physician orders.

c. Monitoring and Documentation:

i. Ensure that the patient is fully ventilated on a controlled rate of breathing (not on pressure support) before administration of NMBA.

ii. Ensure continuous monitoring of ECG heart rate, rhythm, and oxygen saturation with audible alarms and appropriate alarm settings.
iii. Monitor and document vital signs including heart rate (HR), respiratory rate (RR), peripheral capillary oxygen saturation (SPO2), and blood pressure (BP) every 15 minutes until stable and then every 1 hour.
iv. Monitor and document temperature every hour. Assess core temperature if oral temperature is less than 36 degrees or if a cooling or warming blanket is in use.

d. Train of Four Monitoring

i. Assess best location for electrode placement, avoiding areas of the body with edema, hair, diaphoresis, wounds, dressings and arterial or venous catheters.
ii. Assess patient for history or the presence of hemiplegia, hemiparesis, or peripheral neuropathy as receptors may be resistant to NMBAs and impair TOF results.
iii. Ensure patient and family have an understanding of the plan for NMBA use.
iv. Clip hair at electrode placement site (if necessary).
v. Cleanse and thoroughly dry the skin before applying electrodes.
vi. Obtain baseline TOF prior to initiation of initial dose of NMBA. **Document PNS intensity level (1-10) at which 4 of 4 twitches was noted in patients chart.**
vii. Reassess TOF twitch every 15 minutes until 1 of 4 twitches returns. TOF intensity should be set at the baseline intensity level where 4/4 twitches was first observed.
viii. Once 1 of 4 twitches returns, **begin continuous infusion of NMBA according to order.** Reassess and document TOF twitch hourly once the infusion is started. **The goal of therapy is 1-2 twitches out of 4 stimulations (1/4 or 2/4 twitches) and adequate control of ventilation.**
ix. Reassessment of TOF may be reduced to every 4 hours once the patient's condition is stable and the infusion is therapeutic for 4 hours.
x. If ventilation and/or metabolic rate are adequately controlled and TOF is 4/4, do not increase the NMB dose. Conversely, if the patient is breathing above the ventilator and the TOF is 0/4, then titrate the drug to achieve ventilation goals.
xi. Assess the patient's oxygenation, ventilation, neurologic function, and tissue perfusion prior to increasing the rate of the NMBA infusion.
xii. Never use the "Single Twitch," "Tetany," or "Double Burst" settings on the PNS.
xiii. Change PNS electrodes daily and whenever they are loose or when the gel becomes dry.

e. Safety:

i. Maintain continuous sedation and analgesia during NMBA drip therapy.
ii. Continue to explain all procedures to the patient and family.
iii. Obtain order for eye lubricant and administer every 2 hours and PRN. Keep eyelids closed at all times. Lubricating ointments may be sufficient to keep eyelids closed and corneas moist.
iv. Protect against joint/limb injury.
   a) Maintain careful alignment of joints and spine.
   b) Maintain spinal precautions as ordered.
   c) Use pillows to maintain lateral neck alignment and hip abduction during repositioning.
   d) Provide passive range of motion to limbs every 4 hours.

v. Prevent pressure ulcer development.
   a) Complete Braden assessment every shift and implement skin care and treatment according to the PRESSURE INJURY PREVENTION PLAN.

f. Infection Control:

i. Ventilator Associated Pneumonia Prevention
   a) Oral care every two hours and PRN
   b) Endotracheal tube repositioned, retaped and oral cavity inspected daily by nursing and Respiratory Therapy.
   c) Perform deep suction at minimum every 2 hours and more frequently as indicated.
   d) Maintain the head of the bed elevated greater than or equal to 30 degrees at all times as indicated.
   e) Perform daily changes of oral suction catheter and oral airway.

ii. Meticulous hand hygiene before and after care

iii. Daily chlorhexadine bath.

REFERENCES:

- Bittner, E. Neuromuscular blocking agents in critically ill patients: Use, agent selection, administration and adverse effects. Accessed via Uptodate on November 23, 2022. https://www.uptodate.com/contents/neuromuscular-blocking-agents-in-critically-ill-patients-use-agent-selection-administration-and-adverse-effects?search=neuromuscular%20blocking%20agents&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H1232198029

- Elliot J.M., Bion J.F. The use of neuromuscular blocking drugs in intensive care practice. Acta Anaesthesiol Scand Suppl 1995; 106:70.
- Lexicomp Drug reference Handbook (2022). Hudson, Ohio. Lexicomp Information
- Management Service.

CROSS REFERENCES:

- PRESSURE INJURY PREVENTION PLAN

SUBJECT: **NEWBORN SCREENING TESTS**	SECTION: **Page 1 of 2**

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

POLICY:

To comply with California State Department of Health Services Newborn Screening Program Regulations (CCR Title 17, sub chap 9, article 1) and to assure a high quality of collection, documentation, and transport of the newborn screening sample.

INITIAL SPECIMEN:

1. On receipt of written or electronically transmitted Lab orders for Newborn Screening (NBS) from the Maternal Child Health (MCH) Department, a nurse will obtain a whole blood sample by skin puncture from the heel as described in the current circular distributed by the State Health Department.

2. The appropriate timing for the NBS draw will be determined by the Maternal Child Health (MCH) Department.

3. The State approved NBS collection form will be used and obtained through the Maternal Child Health Department. The Maternal Child Health Department will fill out all areas of the form including **DATE, SPECIMEN COLLECTED,** and **INITIALS OF PERSON DRAWING SPECIMEN**.

4. The person drawing specimen will remove the goldenrod copy (AFTER completing the Lab portion of the NBS form) and give to MCH for placement in the newborn's medical record.

5. After collection, MCH personnel will take the NBS form (less goldenrod copy) to the Lab and allow to dry for three hours.

6. The Lab will log the NBS patient on the NEWBORN SCREENING SPECIMEN TRANSPORT LOG and retain the yellow copy of the log for documentation. The Lab should request additional NBS TRANSPORT LOGS from the State-designated Lab.

7. The Lab will then place the NBS specimens and the Transport Log in a special GSO courier envelope pre-addressed to the State designated lab. The GSO courier will pick up the envelope from the Sierra View Medical Center (SVMC) draw station front office Monday through Friday. The Lab should request additional forms, as needed, from the State designated lab, and additional envelopes with address labels from GSO.

8. A charge will be made for the initial NBS test in accordance with current regulations.

INADEQUATE SPECIMEN:

1. Upon notification from the Newborn Screening Coordinator (NSC), outpatient retesting will be done by the Lab.

2. The NBS form will be obtained from the FBC by Lab personnel and labeled with a new reference number as given by the NSC.

3. Demographic and clinical data as stated on the original form will be written on the repeat NBS form by the Lab.

4. These forms will be handled and mailed by the lab in the same way as Initial Specimens.

5. There will be no charge for this service.

RECALL SPECIMEN:

1. Upon notification from the NSC, outpatient retesting will be done by the Lab. The NSC will provide two ID numbers and other date to be used on the NBS form.

2. The lab will obtain a NBS form from the Newborn Screening Program Department and place a special Department of Health Services (pink) "RECALL SPECIMEN" sticker on it. The Lab will write the two ID numbers (see #1) on the sticker. Other information will be written on the form according to any additional data provided by the NSC and/or the parent.

3. The lab will send the NBS form to the State-designated laboratory as stated on the RECALL SPECIMEN sticker by the next business day.

4. A handling charge will be applied.

AFFECTED AREAS/PERSONNEL: *LABORATORY, MATERNAL CHILD HEALTH (MCH)*

REFERENCE:

- California Code of Regulations Title 17, Subchapter 9, Article 1.

SUBJECT: **NON-FORMULARY MEDICATION**	SECTION: *[Enter manual section here]* **Page 1 of 3**

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

PURPOSE:

To provide a mechanism whereby physicians can order needed medications that are not available on the Sierra View Medical Center (SVMC) formulary for appropriate indications where formulary medications are deemed inappropriate (e.g., less effective, concerns of safety, etc.).

DEFINITION:

CPOE: computer physician order entry

DUE: drug utilization evaluation

AFFECTED PERSONNEL/AREAS: *NURSING, PHARMACY, PRESCRIBERS*

POLICY STATEMENT:

It is the policy of SVMC that non-formulary medications may be obtained on order of a physician for individual patients

PROCEDURE:

Process for ordering non-formulary medication:

A. Initiating an order entry for non-formulary medication

1. The prescriber shall order the medication via CPOE under "Nonformulary Medication"

a. Include the following items in the comment section of the CPOE provided space:

i. Medication name

ii. Strength

iii. Dose

iv. Route

v. Frequency

B. Processing the non-formulary drug order

1. Upon receipt of an order for a non-formulary medication, the pharmacist will review it to validate its necessity for the patient and explore alternatives that are available on formulary.

   a. The pharmacist will consult the prescriber with any insufficient documentation/information warranting its use.

      i. If the prescriber cannot be reached, and/or further questions/concerns remain regarding the medication, the pharmacist may, in the professional opinion of the pharmacist, dispense a first-dose to prevent patient harm, (so long as it is in stock and available) while awaiting clarification.

         - The pharmacist will document this activity in Meditech notes section.

2. If the non-formulary drug is appropriate, the pharmacist will process the order and dispense a 3-day supply for delivery to the medication room on the floors.

3. Medication information is available via Meditech monographs & through medication database (Lexicomp/Uptodate) via the intranet. Additional information or clarification can be made with a pharmacist as needed.

4. Caregivers are encouraged to contact Pharmacy for further information.

C. Purchasing the non-formulary medication if unavailable

1. For any non-formulary drug that is unavailable at SVMC, Pharmacy will need time to purchase it from the wholesaler. In case of any anticipated delay in arrival, the prescriber and nurse providing care will be contacted.

   a. Anticipated turn-around time depending on when the physician placed the order:

      i. Sunday – Thursday: 24-48 hours

      ii. Friday – Saturday: Monday at the earliest

   b. The pharmacist will leave a pending order on Meditech explaining that Pharmacy needs to order the drug. This notification can be viewed on the patient's eMAR (electronic medication administration record).

      i. The prescriber shall be notified by the pharmacist on the estimated time to arrival.

c. The pharmacy buyer will submit all drug orders to the wholesaler no later than 21:00 the same day.

EDUCATION:

Patient, Family, Significant Other: N/A

Staff: All staff will receive education regarding the process whereby non-formulary medications are ordered.

REFERENCES:

- ASHP Guidelines on Formulary Management, Title 22 70263 (c) (2). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- ISMP Formulary Guidelines, ISMP Medication Safety Self-Assessment for Hospitals

- The Joint Commission (2022). Hospital accreditation standards (Medication Management 2.01.01). Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PATIENT / FAMILY / CAREGIVER EDUCATION**	SECTION: ***Patient Education (PF)*** **Page 1 of 2**

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

PURPOSE:

The purpose of the "Patient/Family/Caregiver Education" Policy and Procedure is to provide guidance as it applies to responsibilities of healthcare education, and resources available at Sierra View Medical Center (SVMC) for healthcare education of outpatients and inpatients, families and caregivers. This policy also outlines those activities which serve to support the provision and coordination of healthcare education in the hospital and within the community.

POLICY:

A. SVMC supports the provision and coordination of patient, family and caregiver education by:

1. Planning within the context of the mission and scope of services, to provide patient and/or family education considering:

   a. Settings in which care is delivered (i.e. inpatient, outpatient, short stay, community)

   b. Patient populations being served which require education (i.e. different socio-cultural backgrounds, varying languages, different stages of life and whether or not education about community resources to support needed life style changes are needed).

2. Establishing an environment that fosters questioning, learning and participating in health care decision-making and in the care being provided.

3. Assuring that staff providing patient, family and caregiver education are competent to deliver appropriate information in a timely, caring and respectful manner.

4. Ensuring that educational resources provided are available in preferred formats considering:

   a. Patient's diagnosis, age, learning and self-care ability

   b. Hearing, vision and speech impairments/barriers

   c. Language, cultural and religious variables

5. Assessing and improving educational systems and outcomes as part of the organization's performance improvement process.

PROCEDURE:

A. Staff providing care to the patient explains health treatments to patient, family and caregiver, and teaches the patient, family and/or caregiver how to care for the client's health needs.

1. Education and training are provided using the preferred language of the patient, family, caregiver, following the *Interpretive Services Language Assistance Program* policy.

2. If the staff member providing education is not a validated interpreter for the preferred language requested, s/he will obtain an interpreter by:

   a. Using the services of a validated interpreter working in the department or

   b. Calling the Health Care Interpreter Network (HCIN) at extension 6018.

3. Staff will provide education using the teach-back method whenever possible.

4. Patient education is documented in the electronic medical record.

REFERENCES:

- California Code of Regulations, Title 16, Division 14. Board of Registered Nursing. Article 4. 1443.5. STANDARDS OF COMPETENT PERFORMANCE. Retrieved on 11-06-2014 from: http://www.rn.ca.gov/regulations/title16.shtml#1443.5.

CROSS REFERENCE:

- SVMC Interpretive Services Language Assistance Program Policy.

SUBJECT: **PATIENT INFORMATION MINIMUM FOR PHARMACIST REVIEW**	SECTION: **Page 1 of 2**

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

POLICY:

To ensure that medications are obtained, distributed and accounted for in accordance with all Federal and State laws and regulations. Pharmacist will review patient information prior to dispensing to optimize the patient's drug therapy.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, INFORMATION SERVICES*

PROCEDURE:

Upon receipt of an order for inpatient medication preparation and dispensing, the Pharmacy Department staff will assess computer generated profiles for prior historical information of the patient.

The electronic medical record is reviewed by the Pharmacy Department staff upon patient admission to the facility and as appropriate to the patient's continuing condition and medications ordered.
All appropriate patient information is entered into the computerized patient profile located in the Pharmacy Department.

Medications are not dispensed until the Pharmacy Department staff receives at least the following information:

- Patient name, age, sex
- Height and approximate weight, as appropriate
- Current medications
- Clinical diagnoses
- Secondary diagnoses, clinical conditions
- Relevant laboratory values
- Medication allergies, sensitivities, past untoward reactions
- Name of attending physicians, ordering physicians
- Pregnancy and lactation status, as appropriate
- Any other information required for safe medication management, as appropriate

The above listed information is accessible to licensed independent practitioners, nursing and other clinical staff when needed, except in an emergency situation when time may not permit.

REFERENCES:

- Title 22 (n.d.). Retrieved on November 23, 2022, from http://carules.elaws.us/code/t.22_d.5_ch.1_art3
- Pharmacy Law: California Edition. (2022) San Clemente, California: Law Tech Publishing Group.

SUBJECT:	SECTION:
PRECEDEX DRIP FOR SEDATION OF PATIENTS IN THE CRITICAL CARE SETTING	**Page 1 of 6**

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

PURPOSE:

To outline the appropriate use of Precedex® (Dexmedetomidine) for the sedation of initially intubated and mechanically ventilated patients during treatment in an intensive care setting and for sedation of non-intubated patients prior to and/or during surgical and other procedures.

POLICY:

A. When using Precedex® (Dexmedetomidine) the following should be considered:

1. Precedex® should be administered by continuous infusion not to exceed 24 hours (24 hour stop time will default in CPOE). Precedex® infusions may exceed 24 hours in mechanically ventilated patients after explicit physician orders.
2. Precedex® should be administered only by persons skilled in the management of patients in the intensive care or Emergency Department setting.
3. Precedex® patients should be under continuous cardiac monitoring.
4. The most common adverse reactions with Precedex® (incidence >2%) are hypotension, bradycardia and dry mouth.
5. Due to increased incidence of bradycardia and hypotension in the elderly, and the potential for reduced clearance in patients with impaired hepatic or renal function, dose reductions should be considered in these patient types.

AFFECTED PERSONNEL/AREAS: RN/ICU/ED, *PHARMACY*

EQUIPMENT:

- Alaris Smart Infusion Pump
- Cardiac Monitor

PROCEDURE:

A. Physician

1. Before ordering ensure patient is adequately hydrated, to minimize cardiovascular side effects, and does not possess the following contraindications.

   a. Patients with refractory hemodynamic instability, including:

      i. SBP <90 mmHg or MAP <60 mmHG despite significant vasopressor support.
      ii. HR <55 BPM not induced by beta blocking agents
      iii. AV block in the absence of a pacemaker

   b. Microvascular free flap procedures, as α2 agonists may cause direct vasoconstriction and reduction in flap blood flow.

c. Severe liver dysfunction (Child-Pugh class-C)

d. Recent acute epilepsy or uncontrolled seizure activity

e. Neurovascular patients including those with recent intervention for a cerebral aneurysm or arteriovenous malformation, particularly patients within 7 days of aneurysmal or traumatic subarachnoid hemorrhage or those considered at high risk of vasospasm.

f. Pregnancy or breast feeding.

g. Precedex® use has been deemed inappropriate for the following:

i. Deep sedation for the control of intracranial hypertension or to facilitate high frequency or controlled ventilation in acute lung injury
ii. Concomitant use of neuromuscular blocking drugs other than for intubation/mechanical ventilation
iii. Acute encephalopathy that is not delirium induced
iv. Convulsive state

2. **When utilizing CPOE to order Precedex® (Dexmedetomidine) for patient sedation always specify the target RASS score and initial rate.**

3. If desired, place subsequent order for daily Wake-Up protocol ("sedation vacation/sedation holiday")

4. Be ready to assistant RN bedside upon initiation of infusion and as needed for near maximum titrations.

B. Pharmacist

1. Survey patient's medication profile and EMR to rule out any absolute contraindications (mentioned above in Physician section) to Precedex®.

2. Verify order when appropriate. If not appropriate discuss order with physician in an interdisciplinary manner.

3. Assess patients liver function. Precedex® is metabolized almost completely in the liver to inactive metabolites while less than 5% is excreted unchanged. Therefore, a patient with poor hepatic function (i.e. elevate bilirubin, low albumin, elevate INR (not on Warfarin,) etc…) should receive a more conservative dose. **Communicate this fact to the RN when these patients are identified.**

4. Prepare Precedex® (Dexmedetomidine) drip: 400mcg/100mL NS and deliver to ICU or ED RNif not available in premixed formulation.

a. Forward calculate overnight Precedex needs and ensure to supply overnight ICU or ED RN with enough medication to infuse until 0700 the next morning.

C. Registered Nurse in ICU

1. Upon receiving the prepared Precedex® drip from Pharmacy begin administration utilizing the appropriate Alaris Guardrail.

a. Consider the following when initiating a Dexmedetomidine infusion:

i. Dexmedetomidine produces a dose-dependent sedation with peak effect reached 45-60 minutes after commencement of an infusion.
ii. Dexmedetomidine has a strong synergistic effect with other sedatives and opioids, with a 50 to 70% reduction in Propofol (Diprivan®), Midazolam (Versed®) and opioid requirements having been observed.
iii. High dose infusion (> 0.7mcg/kg/hr) can lead to loss of muscle tone with potential for airway obstruction in non-intubated patients.
iv. An average of 10% fall in systolic blood pressure, heart rate and cardiac output has been observed when a dose of 1 mcg/kg/hr is used
v. Dexmedetomidine produces a unique sedation that is best described as "cooperative sedation" where patients respond promptly to verbal stimuli or light touch.
vi. A loading dose is usually unnecessary and not recommended due to the risk of hypotension, especially if patient is dehydrated.
vii. There is no need to wean off of a Dexmedetomidine solution slowly.
viii. Dexmedetomidine is NOT a sedative that can be used for immediate control of a very agitated or combative patient. Therefore, rescue sedation with boluses of Midazolam or Propofol will sometimes be necessary.
ix. If the desired RASS sedation score requires frequent boluses of additional sedatives (i.e. Midazolam or Propofol,) aim to maximize the infusion rate of Dexmedetomidine up to 1.4mcg/kg/hr (may exceed this rate at the physician's discretion) prior to starting infusions of other sedative agents.

a) When adding additional sedative infusions the dose of Midazolam should not exceed 2-3mg/hr and Propofol should not exceed 1mg/kg/hr to minimize any associated hypotensive effects.

b. Dexmedetomidine initial rate should be **0.2mcg/kg/hr (or the rate the physician specifies in the order) for 45 to 60 min,** then

i. **Titrate by 0.2mcg/kg/hr** approximately **every 30 minutes. Maximum rate is 1.4mcg/kg/hr (may exceed this rate at the physician's discretion)** (see figure 1 below)
ii. **Assessment and documentation of RASS score and pain scales** should be performed as part of an ongoing evaluation **at least every 4 hours.**

c. Transitioning from other IV sedatives and analgesics to Dexmedetomidine (see figure 2 below):

   i. The Precedex® infusion should be started at least 2 hours before stopping other sedative medications.
   ii. Consider weaning off of other sedatives and analgesia should be done by decreasing their rates by 25 to 50% every hour, or as per physician discretion.
   iii. The Dexmedetomidine infusion can be **titrated by 0.2mcg/kg/hr every 30 minutes** to the targeted RASS and pain score. **Maximum rate is 1.4mcg/kg/hr (may exceed this rate at the physician's discretion.)**

d. Patients with emergence delirium and/or agitation

   i. This group of patients often requires the highest level of Dexmedetomidine infusion at a dose often greater than 0.7mcg/kg/hr.
   ii. Begin infusion at 0.2mcg/kg/hr (may start at higher rate at the physician's discretion)

REFERENCES:

- Precedex [package insert]. Lake Forest, IL: Hospira, Inc; 2008. 2. Data on file, #3. Hospira, Inc.
- Jacobi J, Fraser GL, Coursin DB, Riker RR, Fontaine D, Wittbrodt ET et al. Clinical practice guidelines for the sustained use of sedatives and analgesics in the critically ill adult. Crit Care Med 2002;30:119-141
- Gerlach AT, Dasta JF. Dexmedetomidine: an updated review. Ann Pharmacother 2007;41:245-52.
- Venn M, Newman J, Grounds M. A phase II study to evaluate the efficacy of dexmedetomidine for sedation in the medical intensive care unit. Intensive Care Med 2003;29:201-7
- Ickeringill M, Shehabi Y, Adamson H, Ruettimann U. Dexmedetomidine infusion without loading dose in surgical patients requiring mechanical ventilation: Haemodynamic effects and efficacy. Anaesth Intensive Care 2004;32:741-5.
- Shehabi Y, Ruettimann U, Adamson H, Innes R, Ickeringill M. Dexmedetomidine infusion for more than 24 hours in critically ill patients: sedative and cardiovascular effects. Intensive Care Med 2004;30:2188-96.
- Kobayashi A, Okuda T, Kotani T, Oda Y. Efficacy of dexmedetomidine for controlling delirium in intensive care unit patients. Masui 2007;56:1155-60.

Figure 1: Critically ill Ventilated Patients

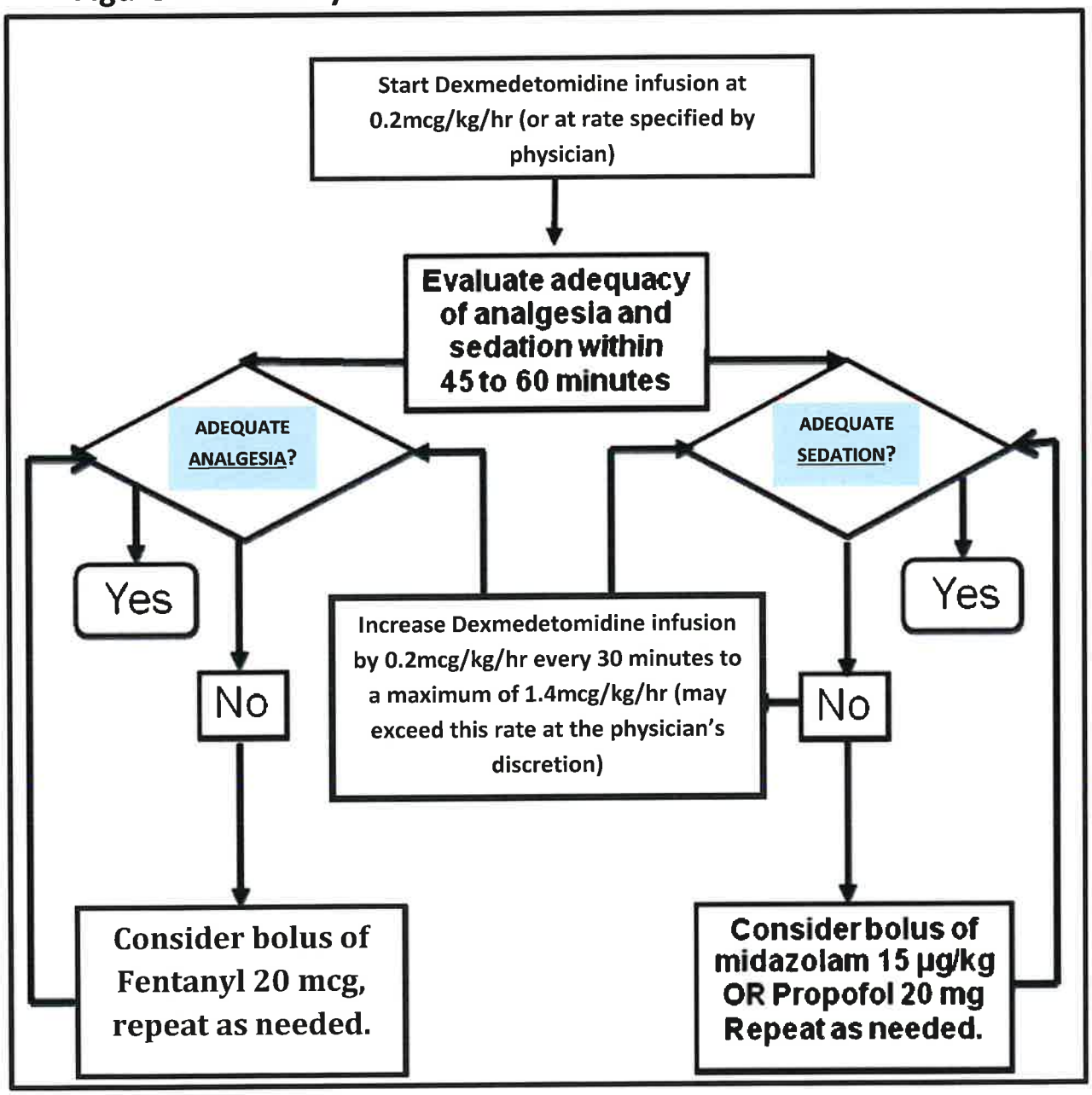
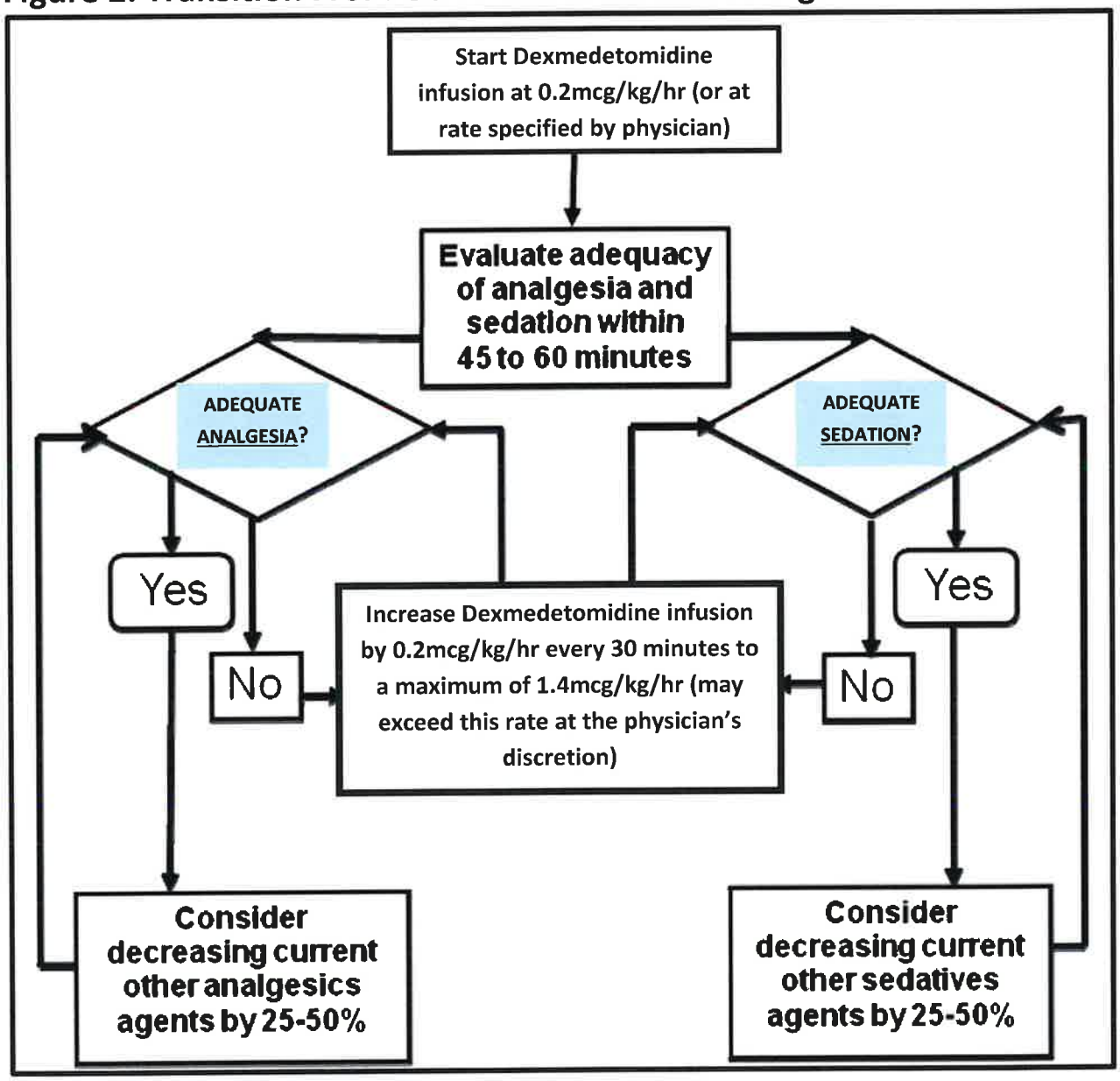


Figure 2: Transition From Other Sedatives and Analgesics



SUBJECT: **PRESCRIBER USE OF OWN MEDICATION**	SECTION: ***Pharmaceutical Services*** **Page 1 of 1**

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

PURPOSE:

To clarify Sierra View Medical Center's (SVMC's) policy on medications brought into the facility for patient use, by Physicians and/or Licensed Independent Practitioners (LIP).

POLICY:

In order to comply with safe medication practices, Prescribers are not allowed to bring into Sierra View Medical Center (SVMC) their own medications for use on patients during their hospital stay. This also includes use on outpatient encounters at SVMC.

AFFECTED AREAS/PERSONNEL: *LICENSED INDEPENENT PRACTICIONERS, MEDICAL STAFF, PHARMACY, NURSING*

PROCEDURE:

In the event that a Physician and/or LIP bring a medication into the hospital for patient use from their office, Pharmacy is to be notified immediately. Pharmacy will speak with the Prescriber to offer assistance with a choice of medications that might be provided by the hospital Pharmacy.

Pharmacy will enter the occurrence into the event reporting system for tracking purposes.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **RESTRICTION OF COMMUNICATION**	SECTION: ***Ethics, Rights and Responsibilities (RI)*** **Page 1 of 1**

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

PURPOSE:

To safeguard patients' health, well-being and recovery, by limiting communication when deemed necessary by the healthcare team.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) for staff to support and foster each patient's right to free communication, be it through visits, telephone (conventional and adaptive), television, mail, and/or other use of audio and video tapes.

In the event that a patient's health or well-being is thought to be at risk due to the impact of certain forms of communication, it is the responsibility of the healthcare team to determine if the effect of that communication is sufficiently grave to warrant a limitation of that communication.

For the competent patient, a member of the healthcare team, usually the Charge Nurse or as applicable, the social worker will discuss with the patient and/or family the perceived detrimental consequences of a particular mode of communication. The goal of this therapeutic exchange is to develop a plan that will affirm the patient's self-determination, maximize self-expression and communication, and support the patient's health, promoting behaviors that may include limitations of some communications. Documentation of this discussion shall be noted in the appropriate section of the patient's record, and on the plan of care.

Limitations on communications will be implemented, in consultation with available family members, to the extent necessary to preserve the well-being of the patient.

The Charge Nurse, Social Worker, and/or physician will communicate the plan and reason for the restriction to the patient as appropriate.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

SUBJECT:	SECTION:
SLIDING SCALE ELECTROLYTE REPLACEMENT PROTOCOL	***Medication Management (MM)*** **Page 1 of 7**

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

PURPOSE:

The purpose of this document is to provide the registered nurse (RN) with an algorithm for replacing non-symptomatic electrolyte abnormalities, specifically potassium, phosphorus, and magnesium.

POLICY:

A. When deemed appropriate, the physician will utilize computerized provider order entry (CPOE) to activate the Sliding Scale Electrolyte Replacement Protocol.

B. The Pharmacists will verify that the order is appropriate and that the patient does not possess any of the following contraindications/exclusion criteria.

- Scr > 2.0
- CrCl < 30 ml/min
- UOP < 0.5 ml/kg/hr
- Hemodialysis/PD
- DKA
- Rhabdomyolysis
- Weight <50 kg (110 lbs)
- TPN/PPN

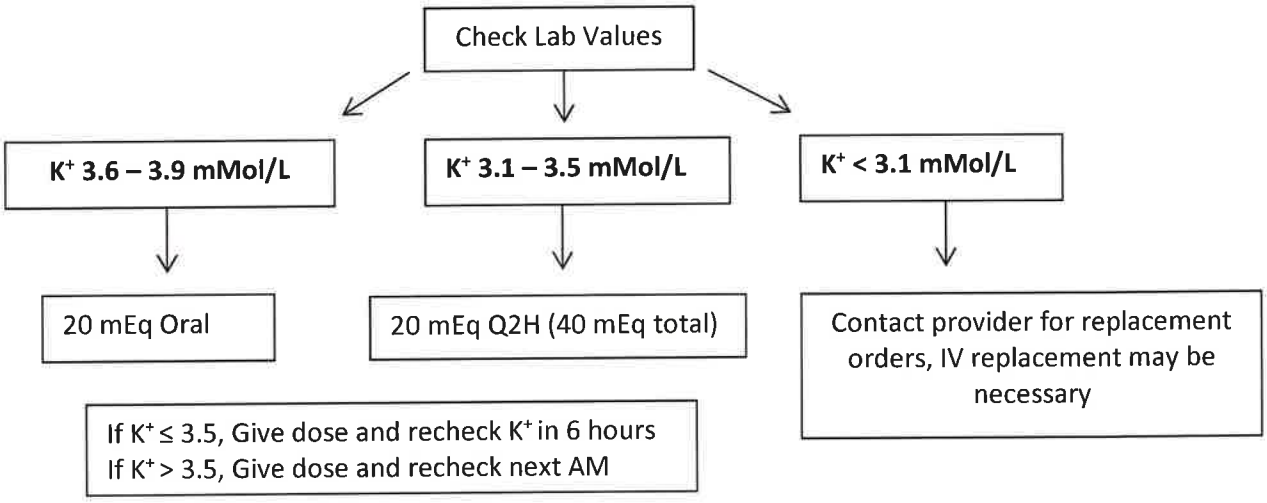
C. The RN will receive the appropriate orders on their electronic medication administration record (eMAR), which will guide them through the appropriate electrolyte replacement using the algorithm in the procedure section starting on the next page.

1. RNs will need to take special care to ensure labs are ordered at appropriate intervals based on the protocol.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES, EMERGENCY DEPARTMENT, INTENSIVE CARE UNIT, TELEMETRY, MEDICAL-SURGICAL UNIT, PHARMACY*

PROCEDURE/ALGORITHM:

ORAL POTASSIUM REPLACEMENT
(K^+ Normal Range 3.5 – 5.1 mMol/L)
ASYMPTOMATIC



IV POTASSIUM REPLACEMENT

(K^+ Normal Range 3.5 – 5.1 mMol/L)

FOR SYMPTOMATIC PATIENTS OR THOSE UNABLE TO TAKE PO MEDS

Symptomatic Hypokalemia:
- Arrhythmias
- Muscle Weakness
- Rhabdomyolysis

Check Lab Values

K^+ 3.6 – 3.9 mMol/L	K^+ 3.1 – 3.5 mMol/L	K^+ < 3.1 mMol/L
KCl IVPB 10 mEq Q1H x 2 doses = 20 mEq Order	Kcl IVPB 10 mEq Q1H x 4 doses =40 mEq total	Begin Initial Order of 60 mEq Total Per Protocol. 10 mEq IVPB x 6 = 60 mEq Order Call provider For Further Orders.

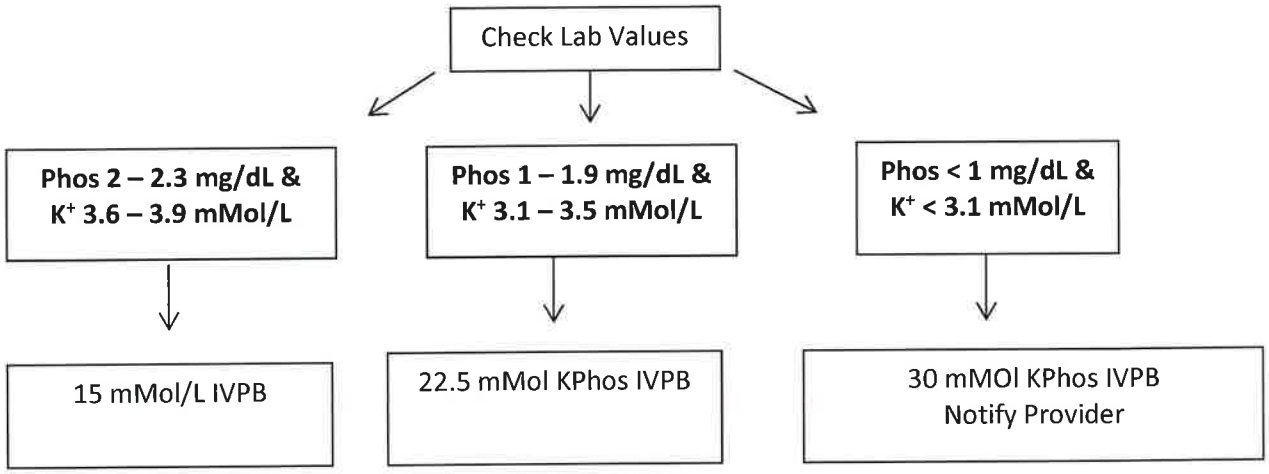
**Replacement orders should only be used in patients with a serum creatinine less than 2 mg/dL, BUN less than 30 mg/dL, CrCl >30 ml/min and urinary output greater than 0.5 ml/kg/hr

Repeat serum potassium level 2 hours after the total replacement is completed. Notify provider and check Mg level if K^+ deficiency does not correct after two replacement attempts.

IV POTASSIUM PHOSPHATES REPLACEMENT

Use When Phosphorus and Potassium need replacement

(**Phos** Normal Range 2.4 – 4.9 mg/dL) ($\mathbf{K^+}$ Normal Range 3.5 – 5.1 mMol/L)



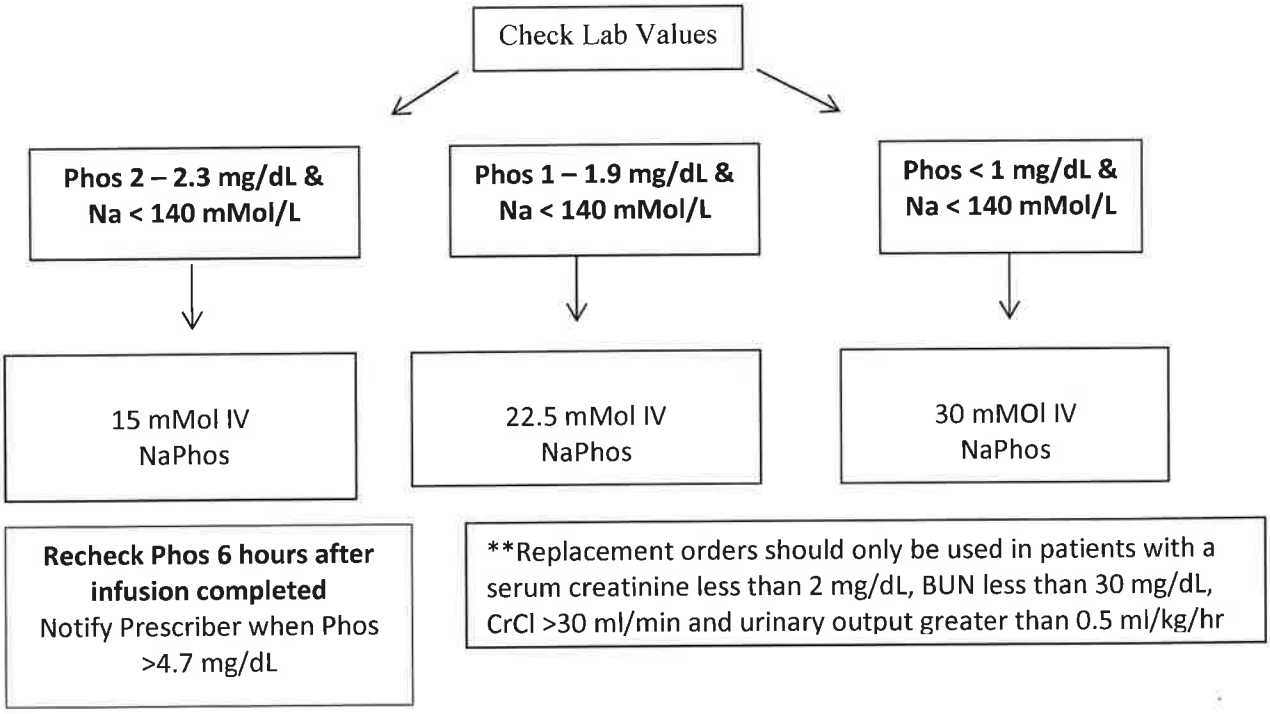
Recheck Phos 6 hours after infusion completed
Notify Prescriber when Phos >4.7 mg/dL

**Replacement orders should only be used in patients with a serum creatinine less than 2 mg/dL, BUN less than 30 mg/dL, CrCl >30 ml/min and urinary output greater than 0.5 ml/kg/hr

IV SODIUM PHOSPHATES REPLACEMENT

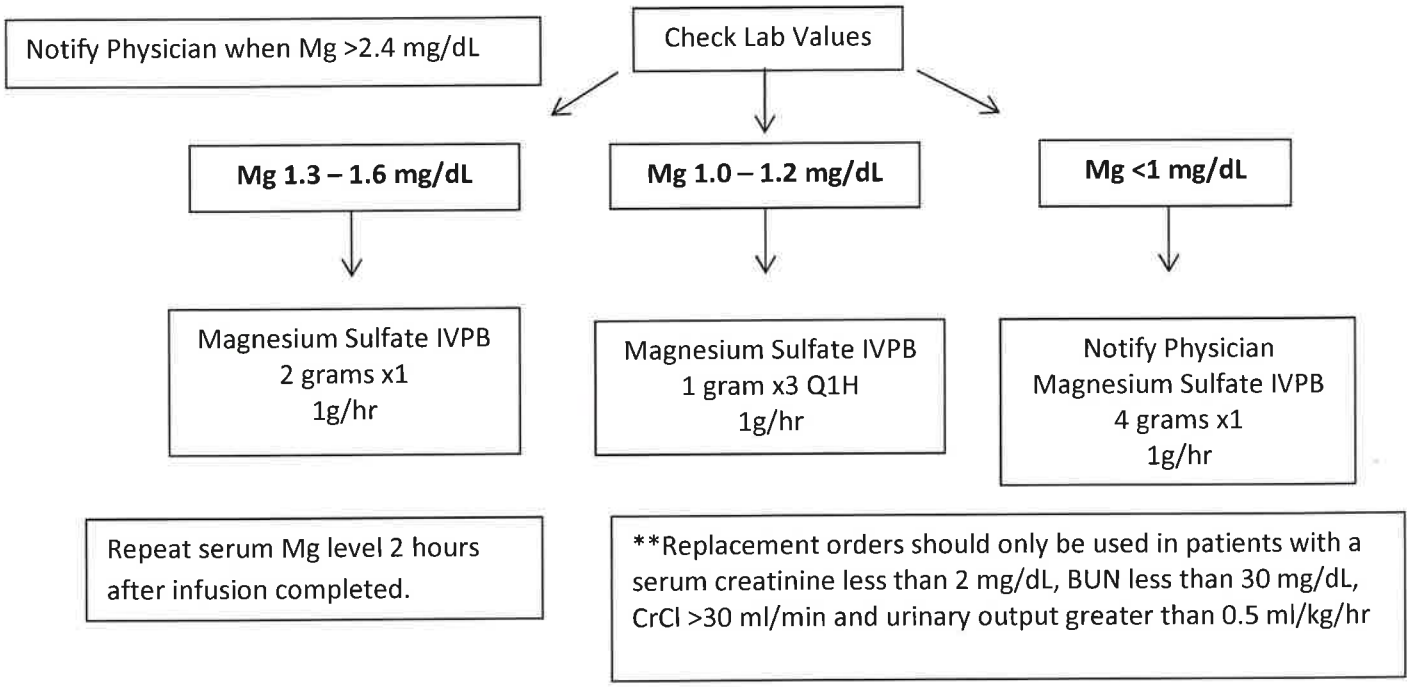
Use when ONLY Phosphorus Needs Replacement

(**Phos** Normal Range 2.4 – 4.5 mg/dL) (**Na** Normal Range 136-145 mmol/L)



IV MAGNESIUM REPLACEMENT

(**Mg** Normal Range 1.8 – 2.4 mg/dL)



Repeat serum Mg level 2 hours after infusion completed.

**Replacement orders should only be used in patients with a serum creatinine less than 2 mg/dL, BUN less than 30 mg/dL, CrCl >30 ml/min and urinary output greater than 0.5 ml/kg/hr

REFERENCES:

- Sterns, Richard. (2017). Maintenance and replacement fluid therapy in adults.
- Up-to-date. Retrieved November 23, 2022, from https://www.uptodate.com/contents/maintenance-and-replacement-fluid-therapy-in-adults.
- Potassium Chloride. Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; November 23, 2022.
- Potassium Phosphate. Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; November 23, 2022.
- Sodium Phosphates. Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; November 23, 2022.
- Magnesium Sulfate. Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; November 23, 2022.

SIERRA VIEW MEDICAL CENTER

House Wide Policy & Procedure Manual

SUBJECT:	SECTION:
VISITOR GUIDELINES	***Rights & Responsibilities of the Individual (RI)***
	Page 1 of 6

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

PURPOSE:

To establish guidelines for visiting hours that are flexible enough to facilitate patient/family/significant other interactions while supporting patient well-being as well as maintaining a safe, therapeutic environment for all patients.

POLICY:

Sierra View Medical Center (SVMC) supports open visiting for all patient care areas as defined below:

A. Persons with respiratory disease or any signs of communicable infections are not permitted to visit hospital patients.

B. All visitors must check-in at the Information Desk before continuing on to the patient care areas.

C. Children 13 years of age and younger must be accompanied by a responsible adult and not left unattended for any reason.

D. Young children, 10 years of age or younger, visiting other children must have permission from the Primary Care Nurse caring for the patient on the unit. The responsible adult will be requested to remove any child exhibiting disruptive behavior.

E. Children 10 years of age or younger visiting patients, will not be permitted to stay between the hours of 9:00pm - 6:30am due to health and safety concerns.

F. Behavior of Visitors:

1. Visitors will not interfere with the activities of any employee.
2. Visitors must behave in a quiet and calm manner.
3. Visitors will remain at the designated patient's bedside or in authorized waiting areas only. Hallways are to remain clear at all times.
4. Visitors who do not comply with hospital policy will be asked to leave.
5. Visitor smoking is not allowed on the hospital and ancillary site campuses.

G. Preferably there should be not more than two (2) visitors per patient at any one time. Exceptions may be made at the discretion of the Primary Care Nurse caring for the patient, including clergy visiting patients who are having life threatening or significant health occurrences that may require the presence of more than the customary desired limit of two visitors at at time.

H. Patients may designate visitors of their choosing if they have decision-making capacity, regardless of the chain of line of succession designated by the State of California:

1. No visitors are allowed.

2. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or would significantly disrupt the operations of the facility.

3. Patients have told the health facility staff that they no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

I. Patients in Isolation

1. -Personal protective equipment and education for their use will be provided to visitors who are visiting a patient in isolation.

2. Visitors must receive appropriate instruction from the nursing staff prior to entering the patient's room.

3. Children 13 years of age and younger will not be allowed to visit patients in isolation.

J. Visiting Hours and Restrictions:

ADULT PATIENTS:

1. Visiting hours are arranged with the Primary Care Nurse caring for a patient based on the needs of the patient.

2. Recommended visiting hours and restrictions for each area are as follows:

Medical/Surgical: 9:00 AM – 9:00 PM. After 9:00 PM, visitors will be allowed at the discretion of the Primary Care Nurse. Only one individual may be allowed to spend the night with the patient if the patient so desires.

Telemetry: 9:00 AM – 9:00 PM. After 9:00 PM, visitors will be allowed at the discretion of the Primary Care Nurse. Only one individual may be allowed to spend the night with the patient if the patient so desires.

Intensive Care Unit/Critical Care Unit: Any time with the following exceptions:

a. No visiting during shift change unless the visitor is the designated patient advocate and the patient wishes for the single visitor to participate in shift report with the off-going and on-coming nurses.

b. Visitors under the age of 13 must be accompanied by an adult.

c. *Exceptions:* will be granted on an individual basis.

Flex Care: 6:00 AM – 5:30 PM. After 4:00 PM at the discretion of the Primary Care Nurse.

Labor & Delivery: Open visiting hours for the father or other support person as chosen by the mother. During the actual delivery of the infant, only 2 people, as chosen by the mother, are allowed to attend. Any children must be accompanied by an adult.

Post-Partum: Father or support person and siblings of the newborn may visit at any time. All others will be allowed between 8:00 AM and 9:00 PM, but limited to a maximum of 3 visitors at one time.

NICU: Parents are allowed in the NICU at all hours except during shift change between 6:30 AM and 8:00 AM and 6:30 PM and 8:00 PM. The number of visitors at the bedside will be determined at the discretion of the bedside nurse; however a parent or legal guardian of the patient must be with the visitors. Children may visit with adult supervision at any time (except during RSV season) but the length of stay may be limited due to the age of the child.

A visitor may be asked to leave the room after all alternatives have been considered if a patient is:

a. Undergoing an emergency or complicated procedure

b. Other infants undergoing emergency or complicated procedure

c. Going to be discussing confidential information with the clinician.

Emergency Department: All patients may have 2 visitors each at the bedside while in the Emergency Department. Exceptions may be made at the discretion of the Primary Care Nurse. Patients who are in the hallway may only have one visitor at the bedside for safety issues.

Post Anesthesia Care Unit: Visitors will be allowed only with the approval of the Primary Care Nurse caring for the patient in the unit.

Surgery: No visitors will be allowed.

DP/SNF: The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. Visitors will be limited to three (3) at a time for each resident.

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The facility will provide:

1. Immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.
2. Immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.
3. Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.
4. Notification to the residents and/or their Authorized Representatives for any clinically necessary or reasonable restriction or limitation or safety restriction or limitation.

For purposes of this guideline, immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a State's common law equivalent. It might also include a foster family where one or more adult serves as a temporary guardian for one or more children to whom they may or may not be biologically related. Residents have the right to define their family. If the resident is unable to express or communicate whom they identify as family, facility staff should discuss this with the resident's authorized representative. Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident. With the consent of the resident, 24-hour access to other non-relative visitors will be provided, subject to reasonable clinical and safety restrictions. If these visitation rights infringe upon the rights of other residents, facility staff must find a location other than a resident's room for visits. Individuals who provide health, social, legal, or other services to the resident have the right of reasonable access to the resident. Space and privacy will be provided for such visits.

~~7:00 a.m. to 9:00 p.m. After 9:00 p.m., visitors will be allowed at the discretion of the Charge Nurse. Visitors will be limited to three (3) at a time for each patient.~~

Acute Dialysis: No visitors are routinely allowed in the acute dialysis treatment room due to space limitations. However, if only one patient is in the dialysis unit then the RN can make a consideration for allowing a visitor. ~~space limitations.~~

PEDIATRIC PATIENTS – ALL AREAS:

1. At least one parent, legal guardian, or other responsible adult will be allowed to remain with a child during the entire hospital stay.

2. At the discretion of the Primary Care Nurse, this person(s) may stay with the patient during minor procedures as long as the physical facility is large enough to accommodate the person(s), and they are able to provide emotional support to the patient.

3. For in-patients, at least one parent, legal guardian, or other responsible adult will be encouraged to stay overnight. However, they are not required to stay.

Visitation Restrictions during RSV (Respiratory Syncytial Virus Season):

SVMC implements RSV visitation restrictions to prevent the spread of these viruses to those who are more susceptible. Visitors under the age of 13 will be restricted from any of our acute care units, as well as from the Distinct Part/Skilled Nursing Facility (DP/SNF), for their own protection, as well as others. As a family-centered hospital, SVMC is taking all necessary precautions to ensure the safety and well-being of patients and community members throughout the season.

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DP/SNF Visitation Restrictions for COVID19

Related to COVID 19, SVMC DP/SNF will adhere to guidance by Centers for Disease Control, Centers for Medicare and Medicaid Services and California Department of Public Health. This guidance is based on the currently available information about COVID 19. It will be refined and updated as more information becomes available and as a response needs change in the United States.

- Restrict all visitation except for end of life situations
- Restrict all volunteers and non-essential healthcare personnel (HCP), including non-essential healthcare personnel (e.g. barbers).
- Cancel all group activities and communal dining

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REFERENCES:

- Cdc.gov
- Cms.gov
- Cdph.ca.gov
- Long-Term Care State Operations Manual, F563 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17).

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SIERRA VIEW MEDICAL CENTER **PHYSICIAN ORDERS DIABETIC KETOACIDOSIS**

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 blanks.
Only checked orders will be implemented.

Goal Blood Glucose = 150-200mg/dL until Resolution of DKA

Hourly I & O's

Foley catheter prn

Fingerstick blood glucose check **every 1 hour until 2 hours post anion gap closure**

☒ Continuous cardiac monitor

☐ Bed rest only ☐ Activity as tolerated.

Consult Case Management for new onset Diabetes.

DIET

☐ NPO - Consult Nutritional Services

☐ Consistent Carbohydrate 1800 Diet ADA DM Diet

Laboratory Studies

Blood Cultures X 2 if Temp > 101° F.

ABG's, CMP & serum lactate and 3-Beta-Hydroxybutyrate [acetone], CBC, Urinalysis, Cardiac Enzymes, Magnesium level and Hgb A 1-C **NOW** if not done already.

Renal Panel , Magnesium, Phosphorous, Venous Blood Gass and Serum Lactate **every 4 hours x 48 hours**

Serum 3-Beta-Hydroxybutyrate [acetone] daily x 3

Other Studies

☐ Portable Chest X-Ray, 1 view ☐ 12-lead EKG

IV Fluids

☐ Lactated Ringers 500 mL/hr over 4 hours (total of 2 Liters) **OR**

☐ Lactated Ringers 1000 mL/hr over 2 hours (total of 2 Liters) **THEN START**

☒ Lactated Ringers at 250 mL/hr

☒ Change IV Fluid to D5-LR at 250 mL/hr if BG ≤ 200 mg/dL or if serum Na+ > 150 mEq.

Potassium Replacement Scale (Not to Exceed 10 mEq/hr except when serum K+ less than 3.3 mM/L)

If K+ level ≥ 5.4 mM/L, then **NO KCL** in IV Fluids

If K+ levels: 5 - 5.3 mM/L – start KCL 10 mEq/liter of IV Fluids
4.5 - 4.9 mM/L – start KCL 20 mEq/liter of IV Fluids
4 - 4.4 mM/L – start KCL 30 mEq/liter of IV Fluids
3.3 - 3.9 mM/L – start KCL 40 mEq/liter of IV Fluids

If K+ level is less than 3.3 mM/L:

Peripheral line: Y-site a 10mEq/100mL K-Rider running at 100ml/hr (10mEq/hr) with the appropriate KCl 40mEq/L IV fluid running at 250mL/hr (**Total: 20mEq/hr of KCL**) until potassium level is greater than 3.3mM/L)

Central line: Y-site a 20mEq/100Ml K-Rider running at 100ml/hr (20mEq/hr) with the appropriate KCL 40mEq/L IV fluid running at 250mL/hr (**Total: 30mEq/hr of KCL**) until potassium level is greater than 3.3 mM/L.

☒ **For serum phosphate ≤ 1 mg/dL initiate IV KPhos 15 mmol in 1 liter of the appropriate fluid (based on current BG) at 250mL/hr (call Pharmacy for IV fluids).**

☒ **For pH ≤ 7.0 give 1 amp of Sodium Bicarbonate IV Push (50mEq)**

☒ Magnesium Replacement: If Magnesium level < 1.8 mg/dL then give 2 g Magnesium Sulfate IVPB over 2 hr. If follow-up Magnesium level remains < 1.8 mg/dL, repeat dose times one.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PATIENT'S LABEL

PHYSICIAN ORDERS DIABETIC KETOACIDOSIS

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SIERRA VIEW MEDICAL CENTER **PHYSICIAN ORDERS DIABETIC KETOACIDOSIS**

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 blanks.
Only checked orders will be implemented.

Goal Blood Glucose = 150-200mg/dL until Resolution of DKA

Start Regular Insulin Infusion of 100 units/100 mL Normal Saline.

Initiating the Infusion:

- ☐ Insulin regular human **0.1 unit/kilogram body weight** intravenously (IVP) once as loading dose.
- ☒ Insulin regular human **0.1 unit/kilogram body weight per hour** continuous intravenous infusion as maintenance dose for any BG greater than 200mg/dL.

When BG is 150 mg/dL – 200 mg/dL:
Adjust Insulin regular human to **0.05 unit/kilogram body weight per hour** continuous intravenous infusion as maintenance dose, with goal of keeping BG at 150-200mg/dL until DKA Resolution

When BG is 100 mg/dL – 149 mg/dL:
Adjust Insulin regular human to **0.025 unit/kilogram body weight per hour** continuous intravenous infusion as maintenance dose, with goal of keeping BG at 150-200mg/dL until DKA Resolution

When BG is less than or equal to 99 mg/dL:
Turn off insulin infusion, and resume insulin infusion when blood glucose > 150 mg/dL. Start insulin infusion at **0.025 unit/kilogram body weight per hour and continue hourly blood glucose** checks. Once BG is greater than or equal to 150 mg/dL **x one hour**, continue insulin infusion per protocol(0.05unit/kg body weight per hour).

When Resolution of DKA is achieved, defined as: Anion gap in normal range(<13), call MD for confirmation and for further orders (i.e. sliding scale/Lantus and diet orders)

- ☐ initiate routine SC insulin sliding scale Q6H (ACHS if eating) and discontinue IV insulin infusion 1hr after first dose.
- ☐ Initiate Lantus (insulin Glargine) 0.5U/kg SC QDAY and discontinue IV insulin infusion 1hr after first dose. Consult MD for future insulin coverage.

OR

- ☐ Initiate Lantus (insulin Glargine) ____ units SC QDAY and discontinue IV insulin infusion 1hr after first dose. Consult MD for future insulin coverage.

Hypoglycemia (BG < 60 mg/dL):

- ☒ Discontinue insulin infusion
- ☒ Give D50W IV 25 mL and recheck BG in 15 minutes. Repeat 25 mL of D50W if BG still < 150 mg/dL
- ☒ Resume insulin infusion per protocol once BG is greater than or equal to mg/dL.
- ☒ Notify physician of all episodes of hypoglycemia.

Nursing Considerations:

- IV insulin infusion should not be discontinued until 2hr after first SC dose in order to avoid rebound hyperglycemia.
- Blood Glucoses are to be monitored and recorded **hourly**.
- Fingerstick Blood Glucose Result and Insulin Infusion Rate should be documented **HOURLY.**
- Blood Glucose may decrease if nutritional therapy (e.g. TPN or tube feeds) are discontinued or reduced
- Renal impairment (SCr > 2 or CrCl <50) may increase insulin sensitivity and decrease BG more rapidly as a result.

NURSE SIGNATURE _____ **DATE:**_____ **TIME:**_____

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

PATIENT'S LABEL

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Senior Leadership Team	2/28/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	2/28/2023

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
February 28, 2023
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
Policies:		Approve ↓
1. Food Service Emergency Plan	1-12	
2. Food Supplies and Storage	13-17	
3. Mandatory Education	18	
4. Meal Periods and Rest Breaks	19-22	
5. Nepotism/Employment of Relatives	23-24	
6. Sierra View Medical Center Logo, Design and Color Scheme	25	
7. Staff Recruitment, Employment and Retention	26-28	
8. SVMC Staff Electronic Signature & Title Policy	29-32	

SUBJECT: **FOOD SERVICE EMERGENCY PLAN**	SECTION: ***Emergency Management Plan*** **1 of 12**

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

PURPOSE:

Sierra View Medical Center (SVMC) will have the means to provide nutritional assistance to staff and patients for ninety six (96) hours in the event of a disaster or emergency situation.

DEFINITIONS:

Emergency: An 'unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services.'

POLICY:

The facility maintains at least a seven days staple and two days perishable foods in inventory. In addition the facility maintains four days (96 hour) emergency meals, potable water and disposable supplies in the facility's secured, temperature-controlled warehouse.

A Nutrition Service disaster and emergency plan is prominently posted in the food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences an emergency/disaster. It is possible that any one or all of these services may be interrupted.

The Food & Nutrition Service Director or Dietitian or Food Service staff member in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration.

If needed, all or part of this emergency meal plan will be implemented to ensure provision of nutritious meals to patients despite the limitations of the disaster. The ***Meals for All*** Emergency Solution menu may be used during an emergency/disaster at the discretion of the Food & Nutrition Service Department, House Supervisor or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the Registered Dietitian will be notified.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS*

EQUIPMENT:

Food preparation tool box

PROCEDURE:

At least once a year, the Food & Nutrition Department conducts an in-service session on disaster plans and emergency procedures in regards to the nutritional assistance that will be provided to patients. The *Quick Guide to Emergency Feeding* guidelines will be posted in food service and the house supervisor office. A copy of the disaster and emergency procedures will be stored with the *Meals for All* emergency food and supplies ready reference. *(See attachment I - Quick Guide to Emergency Feeding Guidelines)*

HEATING SOURCE FOR WATER:

If no heating source is available, *Meals for All* may be reconstituted using unheated potable water. All food items are fully cooked and safe to serve at room temperature.

Do not attempt to cook or boil water over an open flame whenever gas leaks are possible.

FOOD TEMPERATURES / FOOD SAFETY:

For best palatability, hot foods are best served at 135°F or more, cold foods are best served at 41° or colder.

However, all foods on this menu may be safely served at room temperature between 41° - 135° if opened, prepared and served within two hours.

HANDWASHING FOR FOOD PREPARERS:

Proper hand washing when water is scarce requires the use of two basins, one with an approved sanitizing agent, and one with clear rinsing water. Approved hand sanitizer may also be utilized.

FOOD PREPARATION:

Follow instructions on the *Meals for All* containers for proper preparation. *See attachment II*

EMERGENCY FOOD ITEMS STORAGE:

The *Meals for All* emergency meals and other emergency supplies will be secured in the facility storage warehouse and easily accessible during an emergency or disaster situation. All food items are dated by the manufacturer and have a ten year shelf life. During the final year of the expected shelf-life, SVMC will determine if the facility will donate the *Meals for All* to a charitable organization or utilize for a facility disaster exercise.

EQUIPMENT FOR FOOD PREPARATION:

The equipment needed for food preparation is secured and stored in the facility storage warehouse. The equipment is in its own marked container and located next to the *Meals for All* pallets. The equipment toolbox includes but not limited to:

- 4 gray scoops (4oz), 4 green scoops (3oz), 4 spoodles (4oz), 2 serving spoons, 2 slotted serving spoons, 4 ladles (3oz), 2 rubber spatulas, 4 tongs, 2 sets measuring spoons, 2 measuring cups, 4 mixing bowls, 2 containers (12 quart), disposable aluminum pans, 2 spot lights, 6 headlamps; 3 lanterns, 10 flashlights, 72 (D) batteries, disposable gloves, 2 can openers, 4 thermometers, 2 boxes storage bags, 2 boxes hairnets, 2 box cutters & extra blades, black markers, 2 scissors, 2 lighters,

masking tape 72 (D) batteries, 2 boxes storage bags, 2 cases disinfectant wipes, 2 boxes alcohol wipes, 4 bottles hand sanitizer, black markers, 2 scissors, 2 lighters, masking tape , garbage bags.

INVENTORY AND VERIFICATION:

The *Meals for All* Emergency Menu Inventory and Supply list will be maintained in the Food & Nutrition Service Director's Office, and a copy will be placed in the Emergency Operations Procedures manual. The inventory and supply list will be inspected on a semi-annual basis to determine all items are present in the quantities specified. The Emergency Supply Inventory Verification form (attached) will be utilized for documenting the inventory, which will include;

- Date of inventory check.
- Results of the inventory.
- Corrective action if needed.
- Signature of person performing the supply inventory.

The Emergency Supply Inventory Verification form will be kept in the Director of Food & Nutrition office and available upon request. (*See attachment IV: Inventory Verification form.*)

DECENTRALIZED FOOD PREPARATION:

The Food & Nutrition Service Director or designee in charge may designate some or all of the emergency food preparation to be conducted at a decentralized location or on each nursing unit or at a remote locations from the facility. The *Meals for All* are packaged to be easily transportable in the event of an evacuation and can be set up in any decentralized location.

MEAL SERVING HOURS:

The meal serving hours for the *Meals for All* will be modified or staggered depending on the emergent situation and will be determined by the Incident Commander, Food & Nutrition Service Director, or designee. The necessary amount of batch cooking to prepare in order to serve in large quantities to the patients and staff members will be taken into consideration. The meals may be served tableside to facilitate having a limited staff to efficiently prepare and serve during an emergency situation. If emergency circumstances warrant, the meals may be served directly from the cooking container directly to the patient / staff.

USE OF EMERGENCY MENUS:

Depending on the time of day and expected duration of the emergency, the Food & Nutrition Service Director or designee may implement the *Meals for All* emergency menus and may be used for a single meal or for several days. (*See attachment III - 4 Day Emergency Menu.)*

MENUS AND THERAPEUTIC DIETS:

The *Meals for All* menus have been planned to provide basic nutrients and meet the needs of most therapeutic healthcare diets. The *Meals for All* menu and products have been specially prepared to allow their use for most healthcare therapeutic diets. The therapeutic menu is appropriate for *Regular, Mechanical Soft, Cardiac, Sodium Restricted, Diabetic and Renal diets.* Specific Therapeutic Diet modifications are as follows:

- Consistent Carbohydrate, Diabetic Gestational Diabetes and Low/No concentrated Sweets Diets may be served all menu items except the pudding. Offer sugar substitute and diet jelly, if available.
- Low Cholesterol/ Low Fat Diets may be served on all menu items.
- No Added Salt/Low Salt Diets may be served on all menu items, but the salt packets are omitted.
- 2 Gram Sodium Diets may be served on all menu items, but the salt packets are omitted.
- Calorie Controlled diets, 1500 Calorie or less, and Consistent Carbohydrate or Diabetic Diets may be served on all menu items except portions of milk, cracker-biscuits and snacks are reduced and the puddings are omitted. Offer sugar substitute and diet jelly if available.
- Renal and Hepatic Diets may be served on all menu items except the milk, pudding and salt packets are omitted. Limit beverages if fluid restriction is prescribed.
- Resident's allergies will be accommodated by knowledgeable staff by offering suitable foods from the *Meals for All* Emergency menu. Diets may be deficient in one or more nutrients.
- Powdered milk is included in the *Meals for All* to meet nutritional needs.

Clear Liquid Diets shall receive broth, gelatin, and clear soda stocked on the nursing units. Nutritional supplements may be ordered to increase calories and nutrient values.

BEVERAGES / CONDIMENTS:

Beverages will be provided as requested or available during an emergency situation. Patients needing thickened liquids will be served beverages thickened to the appropriate level. Substitute dehydrated milk mixed with water for fluid milk if needed. Condiments such as salt, pepper and sugar are made available when possible and not contraindicated by the prescribed diet order. Consistent Carbohydrate or Diabetics shall receive sugar substitute. Sodium-Restricted, Hepatic and Renal diets will not receive salt packets.

WATER STORAGE GUIDELINES:

The facility will maintain designated emergency water in SVMC's secured, temperature controlled warehouse. The water will be stored in a cool, dry area, away from heat sources, and staff will be instructed not to utilize it for any other purpose except an emergency situation. One gallon of water per person per day for proper hydration will be stored. This allows two quarts for drinking water and two quarts for food preparation. However, *Meals for All* dehydrated emergency foods require approximately one quart of water per person per day for reconstitution. *Refer to Water Requirements Appendix in 4-*

Day Meal Plan Guide for water requirements table for exact amounts of water per can. Storing one gallon of water per person per day is adequate to meet emergency water needs.

Although the bottled water packaging may indicate an expiration date, the United States Food and Drug Administration (FDA), which regulates bottled water as a packaged food, has determined that there is no limit to the shelf life of bottled water.

MEAL / WATER ALLOCATION

DAY 1		DAY 2		DAY 3		DAY 4	
Patients	165	Patients	165	Patients	165	Patients	165
Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400
EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85
Water (gallons)	650	Water gallons)	650	Water gallons)	650	Water (gallons)	650

A MINIMUM OF 1 GALLON PER PERSON PER DAY ON SITE.

A MINIMUM OF 2600 GALLONS STORED ON SITE.

Meals for All

Day 1	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 2	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 3	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 4	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)

Emergency Tool Box

Disposables / Dry Supplies

ATTACHMENTS:

- *Attachment I: Quick Guide to Emergency Feeding*
- *Attachment II: Meal Preparation*
- *Attachment III: Four Day Emergency Meal Menu*
- *Attachment IV: Inventory Verification Form*

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission. (2022). Accreditation Participation Requirements (APR) Manual.
- Nutricopia, *Meals for All* Emergency Solutions (2022). Retrieved from https://www.nutricopiaonline.com.
- International Bottled Water Association (2021). Retrieved from https://www.bottledwater.org/education/bottled-water-storage.

ATTACHMENT I

QUICK GUIDE TO EMERGENCY FEEDING

1. Notify Food & Nutrition Service Director or Clinical Nutritional Manager using the emergency call back list or appoint an alternate to be in charge.

2. Determine nature of emergency or interruption:

   - ELECTRICITY - Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NATURAL GAS - Use alternate heating source if safe. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - WATER SUPPLY - Affects ware washing and cooking, so conserve water and liquids. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NO POWER OR WATER - Use alternate heating source if safe. Affects ware washing and cooking, so conserve water and liquids. Substitute *Meals for All* as needed.

3. SELECT MENU PLAN TO FOLLOW:

   - Usual menu with needed adaptations (uses perishable supplies first)
   - Meals for All emergency solution.

4. DIET MODIFICATIONS: Refer to usual menu, if using.

   - Follow "Emergency Menu Serving Instructions" when using *Meals for All*.
   - Be aware of those with food allergies.
   - Modify texture for chewing/swallow needs (e.g. mince or mash foods, serve thickened liquids.)

5. LOCATE NEEDED ITEMS:

   - Emergency procedures and menus are posted in Nutrition/Food/Dietary Department, Emergency food storage area, and House Supervisor's office.
   - Emergency food supplies are located at the SVMC warehouse.
   - Emergency disposable supplies are located at the SVMC warehouse.
   - Preparation supplies are located in emergency toolbox at the SVMC warehouse.
   - Water supply is located at the SVMC warehouse.

ATTACHMENT II

MEAL PREPARATION

Refer to the label on each product for specific instructions.

General Instructions for Hot Foods:

1. Open can and discard oxygen absorber* packet.
2. Boil water amount as directed, OR mix with room temperature water if there is no heating source.
3. Stir dry contents of can or cans into boiling water.
4. Cover and remove from heat.
5. Allow to stand for 15 minutes for boiling water, 1 hour if room temperature water utilized.
6. Stir and serve 1 1/3 cup (2 x No. 6 Scoop) or as directed

Instructions for Ready to Eat Items (Fruit, Vegetables, Crackers):

1. Remove oxygen absorber* packet.
2. Ready to eat from packaging.
3. If desired, rehydrate as above using cold water for fruit.

Instructions for Pudding Preparation:

1. Open can and discard oxygen absorber* packet.
2. Stir dry contents of one can into cold water, amount as directed.
3. Whisk thoroughly to mix. Allow to stand for 15 minutes.
4. Stir and serve #8 scoop for ½ cup or as directed.

Non-Fat Milk, to prepare:

1. Add water as directed on label, allow to stand 15 minutes, stir and serve 8 ounces or as directed.

Notes:

- Food Safety Note: Food should be consumed within 2 hours of preparation unless maintained at 135° or higher or below 41° for cold foods.
- No heating methods: Allow 1 hour to rehydrate when using cold or room temperature water.
- Product shelf life is ten years when properly stored in a cool, dry environment.

*Contains a non-toxic oxygen

ATTACHMENT III

MEALS FOR ALL EMERGENCY MENU FOUR DAY				
DAY ONE	**DAY TWO**	**DAY THREE**	**DAY FOUR**	**VEGETARIAN**
BREAKFAST				
Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
MID-MEAL				
Beef & Mushrooms with Noodles	Turkey & Potatoes with Cranberry	Southwestern Chicken & Rice	Chicken Curry with Rice	Spaghetti with Mushrooms
Green Peas	Corn Niblets	Green Beans	Garden Mixed Vegetables	Green Peas
Apples Diced	Peaches Diced	Applesauce	Peaches Diced	Applesauce
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
DINNER				
Chicken Curry with Rice	Spaghetti with Mushrooms	Beef Stew with Potatoes	Macaroni & Cheese	Macaroni & Cheese
Carrots	Garden Mixed Vegetables	Broccoli	Green Peas	Green Beans
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Chocolate Pudding	Banana Pudding	Vanilla Pudding	Banana Pudding	Vanilla Pudding
Beverage	Beverage	Beverage	Beverage	Beverage
SNACK				
Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers

ATTACHMENT IV

25 Person Serving Unit

Inventory List (Four Day Emergency Menu)

Case Number	Day	Meal	4-Day Emergency Menu items	Servings Per Can	Number of Cases in Inventory
1-A	1	Breakfast	Apple Cereal, Fortified	25	26
	1	Breakfast	Cracker-Biscuits	25	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Green Peas	25	
	1	Mid-meal	Apples, Diced	25	
1-B	1	Mid-meal	Cracker-Biscuits	25	26
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Carrots	25	
	1	Evening	Cracker-Biscuits	25	
	1	Evening	Chocolate Pudding	25	
2-A	2	Breakfast	Apple Cereal, Fortified	25	26
	2	Breakfast	Cracker-Biscuits	25	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Corn	25	

	2	Mid-meal	Peaches, Diced	25	
2-B	2	Mid-meal	Cracker-Biscuits	25	26
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Garden Mixed Vegetables	25	
	2	Evening	Cracker-Biscuits	25	
	2	Evening	Banana Pudding	25	
3-A	3	Breakfast	Apple Cereal, Fortified	25	26
	3	Breakfast	Cracker-Biscuits	25	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Green Beans	25	
	3	Mid-meal	Applesauce	25	
3-B	3	Mid-meal	Cracker-Biscuits	25	26
	3	Evening	Beef Stew	12.5	
	3	Evening	Beef Stew	12.5	
	3	Evening	Broccoli	25	
	3	Evening	Cracker-Biscuits	25	
	3	Evening	Vanilla Pudding	25	
4-A	4	Breakfast	Apple Cereal, Fortified	25	26
	4	Breakfast	Cracker-Biscuits	25	
	4	Mid-meal	Curry Chicken and Rice	12.5	

	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Garden Mixed Vegetables	25	
	4	Mid-meal	Peaches, Diced	25	
4-B	4	Mid-meal	Cracker-Biscuits	25	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Green Peas	25	
	4	Evening	Cracker-Biscuits	25	
	4	Evening	Banana Pudding	25	26
Milk	1	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 1A/1B
	2	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 2A/2B
	3	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 3A/3B
	4	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 4A/4B
Snack	1	Snack	Peanut Butter	25	
	1	Snack	Cracker-Biscuits	25	incl 1A/1B
	2	Snack	Peanut Butter	25	
	2	Snack	Cracker-Biscuits	25	incl 2A/2B
	3	Snack	Peanut Butter	25	
	3	Snack	Cracker-Biscuits	25	incl 3A/3B
Snack	4	Snack	Peanut Butter	25	
	4	Snack	Cracker-Biscuits	25	incl 4A/4B
				EXPIRATION DATE:	2024

SUBJECT: **FOOD SUPPLIES AND STORAGE**	SECTION: **Page 1 of 5**

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

PURPOSE:

Food and supplies will be stored within regulatory guidelines to maintain optimal nutritional composition and prevent all sources of contamination.

POLICY:

The Food and Nutrition Service (FNS) Department shall ensure that all foods, non-foods and supplies shall be stored in a manner to prevent physical, chemical and bacterial contamination. All food shall be of good quality and procured from sources approved or considered satisfactory by federal, state, and local regulatory agencies.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. At least one week's supply of staple foods and at least two (2) days' supply of perishable foods shall be maintained on the premises.

2. Emergency food for 96 hours shall be stored separate *(Please refer to FOOD SERVICE EMERGENCY PLAN Link).*

3. The storage areas are well ventilated and clean.

4. Food storage refrigerators, walk-ins, and freezers are provided with reliable thermometers. Temperatures are inspected/recorded daily to ensure proper temperature control. Temperature records are retained for reference for one (1) year.

5. Perishables are stored at 41°F or below after delivery.

6. Frozen foods are stored at 0°F or below after delivery.

7. Dry or staple items are stored a minimum of 12 inches above the floor and 18 inches from the ceiling.

8. Food overages held in storage areas are clearly identified, dated, and appropriately covered. Food items will be labeled with the expiration date and will not be re-used more than once.

9. Chemical materials used for cleaning purposes and pesticides are clearly labeled and stored separately, away from food and supplies.

10. All cans that are dented, bulging or leaking shall be considered a possible health risk and will be placed in a designated area for return or discarded.

11. The store room stock is rotated using the FIFO (first in first out) method.

12. Milk is served in individual containers. All liquid beverages are served capped.

13. Foods refrigerated or in other storage areas shall be stored appropriately, clearly labeled if not easily identifiable, and dated.

14. Hermetically sealed foods or beverages shall have been processed in compliance with applicable federal, state and local codes. No home canned foods will be used.

15. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. It is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodents and insects. The storeroom is maintained at a temperature between 50-70°F.

16. Only Food & Nutrition Service (FNS) employees are authorized to enter the storeroom. Any person(s) needing to access or survey the storeroom will be escorted by an authorized hospital employee.

17. The storeroom shelves are cleaned and checked weekly. The floor is swept and mopped daily.

18. The outside storage area is organized and cleaned monthly. All paper products used for eating purposes shall be well-wrapped and stored in boxes. Any uncovered containers shall be discarded to avoid possible contamination.

19. All refrigerators in the FNS department are constructed to maintain a temperature at or below 41°F. Freezers will be at 0°F or colder. The temperatures are recorded for all freezers and refrigerators daily.

20. Each refrigeration unit will house an internal thermometer. The inside thermometer is the primary method of recording temperatures and will be used when documenting temperatures. The outside temperature gauges are not utilized to verify temperatures.

21. Shelving will be constructed to allow for adequate air circulation.

22. All refrigerators and freezers are cleaned weekly.

23. All raw food is stored below cooked foods.

24. All foods in process will be covered, labeled when not clearly identifiable, and dated with expiration date.

25. All foods are dated when received to ensure proper rotation.

26. All frozen foods removed from original packaging will be clearly identified with date received. *Example: An eighty (80) pound case of ground beef may contain eight (8) 10 pound tubes. If six (6) tubes were pulled for production, the remaining two (2) may be removed from the original*

box and placed on the freezer shelf if they are each labeled (ground beef) and with the date received.

27. All meat and egg products are thawed in the refrigerator. In an emergency, frozen meat may be thawed under continuous running potable water.

28. Open cans are not stored in the refrigerator.

29. Items that have been thawed are not refrozen.

30. Foods predated with an expiration date such as milk, sour cream, etc. will be dated the day the container was opened. The pre-dated product will be disposed on the manufacturer expiration date on the container.

31. Prepared items such as mayonnaise, pickles, dressings, etc. will be dated with a 30 day expiration date.

32. Canned or perishable items such as peaches, olives, luncheon meat, etc. will be dated with a three (3) day expiration date after opened.

33. Food will be discarded when it exceeds the established standards based on the date listed on the label, or as stated on the preprinted expiration date on the food item.

Non-definitive Food Dating Labels such as "Best By" and "Enjoy by":

Food labels other than "Use by" may be used on food products received, printed by the manufacturer.

- Per FDA, "Consumers should examine foods for signs of spoilage that are past their "Best if used by" date. If the products have changed noticeably in color, consistency or texture, consumers may want to avoid eating them."- https://www.fda.gov/media/101389/download
- Per USDA, "A "Best if Used By/Before" date indicates when a product will be of best flavor or quality. It is not a purchase or safety date."-: https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

At SVMC, freshness labels will be treated as an expiration date for dry stock items. However for perishable items, such as produce, foods may be used past the "best by" date, if they are inspected for freshness and no signs of spoilage are present, per USDA and FDA guidelines.
No items may be used past an expiration, or "use by" date.

FOOD STORAGE

FROZEN FOOD

Meats
- Uncooked beef, lamb, veal, chicken ..... 6 - 12 months
- Ground meats, sausage, turkey, pork ..... 1 – 3 months
- Cooked ..... 1 month
- Meat casserole ..... 2 – 6 months

Baked goods
- Baked ..... 3 – 6 months
- Unbaked rolls ..... 2 months
- Unbaked cookies ..... 6 months

Ice Cream Products ..... 6 months

Vegetables ..... 8 – 12 months
- Potatoes ..... 2 – 6 months

Fruit juices ..... 8 months

REFRIGERATOR FOODS

Eggs
- Whole raw in shell ..... 30 days
- Cooked whole ..... expiration date

Milk ..... not after date on carton

Cheese ..... 45 – 60 days
- Hard ..... not after date on carton
- Cottage ..... not after date on carton

Juice (thawed) ..... 2 weeks

Canned fruits ..... 3 days

Margarine and butter ..... 30 days

Desserts
- Gelatin (Jell-O) ..... 3 days
- Pudding and custards ..... 3 days

Produce ..... 1 – 2 weeks

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- FDA, Food Facts - How to Cut Food Waste and Maintain Food Safety, Retrieved on 01.16.2023 https://www.fda.gov/media/101389/download
- USDA, Food Product Dating, , Retrieved on 01.16.2023 https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

CROSS REFERENCES:

- FOOD SERVICE EMERGENCY PLAN Link

SUBJECT: **MANDATORY EDUCATION**	SECTION: ***Management of Human Resources (HR)*** **Page 1 of 1**

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

PURPOSE:

To establish a clear understanding of mandatory education

POLICY:

1. Education is mandatory when attendance is required at a class or training session as a condition of continued employment. This includes *initial* Department / Unit-specific certification/course completion that was not previously required at the time of hire or transfer into a specific unit.

2. Classes taken to maintain existing required Department / Unit-specific certification(s) are not considered mandatory, therefore, Sierra View Medical Center will not be financially responsible for either the class or the time off to obtain the required certification/course completion.

AFFECTED AREAS/PERSONNEL: *ALL NURSING DEPARTMENT EMPLOYEES*

PROCEDURE:

1. When a class or training session is designated as *mandatory,* Sierra View Medical Center will pay the employee's time to attend as well as the class.

***Courses must be taken on campus or sponsored by SVMC. If the course requires the employee to attend a mandatory class/course off campus, the employee **must** have their supervisor's permission.

SUBJECT: **MEAL PERIODS AND REST BREAKS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To define the meal and break period procedure for Sierra View Medical Center (SVMC).

POLICY:

Non-exempt employees who work shifts of more than five (5) hours are entitled to a 30-minute uninterrupted and unpaid meal period to be taken no later than the end of the fifth hour of work. An employee who works routinely six hours or less per day may voluntarily choose to waive the meal period using the timekeeping system.

Non-exempt employees who work shifts of more than ten (10) hours must (unless waiver on file) take a second 30-minute uninterrupted and unpaid meal period that begins before the end of the tenth hour of work.

Non-exempt employees who work shifts more than ten (10) hours can execute a waiver of either the first or second meal period of such shift.

Non-exempt employees who work shifts of more than fifteen (15) hours must take a third 30-minute uninterrupted and unpaid meal period that begins before the end of the fifteenth hour of work.

Non-exempt employees are provided a 10-minute paid break for every four hours of work or major portion thereof. A rest period cannot be consolidated with any other rest or meal period.

AFFECTED AREAS/PERSONNEL: *ALL NON-EXEMPT EMPLOYEES*

PROCEDURES:

Meal Periods

Employees shall receive a 30-minute uninterrupted and unpaid meal period in accordance with this policy as follows:

- Work shift of more than 5 hours to 10 hours: One unpaid meal period of no less than 30 minutes to begin before ~~by~~ the end of the fifth hour of work.
- Work shift of more than 10 hours: Two unpaid meal periods of no less than 30 minutes to begin as follows:
  - First meal period: Begin before ~~by~~ the end of the fifth hour of work.
  - Second meal period: Begin before ~~by~~ the end of the tenth hour of work.
- Work shift of more than 15 hours: Three unpaid meal periods of no less than 30 minutes to begin as follows:
  - First meal period: Begin before ~~by~~ the end of the fifth hour of work.
  - Second meal period: Begin before ~~by~~ the end of the tenth hour of work.
  - Third meal period: Begin before ~~by~~ the end of the fifteenth hour of work.

Employees must clock out and clock back in for all meal periods using the meal out and meal in punch buttons. If you perform any work for any reason during your meal period(s), you must record it using the timekeeping system so that you can be paid for your time. Working off-the-clock during any meal period is strictly prohibited. Unpaid meal periods cannot be combined with ten (10) minute rest periods.

It is the responsibility of non-exempt employees to notify their supervisor through the timekeeping system when their meal period is interrupted and/will be less than 30 minutes or forfeited altogether.

When a non-exempt employee performs work during his/her entire meal period, the meal period will be counted as "hours worked" and the employee will be compensated for the entire duration of the meal period. In addition, there may be circumstances due to patient-care services when an on-duty meal period may be required. When the nature of the work prevents an employee from being relieved of all duties, employees will be compensated for all time spent on an on-duty meal period. Evaluation of the need for an on-duty meal period will be determined by and approved at the discretion of department leaders and must be pre- approved.

In circumstances where there is not time to get pre-approval (i.e., patient care) of an interrupted or forfeited meal period, they will still be compensated for the missed meal period that the employee worked.

If, after notifying the employee's supervisor, the employee is unable to take a timely uninterrupted meal period in accordance with the policy, the employee must record such missed meal period using the timekeeping system. The employee will then receive one hour of premium pay for that day at the employee's regular ~~primary position~~ rate of pay. An employee may not claim premium pay for more than one missed meal period in a single workday.

An employee who is provided a timely meal period in accordance with this policy and who voluntarily chooses to skip, delay, or shorten their meal period is not eligible for premium pay for the missed meal period and must record this choice using the timekeeping system .

Staffing should provide for the continuity of patient care and services when scheduling non-exempt employee meal periods. Departments may choose to schedule specific meal periods during shifts to ensure there is minimal to no disruption of patient care services.

Voluntary Meal Period Waiver and On-Duty Meal Period Agreement

Subject to operational needs and the eligibility criteria set forth below, non-exempt employees may voluntarily choose to sign the following waiver form that excuses SVMC's obligation to provide the employee with the waived meal period:

- First or Second Meal Period Waiver: A health care employee who works a shift more than ten (10) hours is eligible to waive either their first or second meal period by signing the "First or Second Employee Meal Period Waiver" form.

- On-Duty Meal Period Agreement: With advanced approval from SVMC Human Resources, an eligible employee may have the opportunity to voluntarily enter into an On-Duty Meal Period Agreement that permits the employee to take their meal period while in an on-duty paid status when the nature of the employee's job prevents them from being relieved of all duties to take an uninterrupted meal period.

An employee's decision to agree to the first or second meal period waiver form or the on-duty meal period agreement is voluntary on the part of the employee. An employee may revoke a meal period waiver or the on-duty meal period agreement any time by providing written notice to SVMC's Payroll.

Paid Rest Breaks

SVMC offers non-exempt employees a 10 -minute paid rest break for every four hours of work or major portion thereof during a work shift.

Non-exempt employees are entitled to rest breaks as follows for the following work shifts:

- Less Than 3.5 Hours: No rest break entitlement
- 3.5 Hours to 6 Hours: Entitled to one (1) rest break of 10 minutes to be taken as close as possible to the middle of the first four hours worked.
- More Than 6 Hours to 10 Hours: Entitled to two (2) rest breaks of 10 minutes each to be taken as close as possible to the middle of each four-hour work period during the shift.
- More Than 10 Hours: Entitled to three (3) rest breaks of 10 -minutes each to be taken as close as possible to the middle of each four-hour work period during the shift.

Employees who work longer shifts would be entitled to another paid rest break of 10 -minutes for each additional four-hour increment or major fraction thereof that is worked.

Rest breaks are intended to provide a time of rest and reprieve from the employee's duties. Leaders should do their best to offer the first paid break during the first four hours of a shift and the second break during the last four hours of a regular shift. Rest breaks are considered "time worked" and employees will be compensated for their rest breaks. Rest breaks may not be combined with meal periods and cannot be taken in conjunction with start or end of the shift.

Rest breaks are scheduled to ensure continuity of patient care and may occur at various times throughout a shift each day. Department leaders may choose to schedule rest breaks to provide proper staffing and to ensure employees receive break periods.

If, after notifying the employee's supervisor, the employee is unable to take a timely rest period in accordance with the policy, the employee must record such missed rest period using the timekeeping system at the end of each shift. The employee will then receive one hour of premium pay for that day at the employee's regular ~~primary positions~~ rate of pay. An employee may not claim premium pay for more than one missed rest period in a single workday.

An employee who is provided a timely rest period in accordance with this policy and who voluntarily chooses to skip, delay, or shorten their rest period is not eligible for premium pay for the missed rest period.

Review for Timecard Accuracy

Employees must attest to the accuracy of their recorded time entries daily, including:

- The start and end times of each meal period taken in the shift;

- Premium pay for any missed meal period in the shift; and
- Premium pay for any missed rest period in the shift.

Supervisors are also required to review employee timekeeping records to ensure accuracy of recorded time entries each pay period for the entries noted above.

In the event that an employee has concerns regarding the accuracy of their recorded time entries (including applicable premium pay), the employee should contact their supervisor or Payroll.

Supervisors shall not dissuade or discourage employees from seeking a missed meal period premium or missed rest period premium when an employee was not provided a timely meal period or rest period in accordance with this policy.

Any failure to follow this policy may lead to disciplinary action in accordance with SVMC's Human Resources Policy & Procedures Manual.

REFERENCES:

- California Labor Code sections 512 and 512.1
- California Industrial Welfare Commission Wage Orders 4-2001 and 5-2001
- Fair Labor Standards Act 1938
- SB-1334 Meal and rest periods

CROSS REFERENCES:

- HEALTH CARE EMPLOYEE FIRST OR SECOND MEAL PERIOD WAIVER
- ON-DUTY MEAL PERIOD AGREEMENT
- RECORDING HOURS WORKED
- EXEMPT STAFF WORKING EXTRA SHIFTS

SUBJECT: **NEPOTISM/EMPLOYMENT OF RELATIVES**	SECTION: **Page 1 of 2**

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

PURPOSE:

This policy was established to ensure compliance with Equal Employment Opportunity guidelines and to preserve and promote non-discrimination regarding the employment relationship in relation to hiring, promotion, and employment practices.

POLICY:

Sierra View Medical Center (SVMC) regulates the reporting relationships of individuals who are related by blood or marriage in order to avoid the appearance of conflict of interest, influence, or favoritism.

DEFINITIONS:

Relative for purposes of this policy is defined as any of the following including those by virtue of blood, marriage, or remarriage: spouse, children (including step and adopted children), parent, grandparents, siblings (including step, in-laws and legal guardians.)

AFFECTED PERSONNEL/AREAS: *ALL SVMC EMPLOYEES*

PROCEDURE:

1. Individuals who are related may be employed by the Hospital provided there is no direct reporting relationship between the relatives.

2. It is considered to be an unacceptable reporting relationship when an employee works under the immediate supervision of a relative or in any position for which a relative participates in the decision to employ, promote, recommend or approve salary adjustments, expense reimbursements, overtime or payroll exceptions, or terminate employment of that employee.

3. The hospital will not allow relatives to be placed or promoted into supervisor/manager reporting relationships.

4. In the case where two employees marry, continuing employment is available for both spouses provided that there is no unacceptable reporting relationship or decision-making influence on conditions of employment.

5. If such relationships exist, the employees must disclose the relationship immediately and the employees must be separated (physically or organizationally), so that one does not have any direct or indirect responsibility, authority or control, real or perceived, over the other. Any and all steps taken to eliminate any real or potential authority or control one employee has over the other must be set forth in writing by the applicable Department Director and filed in the employees' personnel files.

6. Any employee who failed to properly disclose any relationship in violation of this policy at time of hire will be considered to have falsified their employment application and will be subject to disciplinary action, up to and including termination of employment.

7. SVMC reserves the right to exercise appropriate judgment to take such actions as may be necessary to achieve the intent of this policy.

8. SVMC reserves the right to change the direct reporting relationship for business necessity. The reporting structure must be approved by the CEO.

CROSS REFERENCES:

- Equal Employment Opportunity
- Conflict of Interest

SUBJECT:	SECTION:
SIERRA VIEW MEDICAL CENTER LOGO, DESIGN AND COLOR SCHEME	***Leadership***

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

PURPOSE:

To maximize the benefits of Sierra View Medical Center's (SVMC) strong reputation, all departments, programs, and services affiliated with Sierra View Medical Center should be branded with the Sierra View Medical Center name and logo, following color, size and shape consistency outlined in the graphic standards guide. Market research, including focus groups and consumer surveys conducted over the years, clearly illustrates the strength of using the same color and logo.

POLICY:

1. All advertising, marketing materials designed for an external audience that contain the Sierra View Medical Center name and logo must be created and or approved by the Director of Marketing and Community Relations. This includes all brochures, calendars, fliers, handouts, pamphlets, stationary, signage, website, social media and broadcast production, etc.

2. To ensure consistency and prevent erosion, the following criteria have been established for establishing a color scheme within facilities, departments, programs and services. Any changes to existing or new areas must be approved through the Project Planning and Management Department.

    a. The outside of all new buildings will carry the existing color scheme as closely matched to the main campus as possible, including windows, window frames, doors and door jambs. Outside signage will carry the Sierra View Medical Center name and then the department represented.

    b. The inside of all new buildings will carry the teal color scheme as the base color with established SVMC standards to ensure complimentary interior design.

    c. As the interior of existing areas are refurbished, the teal color scheme will carry through the hospital and all buildings affiliated with the hospital as the base for the design as well as the established standards.

AFFECTED AREAS/PERSONNEL:

ALL ENTITIES ASSOCIATED WITH SIERRA VIEW MEDICAL CENTER.

SUBJECT: **STAFF RECRUITMENT, EMPLOYMENT AND RETENTION**	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 assist in the District's goal of promoting equal opportunities for all applicants by providing a consistent process for staff recruitment and for ensuring an engaging and rewarding employment experience resulting in staff retention.

POLICY:

This policy establishes uniform procedures for the recruitment and retention of staff. Employment of candidates is based on qualifications and experience, regardless of race, color, creed, gender (including gender identity and gender expression), religion (all aspects of religious beliefs, observance or practice, including religious dress or grooming practices) marital status, registered domestic partner status, age, national origin or ancestry, physical or mental disability, medical condition (including cancer or a record or history of cancer, and genetic characteristics), sex (including pregnancy, childbirth, breastfeeding or related medical condition), genetic information, sexual orientation, veteran status or any other consideration made unlawful by federal, state, or local laws. It also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. Discrimination can also include failing to reasonably accommodate religious practices or qualified individuals with disabilities where the accommodation does not pose an undue hardship.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES, VOLUNTEERS, CONTRACTORS AND EMPLOYEES OF CONTRACTORS

PROCEDURE:

Job Requisition Form:

1. Appropriate staffing levels shall be reviewed each time a vacancy occurs.

2. A job requisition form (Position Control Form) will be completed by Department Leaders for additions or replacement of staff.

3. Job requisitions must be approved by the employing unit's Vice President and the Chief Executive Officer/President for all positions.

4. Approved job requisitions will be received by the Human Resources Department.

New Position:

1. Department Leaders, in collaboration with Human Resources, will prepare a position description. (See policy: Position Description)

Job title, job code and pay range will be assigned and maintained by Human Resources.

Additions and replacement of staff:

1. Job posting occurs when Human Resources is notified that the job requisition has been approved by Senior Leadership Team. All job openings are posted on the Hospital's Intranet and the Internet for a minimum of (5) five calendar days. If a significant number of applications from qualified candidates are received, job openings will then be removed from the Hospital's Intranet and the Internet when conducting interviews. If a candidate is not selected, the position will be reposted, and the process will be repeated until the position is filled. Human Resources is responsible for administering this policy and for positing job openings.

   Department Leadersand Human Resources will evaluate and determine cost effective recruitment and confirm that it coincides with the time of posting. The use of employment agencies will be determined by Human Resources.

   A deadline for internal and external applicants will be determined on a case-by-case basis by Department Leaders and Human Resources.

   Human Resources is responsible for receiving and screening applications for minimum requirements. Human Resources will conduct additional screening by phone and determine candidate(s) to be interviewed. Interviews will be conducted by the department Leaders and Interview Teams.

   Human Resources, in collaboration with Department Leaders, will establish interview dates and times.

   Department Leaders shall determine selection of the final candidate(s). Interview notes and competency score sheets (balance sheets) shall be provided to Human Resources.

   Human Resources shall conduct background checks and advise the Department Leaders when the employee has cleared the pre-employment process. Evidence of background checks shall be retained within the employee's personnel file.

   Human Resources and Department Leaders will determine the hire date. Preference will be given to the nearest general orientation date.

   Salary offers will be communicated by Human Resources to candidate(s) by telephone and/or letter. Prospective employees will be offered salaries consistent with their experience and shall not exceed the midpoint of their salary range without CEO/President approval.

   Vice Presidents have authority to approve salary offers up to 50% of the incumbent's wage grade.

Staff Retention:

SVMC is committed to continuously evaluating the retention drivers for top talent and providing an engaging work experience for staff.

Retention of staff is a strategic effort of Senior Management, hospital leadership and the Human Resources Department. It is the goal of SVMC to establish retention tools and ongoing education and data management related to the level of engagement of the workforce. This will be done through engagement surveys, exit surveys, succession planning, development opportunities, staff rounding and day to day interactions which promote the values and mission of SVMC.

Staff retention will also be aligned with educational opportunities and programs, wage and benefit activities, and leadership and recognition initiatives.

REFERENCES:

- Title 22 California Code of Regulations Division 5. (n.d.). Retrieved from http://www.nursealliance ca.org/files/2012/06/Title-22-Chapter-5.pdf
- Title VII of the Civil Rights Act of 1964. (n.d.). Retrieved from https://www.eeoc.gov/laws/statutes/titlevii.cfm
- Immigration Reform and Control Act of 1986. (n.d.). Retrieved from https://www.alipac.us/f12/immigration-reform-control-act-1986-a-35974
- Americans with Disabilities Act. (n.d.). Retrieved from https://www.ada.gov.
- Age Discrimination Act. (n.d.). Retrieved from https://www.eeoc.gov/laws/statutes/adea.cfm.
- Rehabilitation Act of 1973, § Section 504. (n.d.). Retrieved from https://www.govinfo.gov/content/pkg/USCODE-2010-title29/pdf/USCODE-2010-title29-chap16-subchapV-sec794.pdf.

CROSS REFERENCES:

- JOB DESCRIPTIONS

SVMC STAFF ELECTRONIC SIGNATURE & TITLE POLICY	SECTION: Page 1 of 4

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

PURPOSE:

This policy formalizes and standardizes SVMC's electronic signatures applied to any Sierra View Medical Center document or electronic form of communication. It governs the use of digital signatures and specifies titles, layout, helps in maintaining a clean and cohesive brand and ensures signatures are valid and uniform across the organization.

POLICY:

A. Sierra View Medical Center requires all employees to use a standardized email signature in all internal and external communication related to the organization. Any employee who uses a business card, letterhead, or an advertisement with their full name should follow the rules outlined in this policy. Signatures should look professional and represent the organization's brand. All employees should follow the below steps. The email signature formats are defined by the Marketing Department, and as representatives of the organization, you are expected to comply with this policy.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

EQUIPMENT:

- N/A

PROCEDURE:

LEADERSHIP EMAIL SIGNATURE STRUCTURE & STYLE

All managers, directors and members of the Senior Leadership Team's email signatures are built as an image and can be edited and set-up by the Sierra View Marketing Department. It is up to the employee to reach out to the Marketing Department for a set-up or change. An employee's full name; approved credentials and title; SVMC email address; office phone number; website URL and SVMC logo must be on the email signature. Another form of contact information including an SVMC fax number, cellphone number or social media icons (Facebook, Twitter, Instagram, LinkedIn) may be added.

Below is an example of the email signature style for leaders.

WHITNEY WATTS
EXECUTIVE ASSISTANT
CLERK TO BOARD OF DIRECTORS
E: wwatts@sierra-view.com
O: 559 788 6101 | **F:** 559 788 6136
VISIT US at www.sierra-view.com
SIERRA VIEW MEDICAL CENTER

1. **Photo** - A photo with a black background should be used in all leadership email signatures. The Marketing Department will provide this photo. It is the employee's duty to contact Marketing at marketing@sierra-view.com to set up a photo session.
2. **Fonts –**The font type for the email signature will appear as seen in the example above.
3. **Titles and credentials –** Full name, professional credentials and job title are to be used, but need to adhere to details found within the Titles Section of this policy.
4. **Outside organizations and affiliations –**No outside organizations or affiliations should be listed. Examples of what should not be listed is the following: a position for an outside association, lecturer at an academic institution, or position on a board.

ALL EMPLOYEE EMAIL SIGNATURE STYLE & STRUCTURE

Employees who are not in a managerial role or higher must use the email signature style below. Do not add information or modify the format of your signature outlined below.

Employee Name
Employee Title
Sierra View Medical Center
p: 559-791-3843
e: JDoe@sierra-view.com
SIERRA VIEW MEDICAL CENTER

Name – first and last name is to be in font size 13.5 point; color is RGB (Red: 14, Green: 113, Blue: 124}
Title Followed by Organization Name– your full title given in your job description should be used in the second line followed by Sierra View Medical Center in the third line; 9 point font size in a gray color.
Font - The font type for the email signature will appear as seen in the example above; Verdana and Calibri
Contact Information – The employee's phone number and SVMC email address should be included. Other forms such as a fax number and cellphone number can be added if applicable. It is highly

discouraged to use a personal cellphone number.

ITEMS THAT APPEAR NEAR AN EMAIL SIGNATURE

SVMC appreciates the uniqueness of each and every employee, but would urge employees not to add anything extra around or near the email signature unless it is a disclaimer or social media icons including Facebook, Twitter, Instagram and LinkedIn.

An up-to-date award that is applicable to an employee's area of work that recognizes SVMC may be included within a signature upon the Marketing Department's approval that is overseen by Senior Leadership.

APPROVED EMAIL DISCLAIMER

To help protect information given to outside entities a disclaimer is highlight recommended. The approved disclaimer is the following at 8 point font size or smaller using a color that is found in the email signature:

DISCLAIMER: The information contained in this email transmission is confidential and intended for the addressee only. If the reader of this message is not the addressee or addressee's agent, you are hereby advised that any dissemination, distribution or copying of the information is strictly prohibited.

The information contained in this email transmission may be protected under the Attorney/Client Privilege and protected from disclosure under California Evidence Code section 1157. If protected by the attorney/client privilege or by California Evidence Code Section 1157, the information contained in this email transmission shall continue to be protected and will not be negated by virtue of sending the information via this email.

TITLES

- Traditional honorifics such as "Mr.," "Mrs.," or "Ms." and pronouns such as "He/Him," "She/Her," "Them/They" etc., should not be a part of an employee signature.

- The use of "Dr." in a clinical setting:
    - Employees who use their name in any sign, business card, letterhead, email signature, or advertisement, with the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," or any other terms or letters indicating or implying that he or she is a physician, surgeon, or practitioner under the terms of this or any other law, or that he or she is entitled to practice hereunder, or who represents or holds himself or herself out as a physician and surgeon, physician, surgeon, or practitioner under the terms of

this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon is guilty of a misdemeanor.

Only the following persons may use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials "M.D.":

- A graduate of a medical school approved or recognized by the Medical Board of California while enrolled in a postgraduate training program approved by the board.
- A graduate of a medical school who does not have a certificate as a physician and surgeon.

SVMC follows the California Legislative ARTICLE 3. License Required and Exemptions [2050 - 2079] Section 2054.

REFERENCES:

California Evidence Code Section 1157
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EVID&sectionNum=1157

California Legislative Article 3. Section 2054
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2054

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

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **January 24, 2023 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Vice Chairman LOMELI called the meeting to order at 4:36 p.m.

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

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Tracy, VP of Human Resources, Marketing and Public Relations, Gomez, Cindy, Director of Compliance, Dickson, Doug, Chief Financial Officer, Espinoza, Alexis, Porterville Recorder, Hefner, Donna, President/Chief Executive Officer, Hirte, Todd, Contracts Administration, Kashyap, Hans, Community Member, Parsons, Malynda, Senior Marketing and Community Relations Specialist, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Shelton, Greg, Community Member, Stringham, Zaelin, Director of Food and Nutrition, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

Vice Chair LOMELI motioned to approve the Agenda. The motion was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Absent
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 4:37 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

Chairman REDDY in at 4:38 p.m.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2024

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

III. Open Session: Chairman REDDY adjourned Closed Session at 5:09 p.m., reconvening in Open Session at 5:12 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 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

2. Quality Division Report

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

D. Discussion Regarding Trade Secrets. Information only; no action taken.

IV. Public Comments

None.

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 Vice Chair LOMELI, 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

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to approve the December 20, 2022 Minutes of the Regular Meeting of the Board of Directors as presented. The motioned carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

VII. Hospital CEO Report

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

In the District:

- End of Year Report available at sierra-view.com/pressroom
- Unitek College partnership R.N. , BSN degree
- New visitation guidelines – COVID patients will be allowed to have visitors beginning 1/10/2023.
- First Friday Coffee – March 3, 2023

Legislative Priorities:

- DHLF, CHA and hospital constituencies are asking for $1.5B of funding for hospitals to deal with the cash flow challenges.

- Met with Senator Hurtado's office to draft emergency funding request for Sierra View

- David Valadao, US Congressman - Virtual Federal Advocacy visits

- Telehealth extended until 2024

VIII. Business Action Items

A. Appointment of Governing Board Director for Zone 3

1. Motion to Appoint Director for Zone 3

It was moved by Director PANDYA to appoint Greg Shelton for Director of Zone 3. There was no second. Motion failed.

It was moved by Vice Chairman LOMELI to appoint Hans Kashyap for Director of Zone 3, the motion was seconded by Director MARTINEZ.

A discussion was brought forth by Director PANDYA in question of a possible conflict of interest Mr. Kashyap may have. Director PANDYA stated that he feels Mr. Kashyap may have a difficult time discussing difficult issues and that family relationships are a conflict; creating a virtual monopoly on this board and giving governance to Family Healthcare Network.

Chairman REDDY clarified that Hans Kashyap is not an employee of Family Healthcare Network and that he is married to a physician on staff at Family Healthcare Network.

Legal Counsel stated that since the Fair Political Practices Commission had declined to declare that it would be a conflict for two or more members of the same medical group to serve concurrently on the Board, it is up to the Board of Directors to decide the appropriateness of having multiple Board Members associated with the Family Healthcare Network.

Following review and discussion; the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	No

Oath of Office was administered to Hans Kashyap by Donna Hefner, President and CEO.

Following review; there was a Motion to direct Hospital Administration to provide immediate notification of the Appointment to Tulare County Elections Official. It was moved by Vice Chairman LOMELI, seconded by

Director MARTINEZ and carried to approve notification to the Tulare County Elections Official. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

B. December 2022 Financials

Doug Dickson, CFO presented the Financials for December 2022. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,541,050. Supplemental Funds were $1,101,532. Total Operating Expenses were $14,856,363. Loss from operations were $2,315,313.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve the December 2022 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Annual Appointments

1. Food and Dietetic Services Director

Doug Dickson, CFO presented credentials for Zaelin Stringham, Director of Food and Nutrition.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve Zaelin Stringham as the Food and Dietetic Services Director as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Environmental Safety/Security Officer

Ron Wheaton, VP Professional Services and Physician Recruitment presented credentials for the Environmental Safety/Security Officer, Gary Wilbur.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve Gary Wilbur as the Environmental Safety/Security Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

3. Patient Safety Officer

Donna Hefner, President and CEO presented credentials for the Patient Safety Officer, Melissa Mitchell.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP and carried to approve Melissa Mitchell as the Patient Safety Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

4. Infection Control Officer

Melissa Mitchell, VP Quality and Regulatory Services presented credentials for Nancy Hurtado Ziola, Infection Control Officer.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve Gary Wilbur as the Environmental Safety/Security Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes

PANDYA Yes
KASHYAP Yes

D. Appointment of Central Valley Healthcare Alliance Board Representative

Chairman REDDY appointed Liberty Lomeli, Vice Chairman as Board Representative. It was seconded by Director MARTINEZ. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

E. Proposal for Changes to SVLHCD Board Bylaws, Time Change of Regular Meetings

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve changes to the SVLHCD Board Bylaws, time change to 5:00 p.m. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

F. SVLHCD Board of Directors Annual Self Evaluation to comply with SVLHCD Bylaw 4.2

Information only; no action taken.

IX. Closed Session: Board adjourned Open Session at 5:59 p.m. and went into Closed Session at 6:16 p.m. to discuss the following items:

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2026

E. 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)

X. Open Session: Board adjourned Closed Session at 7:07 p.m. and went into Open Session at 7:07 p.m. to discuss the following items:

C. Trade Secret. Information only; no action taken.

E. Conference with Legal Counsel. Information only; no action taken.

XII. Announcements:

A. Regular Board of Directors Meeting – February 28, 2023 at 4:30 p.m.

B. Adjournment: There being no further business, a motion to adjourn brought by Chairman REDDY and seconded by Vice Chairman LOMELI. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

The motion having carried, the meeting was adjourned 7:08 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: ww

BYLAWS OF THE BOARD OF DIRECTORS
OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

Pursuant to the provisions of Section 32128 of the Health and Safety Code of the State of California, the Board of Directors of Sierra View Local Health Care District herewith adopts these Bylaws for the governance of the Sierra View Local Heath Care District, superseding all prior codes of Bylaws and Amendments thereto.

ARTICLE I
DEFINITIONS

As used herein, the terms set forth below shall be interpreted as follows:

1.1 Board. "Board" means the Board of Directors of the District.

1.2 District. "District" means the Sierra View Local Health Care District.

1.3 Facilities. "Facilities" means the Hospital and other health care facilities and services operated by the District.

1.4 Hospital. "Hospital" means the Sierra View Medical Center, 465 West Putnam Avenue, Porterville, California.

1.5 Medical Staff. "Medical Staff" means the organized medical staff of the Hospital.

1.6 Practitioner. "Practitioner" means a person, licensed physician (M.D. or D.O.), dentist or podiatrist, inclusive of any allied health professions, who is eligible to apply for, or who has been granted staff privileges at the Hospital. Eligibility is determined pursuant to the Medical Staff bylaws, or, if applicable, the rules and regulations of the Facilities.

1.7 Contents of Sections and Articles. The headings or titles of the various sections and articles are for convenience only and do not control or limit the content of the section(s) or articles to which the heading or title applies. While the manner of numbering of the sections and the sequence of the sections in the Bylaws are to facilitate understanding, such numbering and sequencing shall not prevent the logical reading of the Bylaws as a whole.

ARTICLE II
ORGANIZATION, PURPOSES, POWERS AND DISSOLUTION

2.1 Organization. The District is a political subdivision of the State of California organized under the Local Health Care District Law, Division 23 of the Health and Safety Code.

2.2 Purposes and Powers. The District is organized for the purposes described in the Local Health Care District Law, and shall have and may exercise such powers in the furtherance of its purposes as are now or may hereafter be set forth in the Local Health Care District Law, California Department of Public Health, Title 22, CMS, The Joint Commission and any other

applicable statutes, rules or regulations of the State of California. The powers of the District include, but are not necessarily limited to, the following: those enumerated in Division 23, Chapter 2, Article 2, Section 32121 et. seq. of the Health and Safety Code (Appendix A).

2.3 Dissolution. Any proposal for dissolution of the District shall be subject to confirmation by the voters of the District in accordance with Cortese-Knox Local Government Reorganization Act of 1985, Government Code Section 56000 et seq (Appendix B).

ARTICLE III
OFFICES

3.1 Principal Office. The principal office of the District is hereby fixed and located at 465 West Putnam Avenue, Porterville, California, 93257.

3.2 Other Offices. Branch or subordinate offices may at any time be established by the Board at any place or places.

ARTICLE IV
BOARD

4.1 General Powers. The Board is the governing body of the District. All District powers shall be exercised by or under the direction of the Board. The Board is authorized to make appropriate delegations of its powers and authority to officers and employees.

4.2 Annual Board Self-Evaluation. The Board shall evaluate, at least on an annual basis, the performance of its Chief Executive Officer, and also its own performance. The Board's self-evaluation shall provide for an assessment of the contributions made by the leaders of the hospital toward improving organizational performance and patient safety and shall include, but not be limited to the following: a) Measurable objectives should be identified for improving organizational performance and patient safety; b) Information shall be gathered to assess the Leadership's/Board's effectiveness in improving organizational performance and patient safety, utilization pre-established criteria; and, c) from such assessment activities, conclusions should be drawn based upon their findings, with new goals and objectives identified and developed for improving organizational performance and patient safety.

4.3 General Oversight and Responsibilities. The Board provides for the collaboration of leaders in developing, reviewing and revising the organization's policies and procedures as part of the Board's oversight of the quality of patient care services provided at least every three years.

4.3.1 The Board shall be responsible for effective operations of the Patient Grievance Process and will delegate, in writing, the responsibility to a Patient Grievance Committee, to address patient grievance issues.

4.3.2 The Board shall provide for the Annual Review of the following:
- i. Compliance Program;
- ii. Environment of Care, Emergency Operations Plan & Life Safety

Management Programs;
iii. Human Resource Management Report;
iv. Infection Prevention Plan;
v. Medication Error Reduction Plan;
vi. Patient Safety Plan;
vii. Performance Improvement Plan;
viii. Plan for Provision of Patient Care;
ix. Risk Management Plan; and,
x. Utilization Management Plan; and,

4.3.3 The Board shall provide for a Strategic Plan and/or Master Plan review and revision at least every three years, the purpose to provide for evaluation of interior and exterior space suitable to the nature of the clinical services provided and the ages and other characteristics of the patient population served, as well as processes for providing for the safe use, maintenance, accessibility and supervision of grounds, equipment and special activity areas.

4.3.4 The Board appoints the District's CEO as the local government official to act as the District's prosecuting authority under the California False Claims Act. In the absence of action by the CEO, the Board may act as the prosecuting authority for the District and/or delegate said authority to another District officer to act as prosecuting authority for the District. The prosecuting authority is charged with investigating, filing and conducting civil legal proceedings on behalf of and in the name of the District, and may use private or government counsel.

4.3.5 The Board shall provide for a review of the District's Bylaws and the Bylaws and Rules and Regulations of the Medical Staff at least every three years.

4.3.6 The Board shall receive Performance Improvement reports on a quarterly basis to include, but not limited to, information which will be collected and aggregated on an ongoing basis. The reports shall reflect the Performance Improvement activities conducted throughout the organization, as well as quarterly reports related to the conclusions drawn, recommendations made, and actions taken by the Committees.

4.4 Operating and Capital Equipment Budget. The Board shall provide for the hospital's administration and finance departments to develop an annual operating budget and long-term capital expenditure plan, including a strategy to monitor the plan's implementation.

4.4.1 The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.

4.4.2 The budget must include all anticipated income and expenses.

4.4.3 The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget is specified.

4.4.4 The plan must include and identify in detail the objectives, and the anticipated sources of financing for each anticipated capital expenditure in excess of $600,000 (or a lesser

amount established by the State in which the hospital is located) that relates to any of the following: a) Acquisition of land; b) Improvement of land, buildings, and equipment; or, c) The replacement, modernization and expansion of buildings and equipment.

4.4.5 The plan must be submitted for review to the Office of Statewide Health Planning and Development (OSHPD) and/or the Department of Health Services (if applicable), as required by the State of California.

4.4.6 The plan must be reviewed and updated annually.

4.4.7 The plan must be prepared under the direction of the Board of Directors, the administrative staff, and the medical staff of the hospital.

4.5 Audit. The Board shall provide for the Hospital's financial and administrative leaders to have an annual audit conducted of the hospital's books and records, following approved accounting procedures, and conducted by an outside accounting firm. The Board shall cause to be placed on the agenda of the regular meeting of the Board of Directors, following the completion of the audit, a full presentation and recommendation for approval of the Annual Audit.

4.6 Operation of Facilities. The Board shall be responsible for the operation of the Facilities owned, leased, or operated by the District, according to the best interests of the public health, and shall make and enforce all rules, regulations and bylaws necessary for the administration, governance, protection and maintenance of the Facilities under the Board's management and all property belonging thereto, and may prescribe the terms upon which patients may be admitted thereto. Such rules, regulations and bylaws applicable to the Hospital shall include, but not be limited to, the provisions specified in Health and Safety Code Section 32128, and shall be in accordance with and contain minimum standards no less than the rules and standards of private or voluntary hospitals. Unless specifically prohibited by law, the Board may adopt other rules that could be lawfully adopted by private or voluntary hospitals.

4.7 Rates. The Board shall not contract care for indigent county patients at below the cost for such care. In setting the rates the Board shall, insofar as possible, establish such rates as will permit the Facilities to be operated upon a self-supporting basis. The Board may establish different rates for residents of the District than for persons who do not reside within the District.

4.8 Number and Qualification. The Board shall consist of five (5) members, one elected from each voting zone within the district, each of whom shall be a registered voter residing in the District, and in the zone for which they hold office during their entire tenure in office. The Board members must be a resident of the zone from which he/she is elected for at least 30 days prior to election. The zones are described in Section 4.15 below.

4.9 Conflict of Interest Code. The Board shall adopt and at all times keep in force a Conflict of Interest Code that complies with applicable state law including but not limited to Gov't Code §§ 87300 and 87302 and Regulation 2 CCR 18730, and their successors and as they may be amended in the future. The Code shall require disclosure of financial interest that may cause a conflict of interest for the position that the Code applies to. The Conflict of Interest Code shall apply to all Directors, the President/CEO, all Vice Presidents and such other employees of the

District and consultants to the District as the Board may from time to time designate in its Code. The Code shall require disclosure of financial interest of the persons holding designated positions. Appendix A to the Code shall designate to whom the Code applies. The Code shall designate the scope of disclosures required for each designated position, as Appendix B to the Code. State Form 700, or its successor, shall be used for such disclosures. In addition, to the extent the District adopts internal conflict of interest policies, compliance with such policies shall be in addition to compliance with this state mandated Conflict of Interest Code.

4.10 Additional Conflict of Interest Provisions:

All Directors, policy-making management employees, and medical staff officers shall comply with the following:

(a) Except as provided in sub-section (c) below, each shall not possess any ownership interest in any other hospital serving the same area as that served by the District Hospital of which the person is a director, policy-making management employee, or medical staff officer. For purposes of this section, the possession of any ownership interest, including stocks, bonds or other securities, by the spouse or minor children of any person shall be deemed to be the possession or interest of that person.

(b) Except as provided in sub-section (c) below, each shall not be a director, policy-making management employee, or medical staff officer of any hospital serving the same area as the area served by the District.

(c) No person shall serve concurrently as a director of the District Hospital and as a policy-making management employee of any other hospital serving the same area as the District Hospital, unless the boards of directors of each of those hospitals have determined that the situation will further joint planning, efficient delivery of health care services, and the best interests of the areas served by their respective hospitals, or unless the hospitals are affiliated under common ownership, lease, or any combination thereof.

(d) Any candidate who elects to run for the office of member of the Board of the District, and who owns stock or other interest in or who works for any hospital which does not serve the same area served by the District, shall disclose on the ballot his or her occupation and place of employment.

(e) It being perceived that the positions of member of the Board and officers of the Medical Staff vested in any one individual will necessarily produce in such individual conflicts of interest, or the strong possibility of conflicts of interest, no officer of the Medical Staff shall be eligible also to serve as a member of the Board during his incumbency as such officer. An officer of the Medical Staff shall be eligible for candidacy for election to the Board and may be appointed to the Board in any case in which any other person could be so appointed but shall not assume office on the Board until he or she has resigned his or her office on the Medical Staff. For purposes of this sub-section (e), Medical Staff Officers include chief, vice chief, past chief, department chairs, department vice chairs, any officer as defined in medical staff bylaws and any other similar position with the medical staff governance having similar conflicts

4.11 Election and Term of Office. An election shall be held in the District on the first Tuesday after the first Monday in November in each even-number year, at which a successor shall be chosen for each Director whose term is expiring. The term of an outgoing director shall expire on the first Friday of December following such election. The election of Board members shall be by zone within the District and shall be consolidated with the State-wide general election. As to each zone in which there is an election, the candidate receiving the highest number of votes from the zone for which the candidate is running for the office to be filled at the election shall be elected thereto. The term of office of each elected Board member shall be four (4) years, or until the Board member's successor is elected and has qualified, except as otherwise provided by law in the event of a vacancy. There shall be staggered elections. The seats for zones 3 and 5 shall be elected in November 2018 and in each 4 years thereafter, and the seats for zones 1, 2 and 4 shall be elected in November 2020 and in each 4 years thereafter. An orientation shall be provided which familiarizes each new Board member with his or her duties and responsibilities, including the Board's responsibilities for quality care and the Facilities' quality assurance programs. Continuing education opportunities shall be made available to Board members.

4.12 Vacancies.

4.12.1 When a vacancy occurs on the Board of Directors, and except as otherwise specified in Government Code Section 1780, the remaining Board members may fill any vacancy on the Board by appointment until the next District general election that is scheduled one hundred thirty (130) or more days after the effective date of the vacancy, provided the appointment is made within a period of sixty (60) days immediately subsequent to the effective date of such vacancy and provided a notice of this vacancy is posted in three (3) or more conspicuous places in the District, at least one of which must be in the zone for which the vacancy exists, at least fifteen (15) days before the appointment is made. The appointee must reside in the zone in which the vacancy exists. In lieu of making an appointment, the remaining members of the Board may, within sixty (60) days of the vacancy, call an election to fill the vacancy.

4.12.2 If the vacancy is not filled by the Board as specified, or if the Board has not called for an election within sixty (60) days of the vacancy, the Board of Supervisors of the County of Tulare may fill the vacancy within ninety (90) days of the vacancy or the Board of Supervisors may order the District to call an election to fill the vacancy. Any appointee must reside in the zone in which the vacancy exists. If within ninety (90) days of the vacancy the remaining members of the Board or the Board of Supervisors have not filled the vacancy and no election has been called for, the District shall call an election to fill the vacancy. If the number of remaining Board members falls below a quorum, at the request of the District' Secretary, or a remaining Board member, the Board of Supervisors of the County of Tulare may waive the sixty (60) day period specified above and make an appointment immediately to fill the vacancy, or may call an election to fill the vacancy. The Board of Supervisors shall only fill enough vacancies to provide the Board with a quorum.

Persons appointed to fill the vacancy shall reside in the zone for which the vacancy existed and shall hold office until the next District general election and thereafter until the person elected at such election to fill the vacancy has been qualified, however,

persons elected to fill the vacancy shall hold office for the unexpired balance of the term of office.

4.13 Resignation or Removal:

4.13.1 Any Board member may resign effective upon giving written notice to the Chairman, the Secretary or the Board, unless the notice specifies a later time for the effectiveness of such resignation. The term of any member of the Board shall expire if the member is absent from three (3) consecutive regular meetings or from three (3) of any five (5) consecutive meetings of the Board and if the Board by resolution declares that a vacancy exists on the Board.

4.13.2 All or any of the members of the Board may be recalled at any time by the voters following the recall procedure set forth in Division 16 of the Election Code.

4.13.3 A Board Member who has violated any general law or regulation, or any rule, law, ordinance or resolution of the Hospital may be censured after being given notice and an opportunity to correct the violation. The Hospital shall establish a policy that defines the procedure for hearing a motion for censure. Depending on the severity of the violation(s), the Board Member may be indited by the Tulare County Grand Jury for willful or corrupt misconduct of office under Cal. Gov. Code 3060 *et seq.* and, if convicted, removed from office.

4.14 Compensation. The Board shall serve without compensation except that the Board, by a resolution adopted by a majority vote of the members of the Board, may authorize the payment of, not to exceed, One Hundred Dollars ($100.00) per meeting, not to exceed five (5) meetings per month as compensation to each member of the Board of Directors. Each member of the Board shall be allowed the member's actual necessary traveling and incidental expenses incurred by traveling in the performance of official business of the District as approved by the Board

4.15 Zones and Zone Elections. The District shall be broken up into 5 zones or voting districts. The zones shall be as equal in population as possible, but in no event vary in population size more than as permitted by law. The zones shall be created in compliance with State and Federal law and avoid gerrymandering. The criteria set out in California Elections Code § 22000(a) shall be considered, including 1) topography, 2) geography, 3) cohesiveness of territory, and 4) community of interest of the division. The zones shall be revised at any time as may be needed, if at all, and reviewed and revised as needed after the results of the dicentenial census conducted by the federal government are known, and such changes, if any, shall be implemented in time for the next general election after the census results are known, unless there is insufficient time, in which case the changes, if any, shall be implemented for the election that follows. In determining any new boundaries, the Board shall comply with the public notice and voting requirements of the Election Code including §§ 22000 and 22001, including at least one public hearing on any adjustment proposal before the public meeting at which the Board is to vote on the proposal.

4.16 Privacy and Access to Information

4.16.1 The District will strive to protect individual privacy. The District will not release information without the consent of the individual involved unless required to do so by law.

4.16.2 Except as otherwise expressly provided for in these Bylaws, each Board member shall have the authority to make requests on behalf of the Board to the Chief Executive Officer or the Chief Executive Officer's designee for access to information that is maintained by the Hospital and reasonably necessary for the Board to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board. Except as may have been earlier instructed by the Board, the subject information and materials requested by Board member(s) shall not be released until the Board confirms its need for the same at its next meeting. All other requests for access to Hospital information by any individual Board member shall be addressed in accordance with the California Public Records Act and Sierra View Medical Center's Public Records Request policy.

ARTICLE V
BOARD MEETINGS

All meetings of a legislative body such as the District shall be governed by the procedures set forth in Government Code Sections 54950, et seq., as amended (hereinafter the "Brown Act").

5.1 Board Meeting.

5.1.1 A meeting of the Board is any congregation of a majority of the members at the same time and place to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board. A meeting is also the use of direction communication, personal intermediaries or technological devices that is employed by a majority of the members of the Board to develop a collective concurrence as to action to be taken on an item by the members of the Board.

5.1.2 All meetings of the Board, except for closed sessions, shall be open to the public subject to the provisions of paragraph 5.4

5.1.3 The Board may hold closed session meetings and exclude all persons authorized to be excluded. Breaching confidentiality of closed session not only subjects the Board Member to censure, but civil and criminal sanctions. The Hospital shall create a policy that informs Board Members as to the steps that will be taken by the Board for unauthorized disclosures.

5.2 Regular Meetings. Regular meetings of the Board shall be held as follows:

5.2.1 The Board shall hold regular monthly meetings at the District Hospital on the fourth Tuesday of each month at ~~4:30~~5:00 p.m. After preliminary matters, Closed Session shall begin immediately. Open Session shall follow, beginning no earlier than the time stated on the posted Agenda but no later than ~~5:00~~5:30 p.m. (or as near thereto as practical). If the Closed Session items are not completed before the ~~5:00~~5:30 p.m. start time of the Open Session, then the remaining Close Session items may be heard after

the Open Session. In such case, there will be an Open Session following the Closed Session to report on the Closed Session items and complete the Agenda. In the event the regular monthly meeting date falls on a legal holiday, the meeting shall be held on the following day. The Board may, by motion, alter the dates, times, format and place for any future meeting and at each Board meeting may confirm or change the date, time, format and/or place of the next Board meeting(s). The meeting in December shall also be governed by 5.2.2 below.

5.2.2 The Board's regular meeting in December shall be held on the third Tuesday at the District Hospital and at the same time and in conjunction with the Annual Organizational Meeting. Except for date, it shall follow the procedure of 5.2.1 as closely as practical.

5.3 Notice. At least seventy-two (72) hours before a regular meeting, the Board shall cause to be posted an agenda containing a brief description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of the item generally need not exceed twenty (20) words, and when appropriate, may [shall] utilize the agenda descriptions contained in the Brown Act. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to the members of the public. No action shall be taken on any item not appearing on the posted agenda, unless such action is permitted and is taken in accordance with the Brown Act unless one of the following conditions exists. For purposes of the Bylaws, "action taken" means a collective decision made by a majority of the members of the Board to make a positive or negative decision, or an actual vote by a majority of the Board upon a motion, proposal, resolution or order.

5.4 Members of the Public.

5.4.1 Every agenda for regular meetings shall provide an opportunity for members of the public to directly address the Board on items of interest to the public that are within the subject matter jurisdiction of the Board, provided that no action shall be taken on any item not appearing on the agenda unless the action is otherwise authorized by Section 5.2. The Board may adopt reasonable regulations to insure that the intent of this Section is carried out, including, but not limited to, regulations limiting the total amount of time allocated for public testimony on particular issues and for each individual speaker.

5.4.2 Members of the public shall not be required, as a condition of attendance at a Board meeting, to register his or her name or provide other information. If an attendance list, register or other similar document is posted or circulated at the meeting, it shall state clearly that the signing, registering or completion of the document is voluntary and that all persons may attend the meeting regardless of whether a person does so.

5.5 Annual Organizational Meeting. At its Annual Organizational Board meeting as specified in Section 5.2.2, the Board shall organize by the election of one (1) of its members as Chairman, one (1) as Vice Chairman, and one (1) as Secretary. The election may proceed in any reasonable fashion. The Board shall also appoint by Board resolution the Treasurer at the annual meeting.

5.6 Special Meetings.

5.6.1 A special meeting may be called at any time by the Chairman, or by a majority of the Board members, by delivering personally or by mail written notice to each Board member and to each local newspaper of general circulation, radio or television station requesting notice in writing. Such notice must be delivered personally, by mail or by fax at least twenty-four (24) hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the special meeting and the business to be transacted. No other business shall be considered at special meetings. Such written notice may be dispensed with as to any Board member who at or prior to the time the meeting convenes files with the Secretary a written waiver of notice. Such waiver may be given by telegram. Such written notice may also be dispensed with as to any member who is actually present at the meeting at the time it convenes.

5.6.2 The call and notice shall also be posted at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public. Notice shall be required pursuant to this section 5.6.2 regardless of whether any action is taken at the special meeting.

5.6.3 In the case of an emergency situation involving matters upon which prompt action is necessary due to the disruption or threatened disruption of public facilities, the Board may hold an emergency meeting without complying with the notice requirements, provided the provisions of the Brown Act are followed.

5.7 Quorum. A majority of the members of the Board shall constitute a quorum for the transaction of business. Except as otherwise provided by law, the act of a majority of the Board members that occurs at a duly noticed meeting with a quorum shall be the act of the Board. The Board shall not take action by secret ballot, whether preliminary or final. When the number of Board members able to vote has been reduced to one or two due to conflict of interest, then less than a majority of the Board is allowable, provided the matter is approved by all of the Board members who could have voted in the affirmative.

5.8 Adjournment and Continuance.

5.8.1 The Board may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If no Board Members are present at a meeting, the clerk may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in section 5.6 of these Bylaws for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the meeting was held within twenty-four (24) hours after the time of the adjournment. When a regular or adjourned regular meeting is adjourned as provided in this Section, the resulting adjourned regular meeting is a regular meeting for all purposes.

5.8.2 The Board may continue any hearing being held, or noticed or ordered to be held at any meeting, to a subsequent meeting by order or notice of continuance provided in the same manner as set forth above for the adjournment of meetings; provided, that if the meeting is continued to a time less than twenty-four (24) hours after the time specified in the order or notice of hearing, a copy of the order of notice of continuance of hearing shall be posted immediately following the meeting at which the order or declaration of continuance was adopted or made.

5.9 Public Meetings. Meetings of the Board shall be open to members of the public, except when statutory authority permits the Board to convene in closed session under the Brown Act. The Board may hold closed sessions during a meeting, following the provisions of the Brown Act and applicable Health and Safety Code and Government Code statutes that shall be noted on the Board of Directors Meeting Agenda.

5.10 Medical Staff Representation. The Medical Staff of the Hospital shall have the right of representation at all meetings of the Board, and on any committee deliberating the discharge of medical staff responsibilities, except closed sessions at which such representation is not requested, by and through the Chief of Staff of the Medical Staff, who shall have the right of attendance, the right to participate in Board discussions and deliberations affecting the discharge of medical staff responsibilities, but who shall not have the right to vote.

5.11 Disrupted Meetings. In the event that any meeting is willfully interrupted by a group or groups so as to render the orderly conduct of such meeting unfeasible, and order cannot be restored by the removal of individuals who were willfully interrupting the meeting, the Board may order the meeting room closed and continue in session. Only matters appearing on the agenda may be considered in such session. Representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this Section. The Board may establish a procedure for readmitting an individual or individuals not responsible for willfully disrupting the orderly conduct of the meeting.

ARTICLE VI
BOARD COMMITTEES

6.1 Appointment. All committees, whether standing or special (ad hoc), shall be appointed by the Chairman. The chairman of each committee shall be appointed by the Chairman. All committees shall be advisory only to the Board unless otherwise specifically authorized to act by the Board.

6.2 Standing Committee. Standing committees may from time-to-time be created by resolution duly adopted by the Board of Directors. All standing committees in existence at the date of the adoption of these Bylaws shall continue to exist until abolished by resolution of the Board of Directors.

6.3 Special Committees. Special committees may be appointed by the Chairman for special tasks as circumstances warrant, and upon completion of the task for which appointed, such special committee shall stand discharged.

6.4 Additional Consultants. A committee chairman may invite additional individuals with expertise in a pertinent area to meeting with and assist the committee. Such consultants shall not vote or be counted in determining the existence of a quorum and may be excluded from any committee session.

6.5 Meetings and Notice. Meetings of a committee may be called by the Chairman of the Board, the committee, or a majority of the committee's voting members in accordance with the Brown Act.

6.6 Quorum. A majority of the voting members of a committee shall constitute a quorum for the transaction of business at any meeting of such committee. Each committee shall keep minutes of its proceedings and shall report periodically to the Board.

6.7 Manner of Acting. The act of a majority of the members of a committee present at a meeting at which a quorum is present shall be the act of the committee so meeting. No act taken at a meeting at which less than a quorum was present shall be valid unless approved in writing by the absent members. Action may be taken without a meeting by a writing setting forth the action so taken signed by each member of the committee entitled to vote.

6.8 Tenure. Each member of a committee shall hold office until the annual meeting of the Board as specified in Section 5.1.2, and until a successor is appointed. Any member of a committee may be removed at any time by the Chairman subject to the consent of the Board. A member of the Board shall cease to hold committee membership upon ceasing to be a Board member.

ARTICLE VII
OFFICERS

7.1 Chairman. The Board shall elect one (1) of its members as Chairman at the annual organizational meeting, and the Chairman shall hold office until a successor is elected. In the event of a vacancy in the office of Chairman, the Board may elect a new Chairman. The Chairman shall be the principal officer of the District and the Board, and shall preside at all meetings of the Board. The Chairman shall appoint all Board committee members and committee chairman, and shall perform all duties incidental to the office and such other duties as may be prescribed by the Board from time to time.

7.2 Vice Chairman. The Board shall elect one (1) of its members as Vice Chairman at the annual meeting, and the Vice Chairman shall hold office until a successor is elected. In the absence of the Chairman, the Vice Chairman shall perform the duties of the Chairman.

7.3 Secretary. The Board shall elect one (1) of its members Secretary at the annual meeting, and the Secretary shall hold office until a successor is elected. The Secretary shall provide for the keeping of minutes of all meetings of the Board. The Secretary shall give or cause to be given appropriate notices in accordance with these Bylaws or as required by law and shall act as custodian of District records and reports and of the District's seal. The Board may also elect an Assistant Secretary who shall perform the functions of the Secretary in the case of his/her absence or inability to act.

7.4 Treasurer. The Board shall appoint a Treasurer who shall serve at the pleasure of the Board. The Treasurer shall be charged with the safekeeping and disbursal of the funds in the treasury of the District.

7.5 Chief Executive Officer. The Board shall have the authority to select, employ, control and discharge the Chief Executive Officer. The qualifications of the Chief Executive Officer shall include but not be limited to a Master's Degree in Hospital and/or Business Administration, or comparable discipline, and the Chief Executive Officer shall have a minimum of three years previous management experience in hospital administration. The Chief Executive Officer shall report to the Board, and shall be its direct executive representative in the management of the Hospital. The Chief Executive Officer shall be given the necessary authority, and be held responsible for the administration of the Hospital, in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by the Board, or any of its committees to which it has delegated power for such action. The Chief Executive Officer shall be responsible for the implementation of policies adopted by the Board. By working with standing and special committees of the Board and joint committees of the Medical Staff of the Hospital, the Chief Executive Officer is to participate in the elaboration of policies which provide the framework for patient care of high quality at reasonable cost. The Chief Executive Officer shall act as the "duly authorized representative" of the Board in all matters in which the Board has not formally designated some other person for that specific purpose. The Board of Directors shall conduct at least an annual evaluation of the Chief Executive Officer's performance. Individual members of the Board shall direct concerns they have regarding operational or personnel matters to the Chief Executive Officer. The authorities and duties of the Chief Executive Officer shall be:

7.5.1 To select, control and discharge all employees authorized by the Board, and pursuant to any regulation that may be adopted by the Board.

7.5.2 To have the ultimate responsibility and accountability for maintaining the organization's ongoing compliance with applicable law and regulation, and for taking prompt action on recommendations from planning, accrediting, or regulatory agencies.

7.5.3 Maintain District records and minutes of Board and Committee meetings. To submit regularly to the Board periodic reports showing the services performed and the financial activities of the Hospital.

7.5.4 To attend all meetings of the Board and its committees when required.

7.5.5 To perform any other duty that may be necessary in the best interests of the Hospital.

7.5.6 To serve as the liaison officer and channel of communications for all official communications between the Board and any of its committees, the Medical Staff and the personnel of the District. Providing periodic reports to the Board and to the Medical Staff[s] on the overall activities of the District and the Hospital[s] or other Facilities, as appropriate, as well as pertinent federal, state and local developments that effect the operation of District Facilities.

7.5.7 To supervise all business affairs such as records of financial transactions, collections and accounts, and purchase and issuance of supplies, and to ensure that all funds are collected and expended to the best possible advantage.

7.5.8 To see that all physical properties of the District are kept in a good state of repair and operating condition.

7.5.9 Providing the Board and its committees with adequate staff support.

7.5.10 Maintenance of adequate insurance or self-insurance covering the physical properties and activities of the District.

7.5.11 Designate other individuals by name and position who are, in the order or succession, authorized to act for the Sierra View Local Health Care District during any period of absence.

7.5.12 Summarily to suspend, in accordance with Article VIII of these Bylaws, the Medical Staff Bylaws and applicable law, all or any portion of the clinical privileges of any Practitioner whenever, in his or her opinion, such suspension is necessary in the best interest of patient care and immediate suspension pursuant to Medical Staff bylaws is not a feasible solution to the problem presented.

7.5.13 Be the local government official that acts as the prosecuting authority for the District under the California False Claims Act and is charged with investigating, filing and conducting civil legal proceedings on behalf of or in the name of the District, using private or government counsel.

7.5.14 Such other duties as the Board may from time to time direct.

ARTICLE VIII
MEDICAL STAFF

8.1 Organization. The Board shall cause to be created a medical staff organization, to be known as the "Medical Staff of the Sierra View District Hospital", whose membership shall be comprised of all Practitioners who are privileged to attend patients in the Hospital with appropriate officers and bylaws and with staff appointments on a biennial basis. The members of the Medical Staff shall be self-governing with respect to the professional work performed in the Hospital, governed in their professional conduct by the highest ethical standards of the medical profession, as outlined in the Code of Ethics applicable to the Practitioner. Membership in the Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. No Practitioner shall admit patients to the Hospital unless he/she is a member or the Medical Staff and has admitting privileges. Further, a Medical Staff member shall provide medical services to patients only within the scope of the clinical privileges or temporary privileges he/she is granted in accordance with the procedures in the Medical Staff Bylaws. In addition, the general medical condition of each patient in the Hospital will be the responsibility of a qualified physician member of the Medical Staff.

8.2 Bylaws. The Medical Staff shall propose, adopt, and amend by two-thirds vote, Bylaws, Rules and Regulations, not inconsistent with the Bylaws, for its internal governance which states its purposes, functions, and organization and which shall be subject to, and effective only upon, Board approval, which approval shall not be unreasonably withheld. The Bylaws, Rules and Regulations shall be periodically reviewed for consistency with Hospital policy and applicable legal requirements. The Bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the Medical Staff by the Board. Such Medical Staff Bylaws shall state the purpose, functions and organization of the Medical Staff and shall relate to the qualifications of members of the Medical Staff; requirements for the preparation and maintenance of a complete and accurate medical record for each patient; set forth the policies by which the Medical Staff exercises and accounts for its delegated authority and responsibility; the creation of standing and special committees (ad hoc); and the officers, elections and meetings of the Medical Staff, together with such other matters as the Medical Staff shall deem appropriate to the included in such Bylaws. The Medical Staff may adopt rules and regulations consistent with its bylaws for the conduct of the Medical Staff in its practice in the Hospital and shall also establish mechanisms for the selection of the Medical Staff of its officers, departmental chairman and committees. The Bylaws and Rules and Regulations of the Medical Staff shall be subject to approval by the Board and neither the medical staff nor the governing body may unilaterally amend the Medical Staff Bylaws, Rules or Regulations. It is herewith declared to be the policy of the District that the Medical Staff shall, so far as is consistent with the Local Health Care District Law, be self-governing with respect to the professional work performed in the Hospital.

8.2.1 The Medical Staff shall have the initial responsibility to formulate, adopt and recommend Medical Staff bylaws and amendments thereto to the Board, which shall be effective when approved by the Board. No Medical Staff Bylaws or amendments shall become effective without approval of the Board as herein above provided. If the Medical Staff fails to exercise this responsibility in good faith and in a reasonable, timely and responsible manner, and after written notice from the Board of such effect, including a reasonable period of time for a response, the Board may formulate or amend the Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions.

8.3 Quality Assurance, Performance Improvement. The Board shall require, after considering the recommendation of the Medical Staff, the conduct of specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in the Hospital. The Board shall require that the Medical Executive Committee develop the processes for conducting, evaluating and revising such activities as may be required and delineated in a formal, written Performance Improvement Plan. The Board shall require, at least quarterly, that the Medical Executive Committee present a report on the performance improvement activities and the outcome of those activities, to the Board. The Board shall also require mechanisms to assure the provision of one level of care in the Hospital, and to assure that patients with the same health problem are receiving a consistent level of care. The Board, through the Chief Executive Officer, shall provide whatever administrative assistance is reasonably necessary to support and facilitate these activities including the investigation and evaluation of all matters relating to Medical Staff quality assurance.

8.4 Medical Staff Membership and Clinical Privileges.

8.4.1 Requirements. Membership on the Medical Staff shall be restricted to Practitioners who are currently licensed to practice in this State, competent in their respective fields, worthy in character and in professional ethics. In this latter connection, the practice of the division of fees under any guise whatsoever is prohibited and such practice shall be cause for exclusion from the Medical Staff. A prerequisite to admission to or continuation of membership on the Medical Staff is that the Practitioner present proof satisfactory to the Board of his/her ability to respond in damages, arising out of professional negligence, in the sum not less than one million dollars ($1,000,000.00) per occurrence/claim and not less than three million dollars ($3,000,000.00) in aggregate, and that such insurance be provided by a company that is acceptable to the Board and is licensed or approved by and qualified to do business in the State of California. The bylaws of the Medical Staff may provide for additional qualifications for membership and privileges, as appropriate.

8.4.2 Terms, Conditions and Classification. The terms, conditions and classifications of membership status in the Medial Staff, and of the exercise of clinical privileges, shall be determined by the Medical Staff and be specified in the Medical Staff bylaws. Appointments to the Medical Staff may be for a maximum term of two (2) years.

8.4.3 Appointments and Rules of Procedure/Medical Staff Hearings and Appellate Reviews. All appointments and re-appointments to the Medical Staff shall be made by the Board. In all cases, the Board shall take action on applications for appointment or re-appointment respecting clinical privileges of members of the Medical Staff, in coordination with the Medical Staff; however, regardless of the recommendation or other action of the Medical Staff, final responsibility for appointment to the Medical Staff and privileges of the Medical Staff regarding members of the Medical Staff shall rest with the Board, and the Board shall have the power to make appointments to the maximum extent permitted by applicable statutes, the Bylaws, and the Procedural Rules of the Board of Sierra View Local Health Care District ("Rules of Procedure"/"Medical Staff Hearings and Appellate Reviews"), described below and attached hereto and incorporated herein by reference as Exhibit "A". The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status and clinical privileges shall be specified in the Medical Staff Bylaws. No aspect of Medical Staff membership and/or particular clinical privileges shall be denied on the basis of sex, race, creed, color, national origin, physical or mental impairment, if after reasonable accommodation, the applicant complies with the Medical Staff Bylaws, Rules and Regulations, and policies and procedures and other policies and procedures jointly adopted by the Medical Staff and Board of Directors, or on the basis of any other criterion lacking professional justification.

8.4.4 Board Procedure. In satisfying its responsibilities hereunder, the Board shall exercise functions of an administrative nature and of a judicial nature, as provided herein and in the Rules of Procedure. Procedure of all proceedings under this Section shall be governed by the Rules of Procedure. Such Rules of Procedure may be adopted and from time-to-time amended by the Board and shall have the force and effect of the Bylaws, as to matters of procedure, but may be amended at any regular or special

meeting of the Board without introduction at a prior meeting. Exhibit A is intended to be the most current version of Article VII of the Medical Staff Bylaws as approved by both the Medical Staff and the Board. Any amendment to Article VII of the Medical Staff Bylaws approved by the Board shall also be an approval of the same Amendment to Exhibit A. The Board may amend Exhibit A to its own Bylaws, although such Amendment by the Board unilaterally would not be an Amendment to the Medical Staff Bylaws.

8.4.5 Initial Application. All applications for appointment and re-appointment to the Medical Staff and for the granting or clinical privileges shall be submitted the Medical Staff office. The Medical Staff shall forward the same to the Medical Staff for its processing in such manner as shall be provided by the Medical Staff bylaws, and upon completion of processing by the Medical Staff, the Medical Staff shall make a report and recommendations regarding such application to the Board.

8.4.6 Board Action on Recommendation. At its next meeting after receipt of a recommendation of approval by the Medical Staff relating to appointment or re-appointment of any applicant for membership on the Medical Staff, the Board shall act on the matter by making or denying appointment. In taking action, the Board shall not act in an arbitrary or capricious manner. Such initial action shall be taken without a hearing. If the Board's decision affirms the Medical Staff recommendation, then the decision is final. If the Board's proposed decision is adverse to the Practitioner, the Chief Executive Officer shall promptly notify the applicant of such proposed adverse decision, in accordance with the Rules of Procedure, and such proposed adverse decision shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his rights as provided by Rules of Procedure and until there has been compliance with Section 8.4.8, if appropriate. The Board may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. At its next meeting after receipt of such subsequent recommendation from the Medical Staff, or after expiration of such time limit without receipt of a recommendation, the Board shall proceed as provided by the Rules of Procedure and shall make a decision to either provisionally appoint the Practitioner to the Medical Staff or to reject him/her for Medical Staff membership. All decisions to appoint shall include a delineation of Medical Staff privileges which the Practitioner may exercise. The Practitioner's rights to challenge any adverse action shall pend until the Board acts on any subsequent recommendation of the Medical Staff or after its failure to act. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before. If the aggrieved applicant requests a hearing before the Board as provided for by the Rules of Procedure, and if the hearing results in a decision that is favorable to the applicant, the applicant's application shall thereafter be processed in accordance with the appropriate provisions of the Medical Staff bylaws and the Bylaws.

8.4.7 Final Action. In the event the Practitioner waives or fails to exercise his rights under Section 8.4.12 hereof, the Board's proposed decision shall be considered final, except when the Board defers final determination by referring the matter back to the Medical Staff for further consideration as provided in 8.4.6.

8.4.8 Joint Conference Committee. Whenever the Board's proposed decision is contrary to the recommendation of the Medical Staff, the Medical Staff may submit the matter to the Joint Conference Committee established under Article IX of its Bylaws for review and recommendation and the Board shall consider such recommendation before making its decision final.

8.4.9 Notice of Final Action. When the Board's decision is final, it shall send notices of such decision through the Chief Executive Officer to the Chief of the Medical Staff, to the Chief of the Service concerned and by certified mail, return receipt requested, to the Practitioner affected.

8.4.10 No Timely Medical Staff Action. If, after submission to it of an application for appointment as provided in Section 8.5.1 hereof, the Medical Staff shall fail to make recommendation to the Board within ninety (90) days after such submission, the Board may proceed to consider the application without action by the Medical Staff in such manner as is provided by the Rules of Procedure. If action is favorable to the applicant, the Board shall appoint the applicant to the Medical Staff forthwith. If the action is adverse to the applicant, he or she shall have the right of appeal, as provided by the Rules of Procedure. The time within which the Medical Staff is to take action may be extended by the Chief Executive Officer, for good cause shown, for such period as he/she deems reasonable.

8.4.11 Notice to Board of Adverse Action by Medical Staff. In any case in which the Medical Staff recommends action upon an application for appointment which is adverse to the applicant, it shall specify in detail in its report to the Board the reasons for its recommendation. The Board shall not act on the Medical Staff recommendation except it may refer the matter back to Medical Staff for recommendation as provided below. In such case the Practitioner shall have the appeal rights set out in 4.5.8(b) of the Medical Staff Bylaws. The Board may refer the matter to the Medical Staff for re-consideration, but only if it deems that appropriate, provided it creates a reasonable time in which the Medical Staff may act. In such case, the Practitioner's appeal rights shall pend until the Board acts on any decision of the Medical Staff upon re-consideration, or until it fails to timely act.

8.4.12 Appeals. Any practitioner who is aggrieved by any final action of the Medical Staff or by any action of the Board shall have a right of appeal as set forth in the Rules of Procedure referred to in Section 8.4.3 and the appeal shall be conducted in accordance with such Rules of Procedure.

8.5 Corrective Action; Board Role; Appellate Review.

8.5.1 The Board may take action on any proposed corrective action; it shall take action on proposed corrective action when required under its Bylaws or the Medical Staff Bylaws. Regardless of the recommendation or other action of the Medical Staff, final responsibility for corrective action regarding members of the Medical Staff shall rest with the Board, and the Board shall have the power to take corrective action, to the maximum extent permitted by applicable statutes, the Bylaws, and the Rules of

Procedure described in 8.4.3 and 8.4.4 and Exhibit A. The procedure to be followed by the Medical Staff and the Board in acting on matters of corrective action shall be specified in the Medical Staff Bylaws. In all peer review matters the Board shall give great weight to the actions of the peer review bodies of the Medical Staff, except when a different standard is specified, and shall not act in an arbitrary or capricious manner.

8.5.2 If the Medical Staff recommends an action that is a ground for a hearing, the Practitioner shall be given notice of the adverse recommendation and of the right to request a hearing in accordance with the Medical Staff Bylaws. The Board of Directors may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

8.5.3 If, in the opinion of the Board, disciplinary action as to any Practitioner is required to insure the continued safety of and high standards of care afforded to patients of the Hospital, or because of compelling legal, moral or ethical considerations, and should the Board determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, or take adequate disciplinary action, is contrary to the weight of the evidence then in the possession of the Board, the Board may direct the Medical Executive Committee to initiate an investigation or a disciplinary action or review the extent of disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Medical Executive Committee fails to take action in response to a direction from the Board, the Board may take action on its own initiative. If such action is favorable to the Practitioner or constitutes an admonition, reprimand or warning to the Practitioner, it shall become effective as the final decision of the Board. If such action is one that gives rise to a hearing pursuant to the procedures set forth in the Medical Staff bylaws, the Board shall give the Practitioner written notice of the adverse recommendation in accordance with the Rules of Procedure.

8.5.4 Any practitioner who is aggrieved by any final action of the Medical Staff or by any action of the Board shall have a right of appeal as set forth in the Rules of Procedure referred to in Section 8.5.1 and the appeal shall be conducted in accordance with such Rules of Procedure.

8.5.5 Whenever the Board's proposed decision is contrary to the recommendation of the Medical Staff, the Medical Staff may submit the matter to the Joint Conference Committee established under Article IX of its Bylaws for review and recommendation and the Board shall consider such recommendation before making its decision final.

8.5.6 When the Board's decision is final, it shall send notices of such decision through the Chief Executive Officer to the Chief of the Medical Staff, to the Chief of the Service concerned and by certified mail, return receipt requested, to the Practitioner affected.

8.5.7 Whenever a Practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the life, health or safety of any patient, prospective patient or any other person, the Board or the Chief Executive Officer may summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such Practitioner; provided, however, that the Board or the Chief Executive Officer, before the suspension, makes reasonable attempts to

contact the governing body of the Medical Staff (the "Medical Executive Committee"). A summary suspension by the Board or the Chief Executive Officer which has not been ratified by the Medical Executive Committee within two (2) working days, excluding weekends and holidays, after the suspension, shall automatically terminate.

8.6 Hearings Prompted by Board of Directors Action. If the hearing is based upon an adverse decision or recommendation of the Board of Directors, wherein the Medical Staff recommendation or decision was not adverse, then the Board of Directors or its designee shall fulfill the duties assigned to the Medical Executive Committee or the Chief of Staff for when the Medical Executive Committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

ARTICLE IX
JOINT CONFERENCE COMMITTEE

There shall exist a Joint Conference Committee, composed of Chairman, Vice Chairman, or their designee of the Board of Directors, to avoid a quorum of the membership of the Board of Directors and two members of the Medical Executive Committee, who shall be the Chief of Staff and the Vice Chief of Staff. Members of the Board shall be selected by the Board Chairman. Member of Administration shall include the Chief Executive Office, Vice President as assigned / appointed by the Chief Executive Officer and the Director of Medical Staff Services, who shall be ex officio members and not be entitled to vote.

The Chief Executive Officer, or a person designated by the Chief Executive Officer, shall act as Secretary to meetings of the Joint Conference Committee, and shall record minutes of all meetings, which minutes shall be kept in the office of the Chief Executive Officer and shall be available for inspection by members of the Medical Staff and Board. Minutes shall be available for review by interested participants of the Medical Staff and by Board, and provided that all privileges and confidentialities are maintained.

The Chairmanship of the Joint Conference Committee shall alternate yearly between the Board of Directors and the Medical Staff. Meetings of the Joint Conference Committee shall be held at least annually, at dates fixed by its Chairman, and may also be held at the call of the Chairman. The Committee shall transmit all written reports of its activities to the Medical Executive Committee and to the Board of Directors.

The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice, including issues which arise under Article VIII hereof, and of public relations, especially those pertaining to efficient and effective patient care. It shall provide medico-administrative liaison between the Medical Staff, the Board and the Chief Executive Officer. It shall also have the following specific duties:

9.1 Accreditation. It shall be responsible for establishing and maintaining accreditation policies and protocols similar to those of The Joint Commission on the Accreditation of Healthcare Organizations ("TJH") for which purpose it shall form a subcommittee that includes key

personnel who are important in implementing the Hospital's accreditation program. From time-to-time, it shall require that the JCAHO survey forms be used as a review method to estimate the accreditation status of the Hospital and it should supervise a biennial survey for purposes of constructive self-criticism. It shall identify areas of suspected noncompliance with TJC standards and shall make recommendations to the Medical Executive Committee and the Board for appropriate action.

9.2 Disaster Planning. It shall be responsible for the development and maintenance of methods for the protection and care of Hospital patients and others at the time of internal and external disaster. Specifically, it shall form subcommittees to adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least four (4) times a year, for each shift; and adopt and periodically review a written plan for the care, reception and evacuation of mass casualties, and shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, and that it adequately reflects developments in the Hospital community and the anticipated role of the Hospital in the event of disasters in nearby communities, and that the plan is rehearsed by key personnel at least twice yearly.

9.3 Ad Hoc Committee. Whenever a matter concerning Medical Staff privileges or peer review is referred by the Board back to the Medical Staff because of disagreement and the Medical Executive Committee refers the matter to the Joint Conference Committee to act as an Ad Hoc Dispute Mediation Committee, the Board shall participate therein, and shall deem the decision of such committee as a recommendation to the Board of Directors for final approval.

ARTICLE X
AUXILIARY ORGANIZATIONS

The Board may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its own bylaws, rules and regulations, which shall be subject to Board approval and which shall not be inconsistent with the Bylaws or the policies of the Board.

ARTICLE XI
INDEMNIFICATION OF DIRECTORS AND OFFICERS

Each Board member and officer, including those of the Foundation of the District (here, "Board member or officer") whether or not then in office, shall be indemnified by the District against all liabilities, costs and expenses reasonably incurred by or imposed upon him/her in connection with or arising out of any action, suit or proceeding in which he/she may be involved or to which he/she may be made a party by reason of his/her being or having been Board member or officer of the District, such expenses to include the cost of reasonable settlements made with a view to curtailment of costs of litigation. The District shall not, however, indemnify such Board member or officer with respect to matters as to which he/she shall be finally adjudged in any such action, suit or proceeding to have been derelict in the performance of his/her duty as such Board member or officer, nor shall the District

indemnify such Board member or officer or the District itself, unless specifically voted upon and authorized by a majority of the Board. In no event shall anything herein contained be so construed as to authorize the District to indemnify any such Board member or officer at the time of doing it to willful misfeasance, bad faith, gross negligence or reckless disregard of the duties involved in the conduct or his/her office. The foregoing right of indemnification shall not be exclusive of other rights to which any Board member or officer may be entitled as a matter of law.

ARTICLE XII
AMENDMENT

These Bylaws may be amended or repealed by vote of at least three (3) members of the Board at any Board meeting. Such amendments or repeal shall be effective immediately, except as otherwise indicated by the Board.

SECRETARY'S CERTIFICATE

I, the undersigned and duly appointed, qualified and acting Secretary of the Board of Directors for the Sierra View Local Health Care District, do hereby certify that the twenty-two (22) pages attached hereto constitute a true, complete and correct copy of the current Bylaws of Sierra View Local Health Care District, duly adopted by the Board of Directors on _____.

Dated: _____

_____
Secretary, Sierra View Local Health Care District

(Medical Staff Bylaws Omitted from this Redline as they are unchanged)