Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

3. The pharmacist will review the above criteria and effect the change when appropriate. He/She will enter an order in the patient's chart under "Physician Orders" as "Change I.V. (*insert drug name*) to P.O. per protocol".

4. For any other IV medications, the clinical pharmacist will preview the patient status with regard to their ability to take other oral medications.

REFERENCES:

- Centers for Disease Control and Prevention. Core Elements of Hospital Antibiotic Stewardship Programs. http://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements.html (Accessed on March 16, 2021)

- Holubar, M. Deresinkski, S. Antimicrobial stewardship in Hospital settings. https://www.uptodate.com/contents/antimicrobial-stewardship-in-hospital-settings?search=iv%20to%20po%20antibiotics&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#references (Accessed on October 11, 2022).

- Kopp BJ, Mrsan M, Erstad BL, Duby JJ. Cost implications of and potential adverse events prevented by interventions of a critical care pharmacist. Am J Health-Syst Pharm 2007 Dec 1; 64(23):2483-7.

- Medicare Prescription Drug Improvement and Modernization Act (MMA), December 2003 creation of Medicare Part D and Medication Therapy Management Services.

- Nesbit TW, Shermock KM, Bobek MB, et. al. Implementation and pharmacoeconomic analysis of a clinical staff pharmacist practice model. Am J Health-Syst Pharm 2001 May 1; 58(9):784-90

SUBJECT: **MECHANICAL VENTILATION**	SECTION: **Page 1 of 6**

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

PURPOSE:

To ensure a consistent method of providing ventilator support.

POLICY:

Respiratory Care Practitioners are responsible for the setup, maintenance and care of mechanical ventilators. Respiratory Care is responsible for management of the resident receiving mechanical ventilation.

AFFECTED PERSONNEL/AREAS:

RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN)

PROCEDURE:

1. Check to see if an operation verification of the ventilator has been performed.
2. Perform a system check prior to connecting the resident to the ventilator.
3. Connect oxygen supply tubing and compressed air supply tubing to wall outlets.
4. Connect electrical plug to properly grounded electrical emergency power outlet.
5. Push the ON/OFF switch to start the machine.
6. Set the tidal volume as prescribed by the physician.
7. Set the pressure limit to the maximum and occlude the resident connector to test the pressure alarm.
8. Set the respiratory rate as prescribed by the physician.
9. Set the FiO_2 as prescribed by the physician.
10. Set MODE as prescribed by the physician.
11. The ventilator is now ready to be used on the resident.
12. Observe the peak pressure on the manometer required to deliver the set tidal volume. Set the pressure limit < = 15 cm H_2O higher than the peak inspiratory pressure.

13. Observe the peak pressure on the manometer required to deliver the set tidal volume. Set the low inspiratory pressure alarm 10 cm lower than the peak pressure. ***See the Alarm Setting guidelines.***

14. Allow the resident to stabilize the ventilator. Comfort and reassure the resident as necessary.

15. Fill out the Ventilator Flow Chart completely.

16. Chart all appropriate data in the resident's chart.

17. Refer to resident ventilator system checks.

18. Physician may order vent settings to keep ABGs within parameters.

ASSESSMENT:

Assessment of the mechanically ventilated resident should include:

- Visual observation of adequate chest excursion
- Auscultation of sounds
- Arterial blood gases 30 minutes after starting mechanical ventilation
- Non-invasive monitoring of ventilation and oxygenation

HAZARDS:

- Accidental disconnection from the ventilator
- Accidental extubation
- Loss of airway
- Oxygen toxicity
- Barotrauma
- Nosocomial pneumonia
- Over or under hydration from improperly operating humidification devices

EQUIPMENT:

- Mechanical Ventilator (with complete circuit) and disposable filters

- Manual Resuscitation Device
- Suction Equipment
- Humidification System
- Additional Artificial Airway
- Ventilator Flow Chart
- Cuff manometer
- Stethoscope
- Pulse Oximeter

VENTILATOR CIRCUIT CHANGES:

Description: The ventilator circuit change will be done once per month and prn and will consist of placing a clean ventilator circuit on an operating mechanical ventilator. Ventilator circuits will be disposable. The circuit will consist of large bore tubing, monitoring tubing, and humidifier or heat moisture exchangers (HME), thermal monitoring probes, water traps, and medication delivery devices.

Objectives:

- To limit the occurrence of nosocomial infections
- Assure the circuit maintains its physical integrity

Contraindications/Hazards/Complications:

- Pressure of conditions in the resident's cardiopulmonary status that might make tolerance of a ventilator circuit change hazardous to the resident.
- Manipulation and disconnection of the ventilator's tubing can cause contaminated ventilator condensation to spill into the resident's airway, exposing the resident to further risk of infection.
- Failure to assure proper function prior to reinstituting mechanical ventilation may endanger the resident.

VENTILATOR SYSTEM CHECKS

A resident ventilator system check is a documented evaluation of a mechanical ventilator and of the resident's response to mechanical ventilator support. This procedure is often referred to as a ventilator check.

1. Evaluate and document the resident's response to mechanical ventilation at the time the check is performed.

2. Ensure and document the proper operation of the mechanical ventilator.

3. Verify and document that the ventilator is functioning and is properly connected to the resident.

4. Resident assessment and objectives will be documented every 6 hours.

5. All data relevant to the resident ventilator system check should be documented on the Respiratory Care Services Ventilator Flow Sheet.

    a. Documentation that all alarms are functional/audible and properly set.

    b. Documentation of measured inspired gas temperatures

    c. Endotracheal or tracheostomy tube size

    d. Documentation of any circuit changes

    e. Date and time of resident's ventilator system check

6. Documentation of a "vent check" must include:

    a. FIO2 setting

    b. Temperature setting (if applicable)

    c. Set ventilator frequency

    d. Peak pressures

    e. Set peak inspiratory limits and pressure support level (if applicable)

    f. Set tidal volume

    g. Exhaled tidal volume (Acute Care)

h. Set high variables (if applicable)

i. Set inspiratory time (if applicable)

j. Set I:E ratio, percent inspiration, or inspiratory and expiratory times (if applicable)

k. Set sensitivity threshold (if applicable)

l. Documentation of all alarm settings and activation of appropriate alarms

m. Signature of person performing ventilator system checks

n. A daily assessment of clinical observations indicative to the residents response to mechanical ventilation

o. Documentation of the resident's oxygenation and ventilation status

7. Residents ventilator system check must be performed QID. In addition, a check should be performed:

a. Following any change in ventilatory settings

b. As soon as possible following an acute deterioration of the resident's condition

c. Any time that a ventilator performance is questionable

EQUIPMENT:

- Stethoscope
- Pulse oximeter

INFECTION CONTROL:

- Standard Precautions should be observed.
- Head of bed should be elevated to 35-45 degrees or greater unless contraindicated.

DOCUMENTATION:

- Please see Respiratory Care Policy and Procedure: Documentation

SAFETY PRECAUTIONS:

- Use a properly grounded electrical (red) outlet only.
- Check all alarms every shift.
- Place nothing on top of the ventilator.
- NEVER turn alarms to off position.
- Exercise caution when handling liquids near electrical devices to avoid electrical shock or damage to the machine.
- Only properly licensed personnel are allowed to set-up, monitor or make any adjustments to a mechanical ventilator.

REFERENCES:

- Patient-Ventilator System Checks. (n.d.). Retrieved from https://www.aarc.org/wp-content/uploads/2014/08/08.92.882.pdf
- AARC (2016). Safe initiation and management of mechanical ventilation: A white paper from the American Association for Respiratory Care (AARC) and University HealthSystem Consortium's (UHC) Respiratory Care Network. Retrieved from https://www.aarc.org/wp-content/uploads/2016/05/White-Paper-SAFE-INITIATION-AND-MANAGEMENT-OF-MECHANICAL-VENTILATION.pdf

SUBJECT: **PEDIATRIC ASSESSMENT AND NURSING STANDARDS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define nursing standards of care for the pediatric patient and outline nursing responsibilities in the assessment of pediatric patients.

AFFECTED PERSONNEL/AREAS: *CLINICAL DECISION UNIT NURSING STAFF*

POLICY:

1. Each pediatric patient will receive an initial assessment within four (4) hours of admission, then at regular intervals twice a shift in the course of care to determine the patient response to care. The scope and intensity of reassessment is determined by the patient's diagnosis, the care setting, the patient's desire for care and the patient's response to any previous care.

2. The initial assessment shall include, but is not limited to, the following elements:

   a. Assessment of the patient's emotional, cognitive, communication, education, social and daily activity needs;

   b. Assessment of the patient's developmental age, height (length if non-ambulatory), head circumference, and weight;

   c. Vital signs, including temperature, pulse, and respiration, are to be taken every four hours or more often if indicated or ordered

   d. Pulse oximetry provides estimates of arterial oxyhemoglobin saturations (SaO2) by utilizing selected wavelengths of light to non-invasively determine the saturation of oxyhemoglobin (SpO2). This should be done with each vital signs assessment. Pulse oximetry site and sensor should be changed every 24 hours if the patient is on a continuous monitor. *Note: Bruising may occur in the event the sensor is excessively over tightened upon application. Tissue necrosis may occur with overly tight sensor application and in the presence of compromised perfusion to the site/appendage.*

   e. Blood pressures are taken on all children upon admission, then once every shift or routinely with postoperative vital signs. If condition warrants, vital signs may be taken more frequently.

   f. Assessment of the effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family or guardian;

   g. The patient's immunization status

   h. Assessment of the family's guardian's expectation for and involvement in the patient's assessment, initial treatment, and continuing care

   i. Assessment of the patient's academic educational needs.

3. Data may be obtained from the parent(s) or legal guardian when appropriate.

4. Nursing care will be based on the nursing diagnosis/patient care needs, developmental age and will be consistent with the therapies of other disciplines.

5. The nursing staff shall involve and encourage parent(s) or legal guardian(s) participation in patient care as appropriate.

6. Multidisciplinary collaboration, as appropriate, shall be ongoing throughout the patient stay by the nursing staff. Patient/family teaching is given consideration in the care plan.

7. Discharge planning and patient/parent/guardian education will begin at the time of admission; referrals will be made whenever needed and appropriate and continued until the patient is discharged.

8. Discharge instructions shall include patient's outcomes to the nursing care provided; ability of patient/parent/guardian to manage care at home, any specific instructions, needs/equipment to use will be documented in the patient's record.

Cribs or beds:

1. Cribs and beds are to be checked for proper function and safety prior to placing the patient in them. Cribs are not to be placed near wall sockets, electrical outlets, etc. If the patient is old enough to be in a bed, all four side rails are up and the bed in the low position when the patient is unattended.

2. Select the proper bed or crib for the patient's age, developmental stage or physical or mental condition. Such as patient is 3 years old and under, needs to be placed in crib unless indicated.

3. Make certain that the beds are equipped with side rails that lock.

4. Must have plastic extension tops or bubble top if the child is old enough to climb.

5. The crib sides are to be lowered only when a nurse, parent or physician are directly caring for or examining the patient. Otherwise, all crib rails must be raised and locked at all times. Patient family and visitors left alone with the child should be instructed on crib safety.

NURSING STANDARDS – PEDIATRIC

A. The nursing staff shall be competent in:

   1. The recognition, interpretation and documentation of changes in the pediatric patient's condition.

2. Proficient in the initiation of cardiopulmonary resuscitation (CPR) of children. Emergency care or a code blue will be performed by a nurse proficient in the use of medications and equipment in a pediatric emergency. This nurse will be familiar with the contents of the pediatric emergency cart.

3. Prevention of contamination and cross contamination.

4. Recognition of and attention to the psychological and social needs of the pediatric patient and their families.

REFERENCES:

- Brannagan, M. (2021). Performing physical assessment in pediatric patients. Retrieved on 12/1/22 from **https://www.dynahealth.com/nursing-skills/performing-physical-assessment-in-pediatric-patients/about**

SUBJECT:	SECTION:
PYXIS MEDICATION OVERRIDES AND DISCREPANCY	***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 define the use of the override function in the PYXIS automated dispensing cabinets and identify the best practices associated with its use.

POLICY:

Medications available via the override function shall be limited to those drugs which may result in patient harm due to a delay in administration. The override list shall be reviewed and approved annually by the Pharmacy and Therapeutics Committee.

AFFECTED AREAS/PERSONNEL: *PHARMACY; NURSING*

PROCEDURES:

A. The override groups will include the following categories:

1. **Basic**- Includes controlled substances, over the counter (OTC) medications, respiratory medications.
2. **Emergent-** Includes the Basic group, plus those medications that require special training beyond the scope of the floor nurse to administer.
3. **Nursing House Supervisors**- Access to all medications house wide.
4. **OB Group**- Obstetric and Gynecological-related medications.
5. **RT Group**- Only access to respiratory medications.

B. Pharmacist Review of Override Medications

1. All medications removed via the override function shall be reviewed by the pharmacist the following day. Such review shall include:
   a. Verifying that there was a physician order for the over-ridden medication.
   b. Verifying that the nurse did not remove the medication on override after the order had been entered by a pharmacist.
   c. Verifying that the nurse did not override a medication using one route of administration, while the order was actually for another route.
   d. Verifying that the medication was not withdrawn on override after it had been discontinued or had expired.

e. Verifying proper dose, allergy status, and that interactions with other medications have not occurred.

2. Problems or issues with inappropriate use of the override function shall be documented in the hospital's medication event database and sent to the Nurse Managers for investigation, review and action.

3. Unresolved discrepancies shall be investigated by the Nurse Manager and the Pharmacy Director, as appropriate, and reported via the hospital medication event database and notification of the Chief Nursing Officer, as warranted.

4. For unresolved discrepancies involving controlled substances, refer to the procedures outlined in the Controlled Substances Procurement, Administration and Documentation policy.

Override Group Name	Generic Name	Trade Name
Basics	ACETAMINOPHEN	Tylenol Supp
Basics	ACETAMINOPHEN	Tylenol
Basics	ACETAMINOPHEN	Tylenol Soln
Basics	ACETAMINOPHEN	Tylenol Supp
Basics	ACETAMINOPHEN	Tylenol Es
Basics	ACETAMINOPHEN DROPS	Tylenol Drops
Basics	ACETAMINOPHEN INJ	Ofirmev Inj
Basics	ACETAMINOPHEN W/COD 300-30	Tylenol W/Cod #3
Basics	ACETAMINOPHEN W/COD ELIX	Tylenol w/Cod Elix
Basics	ANAPHYLAXIS KIT	Anaphylaxis Kit
Basics	ATROPINE SULF INJ	Atropine Inj
Basics	CALCIUM CHLORIDE 10% INJ	Calcium Chloride 10% Abboject
Basics	DEXAMETHASONE SOD PHOS INJ	Decadron Inj
Basics	DEXTROSE 50%-WATER INJ	D50w Inj Abboject
Basics	DIAZEPAM	Valium Inj
Basics	DIGOXIN ELIX	Lanoxin Elix

Basics	DiphenhydrAMINE INJ	Benadryl Inj
Basics	EPINEPHRINE INJ	Epinephrine Inj
Basics	ETOMIDATE INJ	Amidate Inj
Basics	FENTANYL CIT INJ	Sublimaze Inj
Basics	FENTANYL PCA	Sublimaze PCA
Basics	FLUMAZENIL INJ	Romazicon Inj
Basics	FOSPHENYTOIN SOD INJ	Cerebyx Inj
Basics	FUROSEMIDE INJ	Lasix Inj
Basics	GUAIFENESIN SYRUP	Robitussin Syrup
Basics	GUAIFENESIN/CODEINE PHOSPHATE	Robitussin Ac Syrup
Basics	HALOPERIDOL LACT INJ	Haldol Inj
Basics	HEPARIN in D5W	Heparin in D5w Ivpb
Basics	HEPARIN SOD INJ	Heparin Inj
Basics	HydrALAzine INJ	Apresoline Inj
Basics	HYDROCOD BIT/APAP ELIX 10/300	LORTAB ELIX (10/300)
Basics	HYDROCORTISONE SOD SUCC INJ	Solu-Cortef Inj
Basics	HYDROMORPHONE HCL	Dilaudid Inj
Basics	HYDROMORPHONE-HP INJ	Dilaudid Pca
Basics	INSULIN 75/25 NPL/LISP	HUMALOG 75/25 INSULIN
Basics	INSULIN ASPART	NovoLOG INSULIN
Basics	INSULIN GLARGINE INJ	Lantus Inj
Basics	INSULIN HUMAN REGULAR PER UNIT	Novolin-R U-100 (Billed Per Un
Basics	INSULIN LISPRO	HUMALOG INSULIN
Basics	KETOROLAC INJ	Toradol Inj
~~Basics~~	~~LIDOCAINE HCL 1%~~	~~Xylocaine Inj 1%~~
~~Basics~~	~~LIDOCAINE HCL 1% (20ML)~~	~~Xylocaine Inj 1% (20ML)~~

Basics	LIDOCAINE HCL 2% - MPF	Xylocaine 2% - MPF Inj
Basics	LIDOCAINE INJ 2%	Xylocaine Inj 2% Abboject
Basics	LIDOCAINE PF 1%	Xylocaine-Mpf Inj 1%
Basics	LORAZEPAM	Ativan Inj
Basics	MAGNESIUM SULF	Magnesium Sulf
Basics	MAGNESIUM SULFATE IVPB	MAGNESIUM IVPB
Basics	MEPERIDINE INJ	Demerol Inj
Basics	MethylPREDNISolone SOD SUC-CL	Solu-Medrol Inj
Basics	METOCLOPRAMIDE INJ	Reglan Inj
Basics	MG HYD/AL HYD/SIM ES SUSP	Maalox Es Susp
Basics	MIDAZOLAM INJ	Versed Inj
Basics	MORPHINE SULF INJ	Morphine Sulfate Inj
Basics	MORPHINE SULF LIQD	Morphine Sulf Liqd
Basics	MORPHINE SULF PCA	Morphine Sulf Pca
Basics	NALOXONE INJ	Narcan Inj
Basics	NIFEdipine	Procardia
Basics	NITROGLYCERIN	Nitrostat 1/150
Basics	NITROGLYCERIN INJ	Nitroglycerin Inj.
Basics	NITROGLYCERIN OINT 2%	Nitro-paste Oint 2%
Basics	ONDANSETRON INJ	Zofran Inj
Basics	PHENOBARBITAL INJ	Phenobarbital Inj
Basics	PROMETHAZINE INJ	Phenergan Inj
Basics	SOD POLYSTYRENE SULFON SUSP	Kayexalate Susp
Basics	SODIUM BICARB INJ 8.4%	Sodium Bicarbonate Inj 8.4%
Basics	SODIUM CHLOR, BACTERIOSTATIC	NaCl Bacterostatic Inj

Basics	STERILE WATER	Sterile Water
Basics	THIAMINE INJ	Vitamin B-1 Inj
Basics	TICAGRELOR	Brilinta
Basics	WATER FOR IRRIGATION,STERILE	Sterile Water Irrig
Emergent	ACETYLCYSTEINE RT SOL 10%	Mucomyst Rt Sol 10%
Emergent	ACETYLCYSTEINE RT SOL 20%	Mucomyst Rt Sol 20%
Emergent	ADENOSINE INJ	Adenocard Inj
Emergent	ALBUMIN HUMAN 25%	Albuminar-25 Ivpb
Emergent	Alteplase 100mg Vial	Activase
Emergent	AMIODARONE HCL/DEXTROSE	Nexterone IVPB
Emergent	AMIODARONE INJ	Cordarone Inj
Emergent	ANTIVENIN, CROTALIDAE	Crofab Inj
Emergent	ANTIVENIN, CROTALIDAE (EQUINE)	Anavip Inj
Emergent	ASPIRIN	Aspirin Chew
Emergent	ASPIRIN EC	Ecotrin
Emergent	BENZOCAINE Spray 20% (Topex)	Topex Spray
Emergent	BUMETANIDE INJ	Bumex Inj
Emergent	CLOPIDOGREL	CLOPIDOGREL
Emergent	COCAINE HCL TOP SOL 4%	Cocaine Topical 4%
Emergent	DEXMEDETOMIDINE/D5W 400MCG IV	PRECEDEX 400MCG/100ML
Emergent	DEXTROSE 5%-WATER (AVIVA)	D5w (Aviva)
Emergent	DILTIAZEM INJ	Cardizem Inj
Emergent	DOBUTamine INJ	Dobutrex Inj
Emergent	DOPamine in D5W IVPB	Intropin in D5w Ivpb
Emergent	DOPamine INJ	Intropin Inj
Emergent	ENALAPRILAT INJ	Vasotec Inj

Emergent	ENOXAPARIN SOD INJ	Lovenox Inj
Emergent	EPTIFIBATIDE INJ	Integrilin Inj
Emergent	EPTIFIBATIDE IVPB	Integrilin Ivpb
Emergent	ESMOLOL INJ	Brevibloc Inj
Emergent	ESOMEPRAZOLE INJ (NON-FORM)	Nexium Inj
Emergent	FAT EMULSIONS 20% IV	Liposyn II 20% Iv
Emergent	FENTANYL in NS (Premix)	Sublimaze in NS Premix
Emergent	FLUORESCEIN/PROPARACAINE OPTH	Flucaine Op Sol
Emergent	GLYCOPYRROLATE INJ	Robinul Inj
Emergent	INSULIN REG 100 UNITS / 100 ML	Myxredlin premixed
Emergent	ISOPROTERENOL INJ	Isuprel Inj
Emergent	KETAMINE HCL INJ	Ketamine Inj
Emergent	KETAMINE HCL INJ SYRINGE	Ketamine HCl Inj Syringe
Emergent	LABETALOL INJ	Trandate Inj
Emergent	LACOSAMIDE	Vimpat
Emergent	LIDOCAINE in D5W IVPB	Xylocaine in D5w Ivpb
Emergent	MAGNESIUM SULF INJ 50%	Magnesium Sulfate 50% Inj
Emergent	MANNITOL INJ 20%	Mannitol Inj 20%
Emergent	METOPROLOL TARTRATE INJ	Lopressor Inj
Emergent	MIDAZOLAM in NS (Premix)	Versed in NS Premix
Emergent	MIDAZOLAM SYRUP	Versed Syrup
Emergent	NITROGLYCERIN in D5W	Nitroglycerin in D5w Ivpb
Emergent	NITROPRUSSIDE SOD INJ	Nitropress Inj
Emergent	NOREPINEPHRINE IN D5W INJ	Levophed in D5W Inj
Emergent	NOREPINEPHRINE IN NS	Levophed in NS

Emergent	OCTREOTIDE ACET INJ	SandoSTATIN Inj
Emergent	PANTOPRAZOLE INJ	Protonix Inj
Emergent	PHENOBARBITAL ELIX	Phenobarbital Elix
Emergent	PHENYLEPHRINE INJ	Neo-synephrine Inj
Emergent	POTASSIUM CHLOR IVPB	Kcl Ivpb
Emergent	POTASSIUM PHOSPHATE IVPB	Potassium Phosphate IVPB
Emergent	PROCAINAMIDE 100MG/ML 10ML	PROCAINAMIDE 100MG/ML 10ML
Emergent	PROPOFOL INJ	Diprivan Inj
Emergent	PROPOFOL INJ	Diprivan Ivpb
Emergent	PROTHROMBIN CMPLX CONC (HUMAN)	Kcentra Kit - 1000 units/kit
Emergent	RIVAROXABAN	Xarelto
Emergent	ROCURONIUM INJ	Zemuron Inj
Emergent	SODIUM BICARB INJ 8.4%	Sodium Bicarbonate Inj 8.4%
Emergent	SODIUM BICARBONATE 4.2%	Sodium Bicarbonate 4.2%
Emergent	SUCCINYLCHOLINE INJ	Anectine Inj
Emergent	TENECTEPLASE INJ	Tnkase Inj
Emergent	TRANEXAMIC ACID INJ	Tranexamic Acid
Emergent	TRANEXAMIC ACID IVPB	Tranexamic Acid IVPB
Emergent	VASOPRESSIN INJ	Pitressin Inj
Emergent	VECURONIUM INJ	Norcuron Inj
Emergent	VERAPAMIL INJ	Calan Inj
OB	AMMONIA	Ammonia Inhalant
OB	AMPICILLIN INJ	Ampicillin Inj
OB	BETAMETHASONE (CELESTONE) INJ	Celestone Inj

OB	CARBOPROST TROMETH INJ	Hemabate Inj
OB	CEFAZOLIN in DEXTROSE	Ancef/Dextrose Ivpb
OB	CEFOXITIN SOD INJ	Mefoxin Inj
OB	CITRIC ACID/SODIUM CITR	Bicitra Soln
OB	CLINDAMYCIN PHOS INJ	Cleocin Inj
OB	CLINDAMYCIN PHOS/D5W	Cleocin/D5w Ivpb
OB	EPHEDRINE SULF INJ	Ephedrine Sulfate Inj
OB	FAMOTIDINE INJ	Pepcid Inj
OB	GENTAMICIN INJ	Gentamicin Inj Ped
OB	KETOROLAC INJ	Toradol Inj
OB	MAGNESIUM SULF IVPB	Magnesium Sulfate Ivpb
OB	METHYLERGONOVINE INJ	Methergine Inj
OB	MISOPROSTOL	Cytotec
OB	MORPHINE SULF PF INJ	Duramorph-Pf Inj
OB	MORPHINE SULFATE PF	Duramorph-PF Inj
OB	Oxytocin 20 Units in LR	Pitocin in LR
OB	Oxytocin 30 Units in LR	Pitocin in LR
OB	OXYTOCIN INJ	Pitocin Inj
OB	PHYTONADIONE	Vitamin K Inj
OB	PORACTANT ALFA INHALANT	Curosurf
OB	RANITIDINE HCL	Zantac Inj (Ped)
OB	RANITIDINE INJ	Zantac Inj
OB	TERBUTALINE SULF INJ	Brethine Inj
RT	ALBUTEROL RT	Proventil Rt Sol
RT	ALBUTEROL/IPRATROP RT 3ML NEBU	Duoneb RT 3ML NEBU
RT	EPINEPHRINE RT SOL 2.25%	RACEPINEPHRINE 2.25%

RT	LEVALBUTEROL RT	Xopenex Rt Sol
RT	SODIUM CHLORIDE 3% RT SOL	Sodium Chloride 3% RT Sol
RT	SODIUM CL RT SOL 0.9%	Normal Saline Rt Sol

REFERENCE:

- The Joint Commission (2021). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **STANDARDIZED PROCEDURES**	SECTION: ***Nursing Administration; From the Office of the Chief Nurse Executive*** **Page 1 of 4**

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

PURPOSE:

This is a defined approval process for new and renewed standardized procedures that nurses are able to perform across the organization (Title 22, § 70706.2, 2019). The Board of Registered Nursing in conjunction with the Medical Board of California (see the requirements of the Medical Board of California, Article 9.5, Chapter 13, Title 16 of the California Code of Regulations) intends, by adopting the regulations contained in the article, to jointly promulgate guidelines for the development of standardized procedures to be used in organized health care systems which are subject to this rule (Board of Registered Nursing, 2019). The purpose of these guidelines is:

- To protect consumers by providing evidence that the nurse meets all requirements to practice safely.
- To provide uniformity in development of standardized procedures.

(Authority cited: Section 2715, Business & Professions Code. Reference: Sections 2725 & 2811.5, Business & Professions Code)

DEFINITIONS:

1. "Standardized procedure functions" means those functions specified in Business and Professions Code Section 2725(c) and (d) which are to be performed according to "standardized procedures";
2. "Organized health care system" means a health facility which is not licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the Health and Safety Code and includes, but is not limited to, clinics, home health agencies, physicians' offices and public or community health services;
3. "Standardized procedures" means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions

(California Nursing Practice Act, 2019, p. 113)

POLICY:

A. An organized health care system, such as SVMC, must develop standardized procedures before permitting registered nurses to perform standardized procedure and functions. A registered nurse may perform standardized procedure functions only under the conditions specified in a health care system's (SVMC) standardized procedures; and must provide the system with a satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform such functions.

§ 1474 Standardized Procedure Guidelines – Board of Registered Nursing

Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing:

1. Standardized procedures shall include a written description of the method used in developing and approving them and revision thereof.
2. Each standardized procedure shall:

a. Be in writing, dated and signed by the organized health care system personnel authorized to approve it.
b. Specify which standardized procedure functions registered nurses may perform and under what circumstances
c. State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.
d. Specify any experience, training, and/or education requirements for performance of standardized procedure functions.
e. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.
f. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
g. Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.
h. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.
i. State the limitations on settings, if any, in which standardized procedures functions may be performed.
j. Specify patient record keeping requirements.
k. Provide for a method of periodic review of the standardized procedures.

B. Title 22 - § 70706.2 Standardized Procedures

a. The Committee on Interdisciplinary Practice shall be responsible for:

i. Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section.
ii. The review and approval of all such standardized procedures covering practice by registered nurses in the facility.
iii. Recommending policies and procedures for the authorization of employee staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing.

b. Each standardized procedure shall:

i. Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice.

ii. Specify the standard procedure functions which registered nurses are authorized to perform and under what circumstances.
iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.
iv. Specify any experience, training or special education requirements for performance of the functions.
v. Establish a method for initial and continuing education evaluation of the competence of those registered nurses authorized to perform the functions.
vi. Provide for a method of maintaining a written record of those persons authorized to perform the functions.
vii. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated, if physician is not required, that fact should be clearly stated.
viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
ix. State any limitations on settings or departments within the facility where the standardized procedure functions may be performed.
x. Specify any special requirements for procedures relating to patient recordkeeping.
xi. Provide for periodic review of the standardized procedure.

C. If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the director of nursing.

AFFECTED PERSONNEL/AREAS: *AFFECTED NURSES AND PHYSICIANS*

PROCEDURE:

A. The Committee on Interdisciplinary Practice will meet yearly, but the Committee may be called at the discretion of the Chief Nurse Executive and/or the President of the Medical Staff.

1. Composition of the Committee

a. Chief Nurse Executive (Chair)
b. Physician Appointed by the President of the Medical Staff (Co-Chair)
c. Physician appointed by the President of the Medical Staff
d. Advanced Practice Nurse
e. Staff Registered Nurse
f. Staff Registered Nurse
g. Nurse Leader

2. The Committee has an agenda prepared by the Chair and/or Co-Chair.
3. Standardized Procedures are initially presented, revised, or on their bi-annual review.
4. The Committee can approve, send back for revision, an/or reject.
5. After approval by the Committee, the standardized procedures are sent to the Medical Executive Committee; and then the Board of Directors for final approval.

REFERENCES:

- Board of Registered Nursing. (2019). California nursing practice act with regulations and related statutes. LexisNexis. Charlottesville, VA.
- Medical Board of California. (2019). Laws regulating the practice of: physicians and surgeons, doctors of podiatric medicine, research psychoanalysts, medical assistants, perfusionists, licensed midwives. LexisNexis, Charlottesville, VA.
- Title 22, § 70706.2. (2019). Standardized procedures. WESTLAW, California Code of Regulations.

SUBJECT: **THROMBOLYTIC THERAPY IN ACUTE ISCHEMIC STROKE**	SECTION: **Page 1 of 14**

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

PURPOSE:

The purpose of this policy is to outline patient eligibility for thrombolytic therapy, drug administration, patient monitoring, and documentation for the care of the patient experiencing Acute Ischemic Stroke (AIS). These guidelines focus on early assessment and management of Emergency Department (ED) and inpatients with AIS.

Alteplase (TPA) is a tissue plasminogen activator indicated for the management of AIS in adults for improving neurological recovery and reducing the incidence of disability. Alteplase therapy may be administered in the setting of an acute cerebral ischemic episode under the direction of a physician in an attempt to lyse the thrombus obstructing a cerebral artery, improve cerebral blood flow, reduce the amount of cerebral ischemia and reduce tissue damage. Treatment with Alteplase within 180 minutes (3 hours) may be more likely to result in a favorable outcome, and later treatment up to 270 minutes (4.5 hours) after onset of stroke symptoms to eligible patients has shown some benefit. Delays in evaluation and initiation of therapy should be avoided; treatment should be initiated as soon as possible after the onset of acute cerebral ischemic symptoms, because the opportunity for improvement is greater with earlier treatment.

Treatment should be initiated within 4.5 hours after the onset of stroke symptoms, and after exclusion of intracranial hemorrhage by a cranial computerized tomography (CT) scan or other diagnostic imaging method sensitive for the presence of hemorrhage.

~~**Tenecteplase (TNK)** is also a thrombolytic drug. It is now recommended in specific situations, per the 2019 Acute Ischemic Stroke guidelines. TNK is not FDA approved in the use of AIS. Compared to Alteplase, it has a longer half-life and higher fibrin specificity. TNK has the benefit of a single bolus administration. TNK is recommended at a dose of 0.25 mg/kg (max 25 mg), administered within 4.5 hours of symptom onset, in the setting of Large Vessel Occlusion (LVO), as it has shown superior recanalization and improved outcomes at 3 months when compared to TPA. TNK had a rate of 1% for intracranial hemorrhage in this patient population. It is also recommended at a dose of 0.4 mg/kg for strokes with minor neurological impairment and no LVO. TNK can be given up to 6 hours after stroke onset. It's safety profile is similar to TPA in this patient population. Inclusion / exclusion criteria and contraindications are the same as Alteplase (TPA) in acute ischemic stroke.~~

Treatment Goals:

To act in accordance with the 8 D's of stroke survival:

a. Detection (Early recognition)
b. Dispatch (Early EMS activation)
c. Delivery (Transport & management)
d. Door (ED triage)
e. Data (ED management, activation of stroke alert)
f. Decision (Neurology & therapy selection)
g. Drug (Reperfusion approaches)
h. Disposition (admit or transfer)

For the inpatient: Early recognition, activation of the Rapid Response Team (RRT) & stroke alert, Decision, Drug, and Disposition.

- Management of the acute stroke patient as measured by time targets for stroke care, including consideration and administration of thrombolytic therapy.
- Reduce the complications of stroke through thrombolysis in eligible patients.
- Improve patient outcomes.

DEFINITIONS:

1. **Acute Ischemic Stroke (AIS):** A disruption of blood flow to the brain that can result in permanent damage. This disruption is usually caused by either cerebral thrombosis or cerebral embolism. AIS accounts for about 87% of all strokes.

2. **Alteplase (rt-PA)**: The only FDA approved thrombolytic for AIS treatment.

3. **Last Known Well Time (LKWT):** The time in hours and minutes that the patient was last known to be at their "baseline" self.

4. **NIHSS – National Institute of Health Stroke Scale**: A stroke severity assessment scale.

5. **Stroke Alert:** An overhead page or electronic notification announcing the presence and location of a potential stroke patient. Activated anytime for any patient, via a defined process, that displays stroke signs and/or symptoms.

    a. Patients with new or worsening neurological deficits (if prior NIHSS done, worsening of 3 or more points).
    b. Anyone with a positive BE FAST, or FAST, exam
    c. Any other sign or symptom concerning for stroke

The alert activates members of the stroke team who respond to the alert in a role-specific way.

~~6. **Teneeteplase** – a thrombolytic agent similar to Alteplase (TPA) with greater fibrin specificity and a longer half – life. Not FDA approved but is recommended in the American Heart / American Stroke Association clinical practice guidelines for specific AIS~~

~~7.~~6. **Thrombolytic**: An intravenously administered medication that binds to a thrombus in a blood vessel causing fibrinolysis, thereby restoring blood flow to the area distal of the clot. Alteplase and Teneceteplase are are thrombolytics.

POLICY:

A. A "stroke alert" may be called for any ED or Intensive Care Unit (ICU) patient presenting with signs or symptoms of an acute stroke. Inpatients, outside of the ICU, will precede the stroke alert with a Rapid Response Team (RRT) notification. The RRT will evaluate the patient and call the stroke alert.

B. Also see policy "Stroke Alert and Acute Care Stroke Management" for additional treatment details.

C. Prior to initiating thrombolytics for the treatment of AIS, the treating physician will evaluate all patients for inclusion and exclusion criteria. Inclusion and exclusion criteria are consistent with FDA approval guidelines.

1. Inclusion Criteria

a. Age 18 years or older – equally recommended for ages ≤80 and > 80
b. Does not have diabetes and prior stroke
c. Working diagnosis of acute ischemic stroke with a measurable neurologic deficit. Mild, but disabling stroke symptoms (as defined by the patient) – thrombolysis is still recommended.

i. Sudden numbness, weakness, or paralysis of the face, arm, or leg
ii. Difficultly speaking or understanding simple statements
iii. Decreased vision or transient blindness in one eye
iv. An episode of double vision
v. Unexplained dizziness, loss of balance, or sudden falls
vi. Sudden, severe headache with no apparent cause

d. LKWT established to be less than 180 minutes (3 hours) before treatment would begin.

i. In some cases, this window may include those with symptom onset 180 to 270 minutes (3 to 4.5 hours) prior to presentation, with these additional EXCLUSION criteria:

- Age > 80 years
- Oral anticoagulant use regardless of INR
- Baseline NIHSS score > 25
- Imaging evidence of ischemic injury involving more than one third of the middle cerebral artery (MCA) territory
- History of both stroke and diabetes
- Intracranial hemorrhage has been **excluded** as the primary cause of stroke signs and symptoms prior to the initiation of Alteplase treatment.

NOTE: Physician discretion may modify this list

2. Exclusion Criteria / Contraindications: Alteplase therapy in patients with AIS is contraindicated in the following situations because of an increased risk of bleeding, which could result in significant disability or death:

   a. Evidence of intracranial hemorrhage on pretreatment evaluation

   b. History of intracranial hemorrhage

   c. Symptoms or imaging suggest subarachnoid hemorrhage on pretreatment evaluation

   d. Active internal bleeding

   e. Patient / family refusal

   f. Presence of intra-cranial conditions that increase the risk of bleeding, such as intracranial neoplasm, arteriovenous malformation, or aneurysm

   g. Recent (within 3 months) intra-cranial, intra-spinal surgery, or serious head trauma

   h. History of ischemic stroke in previous 3 months

   i. Known aortic arch dissection

   j. Infective endocarditis (increased risk of intracranial hemorrhage)

   k. CT scan: No frank hypodensity, but early ischemic changes (mild to mod) are OK

   l. Blood glucose concentration of < 50 mg/dl or > 400 mg/dl

   m. Bleeding diathesis including, but not limited to:

      i. Platelet count < 100,000/mm3, INR > 1.7, aPTT > 40 seconds, **or** PT > 15 seconds.

      ii. History of warfarin use and an INR > 1.7 or PT > 15 sec

      iii. Administration of heparin within 48 hours preceding stroke onset with an elevated aPTT greater than upper limit of normal at presentation

iv. Who have received a treatment dose of low-molecular-weight heparin within the previous 24 hours

v. Who are taking direct thrombin inhibitors or direct Factor Xa inhibitors, unless the laboratory tests are normal or the patient has not received a dose of these agents for > 48 hours.

n. Current, severe, uncontrolled hypertension. Warning exists for systolic blood pressure (SBP) > 185 and diastolic blood pressure (DBP) > 110. Must be controlled and stabilized prior to thrombolysis.

1. Post-thrombolysis, BP is **be maintained less than 180/105**.bold font here

o. Arterial puncture at a non-compressible site in the previous 7 days.

3. Criteria with warnings (consider risk to benefit):

a. Pregnancy (Category C- consult with obstetrician-gynecologist and, possibly, a perinatologist)

b. Major surgery or serious trauma within previous 14 days

c. Recent (within 21 days) gastrointestinal or genitourinary hemorrhage

d. Recent (within 3 months) acute myocardial infarction (AMI) – Treatment with Alteplase is reasonable if the MI was a STEMI involving the right or inferior myocardium

Notes:

- Physician discretion may result in modification of this list based on clinical knowledge.
- In patients without recent use of oral anticoagulants or heparin, treatment with thrombolytics can be initiated before availability of coagulation test results but should be discontinued if INR is > 1.7 or PT is abnormally elevated.
- In patients without a history of thrombocytopenia, treatment with Alteplase can be initiated before availability of platelet count but should be discontinued if platelet count is < 100,000 mm3.

AFFECTED PERSONNEL/AREAS: *ALL INPATIENT NURSING UNITS, EMERGENCY DEPARTMENT, CT, PHARMACY, LABORATORY, MEDICAL STAFF*

EQUIPMENT:

- Stroke Reference Binder or Stroke Box

- Alteplase (rt-PA), ~~or Tenecteplase (TNK),~~ from pharmacy or Pyxis
- Intravenous infusion pump with non-vented tubing

PROCEDURE:

A. Pre-Treatment:

Nurse responsibilities

1. Identify patients with symptoms of neurological changes or acute stroke based on clinical presentation, positive (+) BE FAST exam, or early notification from pre-hospital personnel.

2. Establish and document the LKWT in a date and time format.

3. Immediately call an RRT, or stroke alert, based on nursing unit. The RRT will contact the responsible physician.

4. RRT or ED registered nurse (based on location of the stroke alert) will accompany the patient to the CT scanner and to final disposition.

5. If in the ED, immediately notify the ED physician.

Note: For additional roles and responsibilities, see Stroke Alert and Acute Care Stroke Management: Emergency Department & Inpatient Units policy.

B. Treatment – thrombolytic administration:

Physician responsibilities

1. Definitive treatment decisions regarding thrombolytics and medical management of the patient will be made by the treating physician, in collaboration with the neurologist or tele-neurologist.

2. Validate inclusion / exclusion criteria

3. Document verbal consent obtained from the patient's family

4. Document education provided to the patient and family regarding the risks and benefits of Alteplase.

5. Review the patient's vital signs and recent medical history

   a. Initiate treatment for blood pressure as needed.

   b. If SBP is 180-230 mmHg or DBP is 105-120 mmHg, suggested treatment is:

i. Labetalol 10 mg IV followed by continuous infusion of 2-8 mg/min, or

ii. Nicardipine 5 mg/hour; titrate up to desired effect by 2.5 mg/hour every 5-15 minutes to a maximum of 15 mg/hour

iii. If BP is not controlled or DBP is > 140 mmHg, consider IV sodium nitroprusside (Nipride)

iv. Other agents, such as Hydralazine, can be considered

6. Final review of thrombolytic dose to be administered, in collaboration with nursing and pharmacy, as appropriate.

   a. Calculate correct dose: rt-PA dosing is 0.9 mg/kg, with a maximum dose of 90 mg. 10% of the dose is given as a bolus over 1 minute and the remaining dose is administered via infusion pump over 60 minutes (1 hour).

   b. OR calculate the correct dosage of TNK, based on scenario. For AIS progressing to mechanical thrombectomy, TNK is given at a dose of 0.25 mg/kg, max of 25 mg. For AIS with minor neurological impairment and no intracranial occlusion, TNK is dosed at 0.4 mg/kg. This is an alternate treatment to TPA, and its safety profile is similar. Thrombolytics are not compatible with dextrose solutions, they must be given with Normal Saline (NS).

7. Participate in the Thrombolytic time out process and sign the time out form.

Nursing Responsibilities:

1. Establish / document accurate patient weight.

2. Perform and document the NIHSS prior to treatment.

3. Alteplase & Tenecteplase are a high alert medication, requiring a 2nd registered nurse to verify:

   a. Right patient, right medication, right dose, right time, and right route.

   b. Ensure infusion is going into the intended channel by physically tracing the line from the solution, through the pump, and to the insertion site.

   c. The infusion pump is programmed at the proper rate, including correct entry of patient's weight.

d. Completion of the thrombolytic pretreatment checklist, found in the ED stroke binder or packet.

4. Prior to administration of the thrombolytic bolus, everyone in the room will participate in a "Thrombolytic Time Out"; an intentional pause to verify:

   a. Right patient

   c. Negative head CT

   d. Home medications have been reviewed with the Alteplase prescriber (physician)

   e. Patient is not taking anticoagulation

   f. Thrombolytic checklist completed

   g. Blood pressure is controlled at or less than 180/105

5. Administer the Alteplase (rt-PA) bolus (10% of dose) over 1 minute, by either slow IV push or via infusion pump. Then administer the remaining dose over 60 min (1 hour) via infusion pump. The infusion should be followed by approximately 50 ml of Normal Saline for infusion. Do not administer in a dextrose-containing solution. Compatible only with NS.

6. Alternatively, administer a single IV bolus of Tenecteplase (TNK) over 5-10 sec. using a peripheral vein. Follow with a NS flush. Do not administer in a line containing a dextrose solution as it is incompatible.

7. Document medication administration.

8. Patient monitoring will be completed in the ED or ICU:

   a. Hypertension management:

9. **Must maintain blood pressure (BP) less than 180 / 105 mmHg to limit the risk of intracranial hemorrhage**

   a. Baseline neuro checks and vital signs will be taken with subsequent neurological (neuro) checks and vital signs every 15 min during infusion and for 1 hour after infusion is complete.

   b. Neuro checks and vital signs every 30 minutes from hour 2 to hour 6.

   c. Neuro checks and vital signs every 1 hour for the remaining 16 hours.

Note: Any patient that receives thrombolytics will be monitored at an ICU level of care for the first 24 hours.

Management of suspected intracranial hemorrhage:

1. Suspect the occurrence of intracranial hemorrhage following the start of the thrombolytic infusion if there is any acute neurological deterioration, new headache, acute hypertension, or nausea with vomiting.

2. If hemorrhage is suspected, do the following:

   a. Discontinue the thrombolytic infusion
   b. Immediately notify the responsible physician and the charge nurse.

   c. Immediate non-contrast head CT, stroke protocol, or other imaging sensitive for hemorrhage.

   d. If ordered, draw blood for CBC, PT, PTT, Fibrinogen, and Type and Cross.

3. If intracranial hemorrhage is present, as ordered by the physician:

   a. Obtain fibrinogen results

   b. Consider administering cryoprecipitate or platelets as needed

   c. Consult neurologist and neurosurgeon as needed to arrange for treatment plan and possible surgical treatment options

   d. Prepare for stat transfer to higher level of care

   e. Also see the Thrombolytic Induced Intracranial Hemorrhage pathway.

C. Post-Treatment:

Complete and document post- thrombolytic infusion NIHSS score by RN at hour 2, hour 8, and at hour 24.

- Neuro checks and vital signs as listed above.

  a. Monitor and control blood pressure – less than 180/105

- Continue to monitor for complications:

  a. Bleeding – major and/or minor:

i. Avoid intramuscular injections and trauma to the patient

ii. Monitor any arterial and venous puncture sites frequently

iii. Gentle teeth brushing

iv. Avoid use of a manual razor for 24 hours

b. Orolingual angioedema or anaphylaxis

i. Has been observed up to several hours after rt-PA infusion, especially in patients receiving concomitant angiotensin-converting enzyme inhibitors.

ii. Treatment:

i) Maintain airway – intubation may be necessary
ii) Discontinue alteplase infusion and hold ACE inhibitors
iii) Administer IV methylprednisolone 125 mg, as ordered
iv) Administer IV diphenhydramine 50 mg, as ordered
v) Administer famotidine 20 mg IV, as ordered
vi) If further increase in angioedema, administer epinephrine (0.1%) 0.3 ml subcutaneously or by nebulizer, 0.5 ml, as ordered.
vii) Infusion of Fresh Frozen Plasma (FFP) may be considered for ACEI – related, or refractory angioedema

c. Cholesterol embolization (rare)

d. Other allergic type reactions – rash, urticaria

- Obtain a follow up CT or MRI 24 hours post-treatment, before starting anti-coagulants or antiplatelet agents.
- Perform nursing swallow screen prior to patient receiving any oral medications, liquid, or food (See policy: Stroke Alert and Acute Care Stroke Management: ED & Inpatient Units).
- If in the ED, provide SBAR (Situation, Background, Assessment, Recommendation) nursing report to accepting nurse, specifying details of thrombolytic administration and current status of neuro checks / vital signs. It is imperative that no vital sign or neuro check is missed.

REFERENCES:

- Demaerschalk, B.M., Kleindorfer, D.O., Adeoye, O.M., et al. (2015). Scientific rationale for in the inclusion and exclusion criteria for intravenous Alteplase in acute ischemic stroke: A statement

for healthcare professionals from the American Heart Association / American Stroke Association. Stroke, 2016;(47), pages 1 – 61. http://stroke.ahajournals.org.

- Genentech (2017). *Emergency assessment of acute ischemic stroke.* USA: Genentech USA.
- Lyden, P. (2016). Using the National Institutes of Health Stroke Scale. Stroke, 2017;(48), downloaded from http://stroke.ahajournals.org/.
- Powers, W.J., Rabinstein, A.A., Ackerson, T. et al (2019). 2019 Update to the 2018 guidelines for the early management of patients with acute ischemic stroke: A guideline for healthcare professionals from the American Heart Association / American Stroke Association. Stroke, 2019(50), e344-e418. Downloaded from http://stroke.ahajournals.org/.)
- UpToDate (2020). Tenecteplase: drug information. Retrieved from: https://www.uptodate.com/contents/tenecteplase-drug-information?topicRef=115775&source=see_link#F228469

CROSS REFERENCES:

- *Stroke Alert & Acute Care Stroke Management: Emergency Department & Inpatient Units* – SVMC Policies and Procedures
- *High-Alert Medications and Look Alike Sound Alike Medications* – SVMC Policies and Procedures

ATTACHMENT A

Reconstitution and administration of Alteplase (rt-PA).

Reconstitution should be carried out using the transfer device, the 100 ml vial of sterile water for injection, and the contents of the 100 mg vial of Alteplase (rt-PA) powder provided, according to the package instructions (detailed below). Slight foaming upon reconstitution is not unusual; large bubbles usually dissipate if the vial is left standing undisturbed for a few minutes. **100 mg vials do not contain vacuum.**

a. 100 mg vial reconstitution (Dilution = 1 mg / 1 ml)

b. Use aseptic technique throughout.

c. Remove the protective flip-caps from the vial of rt-PA and the vial of sterile water for injection, USP.

d. Open the package containing the transfer device by peeling the label off the package.

e. Remove the protective cap from one end of the transfer device and, keeping the vial of sterile water upright, insert the piercing pin vertically into the stopper on the vial of sterile water.

f. Remove the protective cap from the other end of the transfer device. **DO NOT INVERT THE VIAL OF STERILE WATER.**

g. Holding the vial of rt-PA powder upside down, position it so that the center of the stopper is directly over the exposed piercing pin of the transfer device. Remembering **"Clouds over water"** may be helpful.

h. Push the vial of rt-PA down so that the piercing pin is inserted through the center of the rt-PA vial stopper.

i. Invert the two vials so that the vial of rt-PA is on the bottom (upright) and the vial of sterile water is upside-down, allowing the sterile water to flow into the rt-PA vial via the transfer device. Approximately 0.5 ml of sterile water will remain in the diluent vial.

Remembering to **"Make it rain"** may be helpful.

j. Remove the transfer device and empty vial of sterile water from the rt-PA vial. Safely discard the transfer device and empty diluent vial.

k. ***Swirl gently to dissolve the rt-PA powder.*** **DO NOT SHAKE!**

l. No other medications should be added to infusion solutions containing rt-PA. It should be infused through a dedicated IV or line port.

ADMINISTRATION (Intravenous only) – After dose is calculated and medication is verified by 2nd RN, as detailed in attached policy.

1. Calculate the volume that will be unused (excess).

2. **Without injecting air**, remove the excess volume from the vial and set aside. DO NOT DISCARD.

3. The bolus dose (10% of the total dose) may be prepared in one of the following ways:

   a. By removing the bolus volume from the reconstituted vial of 1 mg / ml rt-PA using a needle and syringe. The needle should be inserted in the "keyhole port" on the stopper, not the area where the transfer device was inserted. A plastic needle is acceptable. INJECT THE DOSE SLOWLY OVER 1 MINUTE.

   OR

   b. By programming an infusion pump to deliver the appropriate bolus volume over 1 minute, at the initiation of the infusion.

4. The remaining dose is given as follows:

   a. Insert the spike end of a vented infusion set through the same puncture site created by the transfer device in the stopper of the vial of reconstituted rt-PA.

   b. Hang the rt-PA vial from the plastic molded capping attached to the bottom of the vial.

   c. Follow with a 50 ml bag of normal saline to infuse rt-PA completely.

5. Once the infusion is successfully completed, the syringe of excess volume may be discarded.

6. If there are any issues with the infusion, bag the syringe of discarded volume along with the vials of sterile water and rt-PA in a red bag and return to pharmacy with details of the issue.

PRECAUTIONS

1. Use only for ACUTE ISCHEMIC STROKE.
2. Always use an infusion pump.
3. Use vented IV tubing.
4. Account for the amount of drug used to prime the IV tubing when withdrawing excess drug from the vial prior to administration.
5. Use caution for lab draws due to bleeding risk. Use IV lock when possible; avoid drawing through IV used for rt-PA administration.

SUBJECT: **WASTING OR RETURNING CONTROLLED SUBSTANCES**	SECTION: ***Medication Management (MM)*** **Page 1 of 3**

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

PURPOSE: To establish standard guidelines for wasting of controlled substances in accordance with regulations.

POLICY:

1. Upon hire, all Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) will receive training on medication management policies and procedures

2. Upon hire, all Pharmacists and Pharmacy Technicians will receive training on medication management policies and procedures related to how medications are administered, proper wasting, and documentation, and within the unit orientation.

3. After credentialing by Medical Staff Office, (included in medical staff orientation), all licensed independent practitioners will receive training on medication management policies and procedures related to medication ordering, dispensing, administration, wasting and documentation.

4. Unused controlled medications must be disposed of in front of an appropriate witness (see #5) and documented according to policy and procedure (see below).

5. ONLY the following practitioners and employees are authorized to waste and witness the wasting of medications per their scope of practice:

    a. Registered Nurses (RNs)

    b. Pharmacists

    c. Licensed Independent Practitioners (Includes all advanced practice practitioners)

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS- RNs, LVNs, PHARMACISTS, , PHYSICIANS, ANESTHESIOLOGISTS, PAs, NPs, AND CRNAs*

PROCEDURE:

1. Wasted controlled substances will be deposited into the nearest *Cactus Smart Sink®.*

    a. Dispose of any extra medication while being observed by a physically present witness.

2. Solid controlled medications (tablets, capsules) will be wasted into the left hand opening, labeled "Solids Only".

    a. Remove the solid controlled substance from the Pyxis ® Automated Dispensing Cabinet.

    b. Obtain the ordered dose of medication, using the closest unit dose and a clean pill cutter when necessary.

c. Place remaining parts of solid controlled substances or those that have become contaminated into the *Cactus Smart Sink®*.

3. Liquid controlled medications (injectable and oral) will be wasted into the right hand opening, labeled "Liquids Only".

   a. Remove the liquid controlled substance from the Pyxis ® Automated Dispensing Cabinet.

   b. Draw up or pour the ordered dose of liquid medication.

   c. The maximum waste volume permitted in the *Cactus Smart Sink®* is 30mL, which allows for wasting of a complete PCA syringe. Empty the liquid out of the syringe into the receptacle.

   d. Do not insert the syringe or needles.

   e. In the event that the wasted amount is greater in volume than 30mL(for example a 'morphine drip' with 100mL remaining) the following procedure will be followed:

      i. Wasted controlled substance volume remaining, as reflected on the Alaris Infusion Pump, will be witnessed and recorded as the waste amount.
      ii. Note that infusion must remain on the pump until waste amount is witnessed.
      iii. Controlled substance liquid will be witnessed being poured down the drain in the nearest sink.

4. Topical patches (i.e., fentanyl/Duragesic ®, etc.) will be wasted into the center opening slot, labeled "Patches Only".

   a. Fold the used patch, sticky sides together and place over the center opening slot.

   b. Use the provided tool to push the patch into the *Cactus Smart Sink®*.

5. Documentation of witnessed wasted narcotics without visual verification is not permitted and will result in disciplinary action for both parties involved.

   a. For all controlled medication removed from the Pyxis ® with the exception of the PCA and controlled medication infusions such as epidurals or pain management IV drips, waste is documented in the Pyxis ® Automated Dispensing Cabinet with the appropriate witness co-signing the waste.

   b. For all PCA syringes and controlled medication infusions sent up from pharmacy and NOT removed from the Pyxis, the name of the wasted controlled substance and remaining volume will be recorded and co-signed on a Sierra View Medical Center Controlled Substance Log (Pink Sheet).

6. Returning Controlled Medications that were not used to the Pyxis machine

   a. A witness is required to return a controlled substance in Pyxis
   b. Choose the return function
   c. Choose patient name
   d. Choose medication to be returned
   e. Check that the amount that you are returning is accurately reflected on the screen or edit as needed and then select the "accept" button on the Pyxis screen.
   f. Place medication in return slot. Turn the wheel to ensure that the medication drops securely into the return bin. The return bins are labeled to remind users to execute this step.
   g. Pharmacy will run a Return Bin Activity Report twice a day to monitor return activity.

REFERENCES:

- Department of Justice. Drug Enforcement Administration Diversion Control Division. Retrieved September 23, 2019, from https://www.deadiversion.usdoj.gov/21cfr/cfr/index.html.
- Nursing Practice Act.(n.d.). Retrieved September 23, 2019, from http://www.rn.ca.gov/practice/npa.shtml.
- Title 22 (n.d.).Retrieved on October 11 2022, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCE:

- Controlled Substances Policy

SUBJECT:	SECTION:
ZOSYN EXTENDED INFUSION	*[Enter manual section here]* 4 **Page 1 of 5**

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

PURPOSE:

This policy aims to optimize our economic and clinical outcomes with prolonged piperacillin-tazobactam (Zosyn) infusions in patients suspected of infections, and specifically in patients with a confirmed pathogen & elevated MIC (16mg/L). The purpose is also to educate staff that this is a widely accepted and utilized protocol with extensive literature support in terms of the maximization of bactericidal activity by prolonging the infusion period.

DEFINITIONS:

1. MIC- Minimum Inhibitory Concentration
2. Intermittent Infusion- infusion lasting 30 to 60 minutes
3. Extended Infusion- infusion lasting 3 to 4 hours

POLICY:

A. The goal of this policy is to outline procedure for ordering & administration of Pipercillin-Tazobactam (Zosyn) at SVMC.

   1. Define parameters for automatic substitution for extended infusions.

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

EQUIPMENT:

- Pipercillin-Tazobactam
- Infusion Pumps

PROCEDURE:

A. Ordering in CPOE

   1. Any order for Pipercillin-Tazobactam will default to the extended infusion regimen, with the exception of one-time orders in the Emergency Department (ED), Operating Room/Post Anesthesia Care Unit (OR/PACU), Pediatrics, and ambulatory care areas.

      a. The intermittent infusion orders will be restricted to PHA (Pharmacy). Providers will be allowed to order intermittent infusions, but must note applicable exclusion criteria from exclusion table provided in this policy.

      b. First doses will default to the one-time 30 minute infusion to prevent a delay in care, while future maintenance doses will be adjusted to extended infusions.

B. Pharmacist Verification

1. Pharmacists will review each order to confirm no normal exclusion criteria exist for treatment. (Allergies, indication, drug interactions etc.)

2. With no objection to medication selection, the pharmacist will then proceed with automatic interchange protocol by adjusting to extended infusion so long as the patient/order does not meet any exclusion criteria.

3. The pharmacist will also be responsible for automatic dosage adjustment for Renal Dose Adjustment as defined in Dosing Recommendations Table.

4. In the event that a pharmacist finds the extended infusion regimen cannot work for a particular patient, they may adjust to intermittent infusion without physician order, but must document the intervention in the electronic medical record (EMR).

5. Timing of the regimen will also be done in a manner to avoid overlap with other IV medications with compatibility issues, if appropriate. (See Zosyn Compatibility Sheet)

C. Dosing Recommendations

1. Pharmacists will be responsible for addressing & adjusting a patient's dose with extended infusions following the dosing chart below.

Renal Function	**CrCl > 40 ml/min**	**CrCl 20-40 ml/min**	**CrCl < 20 ml/min**	**IHD, PD**	**CRRT**
Intermittent Dosing (30-min infusion)					
General	3.375 IV Q6H	2.25 gm IV Q6H	2.25 gm IV Q8H	2.25 gm IV Q12H	3.375 gm IV Q6H
Pseudomonas/ nosocomial PNA/CF	4.5 gm IV Q6H	3.375 gm IV Q6H	2.25 gm IV Q6H	2.25 gm IV Q8H	
Extended-Infusion Dosing (4-hour infusion)†					
General, Pseudomonas, nosocomial PNA,CF	3.375 gm IV Q8H (4.5g IV Q8H in select populations*)		3.375 gm IV Q12H	3.375 gm IV Q12H	3.375 gm IV Q8H*

* In select cases, more intensive Zosyn® dosing may be warranted, e.g. critically ill patients with severe or deep seated infections, infections with MIC > 16

D. Criteria for Exclusion

1. Orders for Pipercillin-Tazobactam originating from the ambulatory clinics, pre-op OR/PACU doses, or Emergency Department pre-admission orders.

2. Patients less than 18 years of age.

3. When there are unresolvable conflicts with scheduling and/or compatibilities with other medications that cannot be resolved by placing additional lines.

4. If there are other non-pharmaceutical interventions that would be unable to be performed as a result of the prolonged infusion. (i.e., physical therapy)

5. Patients that are already on a prolonged course of antibiotics that are clinically improving, AND organism has MIC < or equal to 4.

E. Nursing Role & Administration

1. It is recommended to have a dedicated line for administration of Pipercillin-Tazobactam, to resolve compatibility issues, but this is not required.

2. Follow Medication Administration Guidelines as per SVMC policy.

3. Contact the pharmacist if the patient's access is limited and/or concerns with compatibility issues.

4. Be able to use Lexicomp/Uptodate for reference of IV compatibility.

REFERENCES:

- Drusano GL. Antimicrobial pharmacodynamics: critical interactions of 'bug and drug'. *Nature reviews. Microbiology.* Apr 2004; 2(4):289-300.
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- Lodise TP, Jr., Lomaestro B, Drusano GL. Piperacillin-tazobactam for Pseudomonas aeruginosa infection: clinical implications of an extended-infusion dosing strategy. *Clinical infectious diseases: an official publication of the Infectious Diseases Society of America.* Feb 1 2007; 44(3):357-363.
- Roos JF, Bulitta J, Lipman J, Kirkpatrick CM. Pharmacokinetic-pharmacodynamic rationale for cefepime dosing regimens in intensive care units. *The Journal of antimicrobial chemotherapy.* Nov 2006; 58(5):987-993.
- Bauer KA, West JE, O'Brien JM, Goff DA. Extended-infusion cefepime reduces mortality in patients with Pseudomonas aeruginosa infections. *Antimicrobial agents and chemotherapy.* Jul 2013; 57(7):2907-2912.

- Lomaestro BM, Drusano GL. Pharmacodynamic evaluation of extending the administration time of meropenem using a Monte Carlo simulation. *Antimicrobial agents and chemotherapy.* Jan 2005; 49(1):461-463.
- Kuti JL, Dandekar PK, Nightingale CH, Nicolau DP. Use of Monte Carlo simulation to design an optimized pharmacodynamic dosing strategy for meropenem. *Journal of clinical pharmacology.* Oct 2003; 43(10):1116-1123.
- Kays MB B, DS, Denys GA. Pharmacodynamic evaluation of six beta-lactams against recent clinical isolates of Pseudomonas aeruginosa using Monte Carlo analysis [abstr]. *Program and abstracts of the 42nd interscience conference on antimicrobial agents and chemotherapy.* 2002.
- Ariano RE, Nyhlen A, Donnelly JP, Sitar DS, Harding GK, Zelenitsky SA. Pharmacokinetics and pharmacodynamics of meropenem in febrile neutropenic patients with bacteremia. *The Annals of pharmacotherapy.* Jan 2005; 39(1):32-38.
- Kim A et al, Optimal Dosing of Piperacillin-Tazobactam for the Treatment of *Pseudomonas aeruginosa* Infections: Prolonged or Continuous Infusion?*Pharmacotherapy* 2007;27(11):1490–1497
- Mui, Emily, Medication Administration: Extended-Infusion Pipercillin/Tazobactam (Zosyn) Protocol, *Standford Health Care (Pharmacy Department Policy)* Mar 2015; 1-7.
- Rhodes NJ et al, Impact of loading doses on the time to adequate predicted beta-lactam concentrations in prolonged and continuous infusion dosing schemes, *Clin Infect Dis*. 2014 Sep 15;59(6):905-7
- Trissel, L.A. *Handbook on Injectable Drugs16th Edition*. Bethesda, Maryland: American Society of Health-System Pharmacist, 2011. Print
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- Moehring, R. Sarubbi, C. Prolonged infusions of beta-lactam antibiotics. Accessed October 11, 2022. https://www.uptodate.com/contents/prolonged-infusions-of-beta-lactam-antibiotics/print?search=zosyn&source=Out%20of%20date%20-%20zh-Hans&selectedTitle=4~86

CROSS REFERENCE:

- Medication Administration

Indications for Use

- Triglycerides >1000 mg/dL with or without acute pancreatitis
- If DKA or HHS present, use ICU - IV Insulin for DKA/HHS order set

General Nursing

☐ Obtain baseline blood glucose value prior to initiating insulin or dextrose

Notify Provider

☐ If blood glucose falls below 70 mg/dL, hold insulin, initiate hypoglycemia treatment, restart IV insulin at 50% of the previous rate when blood glucose is >100 mg/dL

Condition Specific Medications

IV Insulin

Start insulin at 0.1-0.2 units/kg/hr. If triglycerides do not decrease, consider increasing rate by 0.05-0.1 units/kg/hr. Insulin infusion should be stopped when triglyceride levels are <500 mg/dL.

☐ **Insulin regular (HumuLIN-R) IV infusion**
0.1 units per kilogram per hour
* Do not titrate. Modification of order required for dose changes*

☐ **Insulin regular (HumuLIN-R) IV infusion**
0.2 units per kilogram per hour
* Do not titrate. Modification of order required for dose changes*

Dextrose Continuous Infusion

☐ **Dextrose 10% infusion**
Use the titration schedule below to determine rate

Blood Glucose	Rate
70-100 mg/dL	250 ml/hr
101-140 mg/dL	150 ml/hr
141-180 mg/dL	125 ml/hr
181-240 mg/dL	75 ml/hr
>240 mg/dL	Hold

Hypoglycemia Treatment (default checked)

Hypoglycemia management for BG <70
For patient with IV access administer D50, if IV access is not available administer Glucagon

☐ **Dextrose 50% solution 12.5 grams**
12.5 g, intravenous, every 15 min prn, low blood sugar, for blood sugar between 50 mg/dL and 69 mg/dL

☐ **Dextrose 50% solution 25 grams**
25 g, intravenous, every 15 min prn, low blood sugar, for blood sugar less than 50 mg/dL

☐ **Glucagon injection 1 mg**
1 mg, intramuscular, daily prn, low blood sugar, for blood sugar less than 70 mg/dL

PO Medications
Start when patient is able to tolerate oral medications

☐ **Gemfibrozil**
600 mg PO twice daily 30 minutes before breakfast and dinner

☐ **Fenofibrate**
145 mg PO once daily

Labs
☐ Serum triglycerides every 12 hours
☐ Glucose fingerstick POCT every hour
☐ Potassium levels every 8 hours

Senior Leadership Team	1/24/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	1/24/2023

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
January 24, 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. Access to Personnel File	1-2	
2. Approval Matrix	3-9	
3. Compliance Auditing and Monitoring	10-12	
4. Employee Education Assistance	13-21	
5. Gift and Business Courtesies, Exchange of	22-26	
6. Just Culture	27-31	
7. Non-Retaliation Compliance Issue Reporting	32-34	
8. Professional Courtesy Discount	35-36	
9. Risk Management Plan	37-42	
10. Sanction Screening	43-46	

SUBJECT:	SECTION:
ACCESS TO PERSONNEL FILE	***Human Resources Dept.***

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

PURPOSE:

To ensure confidentiality of personnel files and compliance with applicable law by defining the conditions under which current and former employees and/or employee representatives may review personnel files.

Personnel files are maintained and kept secure by the Human Resources Department. Current employees and former employees who have been terminated for three (3) years or less and/or an employee representative designated in writing by the employee(s) may have access to personnel file information as defined below. Legitimate accrediting bodies, when they are in the process of their appropriate functions, may have access to personnel files at the direction of the Vice President (V.P.) of Human Resources or designee.

POLICY:

1. All current employees and former employees who have been terminated for three years (3) or less and/or an employee representative designated in writing by the employee(s), have access to the contents of their personnel file except for letters of reference, and investigatory information regarding a possible criminal offense. The following guidelines apply when requesting access:

    a. Advance written notice with signed authorization must be provided by the employee and/or his/her designated representative to the Human Resources Department.

    b. Record requesting to be copied and provided to the employee will be available within a reasonable timeframe not to exceed thirty (30) days of receiving a request.

    c. The inspection of the personnel file by the employee and/or former employee will be in the presence of a Human Resources Department staff member within the Human Resources Department or designated area.

    d. Copies of the personnel file may be provided at the requesting party's expense. Copies of documents that an employee signed to obtain or retain employment will be provided free of charge. (e.g. job applications, signed employee evaluations).

    e. The Hospital is not obligated to comply with more than 50 requests for inspections or copies of personnel files filed by representative(s) of employees per calendar month.

    f. The Hospital will provide one copy per year of personnel records requested by a former employee and one time to inspect o his or her personnel records per year.

2. At no time is custody of the personnel file relinquished by the Human Resources Department unless requested by a legitimate accrediting body or if otherwise required to do so by law.

3. Former employees whose employment has been terminated more than three (3) years may not access their personnel files.

4. Outside Parties: No information or document from any personnel file will be released to any outside party without the written authorization and consent of the employee, unless required by law and requested in a lawful manner. In such cases, the employee will be notified.

CONFIDENTIALITY

Employee medical records shall be considered confidential and will be maintained in a file separate from the employee's personnel records.

RETENTION OF PERSONNEL FILES

It is the policy of this facility to retain current personnel files for the duration of employment. When the employment status is terminated, the file will be retained in the "terminated" files for a period of time no less than three (3) years. Personnel files may not be destroyed or removed from storage areas without the written authorization of the V.P. of Human Resource and/or CEO.

OWNERSHIP OF PERSONNEL FILES

Ownership of all personnel files maintained by the Human Resources Department is that of the facility. No personnel file is to be removed from the Human Resources Office without approval of the V.P. of Human Resources and/or CEO. No personnel file will be removed from the premises unless approved by the CEO.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- State of California Department of Industrial Relations (20122. Personnel Files and Records. Retrieved from https://www.dir.ca.gov/dlse/FAQ_RightToInspectPersonnelFiles.htm.

CROSS REFERENCES:

- Employee Right to Privacy
- Applicant References and Request for References

Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

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

CORRESPONDENCE TO THE BOARD

INVOLVED/REPORTING PARTY	DELEGATE RESPONSIBILITY/RESOLUTION TO
Board of Directors	Board or Fair Political Practices Commission
CEO	Board
Community members (non-patient/family)	Board
Contracted Entity and/or Vendors	CEO and Chief of Staff (if involving Medical Staff members)
Employee	Human Resources
Foundation	CEO
Medical Staff Independent Contractor	Chief of Staff and CEO (if involving hospital operations)
Medical Staff employed by Contracted Entity	Contracted Entity and/or Chief of Staff and/or CEO
Patient/Patient Family	Patient Grievance Committee
Senior Leadership Team	CEO
Volunteers/Chaplain Assistants	Human Resources

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

Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
ARTICLES AND BYLAWS			
Amend articles, bylaws, or other governing documents	Approve	Recommend to Board	
Amend bylaws of Volunteer League	Approve	Recommend to Board	Develop in consultation with others
Amend bylaws of Foundation Boards	Approve	Recommend to Board	Develop in consultation with others
STRATEGIC DEVELOPMENT AFFILIATIONS/ACQUISITIONS			
Acquisition arrangements	Approve	Recommend to Board	Participate in consultation with others.
Management contract (entire health care facility)		Approve	
A. Annual aggregate capital commitment is budgeted	Approve	Recommend to Board	Recommend Contract
B. Annual aggregate capital commitment is unbudgeted	Approve if >$500,000	Approve if under $500,000 Recommend if over $500,000	Recommend Contract
Lease of health care facility with annual aggregate financial commitment over specified amount where SVMC is either landlord or tenant	Approve if > $500,000	Approve if under $500,000 Recommend if over $500,000	Develop lease and/or contract
Partnership/ LLC/ Joint Venture	Approve	Recommend to Board	Participation in consult with others
Formation of new legal entities that involve major work	Approve	Recommend to Board	Participation in consult with others
STRATEGIC PLANNING			
Strategic Plan	Approve	Recommend to Board	Develop in consultation with others

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Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
Annual goals and objectives	Approve	Recommend to Board	Develop goals and objectives
Comprehensive master plan and annual program development plans	Approve	Recommend to Board	Develop in consultation with others
PROGRAMS AND SERVICES			
Establish/change names of system and corporations	Approve	Recommend to Board	Develop recommendation
Initiation or closure of major work	Approve	Recommend to Board	Develop recommendation
Construction Budget of Master Plan approval	Approve Annual & all projects >$500,000 unbudgeted	Recommend to Board	Develop recommendation
CORPORATE RESTRUCTURING			
Dissolution, liquidation, consolidation or mergers of corporations or other legal entities	Approve	Recommend to Board	Develop plan.
FINANCE			
Debt authorization (including loan guarantees)	Approve	Recommend to Board	Develop
Long range financial plan (LRFP)	Approve	Recommend to Board	Develop
Unbudgeted expenditures	Approve >$500,000	Approve <$500,000	Recommend Project Initiation Document
Cumulative substitutions of capital	Approve if over $1M	Recommend to Board	Develop
Sale of property	Approve	Recommend to Board	Develop
Purchase of Property(Limited to geographic area: West Oak from Jaye Street to North Sinarle Place; Sinarle Place between West Oak and West Garden; West Garden from Sinarle Place to Jaye Street;	Ratify and approve all purchases up to $500,000 or approve over the $500,000	Approve up to $500,000 (Ref. Resolution 02-25-2020/01)	Participate

Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
West side of Jaye Street from West Oak Street to half way between Garden Street and Olive Avenue.			
Appointment of External System Auditor	Approve/Appoint	Recommend to Board	Participate
External Audit Report	Approve	Recommend to Board	Participate
Divesture of Services/Department	Approve	Recommend to Board	Participate
QUALITY/MEDICAL STAFF			
SVMC Quality Principles, Performance Metrics and Plan	Approve	Recommend to Board	Develop
Annual Summary Report on Delegated Governance Responsibilities	Approve format and review annual Quality Performance Improvement Plan. Facility Annual Plan Review and Proposed Plans.	Recommend to Board	Present to the Board
Annual Plan Review & Proposed Plan: Provision for Patient Care, Infection Prevention, Utilization Management, Risk, Performance Improvement, Med Error, Emergency Operations Plan & Life Safety Management Plan Annual Plan Review & Proposed Plan	Approve	Recommend to Board	Present to the Board
Quarterly Compliance, Marketing, Patient Experience Reports	Approve	Recommend to Board	Present to the Board
Annual Human Resources, Nursing Summary Reports	Approve	Recommend to Board	Present to the Board
Medical Staff bylaws/amendments	Approve		
Medical Staff Appointments	Approve		
Medical Staff Credentialing and Privileges	Approve		

Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
Medical Staff disciplinary matters	Approve/Summarily suspend in accordance of Governing Bylaws	Summarily to suspend in accordance to Governing Bylaws.	
Grievances Review	Delegated to Grievance Committee	Participate	Participate/Approve Actions
Joint Conference Committee	Approve	Recommend to Board	Participate
MANAGEMENT STRUCTURE			
Appoint/ Remove President/CEO (and receive copy of annual evaluation	Appoint/Remove		
Appoint/Remove all Vice Presidents		Approve	
Appoint/Remove Directors			Approve
HUMAN RESOURCES			
Performance Merit Program	Approve	Recommend to Board	Develop
Administer Performance Merit Program		Approve	Manage
Employee Benefits:			
A. Retirement	Approve	Recommend to Board	Manage
B. Employee Benefits		Approve	Develop
C. Executive Benefits	Approve	Recommend to Board	Develop
Changes in overall compensation philosophy	Approve	Recommend to Board	Develop

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Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
Compensation policies and procedures Establish wage and salary structure and:			
A. Executive Management	Approve	Recommend to Board	Develop
B. Leadership Development and Succession planning and processes		Approve	Develop
C. Employee's		Approve	Develop
Major system-wide human resources policies and procedures	Approve	Recommend to Board	Develop
Union/Agency shop, other precedent setting language – Employer Resolution	Approve	Recommend to Board	Develop
INSURANCE/RISK MANAGEMENT			
Level of risk assumption in insurance program		Approve	Participate & Recommend
Policies and guidelines for insurance coverage		Approve	Participate & Recommend
Claims/Litigation			
General/Professional Insurance (Malpractice)/Workers Comp:			
A. Accepts or Rejects Claims or Suits	Approve	Recommend to Board	Participate & Recommend
B. Settlements over $200,000	Approve	Recommend to Board	Participate & Recommend
C. Settlements under $200,000		Approve	Participate & Recommend
Commercial litigation/uninsurable settlements			
A. Over $200,000	Approve	Recommend to Board	Participate & Recommend

Sierra View Medical Center

Shared Governance and Management Authority and Responsibility Matrix

FUNCTIONS	BOARD OF DIRECTORS	CEO	SENIOR MANAGEMENT
B. Under $200,000		Approve	Participate & Recommend
Initiation of Claims or Suits		Approve as prosecuting authority.	Participate
Contracts/Leases			
A. Managed Care/Third Party payer agreements		Approve or delegate to CFO	CFO Approve
B. Lease or purchase of medical or other equipment and supplies with a total value in excess of $500,000 per contract/purchase order		Approve or delegate to CFO	CFO Approve
C. Real Estate purchases/sales/leases	Approve	Recommend to Board	Recommend & Develop transaction
D. Hospital or Health System/ Physician agreements		Approve	Recommend
E. Information service / technology agreements in excess of $250,000	If unbudgeted	Approve if budgeted	Develop
F. Management agreements	If unbudgeted	Approve if budgeted	Develop
G. Service agreements	If unbudgeted	Approve if budgeted	Develop
H. Consulting agreements	If unbudgeted	Approve if budgeted	Develop
COMPLIANCE			
Compliance policies and procedures & program	Approve	Recommend to Board	Develop

Decision Matrix – Terms and Definitions

Approve – endorse, support and agree

Develop – create, draft

Consult – confer with; seek advice from, prior to decision

Participate – actively create

Recommend – propose, suggest

Senior Team Approval:

Board of Directors Approval:

Revised: 9/8/2020

SUBJECT: **COMPLIANCE AUDITING AND MONITORING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish the manner by which Sierra View Medical Center (SVMC) will effectively and efficiently audit and monitor identified risk areas related to federal, state and local laws and regulations, as well as organizational policies, procedures, and standards of conduct.

POLICY:

The Compliance Officer (CO), and leadership, shall be responsible to ensure that ongoing auditing and monitoring is properly executed, documented, and evidenced in accordance with the OIG auditing standards.

DEFINITIONS:

Monitoring: Day to day observance to ensure processes and procedures are in compliance with laws, regulations and local policies, which should be performed by the process owners.

Auditing: An objective, independent and formalized measure of compliance with either a procedure or outcome. Focus should be on areas of inherent or residual risk.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. Department directors, managers and supervisors are charged with the responsibility of monitoring all their departmental processes and procedures for compliance.

2. The CO and/or Compliance Committee will recommend and facilitate auditing and monitoring of identified risk areas (with emphasis on auditing). Risk areas may be identified through the regular course of business, external alerts, or internal reporting channels. Special attention will be given to the annually released Office of Inspector General's (OIG) Work Plan, which identifies specific topics of most concern to government agencies. Items on the OIG Work Plan which appear most applicable to SVMC will be strongly considered for internal audits.

3. Probe audits should be conducted a minimum of once per quarter (variation may occur based on size/scope of audit). Probe audits are smaller in scale, designed to quickly gauge if a particular process is performing acceptably, as opposed to a robust audit which identifies a more exact error rate. Sample size can vary depending on the risk and impact of having out-of-specification findings, and anticipated outcome. In general, most probe audits in this facility would be well-supported by a sample size of 30.

4. A probe audit producing significant findings will warrant a more robust audit, especially if a payback to the Centers for Medicare and Medicaid Services (CMS) is anticipated. The probe audit should be completely random, with the sample selection performed in such a manner as to prevent bias. Use of the OIG-sponsored "Rat-Stats" program is recommended, or at least its methodology, in determining sample sizes and selecting random samples.

5. Acceptable audit error rates will vary depending on the particular subject, but often a figure of 10% is utilized in the healthcare profession as a maximum allowable limit. In which case, audits producing less than a 10% error rate would require corrective action (reimbursement); performance improvement measures could be enacted, but no further action may be required. For audits producing greater than a 10% error rate, a payback plan would need to be comprehensive and require advice by legal counsel, especially if systematic negligence or criminal conduct is suspected. Significant error rates generally indicate a trend dating back to an earlier point in time. A corrective action plan would be mandatory. In either case, findings of errors will be reported to the responsible director, who will be referred to the Audit Review and Resolution policy for how to implement corrective action.

6. Any audit producing significant findings (resulting in a corrective action plan) shall require a follow-up audit, to be scheduled on a date after corrective action has been performed. The purpose will be to measure the effectiveness of the corrective action. This follow-up audit need not be as robust as the initial audit. Following a significant problem, random audits (sample size = 30) will be conducted once per quarter for at least two consecutive quarters. If the error rate remains at <10% after the first two quarters, the audits can be discontinued.

7. Directors will be primarily responsible for conducting and/or overseeing their own monitoring activities. Audits, however, will generally be performed with direction and guidance from the CO and Compliance Committee, and may involve contracted professionals. The CO will ensure the audits are conducted in accordance with guidelines set forth by the OIG.

8. The CO will verify completion of audits and any corrective action measures arising from them. The CO will also be required to validate corrective measures that address any weaknesses identified by the process.

9. The CO is responsible for regular, periodic reporting, but no less than annually, to the CEO and/or Board of Directors on the general status and outcome of compliance auditing and monitoring.

REFERENCES:

- U.S. Department of Health & Human Services. (July 2018). *Audit Protocol*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/protocol/index.html.

CROSS REFERENCES:

- Compliance Reviews and Assessments
- COMPLIANCE PROGRAM/PLAN

SUBJECT: **COMPLIANCE AUDITING AND MONITORING**	SECTION: **Page 3 of 3**

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

SUBJECT: **EMPLOYEE EDUCATION ASSISTANCE**	SECTION:

PURPOSE:

To define the process by which eligible employees may receive education assistance or reimbursement for tuition for approved academic programs or courses and to encourage employee self-development.

To provide employees with support for outside education and/or certification that will enhance competency within an employee's present Sierra View Medical Center (SVMC) position or offer growth toward a SVMC position to which an employee may transfer or progress in the future.

POLICY:

A. Sierra View Medical Center (SVMC) encourages the development of an educated, highly skilled workforce. Each fiscal year, funds will be budgeted for Education Assistance purposes. SVMC reserves the right of fund discretion.

B. Education Assistance should be considered as a privilege rather than a right of a staff member. If Educational Assistance is approved, it will be considered as an interest-free loan and will be forgiven when the staff member has met the required work time payback and/or other criteria as outlined in this policy.

C. Approved courses: Courses must be academic courses toward an undergraduate degree or higher level and not continuing education units (CEU), workshops, or general education classes.

D. Approved certifications are awarded by a national, professional organization. The certification awarded denotes that the participant possesses a minimum educational level, licensure and experience, plus additional knowledge, skills, or competencies.

DEFINITIONS:

1. Academic courses: Courses taught by education institutions for which credit may be given towards a degree, or approved certificate.

2. Professional certifications: Certifications address a professional body of knowledge, which typically has been defined in a scope and standards of practice. Professional certification is a voluntary process by which a non-governmental body grants time-limited recognition and use of a credential to individuals who have demonstrated that they have met predetermined and standardized criteria for required knowledge, skill, or competencies. The certification is available at a national level (i.e., it is not a state-based or system-based certification). Skill-based and technical certificates or provider cards such as Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Program (NRP), etc., do not meet this requirement.

AFFECTED AREAS/PERSONNEL: *ALL ELIGIBLE SVMC PERSONNEL*
(RESIDENTS: REFER TO YOUR SPECIFIC GME RESIDENCY POLICIES.)

PROCEDURE:

A. Academic Course Selection, Approved Schools & Professional Organizations

1. Education institutions approved for this program may include any accredited public or private secondary school, university, scientific or technical institute, vocational, correspondence, extension, or business school. Online programs offered by these institutions are also acceptable.

2. Correspondence courses given by an accredited school may be included.

3. Recognized professional organizations offering concentrated courses of instruction are acceptable. Conference or conventional activities are NOT included.

4. Employees receiving college credit by challenge exam for a course that would have been approved for tuition assistance may submit proof of credit and receive reimbursement for the challenge examination fee with the same limits as applied to regular course work.

5. Certifications must be attained from a professional certification program.

6. Courses and Certifications must meet one or more of the following criteria:

   a. Provide/demonstrate particular knowledge, skills, or competencies directly applicable to present position

   b. Prepare an individual for career advancement at SVMC

   c. Be a required part of a degree program which is directly applicable to present position or area of work

   d. Prepare an individual for another position within SVMC

B. Eligibility

1. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance based on their course of study. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying to the employee education assistance program.

2. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance (reimbursement) for a first-time (one time only) completion of a qualified professional certification. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying.

3. Employees must remain in full time status throughout the time taking courses and during the work payback period.

4. Employees will be disqualified from the Education Assistance Program and any monies paid in assistance by SVMC must be repaid by the employee if any of the following occur:

   a. Grade below "C" or "Fail" if "Pass/Fail" for any course work or a withdrawal from a course

   b. A grade of "incomplete" will be considered a "Fail" if not corrected within 60 days of the end of the course

   c. An overall rating below 2% of eligible points on their most recent work performance evaluation

   d. Is within the Disciplinary Action Process and has received a written warning or higher

   e. Any type of Personal Leave of Absence (PLOA) from SVMC during the school term

   f. Termination of employment prior to completion of the course work and/or prior to submitting grades and receipts

   g. Changes to less than full time employment status.
   h.

5. If the employee terminates employment and/or is disqualified from the Education Assistance Program for any reason, he/she will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the work payback period as defined below in Section C.2.

6. SVMC has the right to select applicants based on the course of study and their tenure with SVMC. (See Education Assistance Programs available on page 7-8.)

7. SVMC Nursing School with Unitek: Per Diem and Full-Time employees are eligible for sponsorship after 6 months of hire, at the time of application ($10,000 per year, up to 3 years if attend all three years towards a BSN degree, OR, Per Diem and Full-Time employees after 6 months of hire, prior to submitting an application, of tuition reimbursement up to 3 years in the BSN program. Grades have to be consistently at the "C" level or better to receive sponsorship or tuition reimbursement. SVMC reserves the right to determine the number of sponsored and tuition reimbursement selected students for each cohort.

C. Application Process for Educational Assistance - Degree

1. Staff must apply for assistance and complete the *Education Assistance Application Form* available in Education Department.

2. Employees applying for the program must agree to a work payback period for SVMC for no less than 12 months for each year reimbursed but not more than 12 months after receiving reimbursement.

3. Applications will be accepted twice per year in the months of May and November.

4. Employees who terminate or are terminated from employment with SVMC for any reason before the required work payback time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

5. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

6. The *Contingent Repayment Authorization Form* must be signed by the employee at the time tuition reimbursement is distributed.

7. The Education Coordinator will forward copies of the *Contingent Repayment Authorization Form* as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

8. The *Employer Provided Educational Assistance Form* must be signed by the employee and Director upon application for Education Assistance. The Department Director is responsible for identifying the job-related or non-job-related areas. This form must be sent with the *Education Assistance Application Form* to the Education Department. Federal and Social Security taxes will be deducted from the reimbursed amount for those courses which are non-job related.

9. The *Education Assistance Application Form* must be completed and signed by the staff member's Department Director with a letter of recommendation and forwarded to the respective Vice President (VP) for signature before routing to the Education Assistance Committee for final approval and processing.

10. Applicants will be required to indicate their education goals.

11. The Director and respective VP have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

12. Requests for tuition reimbursement will be considered for any coursework completed within the last six months of the application deadlines.

13. SVMC School of Nursing with Unitek – prospective student must register with Unitek College. Options for selecting sponsorship or tuition reimbursement is part of the registration process. The SVMC Education Department has additional templates and documents for prospective students to use in the application process to SVMC.

D. Approval Process for Professional Certification Reimbursement:

1. Staff planning on sitting for national professional certification must submit a request for reimbursement and receive approval from their Director and the Selection Committee. If staff have already taken a certification exam, they will still be considered for reimbursement if they have taken the exam within 6 months from submitting for reimbursement.

2. Only one time/first time certification will be reimbursed. Certification renewal fees are not reimbursable.

3. The Director and respective Vice President have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

4. Employees requesting reimbursement for a professional certification must agree to a work payback period for SVMC for not less than twelve (12) months.

5. Employees who terminate or are terminated for any reason before the required work time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

6. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

7. The *Contingent Repayment Authorization* must be signed by the employee at the time tuition reimbursement is distributed.

8. The Education Coordinator will forward copies of this form as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

9. SVMC School of Nursing with Unitek – SVMC will use a grading rubric, documents submitted from the student, along with a personal interview in the decision-making process for sponsored and tuition reimbursement. Sponsored and Tuition Reimbursement programs required a 1:1 year of payback working at SVMC full-time after graduation. Failure to finish the program and graduate, will be a required payback of any financial assistance/support to SVMC

E. Department Director Responsibility

1. In determining whether to approve a request for tuition/certification reimbursement, Department Directors and Vice Presidents will consider the necessity of the "Job Enhancement", the priority of the position to be achieved, as well as the length of service of the staff member (minimum of 12 months) and their job performance and/or attendance.

2. A letter of recommendation for degree completion (not certification reimbursement) written by the Department Director must accompany the employee's application when forwarded to the respective VP or Employee Education Assistance Committee (EEAC) for review.

3. Department Directors will notify staff that has been denied eligibility due to these factors.

F. Employee Education Assistance Committee (EEAC)

1. The EEAC shall consist of the following members:

   a. Vice President of Finance

   b. Vice President Patient Care Services

   c. Vice President of Human Resources

   d. Director of Nursing Education

2. The EEAC will be responsible for reviewing all applications presented looking at the following factors:

   a. Completeness of application packet

   b. The nature and purpose of the course of study

   c. The benefits to be derived by the staff member and by the District

3. Only those applications with all required information will be considered.

4. The EEAC will make the decision for final approval prior to processing.

   The Education Department will notify the employee and the employee's Department Director of the EEAC's decision.

G. Reimbursement

1. At successful completion of their course of study, and after receiving approval from the EEAC, staff members must submit receipts for approved expenses to the Education Department for reimbursement.

NOTE: Employees will only receive reimbursement upon successful completion of the course or first time approved certification.

2. The Education Department will then ensure that reimbursement is based upon actual receipts that are attached to the original form and forwarded for processing.

3. Costs excluded from the program are:

   a. Insurance

   b. Seminars and conventions

   c. Institutions/programs not approved by the District

   d. Report preparation

   e. Supplies (i.e., pens, pencils, calculators, recording devices, notebooks, etc.)

   f. Uniforms

   g. Transportation/mileage

   h. Parking expense

   i. Meals and lodging

   j. Skill-based and technical certificates or certification tuition such as ACLS

4. After successful completion of EACH grading period with a course grade, or passing a "pass-fail" course, or completion of a recognized professional certification, the staff member will submit the transcript of the grades received or copy of the certification and receipts to the Education Department.

   a. Future reimbursement will not be made until this information is received

   b. Anything lower than a grade of "C", "Fail", or "Incomplete" will not be reimbursed

5. To be eligible for reimbursement, the receipt must be turned in within thirty (30) days after completion of the course, or it will not be paid.

6. The Education Department will submit a Check Request to the Accounting Department along with the required supporting documents to have a check issued as follows:

   a. If the courses or certification exam taken were job-related, so that there are no payroll deductions, separate checks will be sent to the employee's Department Director for distribution to the employee

   b. If the courses or certification exam taken were not job-related, or otherwise subject to payroll deductions, the reimbursement money will be included in the employee's bi-weekly payroll check

Note: All checks will be processed according to current Accounts Payable and Payroll Policies and Procedures.

H. Miscellaneous

1. Class attendance, completion of study assignments, and certification exam preparation will be accomplished outside of the staff member's regularly scheduled working hours.

2. It is expected that educational activities/preparation will not interfere with the staff member's work. However, exceptions will be decided on a case-by-case basis by the respective Department Director and VP.

3. Any unsatisfactory job performance or attendance issues during enrollment may result in termination of education assistance, as well as affecting the individual's employment status, as it would for employees who are not receiving educational assistance.

4. Employees will be reimbursed for up to 2 years maximum for an undergraduate degree and up to 2 years maximum for a graduate degree and higher. However, in the SVMC School of Nursing with Unitek, the sponsorship or tuition reimbursement is for up to 3-years.

I. Education Assistance Programs Available:

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Bachelors, Masters, Doctorate	Up to $3,000/fiscal year. Last day of course determines which year reimbursement will apply (max 2-years) SVMC School of Nursing with Unitek – Sponsored program for up to 3-years of

	$10,000 or up to 3-years for Tuition Reimbursement program. Requires at least 6 months of FT or PD status prior to application to the program.

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Professional Certification which addresses a professional body of knowledge, defined in a scope and standards of practice.	Up to $500 x one (1) time reimbursement of certification exam fee – First time only!

NOTE: Annual reimbursement of costs are based on a fiscal year and divided into two 6-month periods beginning on July 1st and January 1st.

J. Terms and Conditions

1. It is naturally expected that staff members who have received education assistance will remain with SVMC and will apply their acquired skills and knowledge to improve SVMC's overall performance.

2. A staff member who voluntarily leaves SVMC's employment or who is terminated for cause prior to completing the course or who does not complete their course will be expected to repay monies per contractual provisions.

K. Disclaimer

1. Nothing in this program represents an assurance of continued employment with SVMC.

2. Employment is at the mutual consent of the employee and SVMC and is entirely at will. No one is authorized to modify this Program without the consent of the Board of Directors.

SUBJECT: **GIFTS AND BUSINESS COURTESIES, EXCHANGE OF**	SECTION: **Page 1 of 5**

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

PURPOSE:

To provide limitations and conditions concerning the exchange of gifts and business courtesies from outside sources and Sierra View Medical Center (SVMC) employees and associates. Business and healthcare decisions made by SVMC must be (and appear to be) based on what is best for our patients and consistent with the hospital's mission, vision, and Code of Conduct. Decisions should not be influenced by actions or gestures which promote personal interest or gain.

AFFECTED AREAS/PERSONNEL:

ALL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTORS, AGENTS OF SVMC, AND OTHERS AS MAY BE DETERMINED BY THE BOARD OF DIRECTORS OR CHIEF EXECUTIVE OFFICER (CEO).

DEFINITIONS:

For the purpose of this policy, the following definitions apply:

Gifts: Items having a monetary value exchanged between employees and contractors of SVMC, current or potential vendors, business associates, and patients. Gifts include meals, entertainment, and gift cards.

Gift Cards/Gift Certificates: A gift card or gift certificate for purposes of this policy shall mean that which enables the recipient to select an item in an establishment. This would include store gift cards, such as a $25 Starbucks card.

Credit Gift Cards: A credit gift card for purposes of this policy shall mean that which enables the recipient to select any item in any establishment as though the card or certificate were equivalent to cash, such as temporary Visa, MasterCard or American Express card.

Vendor/supplier of any entity of SVMC: Includes any organization which provides services or supplies to SVMC, any subcontractor to a supplier of any entity of SVMC or any individual who provides services or supplies to any entity of SVMC.

Employee/Volunteer: Includes all regular full-time, part-time, temporary, per-diem, casual per-diem employees and volunteers.

Contractor: A person who performs specific services for SVMC or is employed by a contracted agency to perform specific services for SVMC, in exchange for compensation, per signed agreement, on a per-diem, part-time or full-time basis, and who might otherwise appear as a SVMC employee.

Entertainment: A social event (*e.g.*, a meal, attendance at a sporting or cultural event, participation in a sporting activity) at which business matters are discussed but where it is apparent that the event is not primarily intended as a business meeting. Includes social events arranged by the sponsors of a business event which you are attending.

DECLARATIONS:

1. Gifts received from all vendors, including but not limited to pharmaceutical or medical equipment/supply vendors by SVMC employees or representatives of SVMC: The following are examples of gift limitations:

   a. Acceptance of gifts or favors (during the course of your duties as an employee, agent, volunteer or contractor of SVMC) from any person or entity, with a value in excess of $50.00, is not permitted.

   b. Promotional items may be accepted as long as they are nominal in value ($10.00 or less). Promotional items include, but are not limited to pens, notepads, mugs, binders or similar items which are pre-printed or embossed with the logo of a vendor or product name. Any gifts that are embossed or preprinted with the logo of a vendor or product name that exceed the $10.00 value are unacceptable even if they do not reach the $50.00 limit.

   c. It is not permitted to accept *any* amount of cash or cash equivalent such as checks, money orders, gift card/gift certificates, or credit gift cards during the course of your duties as an agent, employee, volunteer or contractor of SVMC, from any person or entity.

   d. Meals (i.e., lunch) may be provided to SVMC departments or groups by a vendor, on occasion as opposed to habitually. Department directors, managers or supervisors shall collaborate with the Compliance Officer (CO) to ensure that the gift offered to their department may be accepted.

   e. It is the responsibility of the Department Directors to monitor the value of all gifts received, and to contact the Compliance Department should there be a question as whether a gift is appropriate or not.

   f. All gifts received from a single source (company or individual) by a Board member or employee designated in the SVMC Conflict of Interest Code are subject to an aggregate annual limit of $520.00 (effective 1/1/21 – 12/31/22) in accordance with the California Political Reform Act.

2. Gifts exchanged between patients and employees: Discretion should be applied because patients not giving or receiving gifts may have the impression that the quality of care they receive is less than the patient who gives or receives a gift.

   a. Gift from the patient to an employee:

- May be accepted if it is not solicited, and does not exceed the maximum gift allowance of $50.00.
- Patients may donate to the Sierra View Foundation or other charitable organization in the name of the SVMC employee or employees they wish to recognize.
- It is not permitted to accept any amount of cash or cash equivalent such as checks, money orders, gift card/gift certificate, or credit gift cards during the course of your duties as an agent, employee, volunteer or contractor of SVMC, from any person or entity.

b. Gift from employee to patients: Should be given with discretion to avoid appearances of preferential treatment to a particular patient, and with department supervisory approval. Gifts should be of nominal value (no more than $10.00).

3. Gifts in recognition of volunteer efforts: Reasonable flexibility is permissible in giving gifts to individuals in recognition of volunteer efforts on behalf of SVMC. Gifts may be given that are in excess of $50.00 in value, to include gift certificates, to individuals who have made substantial, non-compensated time commitments to SVMC. A SVMC employee must obtain written approval by his/her supervisor, the CO and the Chief Executive Officer (CEO) before giving a gift in excess of $50.00 to an individual in recognition of his/her volunteer efforts on behalf of the organization. If the single gift (or aggregate gifts over the course of 12 months) is in excess of $250.00, written approval must be granted by the Board of Directors. Any gifts to volunteers who have any sort of business relationship with SVMC (i.e. vendors or physicians) must be reported to, and approved in advance, by the CO.

4. Off-Site Dinners and/or Entertainment (either hosting or receiving):

a. If it was anticipated the cost per person of a business entertainment activity would not exceed $50.00, but the cost per person appears to have exceeded $50.00, a report must be filed with the CO.

b. For any ticketed event, the figure used in calculating whether it is over or under the accepted limit is the face value of the ticket unless the event host actually paid more, in which case the cost is the amount actually paid.

c. For a charity event, the figure used in calculating whether it is over or under the accepted limit is the fair market value of the activity provided as opposed to the full amount of the ticket (*i.e.,* the amount of the charitable contribution may be excluded from the value of the entertainment event provided to the colleague or business associate).

d. If prior to engaging in an entertainment activity it is anticipated the cost per person will exceed $50.00, one must receive advance approval from the CEO. A copy of the approval should be provided to the CO.

e. All events occurring on the same day and offered by the same individual or entity are considered the same event and must fall within the $50.00 limit.

f. It is **not** permissible to pay part of the cost of entertainment that is offered with a value exceeding $50.00 to reduce the value to less than $50.00 and then accept the entertainment. However, it is acceptable to pay the full value of such an entertainment activity and then participate in the event.

g. Hosted Events (a day or more in duration): It is anticipated that SVMC would not host such events free of charge other than for voluntary leadership of hospitals (*e.g.*, Board retreats or meetings). In the rare circumstance SVMC seeks to host such an event for a group of non-SVMC employees other than members of the governing board, such events should be approved in advance by the CO, Chief Executive Officer (CEO) and Board of Directors, especially if there is a chance that the value of the event exceeds $50.00 per attendee.

5. Honoraria:

If an employee is offered payment for services provided to another organization (such as to cover honoraria or travel expenses associated with speaking engagements), the CO should be consulted in advance of acceptance. Checks/payments received for honoraria are customarily donated to a charitable organization. If the SVMC employee's expertise is being sought by the sponsoring agency – on issues not related to their employment at SVMC - it would be permissible to accept reimbursement for travel expenses. In cases where the employee or board member will be representing SVMC at a speaking engagement, consult the Compliance Officer to ensure appropriate exceptions are met. SVMC board members in their role as elected officials fall under more stringent exceptions (to the Honoraria Ban), per the Political Reform Act.

PROCEDURE:

1. Reporting gifts/meals: The receiving party/department shall notify the CO that a gift was received. It is the responsibility of the individual department directors to track the value of the gifts received and make the appropriate report to the CO.

2. Clarification: If a gift or entertainment is being offered and you are not sure if you are within limitations set forth in this policy in accepting it, bring the facts to the attention of the CO via your direct supervisor. The CO will conduct a fair market value assessment of the item(s) if it is not evident.

3. Duty to Disclose: Any employee who believes that he/she has received a gift which exceeds the limits stated above, or has exceeded any other limits provided herein, must disclose the facts in a memorandum to his/her supervisor. A copy must be filed with the CO. The CO will decide what course of action to take (i.e., returning the gift, paying for the gift, etc.).

4. Investigation of Potential Violations: Reports of known or suspected violations will be investigated by the CO or designee. Results of the investigation will be communicated to the individual named as well as to their immediate supervisor. Violations are subject to disciplinary action, up to and including termination if the severity of the violation warrants such action.

5. Detection and Prevention: Aside from self-disclosure, employees should be vigilant in this matter, and be sure to remind co-workers of the policy limitations in event of a potential violation. For known or suspected violations, employees have an obligation to report the misconduct.

REFERENCES:

- AdvaMed Code of Ethics on Interactions with Healthcare Professionals 2022, https://www.advamed.org/wp-content/uploads/2022/03/2022-AdvaMed-Code-of-Ethics-Digital.pdf
- California Political Reform Act
- Fair Political Practices Commission Limitations and Restrictions on Gifts, Honoraria, Travel and Loans 2022, https://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/The%20Political%20Reform%20Act/2022_Act_Highlighted_Final.pdf
- Federal Register / Vol. 70, No. 19 / Jan 31, 2005 / Notices / pg. 4871, https://www.govinfo.gov/content/pkg/FR-2005-01-31/pdf/05-1620.pdf
- Pharmaceutical Research and Manufacturers of America (PhRMA) Code on Interactions with Healthcare Professionals 2009. (Revised 2019) , https://phrma.org/resource-center/Topics/STEM/Code-on-Interactions-with-Health-Care-Professionals

CROSS REFERENCE:

- CODE OF CONDUCT
- CONFLICT OF INTEREST
- CONFLICT OF INTEREST CODE

SUBJECT:	SECTION:
JUST CULTURE	***Human Resources***

PURPOSE:

Sierra View Medical Center's (SVMC) philosophy for building and supporting the culture of patient safety includes promoting a fair, just and supportive environment for those employees that self-report potential or actual safety risk or hazard events as described in this policy. The Just Culture model provides a mechanism to:

1. Encourage an open environment of reporting all potential or actual safety risk or hazard events without fear of reprisal;

2. Increase knowledge regarding types of recurring potential or actual safety risk or hazard events that take place at SVMC.

3. Focus attention on systems and processes, rather than individual blame, in an effort to continuously improve patient safety; and identify precursors to errors in order to fix system issues.

4. Retain competent staff.

SVMC staff is encouraged to bring patient-safety and patient-care issues to the attention of their director or supervisor. Staff may also report patient-safety and care issues by completing an online occurrence report. Our employees also have the right to report concerns about the safety or quality of patient care to The Joint Commission. The hospital will not retaliate against an employee for bringing patient safety and patient-care issues forward via the event reporting system, The Joint Commission, or any other regulatory agency. Appropriate actions will be taken by the hospital depending on the facts and circumstances of any reported issues, concerns, or errors.

Nothing in this policy provides any contractual rights regarding employee discipline or counseling nor should anything in this policy be read or construed as modifying or altering the employment-at-will relationship between SVMC and its employees.

DEFINITIONS:

Potential or actual safety risk or hazard events are defined as follows:

1. Hazard: A source of danger that is potentially harmful to patients, visitors, hospital staff, physician staff, or is disrupting the orderly operation of the hospital.

2. Risk: An occurrence or incident that has the potential or actual effect of exposing a patient and/or others in the hospital to the chance of loss or danger.

3. Event or incident is: a) an unexpected, unintended, undesirable occurrence transpiring in or on the premises of the hospital facility or b) an unexpected, unintended, undesirable departure from the policies or standards of patient care or behavior required by the hospital.

4. Ongoing threat to safety: An incident in which there is ongoing exposure to the risk or hazard unless immediate action is taken to resolve the risk or hazard. Examples include:

   - Water on the floor associated with an electrical hazard that could lead to electrical shock
   - Staff member or physician who arrives at the hospital to engage in care who may be under the influence of drugs or alcohol
   - A visitor who exhibits disruptive behavior that impairs quality patient care.

Human Error (Blameless Act): An unintentional act either of omission or commission in which blame against an individual is not assigned. A human error occurs when either a correct action is not executed properly or an incorrect action is executed. Error is then managed through process, system, or environmental changes. Discipline is not warranted or productive since the staff member did not intend the action or the risk of harm that resulted. However, if after the staff member has been educated and no improvement is noted which is supported by a pattern of successive human errors, they will be subject to disciplinary action. Inadvertent actions associated with human error include: situations in which organizational processes contributed to the event. Situations that involve gross negligence and/or disregard for policies and procedures are not to be defined as a blameless act.

Slips: Occurs in situations that are so routine that there is no conscious awareness of them.

Lapses: Missed actions and omissions. For example: when somebody has failed to do something due to lack of attention or because they have forgotten something.

Mistakes: Judgment failures that are more subtle and complex than slips; can go unnoticed for a period of time and when detected may generate differences of opinion.

At-Risk Behavior: A behavioral choice that increases the risk where risk is not recognized or is mistakenly believed to be justified. Examples: drifting into unsafe habits and behaviors which are often rooted in the system. At-risk behavior should be managed by:

1. Uncovering, addressing and removing incentives for unsafe behaviors including identifying the system-based reason for the behavior (Example: perception of saved time.)
2. Decreasing staff tolerance for risk-taking by creating incentives for healthy behaviors.
3. Staff members should be coached and educated on making better behavioral choices (once the incentives for their at-risk behaviors have been addressed.) If, after the staff member has been educated, no improvement is noted which is supported by a pattern of successive at-risk behaviors, they will be subject to disciplinary action.

Intentional Act (Reckless Behavior): An act knowingly committed with the intent to harm or deceive. SVMC has a zero tolerance for reckless behavior. Examples: Person knows that others are engaging in unsafe behavior and fails to report it while understanding the risk is substantial, making a conscious choice to disregard the substantial and unjustifiable risk, and falsification or purposeful omission of

known information that can result in a harm event. Reckless behavior is "blameworthy" behavior and should be managed through remedial or disciplinary actions according to the District's progressive disciplinary process.

Non-Punitive: No punishment or disciplinary action will be imposed for any specific error for those staff who report a human error (blameless act) that has resulted in a potential or actual safety risk or hazard event.

POLICY:

The Just Culture Model embraces three duties for all employees to fulfill:

1. The duty to avoid causing unjustifiable risk or causing harm;

2. The duty to follow a procedural rule/policy; and

3. The duty to produce an outcome.

Potential or actual safety risk or hazard events are tracked in an attempt to establish trends and patterns, to learn from them, and to prevent recurrence. Staff involved in potential or actual safety risk or hazard events are encouraged to participate in analyzing the event and in developing the action plans for improved processes.

Crisis intervention will be made available to staff involved and/or affected by a potential or actual safety risk or hazard event.

Human error occurs when an employee inadvertently performs a task or an action other than what should have been done (a slip, a lapse, or a mistake). Individual performance may be affected by fatigue, stress, or interruptions. A human error may have been caused by a fault in the system or the process, by the characteristics of equipment being used, or by environmental factors such as noise or poor lighting. When a system fault or process error occurs, the matter will be referred to the appropriate parties for process improvement review and planning to correct the deficiency. If the event is determined to be human error (blameless act) disciplinary action is not taken until event is investigated. In cases of reckless behavior, blatant disregard for safety, or purposefully not following established policies, disciplinary action will be considered.

In the event that it becomes clear that staff competency is the root cause for a pattern of errors, management makes every effort to ensure that staff is provided with the education and resources needed to reliably deliver safe care. If it becomes clear that a staff member cannot practice in a reliably safe manner in spite of education and counseling, this situation is treated as a staff performance issue through normal disciplinary procedures.

AFFECTED PERSONNEL/AREAS: *SVMC STAFF MEMBERS & PHYSICIANS*

PROCEDURE:

Staff members are subject to disciplinary action if they:

1. Intentionally fail to report a potential or actual safety risk or hazard event;
2. Knowingly violate established operating procedures;
3. Violate established operating procedures despite documented education and counseling;
4. Make successive slips, lapses, mistakes, and/or continue to demonstrate at-risk behavior after receiving remedial education/training and coaching;
5. Operate outside of the employee's scope of practice, licensure, certification, registration, training, and/or job description
6. Intentionally cause harm.

Prior to taking any disciplinary action for suspension or termination related to a safety risk or hazard event, Human Resources arranges for a Just Culture review panel consisting of an Employee Relations staff member, the staff member's Director and/or Manager, the Manager of Risk and/or Administrative Director of Quality and Care, and another director (preferably one who is familiar with the systems and processes involved in the type of incident/error reported and/or duty that may not have been fulfilled). This panel reviews the information and circumstances of the alleged policy violation and makes a recommendation for appropriate action to the Director of Human Resources and the Senior Team member.

Taking into consideration the heightened requirements for compliance of confidentiality and privacy of patient information, the Just Culture algorithm and review panel do not apply to violations of the hospital's patient privacy policies and federal and state laws. Depending on the facts and circumstances of a policy or privacy violation, even a first offense may result in a written warning or other disciplinary action, up to and including termination of employment.

REFERENCES:

- Marx, D. (2014). *Whack-a-mole: The Price We Pay for Expecting Perfection*. Plano, TX: By Your Side Studios.
- Miller, V. B., & Jones, T. L. (2011). *Creating a Just Culture: A Nurse Leader's Guide*. Danvers, MA: HCPro.
- Reason, J.T. (2016). *Managing the Risks of Organizational Accidents*. London: Routledge.

CROSS REFERENCES:

- PERFORMANCE ACCOUNTABILITY AND COMMITMENT
- PERSONAL CONDUCT

SUBJECT: **NON RETALIATION - COMPLIANCE ISSUE REPORTING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish a culture and process in which employees may report actual, potential or suspected compliance issues, in good faith, without fear of retaliation.

POLICY:

Sierra View Medical Center (SVMC) is committed to the establishment of a culture that promotes prevention, detection, mitigation and resolution of instances of conduct that does not conform to federal and state laws and regulations, requirements of private payer health care programs, SVMC policies and SVMC's Code of Conduct. SVMC has established an environment and process for employees who report concerns in good faith to be protected from retaliation.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

DEFINITIONS:

Retaliation: Any adverse action, or the threat of adverse action, against an employee because they file a complaint, raise a concern, provide information to investigators, or otherwise assist in an investigation or proceeding relating to an issue they believed "in good faith" to violate the SVMC Code of Conduct, any SVMC policy, or any applicable law or regulation. Retaliation is designed to punish or penalize an individual for raising concerns or assisting in investigations.

Retaliation includes, but is not limited to: termination; being transferred to a less desirable shift, location, or position; reduction in duties or demotion; threats or harassment; and negative performance reviews solely as a result of reporting a concern.

Other forms of retaliation may be more subtle including: not being invited to business calls, meetings or social gatherings or no longer having input into projects.

All forms of retaliation create a hostile, threatening, or uncomfortable environment that can negatively affect employment conditions for all staff.

In good faith: The individual reasonably believes or perceives the information reported to be true.

PROCEDURE:

1. All SVMC employees have an affirmative duty and responsibility to report actual, potential or suspected misconduct, violations of laws, regulations, policies, procedures, or the SVMC Code of Conduct. See Compliance Issue Reporting policy.

2. To the extent practicable or allowed by law, the Compliance Officer (CO) must, when requested, maintain the confidentiality or anonymity of an employee who reports a compliance-related concern.

3. Any form of retaliation against any employee who reports an actual, potential or perceived problem or concern in good faith is strictly prohibited.

4. Any employee who commits or condones any form of retaliation will be subject to discipline up to, and including, termination.

5. Employees cannot exempt themselves from the consequences of their own misconduct by reporting the misconduct, although self-reporting may be taken into account in determining the appropriate course of action.

6. Any employee who intentionally provides false information may be subject to disciplinary action up to and including termination.

PROCEDURES THAT APPLY TO LEADERSHIP
(Executives, vice presidents, directors, managers, and supervisors):

All levels of leadership will support and adhere to this strict non-retaliation policy in an effort to protect employees who report problems and concerns, in good faith, from retaliation. Any form of retaliation can undermine the problem-reporting process and result in a failure of communication channels in the organization.

1. Leadership will take appropriate measures to safeguard employees against retaliation. At a minimum, the following actions should be taken and become an ongoing aspect of the leadership process:

    a. Maintain an "open door" policy to support and encourage employee's reporting of work-related issues or concerns;
    b. Communicate to employees that they may, without fear of retaliation, report violations and concerns to the CO;
    c. Ensure that reports are handled confidentially;
    Focus on the issue raised and not the individual(s) involved;
    d. Report to the CO or Compliance Hotline any instance of retaliation against an employee for reporting a compliance-related concern.

PROCEDURES THAT APPLY TO THE CO:

1. The CO will be responsible for the investigation and follow-up of any reported retaliation against an employee.

2. The CO will report the results of an investigation into suspected retaliation to the Chief Executive Officer and/or the Board of Directors.

REFERENCES:

- Federal Register/Vol. 63, No. 35/Monday, February 23, 1998

CROSS REFERENCES:

- CODE OF CONDUCT
- COMPLIANCE ISSUE REPORTING

SUBJECT: **PROFESSIONAL COURTESY DISCOUNT**	SECTION: **Page 1 of 2**

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

PURPOSE:

A professional courtesy discount for services provided by Sierra View Medical Center (SVMC) medical staff with hospital privileges ("hospital") will be available to all members of the medical staff of the Hospital and their immediate family members, without regard to the volume or value of referrals or other business generated between the physicians and Hospital.

DEFINITIONS:

Immediate family members is defined as husband or wife and children that are under the age of 26 who are unmarried.

POLICY:

All Sierra View Medical Center medical staff and their immediate family are eligible for the professional courtesy discount on health services provided at any location owned or operated by Sierra View Local Healthcare District.
The professional courtesy discount will be (1) applied only on that portion of the Hospital charge that is the physician's (or family member's) financial responsibility and (2) applied so as to reduce the total amount collected by 25%. The maximum amount of the professional courtesy discount provided under this policy will be $5,000.00 (five thousand dollars) per calendar year to any individual physician and his/her family member combined.
SVMC Medical Staff and Immediate Family discount process:

A. All SVMC medical staff and their immediate family are eligible to receive a 25% discount off the patient responsibility portion of their bill for SVMC-provided outpatient and inpatient services, not to exceed $5,000.00 per calendar year combined.

B. The professional courtesy discount cannot be offered to any physician (or family member) who is a federal health care program beneficiary (e.g. Medicare). Such person may be eligible for discounts based on financial need under the Hospital's charity care policy.

C. The health care items and services discounted must be of the type routinely provided by the Hospital.

D. Those procedures deemed to be "cosmetic" are not eligible for any discount.

AFFECTED PERSONNEL/AREAS: *ALL MEDICAL STAFF*

PROCEDURE:

1. The physician shall have the responsibility to request a discount by notifying the Manager of Patient Accounting.

2. All requests shall be forwarded with supporting documentation to the Administrative Director of Revenue Cycle or Patient Accounting Manager for review.

3. Patient Accounting Manager can approve adjustments up to $5,000.00 and Administrative Director of Revenue Cycle can approve up to $10,000; any amount greater than that must also have the signature of the Chief Financial Officer.

References:

• 42 C.F.R. §411.350- 411.361 (Stark Regulations) (Oct 11, 1989). https://www.law.cornell.edu/cfr/text/42/part-411.

• Centers for Medicare and Medicaid Services (11/23/18). CPI-U Updates: Non-Monetary Compensation and Medical Staff Incidental Benefits Exceptions. Retrieved May 30, 2019 from https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates.html.

- 42 U.S.C 1320a-7b (Feb 9, 2018). https://www.law.cornell.edu/uscode/text/42/1320a-7b

CROSS REFERENCES:

Non-Monetary Compensation and Medical Staff Incidental Benefits Policy

SUBJECT: **RISK MANAGEMENT PLAN**	SECTION: ***Improving Organizational Performance (PI)*** **Page 1 of 6**

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

PURPOSE:

The Risk Management Plan is designed to support the mission and vision of the organization as it pertains to clinical risk, as well as potential business, operational, and property risks.

GUIDING PRINCIPLES:

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program.

The organization's Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution
- Trend analysis of events, near misses, and claims

GOVERNING BODY LEADERSHIP

The success of the organization's Risk Management Program requires top-level commitment and support. The Governing Board authorizes the formal program and adoption of this Plan as documented in Board meeting minutes.

Risk management will provide quarterly reports. to the governing body summarizing activities, achievements, and ongoing risk management issues that have occurred since the prior report. As necessary, the Board will receive interim reports of new risk exposures that require board intervention and action.

PROGRAM GOALS AND OBJECTIVES

The Risk Management Program goals and objectives are to:

- Minimize adverse effects of errors, events, and system breakdowns when they occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements.
- Protect human and intangible resources (e.g., reputation).

SCOPE AND FUNCTIONS OF THE PROGRAM

The organization's Risk Management program interfaces with many operational departments and services throughout the organization. Risk Management's role is to influence, persuade and educate leaders within the organization in order to achieve quality care in a safe environment and protect the organization's resources.

Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with facility-wide performance improvement activities, Risk Management will work with the various committees structured to enhance the performance of the facility in the communication and resolution of risk-related issues. Risk management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.1 Functional Interfaces

Risk Management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.2 Risk Management Program Functions

Risk Management functional responsibilities include, but are not limited to:

- Promoting the quality of patient care, in collaboration with quality/performance improvement activities.
- Enhancing patient satisfaction.
- Minimizing the frequency and severity of adverse events.
- The timely reporting of events as it pertains to the following:
  - Centers for Medicare and Medicaid Services (CMS) established reportable requirement for certain restraint and seclusion events.
  - Assists in Food and Drug Administration (FDA), Safe Medical Device Act both mandatory and voluntary reporting elements related to device malfunctions and/or biological malfunctions.
- Assisting in the maintenance of a robust event reporting system that is used to report actual events or events with the potential of causing adverse patient outcomes or other injuries to people, property or other assets of the organization. (Refer to housewide policy & procedure, *Patient Safety Event*).

- Managing of patient and family complaints/grievances as required by CMS. (refer to house-wide policy and procedure, Complaints and Grievances, Handling of)
- Maintaining a robust insurance portfolio to safeguard the organization against financial risk arising from claims made.
- Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.
- Enhancing environmental safety for patients, visitors and staff through participation in various improvement committees.
- Utilizing risk management strategies to identify and minimize the frequency and severity of near misses, incidents and claims.
- Monitoring adverse events and injuries to minimize financial loss to include employment-attributed injury and illnesses (worker's comp).
- Evaluating systems that can contribute to patient care, error or injury.
- Educating stakeholders on emerging and known risk exposures and risk reduction initiatives.
- Serving as a resource for staff concerning actual or potential legal matters related to the provision of care.
- Contributing to the achievement of requirements implemented by accrediting organizations.
- Complying with state-specific scope of practice, applicable laws, regulations and standards.
- Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:
  - Claims and claim trends
  - Ongoing risk assessment information
  - Patient's and/or family's perceptions of how well the organization meets their needs and expectations
  - Quality performance data

- Research data
- Completing insurance and deeming applications.

1. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Risk Management Program is administered through the Risk Department's leadership, and reports to the Vice President of Quality & Regulatory Affairs. Department leadership interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Leader (or alternate as designated by VP) chairs the activities of the Patient Safety Committee and the Threat Assessment Team. The two committee's activities are an integral part of patient safety, quality improvement, and risk mitigation activities.

Risk Leadership is responsible for overseeing day-to-day monitoring of patient safety and risk management activities to include the investigation of and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contractsk Risk Leadership serves as the primary contact between the organization and other external parties on matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. Risk Leadership or alternative as designated by VP of Quality and Regulatory Affairs oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

2. ANNUAL PROGRAM EVALUATION

Risk Management/Patient Safety, in concert with members of the Performance Improvement and Patient Safety (PIPS) Committee, analyzes data and trends. During the year, events that have shown a trend of reoccurrence, a high likelihood of harm to patients or staff, or that have created delays in care across two or more departments are reviewed by responsible leadership in collaboration with Risk Management and Patient Safety. The events are reviewed via the Crisis Management Team (CMT) and Root Cause Analysis (RCA) process. CMTs and RCAs are reported quarterly to the PIPS Committee. At the end of each year, a risk assessment is conducted based on CMT, RCA, and Incident Reporting System data using a numeric scoring to assign a degree of likelihood, consequence and response to arrive at a collective risk score and a hierarchy of action. Specific risk reduction goals will focus on elements scored in the upper quartile. The reduction of risk-related exposures is a facility-wide initiative and is owned by everyone. The successful attainment of the identified goals will involve stakeholders who have influence and experience with key components of the issue.

7.1 GOALS FOR 2022-2023

1. Continue occurrence reporting training housewide to ensure quality data
2. Continue Just Culture training to support Culture of Safety in organization.

3. Maintain a current and robust insurance portfolio
4. Remain current on grievance and complaints (logs and correspondence)

3. PROTECTION OF RISK MANAGEMENT INFORMATION

Any and all documents and records that are part of the risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, patient safety work product, and peer review protections.

REFERENCES:

- California Evidence Code §1157 (January 1, 2018). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EVID&sectionNum=1157.
- Department of Health and Human Services, FDA: 21 CFR Parts 803 and 804 (April 1, 2021). Retrieved from https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=803.
- California Health & Safety Code, §1279.1(b): 1279.2, 1279.3, 1279.4, &100171 (January 1, 2008). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC
- *The Safe Medical Devices Act of 1990 and the Medical Device Amendments of 1992.* (1993). Washington, D.C.: U.S. Dept. of Health and Human Services, Public Health Services / Food and Drug Administration, Center for Devices and Radiological Health.
- Code of Federal Regulations 482.13(e)-(g) (September 30, 2019). Retrieved from https://www.law.cornell.edu/cfr/text/42/482.13.
-
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES

- *Patient Safety Event*
- Housewide Policy & Procedure Manual, *Serious Clinical Adverse Event*
- Housewide Policy & Procedure, *Complaints and Grievances, Handling of*

- Housewide Policy & Procedure, *Patient Safety Plan*
- *Environment of Care Policy and Procedure Manual, Medical Device Tracking & FDA Reporting Product Recalls*

SUBJECT: **SANCTION SCREENING – EXCLUDED INDIVIDUALS/ENTITIES**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish procedures to prevent Sierra View Medical Center's (SVMC) hiring, employing, contracting with and/or giving the provision of Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program or Procurement Program.

POLICY:

All current and prospective employees, Medical Staff members, independent contractors, vendors, suppliers, and consultants shall at a minimum be searched against the Department of Health and Human Services/Office of Inspector General's List of Excluded Individuals/Entities (OIG) the General Systems Administration (GSA) List of Excluded Individuals/Entities and the California Department of Health Care Services Suspended and Ineligible Provider List based on the frequency outlined in this policy. A third party vendor may be used to perform the exclusion checks and monitoring. The Compliance Officer or designee will manage the uploading of reports to the third party vendor and perform adjudication, if necessary.

Following investigation, once an individual or entity is confirmed as being ineligible to participate in a Federal or State Health Care Program or procurement program, the individual or entity will immediately be relieved by SVMC from responsibilities at SVMC. Any instance of identifying an ineligible individual or entity shall be reported to the Compliance Office.

Definition of an Excluded Person/Entity: An excluded person can be an employee, Medical Staff member, independent contractor, vendor, supplier, consultant, or entity who has been identified by the Federal or State government as committing an act that excludes the individual/entity from participating in a Federal or State Health Care Program, or Federal/State procurement program. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES/MEDICAL STAFF MEMBERS/ INDEPENDENT CONTRACTORS/VENDORS/SUPPLIERS/CONSULTANTS*

PROCEDURE:

1. Employment Applicants:

    a. Human Resources shall initiate a background investigation, post-employment offer, which includes a search of the OIG/GSA/State Exclusion Lists. In the event the applicant is on the OIG/GSA/State Exclusion List, the offer of employment shall be postponed pending an investigation and determination from the VP of Human Resources and Compliance Officer. If it is confirmed that an individual is excluded from a federal or state healthcare program, the offer of employment will be rescinded.

2. New Contingency Staff:

   a. Human Resources requires companies providing SVMC contingency staff to search the OIG/GSA/State Exclusion Lists and validate the individual is not excluded, prior to placement with SVMC.

3. Current Employees/Volunteers/Contracted Individuals/Contingency Staff:

   a. Human Resources staff shall send a monthly list of all current employees, volunteers, contracted individuals and contingency staff to the Compliance Officer or designee. The OIG/GSA/State Exclusion Lists shall be searched monthly to determine if a SVMC employee has been identified as an Excluded Person.

   b. In the event that an employee, volunteer, contracted individual or contingency staff member is identified as an Excluded Person, the VP of Human Resources and Compliance Officer will investigate and/or review the findings. Confirmation of the excluded status will be cause for immediate termination of employment or service.

4. Medical Staff/Allied Health Staff:

   a. Before approving a physician for Medical Staff privileges or authorizing an allied health staff person to provide services, the Director of Medical Staff Services Department or designee shall ensure that the individual is not an Excluded Person.

   b. If a physician or allied health professional is identified on the OIG/GSA/State Exclusion List, Medical Staff privileges/authorization to provide services shall not be granted.

   c. Any physician or allied health professional with a change in status, such as an exclusion from Federal or State Health Care Program participation, shall immediately report such change to the Chief of Staff and the CEO in writing and no later than 7 calendar days of action per Medical Staff Bylaws 2.6 (O). Failure to provide the notice required under Section 2.6 (O) regarding exclusions from a federal or stated program in a timely manner shall result in automatic termination of the member's membership and privileges,

   d. For ongoing exclusion monitoring, the Medical Staff Services Director or designee shall send a list of all current providers to the Compliance Officer or designee. The OIG/GSA/State Exclusion lists shall be searched monthly to ensure that any SVMC Medical Staff or allied health professional is not an Excluded Person.

e. In the event that a physician or allied health professional is on the OIG/GSA/State Exclusion List, the Director of Medical Staff Services Department and the Compliance Officer will review the findings and once exclusion is confirmed, the provider shall be automatically terminated from the medical staff per Medical Staff Bylaws 6.4-6

5. Non SVMC Staff Ordering and Referring Providers

a. The Compliance Officer or designee will compile a monthly list of ordering and referring providers using the Business Clinical Analytics application. This list will be used to search the OIG/GSA/State Exclusion lists monthly to ensure that the providers are not an excluded person/entity.

b. In the event that an ordering or referring provider is on the OIG/GSA/State Exclusion List, the Compliance Officer or designee will investigate and review the findings. Confirmation of the excluded status will be cause for immediate suspension of ordering privileges.

6. Vendors/Suppliers:

a. Before entering into a contract or agreement with a vendor or supplier the Contract Administrator or designee shall ensure that the vendor or supplier is not an Excluded Person/Entity. If a vendor/supplier is identified on the OIG/GSA/State Exclusion List, the contract shall not be executed.

b. All new or renewed contracts shall have a clause which requires the vendor/suppliers to notify SVMC immediately should they become ineligible to participate in a Federal or State Health Care Program or Procurement Program. The contract shall also specify SVMC's authority to immediately terminate the agreement in the event that the vendor becomes excluded.

c. Before Accounts Payable adds a new non-contracted vendor in the Vendor Master, Accounts payable staff shall access the third party vendor to search the OIG/GSA/State Exclusion Lists to ensure that the applicant is not an Excluded Person/Entity. In the event the vendor/supplier is on the OIG/GSA/State Exclusion List, the Director of General Accounting/Controller and Compliance Officer will investigate and review the findings. Confirmation of the excluded status will be cause for the Vendor/Supplier to not be added to the Master Vendor List.

d. The Compliance Officer or designee will compile a monthly vendor list using the Business Clinical Analytics application to search the OIG/GSA/State Exclusion Lists monthly to ensure the vendor/supplier is not an Excluded Person/Entity. In the event that a vendor/supplier is on the OIG/GSA/State Exclusion List, the Director of Materials Management or designee and the Compliance Officer will investigate and review the findings. Confirmation of the excluded status will be cause for immediate termination of the vendor's/supplier's services.

e. Any vendor/supplier found to be excluded shall be immediately notified that their contract with SVMC is terminated.

7. Investigations of Excluded Person(s)/Entity(ies):

a. In the event that an Excluded Person/Entity is identified, the Compliance Officer or designee and appropriate leadership shall conduct an investigation with the excluded individual or entity and make a recommendation for resolution.

b. In the event that an Excluded Person/Entity is identified, Insurance Plan Sponsors and/or payors will be notified (when appropriate).

REFERENCES:

- 42 U.S.C. 1320A-7B (2006)
- Department of Health and Human Services Office of Inspector General. OIG Supplemental Compliance Program Guidance for Hospitals. (January 31, 2005)
- Department of Health and Human Services Office of Inspector General. OIG Compliance Program Guidance for Hospitals. (February 23, 1998)

CROSS REFERENCES:

- CRIMINAL BACKGROUND SCREENS FOR EMPLOYMENT
- VENDOR MANAGEMENT
- VENDOR DICTIONARY

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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 **December 20, 2022 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 4:36 p.m.

Directors Present: LOMELI, MARTINEZ, REDDY, and PANDYA

Others Present: Blazar, Dan, Patient Experience Officer, Camacho, Lorena, Patient Safety R.N. Canales, Tracy, VP of Human Resources, Marketing and Public Relations, Gomez, Cindy, Director of Compliance, Hefner, Donna, President/Chief Executive Officer, Kim, Owen, MD, Secretary Medical Staff Executive Committee, Martinez, Felipe, Community Member, Michael Martinez and Family, Community Members, Porterville Recorder, Parsons, Malynda, Senior Marketing and Community Relations Specialist, Reed-Krase, Alex, Legal Counsel, 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. Oath of Office and Installation of newly elected/re-elected Directors:

The Oath of Office was administered to Ms. Areli Martinez, Director representing Zone 5, by Donna Hefner, President and CEO.

II. Approval of Agenda:

Vice Chair LOMELI motioned to approve the Agenda. The motion was seconded by Chairman REDDY, and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

III. Closed Session: Board adjourned Open Session and went into Closed Session at 4:40 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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel

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

IV. Open Session: Chairman REDDY adjourned Closed Session at 5:23 p.m., reconvening in Open Session at 5:24 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 Secretary, Owen Kim, M.D. 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 Vice Chair LOMELI, 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 Vice Chairman LOMELI, seconded by Director PANDYA, 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

V. Public Comments

None.

VI. 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 PANDYA, 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

VII. Approval of Minutes:

Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director PANDYA to approve the November 22, 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	Abstain
PANDYA	Yes

VIII. Hospital CEO Report

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

In the District:

- Medical Records Office Hours change Monday – Friday 8:00 a.m. – 4:30 p.m.
- Free home COVID-19 test kits are available at 385 Pearson Drive. Test kits have been provided by TCHHSA
- Community Vaccine Clinic closes
- Mini Christmas Tree Auction raises $4500 for the Cancer Treatment Center
- 240 kids in our community were adopted by our SVMC team members for this year's Tree of Angels

IX. Appointment of Governing Board Director for Zone 3

To date, no applicants have been received. Notice for the vacancy has been posted to the SVLHCD website, various social media platforms and physically posted in a few locations within the district.

A Special Board Meeting has been set for January 12, 2023 at 4:30 p.m. in the Board Room at Sierra View Medical Center.

X. Business Action Items

A. November 2022 Financials

Donna Hefner, President/CEO presented the Financials for November 2022. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,555,975. Supplemental Funds were $1,043,256. Total Operating Expenses were $13,888,391. Loss from operations were $1,332,416.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the November 2022 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

B. Retirement Planning Advisory Committee Report

Donna Hefner, President/CEO presented the RPAC 2022 Summary:

For 2022:

- No fund changes were recommended or made
- Service performance metrics met with satisfactory scores
- Fixed 0.9% Vanguard Retirement (Target-Date) with Institutional Share Class
- Custom Education communication
- Ensure participant fees are within peer fee range
- Free-of-charge service for participants; investment advice, rollover, distribution advice and salary deferral recommendations
- No participant complaints or IRS inquiries
- Began process of loan repayment from Payroll to ACH

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the Retirement Planning Advisory Committee Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes

MARTINEZ Yes
PANDYA Yes

C. Election of Officers

Chairman REDDY appointed Doug Dickson, CFO as Treasurer. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes

Following review and discussion, it was moved by Vice Chairman LOMELI, to nominate Director MARTINEZ for Secretary. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes

Following review and discussion, it was moved by Vice Chairman LOMELI, to nominate Chairman REDDY to continue as Chairman. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA No

Following review and discussion, it was moved by Chairman REDDY, to nominate Vice Chairman LOMELI to continue as Vice Chairman. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA No

XI. Closed Session: Board adjourned Open Session at 5:58 p.m. and went into Closed Session at 5:59 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2025

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)

XII. Open Session: Board adjourned Closed Session at 6:40 p.m. and went into Open Session at 6:40 p.m. to discuss the following items:

D. Trade Secret. Information only; no action taken.

E. Conference with Legal Counsel. Information only; no action taken.

XII. Announcements:

A. Special Board of Directors Meeting – January 12, 2023 at 4:30 p.m.

B. Regular Board of Directors Meeting – January 24, 2023 at 4:30 p.m.

C. Adjournment: There being no further business, a motion to adjourn brought by Vice Chairman LOMELI and seconded by Director PANDYA. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

The motion having carried, the meeting was adjourned 6:41 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: ww

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

The special meeting of the Board of Directors of Sierra View Local Health Care District was held **January 12, 2023 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California.

Directors Present: **BEHL, LOMELI, MARTINEZ, and PANDYA**

Others Present:

Anderson, Lori, Community Member
Espinoza, A., Community Member
Hefner, Donna, President/CEO
Kashyap, Hans, Community Member
Reed-Krase, Alex, Legal Counsel
Shelton, Greg, Community Member
Watts, Whitney, Executive Assistant and Clerk to Board of Directors

I. Call to Order: Chairman REDDY called the meeting to order at 4:55 p.m. due to a lack of quorum.

II. Approval of Agendas: Chairman REDDY asked for approval of the agenda. It was moved by Vice Chairman LOMELI and seconded by Director PANDYA, and carried to approve the agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

III. Closed Session: Board adjourned Open Session and went into Closed Session at 4:40 p.m. to discuss the following items:

A. 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)

IV. Open Session: Board adjourned Closed Session at 5:12 p.m. and went into Open Session at 5:14 p.m. to discuss the following items:

A. Information only; no action taken.

V. Public Comments

None.

VI. Business Items

A. Directors to Publicly review applications to fill vacancy for Zone 3 of the Board of Directors and may interview candidates and deliberate
Recommended Action: Appoint Director to Vacancy for Zone 3

Counsel KRASE provided an introduction to the public, stating four candidates have applied for the vacancy for Zone 3; Lori Anderson, Hans Kashyap, Greg Shelton, and Sonia Duran-Aguilar. It was noted that Ms. Duran-Aguilar is interested in the vacancy but unable to attend tonight's special board meeting.

Counsel KRASE asked Ms. Anderson to confirm her address as it was not listed on the application received. Ms. Anderson stated her home address; 574 S. Main Street, Apartment "F" Porterville, CA. Ms. Anderson's address is located in Zone 2, not in Zone 3, therefore Ms. Anderson's application cannot be considered.

Counsel KRASE confirmed Ms. Duran-Aguilar's home address as 983 West Cleo Avenue, Porterville, CA. Ms. Duran-Aguilar's address is located in Zone 2 and not in Zone 3, therefore Ms. Duran-Aguilar's application cannot be considered.

Counsel KRASE and Board Directors thanked Ms. Anderson and Ms. Duran-Aguilar for their interest.

Mr. Kashyap and Mr. Shelton were interviewed by Directors of the Board and asked a series of seven questions:

What drew you to apply for the Board Director Zone 3 Position and what would you find rewarding about it?

What do you believe is your greatest skill or strength as a potential Board Director? What is an area of opportunity for you?

What values do you hold as a potential Board Director?

How would you deal with a community member that approaches you to express dissatisfaction with health care services at Sierra View?

What is one professional accomplishment that you are most proud of and why?

What can you bring to the Board that makes you stand out amongst other candidates?

What are your goals you would like to see the Board accomplish this coming year?

Hans Kashyap has over 45 years of experience in over 15 disciplines that include; Healthcare, C-Suite Consulting, Long-Range and Strategic Planning, Engineering,

Energy, Defense Analysis, and International Finance. He has been a resident of Porterville since 2004. Mr. Kashyap's strengths include, problem-solving, strategic planning, economic analysis and forecasting, non-remunerative motivation techniques, innovative thinking, exacting perspective and streamlining profitability.

Mr. Kashyap is interested in big-picture thinking, long-range strategic planning and oversight of processes and organizational systems to ensure fulfillment of mission, cost and budget control and oversight financial forecasting and prudent practices including hedging risk. Mr. Kashyap believes it is important to have a profitable, efficient and patient-friendly, thriving hospital. He believes many individuals in our community are seeking services elsewhere and that we can help change the experience for our patients.

Greg Shelton is a lifelong resident of Porterville; 50 plus years. Mr. Shelton has been involved in local politics for the last 25 years, holding positions such as; City of Porterville Parks and Leisure Commissioner, Tulare County Grand Jury Member, City of Porterville City Council Member, Tulare County Local Benefit Gaming Commission Member, City of Porterville Transaction and Use Tax Oversight Committee Member, City of Porterville Contractor Oversight Board Member, City of Porterville Redevelopment Agency Member, City of Porterville appointee to the California Air Resources Board Advisory Committee, Porterville Unified School District Surplus Property Ad Hoc Committee Member.

Mr. Shelton has been an involved member of the community, providing service and standing up for the people of Porterville and its "uniqueness". Mr. Shelton believes his background in local government policies and procedures will help the district have a voice.

Following discussion and review, the vote of the Board is as follows:

REDDY	Hans Kashyap
LOMELI	Hans Kashyap
MARTINEZ	Greg Shelton
PANDYA	Greg Shelton

The vote resulting in a tie.

Director PANDYA made a motion to appoint Mr. Greg Shelton. There was no second; motion failed.

Chairman REDDY made a motion to appoint Mr. Hans Kashyap to Zone 3, the motion was seconded by Vice Chair LOMELI. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes

MARTINEZ No
PANDYA No

The vote resulting in a tie.

Legal Counsel KRASE advised the Board of Directors to move to table the item to the regularly scheduled Board of Directors meeting, January 24, 2023 at 5:00 p.m.

B. Administering Oath of Office to Appoint Director
Recommended Action: Motion directing Hospital Administration to immediately notify the Tulare County Elections Official of the appointment

This item was deferred to January 24, 2023.

XIII. Announcements:

A. Regular Board of Directors Meeting – January 24, 2023

Adjournment: There being no further business, the meeting was adjourned at 6:45 p.m. moved by Chairman REDDY, seconded by Secretary MARTINEZ.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: ww

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FINANCIAL PACKAGE
December 2022

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
December 2022

Statistic	Dec-22 Actual	Dec-22 Budget	Dec-22 Over/ (Under)	Dec-22 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 22 YTD	Increase/ (Decrease) 12/2021	% Change
Utilization											
SNF Patient Days											
Total	149	75	74	98.7%	737	450	287	63.8%	468	269	57.5%
Medi-Cal	118	48	70	145.8%	515	370	145	39.0%	400	115	28.8%
Sub-Acute Patient Days											
Total	874	903	(29)	-3.2%	5,162	5,418	(256)	-4.7%	5,502	(340)	-6.2%
Medi-Cal	581	621	(40)	-6.5%	3,567	3,445	122	3.5%	3,497	70	2.0%
Acute Patient Days	2,072	1,923	149	7.8%	10,870	11,537	(667)	-5.8%	13,800	(2,930)	-21.2%
Acute Discharges	506	469	37	7.9%	2,834	2,814	20	0.7%	2,942	(108)	-3.7%
Medicare	194	176	18	10.1%	1,074	1,036	38	3.7%	1,083	(9)	-0.8%
Medi-Cal	260	235	25	10.6%	1,398	1,380	18	1.3%	1,445	(47)	-3.3%
Contract	50	59	(9)	-14.9%	348	378	(30)	-7.8%	393	(45)	-11.5%
Other	2	1	1	100.0%	14	20	(6)	-30.3%	21	(7)	-33.3%
Average Length of Stay	4.09	4.10	(0.00)	-0.1%	3.84	4.10	(0.26)	-6.4%	4.69	(0.86)	-18.2%
Newborn Patient Days											
Medi-Cal	211	179	32	17.9%	1,118	1,062	56	5.2%	1,112	6	0.5%
Other	30	34	(4)	-11.8%	211	216	(5)	-2.2%	245	(34)	-13.9%
Total	241	213	28	13.1%	1,329	1,278	51	4.0%	1,357	(28)	-2.1%
Total Deliveries	121	112	9	8.0%	730	672	58	8.6%	693	37	5.3%
Medi-Cal %	85.00%	82.98%	2.02%	2.4%	82.73%	82.98%	-0.24%	-0.3%	82.46%	0.27%	0.3%
Case Mix Index											
Medicare	1.7036	1.6783	0.0253	1.5%	1.6117	1.6783	(0.0666)	-4.0%	1.7161	(0.1044)	-6.1%
Medi-Cal	1.0934	1.2438	(0.1504)	-12.1%	1.1667	1.2438	(0.0771)	-6.2%	1.2528	(0.0861)	-6.9%
Overall	1.3245	1.4431	(0.1186)	-8.2%	1.3430	1.4431	(0.1001)	-6.9%	1.4722	(0.1292)	-8.8%
Ancillary Services											
Inpatient											
Surgery Minutes	9,287	8,728	559	6.4%	53,374	52,368	1,006	1.9%	52,015	1,359	2.6%
Surgery Cases	115	100	15	15.0%	648	600	48	8.0%	616	32	5.2%
Imaging Procedures	1,746	1,231	515	41.8%	8,997	7,386	1,611	21.8%	9,306	(309)	-3.3%
Outpatient											
Surgery Minutes	10,715	13,010	(2,295)	-17.6%	70,658	78,060	(7,402)	-9.5%	66,220	4,438	6.7%
Surgery Cases	162	198	(36)	-18.2%	1,082	1,188	(106)	-8.9%	991	91	9.2%
Endoscopy Procedures	186	185	1	0.5%	1,048	1,110	(62)	-5.6%	982	66	6.7%
Imaging Procedures	3,863	3,880	(17)	-0.4%	23,232	23,280	(48)	-0.2%	21,096	2,136	10.1%
MRI Procedures	238	290	(52)	-17.9%	1,772	1,740	32	1.8%	1,824	(52)	-2.9%
CT Procedures	1,077	1,009	68	6.7%	7,031	6,054	977	16.1%	5,926	1,105	18.6%
Ultrasound Procedures	846	904	(58)	-6.4%	5,766	5,424	342	6.3%	5,497	269	4.9%
Lab Tests	31,494	30,494	1,000	3.3%	203,378	182,964	20,414	11.2%	237,492	(34,114)	-14.4%
Dialysis	4	5	(1)	-20.0%	12	30	(18)	-60.0%	30	(18)	-60.0%

Sierra View Medical Center
Financial Statistics Summary Report
December 2022

Statistic	Dec-22 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 22 YTD	Increase/ (Decrease) 12/2021	% Change
Cancer Treatment Center											
Chemo Treatments	2,119	1,794	325	18.1%	10,939	10,764	175	1.6%	10,861	78	0.7%
Radiation Treatments	1,508	1,817	(309)	-17.0%	9,515	10,902	(1,387)	-12.7%	10,009	(494)	-4.9%
Cardiac Cath Lab											
Cath Lab IP Procedures	8	9	(1)	-11.1%	55	54	1	1.9%	55	-	0.0%
Cath Lab OP Procedures	26	24	2	8.3%	177	144	33	22.9%	142	35	24.6%
Total Cardiac Cath Lab	34	33	1	3.0%	232	198	34	17.2%	197	35	17.8%
Outpatient Visits											
Emergency	3,320	3,249	71	2.2%	20,849	19,494	1,355	7.0%	18,390	2,459	13.4%
Total Outpatient	12,273	13,731	(1,458)	-10.6%	77,788	82,386	(4,598)	-5.6%	73,352	4,436	6.0%
Staffing											
Paid FTE's	899.05	935.67	(36.62)	-3.9%	903.96	935.67	(31.71)	-3.4%	906.87	(2.91)	-0.3%
Productive FTE's	755.50	804.83	(49.32)	-6.1%	766.66	804.83	(38.17)	-4.7%	770.79	(4.13)	-0.5%
Paid FTE's/AOB	5.24	5.51	(0.27)	-4.9%	5.36	5.46	(0.09)	-1.7%	5.07	0.29	5.8%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,935	10,468	467	4.5%	10,823	10,392	431	4.1%	10,231	592	5.8%
Cost/Adj.Patient Day	2,795	2,592	203	7.8%	2,733	2,593	140	5.4%	2,478	254	10.3%
Revenue/Adj. Discharge	54,972	53,412	1,560	2.9%	51,976	53,025	(1,048)	-2.0%	60,781	(8,804)	-14.5%
Cost/Adj. Discharge	14,049	13,226	823	6.2%	13,124	13,232	(108)	-0.8%	14,723	(1,600)	-10.9%
Adj. Discharge	1,057	1,032	26	2.5%	6,459	6,185	274	4.4%	5,542	917	16.5%
Net Op. Gain/(Loss) %	-16.46%	-6.32%	-12.15%	192.3%	-16.28%	-6.32%	-9.96%	157.7%	-4.47%	-11.80%	264.0%
Net Op. Gain/(Loss) $	(2,315,313)	(810,562)	(1,504,751)	185.6%	(11,865,389)	(5,372,486)	(6,492,903)	120.9%	(3,492,548)	(8,372,841)	239.7%
Gross Days in Accts Rec.	90.18	85.78	4.40	5.1%	90.18	85.78	4.40	5.1%	83.50	6.68	8.0%
Net Days in Accts. Rec.	76.48	66.37	10.11	15.2%	76.48	66.37	10.11	15.2%	62.76	13.73	21.9%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	DEC 2022	NOV 2022
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 7,487,555	$ 6,400,780
SHORT-TERM INVESTMENTS	3,076,762	4,098,093
ASSETS LIMITED AS TO USE	371,971	369,470
PATIENT ACCOUNTS RECEIVABLE	167,033,671	161,732,909
LESS UNCOLLECTIBLES	(25,310,608)	(25,349,606)
CONTRACTUAL ALLOWANCES	(111,832,053)	(107,367,172)
OTHER RECEIVABLES	13,513,846	14,340,012
INVENTORIES	4,115,410	4,107,508
PREPAID EXPENSES AND DEPOSITS	2,254,922	1,988,818
LEASE RECEIVABLE - CURRENT	357,240	353,223
TOTAL CURRENT ASSETS	61,068,715	60,674,035
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,460,746	31,903,470
LONG-TERM INVESTMENTS	136,081,101	136,474,157
PROPERTY, PLANT AND EQUIPMENT, NET	90,529,445	91,293,250
INTANGIBLE RIGHT OF USE ASSETS	661,120	674,896
LEASE RECEIVABLE - LT	1,493,012	1,491,320
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,888,164	1,909,144
TOTAL ASSETS	$ 324,432,302	$ 324,670,271

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	DEC 2022	NOV 2022
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 869,950	$ 724,958
CURRENT MATURITIES OF BONDS PAYABLE	3,880,000	3,880,000
CURRENT MATURITIES OF LONG TERM DEBT	1,188,800	1,188,800
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	8,339,225	7,778,857
ACCRUED PAYROLL AND RELATED COSTS	7,741,536	6,898,876
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,777,111	3,840,187
LEASE LIABILITY - CURRENT	124,753	124,753
TOTAL CURRENT LIABILITIES	25,921,375	24,436,432
SELF-INSURANCE RESERVES	1,853,000	1,853,000
CAPITAL LEASE LIAB LT	2,448,895	2,531,240
BONDS PAYABLE, LESS CURR REQT	41,565,000	41,565,000
BOND PREMIUM LIABILITY - LT	3,794,337	3,859,243
LEASE LIABILITY - LT	540,623	553,025
OTHER NON CURRENT LIABILITIES	375,854	375,854
DEFERRED INFLOW - LEASES	1,794,526	1,790,957
TOTAL LIABILITIES	78,293,609	76,964,750
UNRESTRICTED FUND	258,952,972	258,952,972
PROFIT OR (LOSS)	(12,814,279)	(11,247,452)
TOTAL LIABILITIES AND FUND BALANCE	$ 324,432,302	$ 324,670,271

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

DEC 2022 ACTUAL	DEC 2022 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,692,072	5,482,863	(209,209)	4%	INPATIENT - NURSING	30,650,973	32,577,780	1,926,807	(6)%
22,151,430	19,567,400	(2,584,030)	13%	INPATIENT - ANCILLARY	116,923,215	116,633,678	(289,537)	0%
27,843,502	25,050,263	(2,793,239)	11%	TOTAL INPATIENT REVENUE	147,574,188	149,211,458	1,637,270	(1)%
30,287,641	30,050,450	(237,191)	1%	OUTPATIENT - ANCILLARY	188,130,574	178,730,352	(9,400,222)	5%
58,131,143	55,100,713	(3,030,430)	6%	TOTAL PATIENT REVENUE	335,704,761	327,941,810	(7,762,951)	2%
				DEDUCTIONS FROM REVENUE				
(17,683,226)	(17,761,628)	(78,402)	0%	MEDICARE	(102,935,347)	(105,705,336)	(2,769,990)	(3)%
(22,060,586)	(17,597,797)	4,462,789	25%	MEDI-CAL	(119,899,835)	(104,686,002)	15,213,833	15%
(5,782,473)	(6,898,909)	(1,116,436)	(16)%	OTHER/CHARITY	(38,985,357)	(41,059,140)	(2,073,783)	(5)%
(46,273)	(10,755)	35,518	330%	DISCOUNTS & ALLOWANCES	(172,131)	(64,012)	108,119	169%
(609,664)	(494,656)	115,008	23%	BAD DEBTS	(3,309,958)	(2,944,034)	365,924	12%
(46,182,221)	(42,763,745)	3,418,476	8%	TOTAL DEDUCTIONS	(265,302,627)	(254,458,524)	10,844,103	4%
11,948,922	12,336,968	388,046	(3)%	NET SERVICE REVENUE	70,402,134	73,483,286	3,081,152	(4)%
592,128	496,384	(95,744)	19%	OTHER OPERATING REVENUE	2,495,206	2,978,307	483,101	(16)%
12,541,050	12,833,352	292,302	(2)%	TOTAL OPERATING REVENUE	72,897,340	76,461,593	3,564,253	(5)%
				***** OPERATING EXPENSE *****				
5,238,159	5,190,529	47,630	1%	SALARIES	31,459,954	30,811,740	648,214	2%
548,400	657,306	(108,906)	(17)%	S&W PTO	4,048,497	3,887,147	161,350	4%
1,230,851	1,408,785	(177,934)	(13)%	EMPLOYEE BENEFITS	7,955,892	8,530,995	(575,103)	(7)%
2,885,772	1,826,053	1,059,719	58%	PROFESSIONAL FEES	12,914,768	11,106,758	1,808,010	16%
799,815	743,529	56,286	8%	PURCHASED SERVICES	5,040,665	4,487,560	553,105	12%
2,408,415	2,009,035	399,380	20%	SUPPLIES & EXPENSES	12,575,070	12,052,810	522,260	4%
209,178	211,644	(2,466)	(1)%	MAINTENANCE & REPAIRS	1,292,784	1,301,350	(8,567)	(1)%
209,233	212,617	(3,385)	(2)%	UTILITIES	1,512,283	1,275,702	236,581	19%
33,471	45,029	(11,558)	(26)%	RENT/LEASE	210,727	270,174	(59,447)	(22)%
116,630	100,975	15,655	16%	INSURANCE	636,002	605,850	30,152	5%
836,100	873,569	(37,470)	(4)%	DEPRECIATION/AMORTIZATION	5,046,094	5,246,811	(200,717)	(4)%
340,339	364,843	(24,504)	(7)%	OTHER EXPENSE	2,069,994	2,257,182	(187,188)	(8)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,856,363	13,643,914	1,212,449	9%	TOTAL OPERATING EXPENSE	84,762,729	81,834,079	2,928,650	4%
(2,315,313)	(810,562)	1,504,751	186%	NET GAIN/(LOSS) FROM OPERATIONS	(11,865,389)	(5,372,486)	6,492,903	121%
112,969	112,969	0	0%	DISTRICT TAXES	677,814	677,816	2	0%
313,339	169,712	(143,627)	85%	INVESTMENTS INCOME	1,778,497	1,018,272	(760,225)	75%
61,705	37,742	(23,963)	64%	OTHER NON OPERATING INCOME	398,661	226,448	(172,213)	76%
(86,891)	(84,841)	2,050	2%	INTEREST EXPENSE	(516,728)	(509,040)	7,688	2%
(20,480)	(50,587)	(30,107)	(60)%	NON-OPERATING EXPENSE	(252,913)	(303,530)	(50,618)	(17)%
380,642	184,995	(195,647)	106%	TOTAL NON-OPERATING INCOME	2,085,331	1,109,966	(975,365)	88%
(1,934,671)	(625,567)	1,309,104	209%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(9,780,058)	(4,262,520)	5,517,538	129%
367,844	0	(367,844)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	(3,034,221)	0	3,034,221	
(1,566,827)	(625,567)	941,260	151%	NET GAIN/(LOSS)	(12,814,279)	(4,262,520)	8,551,759	201%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
12/31/22

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(2,315,313)	(11,865,389)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	836,100	5,046,094
Provision for bad debts	(38,998)	2,283,256
Change in assets and liabilities:		
Patient accounts receivable, net	(835,880)	(2,807,953)
Other receivables	826,166	(4,907,055)
Inventories	(7,902)	(169,915)
Prepaid expenses and deposits	(266,104)	23,331
Advance refunding of bonds payable, net	20,980	125,879
Accounts payable and accrued expenses	560,366	120,231
Deferred inflows - leases	3,569	137,087
Accrued payroll and related costs	842,660	(181,242)
Estimated third-party payor settlements	(63,076)	(378,456)
Self-insurance reserves	-	-
Total adjustments	1,877,881	(708,743)
Net cash provided by (used in) operating activities	(437,432)	(12,574,132)
Cash flows from noncapital financing activities:		
District tax revenues	112,969	677,814
Noncapital grants and contributions, net of other expenses	38,037	132,503
Net cash provided by (used in) noncapital financing activities	151,006	810,317
Cash flows from capital and related financing activities:		
Purchase of capital assets	(58,519)	(4,398,156)
Proceeds from lease receivable, net	(5,709)	(143,476)
Principal payments on debt borrowings	-	(3,715,000)
Interest payments	(3,617)	(975,444)
Net change in notes payable and lease liability	(94,747)	(98,500)
Net changes in assets limited as to use	(559,777)	2,985,687
Net cash provided by (used in) capital and related financing activities	(722,369)	(6,344,889)
Cash flows from investing activities:		
Net (purchase) or sale of investments	760,900	(1,378,615)
Investment income	313,339	1,778,497
Net cash provided by (used in) investing activities	1,074,239	399,882
Net increase (decrease) in cash and cash equivalents:	65,444	(17,708,822)
Cash and cash equivalents at beginning of month/year	10,498,873	28,273,139
Cash and cash equivalents at end of month	10,564,317	10,564,317

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
December 2022

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Jan-22	9,101,598	3,002,395	12,103,993
Feb-22	9,223,160	1,873,199	11,096,359
Mar-22	11,160,102	6,179,876	17,339,978
Apr-22	10,302,842	5,121,377	15,424,219
May-22	10,717,469	760,349	11,477,818
Jun-22	11,174,875	4,902,151	16,077,026
Jul-22	10,591,327	206,562	10,797,889
Aug-22	11,384,869	198,928	11,583,797
Sep-22	11,025,336	384,733	11,410,069
Oct-22	10,879,234	1,521,302	12,400,536
Nov-22	10,716,042	298,921	11,014,963
Dec-22	**9,551,250**	**2,895,404**	**12,446,654**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - cash receipts for Cafe and Coffee Corner sales, rebates, refunds, and receipts from miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH funds received
- Medi-Cal and Medi-Care Tentative Cost Settlements received for prior year
- Grants, IGT, & HQAF
- Medicare interim payments received

December 2022 Summary of Other Activity:

796,986	Property Taxes
46,671	Tulare County First 5 1st Qtr 07/22 - 09/22
581,257	M-Cal HQAF7 Direct Grant CY22
315,662	M-Cal IP DSH 6/22 Phase 2
748,190	M-Cal IP DSH 2nd Qtr 10/22 - 11/22
406,638	Miscellaneous
2,895,404	12/22 Total Other Activity

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SIERRA VIEW
MEDICAL CENTER

Appointment of Environmental Safety/Security Officer
2023

Mr. Gary Wilbur has been appointed to the position of *Environmental Safety/Security Officer* by the Board of Directors and President/CEO of Sierra View Local Health Care District.

Qualifications:

Mr. Gary Wilbur has over twenty (23) years of experience in the field of; Fire Protection, Installation and maintenance of Security Systems, Telecommunication Engineering, and Facility Project Management. In addition, he has installed Fire Alarm Systems and Surveillance Cameras.

Mr. Wilbur has participated in Facility Master Plan design. Furthermore he has, and currently serves as Director of our IT and Project Management departments. He has immense knowledge of the facility plant and its infrastructure.

Mr. Wilbur is a member of:
National Fire Protection Agency
Project Management Institute

Mr. Wilbur has certifications from:
California State Fire Marshall
Fire Protection Agency
Governor's Office of Emergency Services
California Specialized Training Institute for HAZMAT Awareness
Global Information Assurance Certification

Authority:

The Environmental Safety/Security Officer, through the Environmental Safety Committee, has the authority to intervene whenever conditions exist that pose an immediate threat to life, health or pose an immediate threat of damage to equipment, buildings and assets.

Responsibility:

The Environmental Safety/Security Officer will:

- Chair the Environmental Safety Committee Meetings;
- Participate in and oversee hazard surveillance and reporting of the findings to the Environmental Safety Committee, and will ensure that any problems identified are effectively corrected and reported to the Environmental Safety Committee;
- Participate in the Safety Education Orientation Program for new employees and continuing education for all employees, physicians and volunteers;
- Monitor, evaluate and oversee the Hazardous Materials and Hazardous Waste Management Program and Hazard Communication Program;
- Implement and enforce the physical Security Plan and Program, and report on Security Program actions and incident occurrence findings at least quarterly to the Environmental Safety Committee;

- Will assist in the development, implementation and continued assessment of the facility's Emergency Management Program and Emergency Operation Plan in conjunction with the Environmental Safety Committee;
- Will be responsible for the Life Safety Management Program, and report monthly fire drill and quarterly fire alarm system testing analysis to the Environmental Safety Committee;
- Will be responsible for reviewing Incident Reports in conjunction with Risk Management and Employee Health when applicable;
- Ensure that findings generated from the Environmental Safety Committee's Program activities are communicated at least quarterly to the Performance Improvement Council, Hospital Leadership, Medical Staff, CEO and the Board of Directors;
- Participate in the development of organization-wide Safety, Emergency Operations and Environment of Care policies and procedures, in addition to department specific safety policies and procedures; and
- Develop and provide annual evaluations of the effectiveness for all Environment of Care programs to the Environmental Safety Committee, CEO and the Board of Directors.

Donna Hefner
President/CEO

Chairman of the Board

SIERRA VIEW
MEDICAL CENTER

Appointment of Food and Dietetic Services Director
2023

In compliance with CMS A-0620, Section 482.28(a) (1), Zaelin Stringham is hereby appointed to the position of *Food and Dietetic Services Director* by the Board of Directors and President/CEO of Sierra View Local Health Care District dba Sierra View Medical Center for 2023.

Zaelin Stringham, MS, RD, is a full-time employee who has worked in the field of Food and Nutrition for eight plus years, Ms. Stringham holds a Master's Degree in Nutrition and Dietetics, is a Registered Dietetian, certified by the Commission on Dietetic Registration holds a national certification as a ServSafe Food Protection Manager, and ServSafe Instructor and Proctor. Ms. Stringham is granted the authority and delegated responsibility by the Sierra View Local Health Care District Board of Directors for the operation of the Food and Dietetic Services Department.

Authority:

The Food and Dietetic Services Director has the authority and responsibility for daily management of dietary services, implementing training programs for dietary staff and ensuring that established policies and procedures are maintained to address at least the following:

Responsibility:

The Director of Food & Nutrition Service will:

- Ensure appropriate safety practices for food handling;
- Ensure appropriate emergency food supplies;
- Ensure department orientation, work assignments, supervision of work and personnel performance;
- Ensure menu planning, purchasing of foods and supplies, and retention of essential records (e.g. cost, menus, personnel, training records, Quality Assurance/Performance Improvement – QA/PI Reports, etc.); and,
- Chair the Food and Nutrition Service Department QA/PI Program.

President/CEO	Date	Chairman of the Board	Date

SIERRA VIEW
MEDICAL CENTER

Appointment of Infection Control Officer
2023

In compliance with CMS A-0620, Section 482.42(a), Nancy Hurtado-Ziola, Ph.D. is hereby appointed to the position of *Infection Control Officer* by the Board of Directors and President/CEO of Sierra View Local Health Care District dba Sierra View Medical Center for 2021.

Qualifications:

Nancy Hurtado-Ziola, Ph.D., is a full-time employee who has been granted the authority and delegated responsibility by the Sierra View Local Health Care District, Board of Directors for the operation of the Infection Control Department.

Nancy earned her Doctoral Degree in Biomedical Science from UC San Diego School of Medicine, where she focused on aspects of the immune system in a biomedical research environment. Nancy completed her post-doctoral fellowship at UC San Diego. During her career she worked Children's Hospital Los Angeles, UCSD, and UCLA where she was part of the Epidemiologic Catchment Area Project. Nancy has a strong working knowledge of microbiology, epidemiology, infection disease, and aseptic techniques. Nancy is also part-time faculty for Central New Mexico Community College where she teaches biology, anatomy & physiology, and pathophysiology.

Responsibility:

The Infection Control Officer must:

- Develop and implement policies governing control of infections and communicable diseases;
- Develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel; and
- Maintain a log of incidents related to infections and communicable diseases.

President/CEO Date Chairman of the Board Date

SIERRA VIEW
MEDICAL CENTER

Appointment of Patient Safety Officer
2023

Melissa Mitchell, DHA, LCSW, CCM, CPHQ, Vice President of Quality and Regulatory Affairs has been appointed to the position of *Patient Safety Officer* by the Board of Directors and President/CEO of Sierra View Local Health Care District.

Qualifications:

Ms. Melissa Mitchell has over 17 years of experience in the healthcare field, in a variety of settings. Within that time she has experience working in the Emergency Room in a level 1 Trauma/Burn facility, substance abuse treatment, and mental health assessment and intervention. Ms. Mitchell is currently the VP of Quality and Regulatory Affairs and is the executive sponsor of the Beta Heart initiative – focused on reducing medical harm.

Authority:

The Patient Safety Officer, through the Patient Safety Committee, has the authority to intervene whenever conditions exist that pose a threat to patient safety.

Responsibility:

The Patient Safety Officer will:

- Integrate a patient safety program throughout the organization that provides oversight, ensures alignment of patient safety activities and provides opportunities for all individuals who work in the organization to be educated and participate in patient safety and quality initiatives;
- Serve as the primary point of contact for questions about patient safety and who coordinates patient safety for education and the deployment of system changes;
- Foster a just culture environment in which frontline personnel feel comfortable in disclosing errors, including their own, while maintaining professional accountability;
- Participate in and oversee the patient occurrence reporting function and ensure that identified patient safety issues are effectively corrected and reported to the Patient Safety Committee, MEC and Board of Directors;
- Co-Chair the interdisciplinary Patient Safety Committee Meetings whose focus is to create, implement and administer mechanisms to oversee root cause analysis of every appropriate incident;
- Provide feedback to frontline staff about lessons learned, disclose the organization's progress toward implementing safe practices and provide professional training and teamwork techniques;
- Assist in the development, implementation and continued assessment of the facility's Risk Management Plan and Patient Safety Plan; and
- Maintain compliance with reporting of Adverse Events to the appropriate external mandatory programs.

_____ _____ _____ _____

President/CEO Date Chairman of the Board Date

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SIERRA VIEW LOCAL HEALTH CARE DISTRICT

BOARD DIRECTOR ANNUAL SELF EVALUATION

Assessment	Exceeds Expectation	Meets Expectation	Below Expectation
Director has knowledge and understanding of the following:			
1. Mission & Goals	_____	_____	_____
2. District's Priorities	_____	_____	_____
3. District's Financial Status	_____	_____	_____
4. District's Quality of Care issues	_____	_____	_____
Director has been able to devote sufficient time to board responsibilities, including reviewing and analyzing board materials before each meeting	_____	_____	_____
Director regularly attends board meetings and actively participates	_____	_____	_____
Director has satisfactory working relationships with the board chair, other board members and CEO	_____	_____	_____

_____ _____

Director Date